No. _____

In The
Supreme Court of the United States

YOLANDA HAMILTON, Medical Doctor,

Petitioner,

v.

UNITED STATES OF AMERICA,

Respondent.

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

PETITION FOR WRIT OF CERTIORARI

KEVIN H. DUBOSE
ALEXANDER DUBOSE & JEFFERSON LLP
1844 Harvard Street
Houston, Texas 77008-4342
(713) 523-2358
kdubose@adjtlaw.com

MARCY HOGAN GREER
Counsel of Record
ANNA M. BAKER
ALEXANDER DUBOSE & JEFFERSON LLP
515 Congress Avenue, Suite 2350
Austin, Texas 78701-3562
(512) 482-9300
mgreer@adjtlaw.com
abaker@adjtlaw.com

Attorneys for Petitioner Yolanda Hamilton, M.D.

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COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

QUESTIONS PRESENTED

1. Medicare reimburses healthcare providers who provide home-health services to qualifying Medicare patients. Congress requires a physician to certify a patient for home-healthcare services based on a number of specific considerations that amount to a showing of medical necessity for the services. Can a physician be criminally liable for Medicare fraud when the Government fails to produce medical expert testimony and instead relies solely on lay testimony to establish the lack of medical necessity?

2. In a case without any showing or finding of pervasive fraud, is it permissible to increase the base-level punishment by extrapolating two claims presented at trial to thousands of Medicare claims without any proof that these additional claims were themselves fraudulent?

LIST OF PARTIES

Petitioner Yolanda Hamilton, M.D., was the Defendant-Appellant in the matters below.

Respondent the United States of America was the Plaintiff-Appellee in the matters below.

RELATED PROCEEDINGS

United States District Court (S.D. Tex.):

United States v. Yolanda Hamilton, M.D., No. 4:17-cr-00418 (Nov. 25, 2020).

United States Court of Appeals (5th Cir.):

United States v. Yolanda Hamilton, Medical Doctor, No. 20-20645 (June 15, 2022).

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Petitioner Yolanda Hamilton, M.D., respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 37 F.4th 246. Pet.

App. 1. The judgment of the United States District Court for the Southern District of Texas was entered on November 25, 2020. Pet. App. 34.

JURISDICTION

The judgment of the United States Court of Appeals for the Fifth Circuit was entered on June 15, 2022. Pet. App. 34. A petition for rehearing was denied on July 22, 2022. Pet. App. 47. This Court has jurisdiction under 28 U.S.C. § 1254.

STATUTORY AND REGULATORY PROVISIONS INVOLVED

42 U.S.C. § 1395n. Procedures for payment of claims of providers of services

> **(a) Conditions for payment for services described in section 1395k(a)(2) of this title**
>
> . . . [P]ayment for services described in section 1395k(a)(2) of this title furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc(a) of this title, and only if—
>
> * * *
>
> (2) a physician . . . certifies . . . that—
>
> (A) in the case of home health services (i) such services are or were required because the

individual is or was confined to his home (except when receiving items and services referred to in section 1395x(m)(7) of this title) and needs or needed skilled nursing care . . . on an intermittent basis . . .

* * *

For purposes of paragraph (2)(A), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker) or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home." Any other absence of an individual from the home shall

not so disqualify an individual if the absence is of infrequent or of relatively short duration.

* * *

42 U.S.C. § 1395f. Conditions of and limitations on payment for services

(a) Requirements of requests and certifications

Except as provided in subsections (d) and (g) and in section 1395mm of this title, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1395cc of this title and only if—

* * *

(2) a physician, . . . or, in the case of services described in subparagraph (C), a physician enrolled under section 1395cc(j) of this title, certifies . . . that—

* * *

(C) in the case of home health services, such services are or were required because the individual is or was confined to his home. . . .

For purposes of paragraph (2)(C), an individual shall be considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker) or

> if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home." Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration.
>
> * * *

42 C.F.R. § 424.22. Requirements for home health services

> Medicare Part A or Part B pays for home health services only if a physician or allowed practitioner as defined at § 484.2 of this chapter certifies and recertifies the content specified in paragraphs (a)(1) and (b)(2) of this section, as appropriate.

(a) Certification—

(1) Content of certification. As a condition for payment of home health services under Medicare Part A or Medicare Part B, a physician or allowed practitioner must certify the patient's eligibility for the home health benefit, as outlined in sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act, as follows in paragraphs (a)(1)(i) through (v) of this section.

* * *

INTRODUCTION

Dr. Yolanda Hamilton was convicted of fraudulently certifying Medicare patients for home healthcare. The government's theory was that Dr. Hamilton falsely certified patients for home healthcare and accepted "kickbacks" from home-health agencies in return.

There is no dispute that there was a very large home-healthcare conspiracy in Houston, Texas, that defrauded Medicare out of millions of dollars—with the Government paying for services never provided.[1]

[1] Gabrielle Banks, *Largest Medicare fraud takedown in history nabs 22 in Houston area* (June 22, 2016), https://www.houstonchronicle.com/news/houston-texas/houston/article/Largest-Medicare-fraud-takedown-in-history-nabs-8319743.php ("More than 300 people across the nation—including 22 in the Houston area—have been charged with stealing more than $900 million in what federal investigators say is the 'largest Medicare fraud takedown in history.' ").

Some of the home-health agency ("HHA") conspirators targeted Dr. Hamilton's practice.[2] There is also no question that several of Dr. Hamilton's patients and the home-health agencies that provided them with services were involved in a conspiracy to falsely obtain Medicare benefits. Some of those conspirators have pled guilty or been convicted. Those HHA conspirators admittedly paid patients to obtain certifications from Dr. Hamilton and falsified information on the Medicare forms they provided to Dr. Hamilton. The only question was whether Dr. Hamilton was a knowing participant in that conspiracy or an unwitting conduit.

Congress has directed that a ***physician*** must certify a Medicare patient for home-healthcare services by making a determination that "such services are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care on an intermittent basis."[3] In other words, to show that Dr. Hamilton's certifications were fraudulent, the Government had to demonstrate—beyond a reasonable doubt—that home healthcare was not medically necessary for the patients Dr. Hamilton certified.

Dr. Hamilton made certification decisions regarding home healthcare only after personally examining the patients, performing or obtaining necessary diagnostic testing, and reviewing the medical records she

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[2] *E.g.*, UNITED STATES DEPT. OF JUSTICE, *Texas Physician Sentenced for Multi-Million Medicare Fraud Scheme* (Nov. 18, 2020), https://www.justice.gov/opa/pr/texas-physician-sentenced-multi-million-medicare-fraud-scheme.

[3] 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2)(A).

was provided. The certifications at issue—made by a medical doctor after examining the patient, consulting test results, and reviewing patient medical records—are not matters within the lay experience of jurors. Questioning Dr. Hamilton's medical judgment about the services her patients needed required the expertise and experience of a physician. There are certainly Medicare-fraud cases where an expert is not required because the elemental fraud is within a lay juror's experience—like charging Medicare for motorized wheelchairs while only providing scooters, or signing certifications without even examining the patients. But to establish that Dr. Hamilton's certification decisions lacked "medical necessity," the Government was required to provide expert testimony about what was medically necessary.

The Government made no attempt to provide medical expert testimony. Instead, the Government relied exclusively on lay witnesses—patients, home-healthcare agencies, and Dr. Hamilton's non-physician employees—in its attempt to prove that her home-healthcare certifications lacked medical necessity. And the Government prevented Dr. Hamilton from calling her own medical expert.

As a consequence of the Government's strategy, the lay jury was left without ***any*** medical expert guidance; instead, it was impermissibly allowed to dispute Dr. Hamilton's professional decisions about the medical necessity of home healthcare that were based on her examination of the patients, their records, and her experience and professional judgment. Expert

testimony was required to establish that Dr. Hamilton's home-healthcare certifications were not medically justified, and the Government's strategic decision to ignore this fundamental and probative element of the alleged fraud should have been fatal to its convictions.

A fundamental error also occurred in sentencing. In separate proceedings, the Government obtained fraud convictions for two of Dr. Hamilton's patients. It then relied on only those two patients to claim that the fraud loss calculation for sentencing Dr. Hamilton should be based on ***all*** the patients Dr. Hamilton ever certified, despite the absence of evidence of fraud for ***any*** of the other certified patients. Even if the Government had proven fraud as to the two patients for whom it obtained convictions, it lacked a basis for extrapolating from those two cases to every patient whom Dr. Hamilton certified for home-health services. There was ample evidence that Dr. Hamilton legitimately certified patients for home healthcare, and the Government stipulated that at least some of those patients needed that care. Yet the Government's loss calculation extrapolated from these two patients to thousands of patient claims for which it had ***zero*** proof that the home-health services were medically unnecessary. The Fifth Circuit did not address this issue, much less explain its decision to uphold the Government's overreach.

STATEMENT

1. Factual History

a) Dr. Hamilton's Practice

Dr. Hamilton is a board-certified gastroenterologist. ROA.2942. After holding faculty teaching positions as an Assistant Professor of Medicine at the University of Texas M.D. Anderson Cancer Center and the University of Texas Health Science Center ("UT") for over ten years, a decline in her father's health prompted her to leave academia and commute to New York to assist with his care, which included services provided by home-health agencies. ROA.3572-74, 3577, 3583-87.

Returning to practice in Houston, Dr. Hamilton started a clinic in a low-income area, establishing a general family practice. ROA.3587-88. Her focus was on elderly and disabled patients, particularly underserved minority patients. She maintained a heavy patient population, worked long hours, and took time with each patient. ROA.2942, 2946. Her patients testified that Dr. Hamilton "was very professional. A good doctor" who "did everything she could to treat [her patient's] conditions." ROA.3303; *see also* ROA.3040 ("I feel like she went above and all helping herself [sic] with the conditions I had."). The only complaint about her care was that patients often waited for appointments because of the time she spent with each patient. ROA.2942.

Although Dr. Hamilton had extensive experience treating patients in hospitals, she had no experience

running a medical practice. ROA.3589. While she had treated Medicare patients at M.D. Anderson and UT, those facilities had large billing departments to handle compliance and billing matters. ROA.3574-75, 3579. Consequently, Dr. Hamilton hired an office manager and others who she believed had the requisite Medicare experience. ROA.3589-91.

b) Medicare

To qualify for home-healthcare services, a Medicare patient must have a physician certify that "home health services" "are or were required because the individual is or was confined to his home . . . and needs or needed skilled nursing care. . . ." 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2)(A). Medicare regulations further dictate that home-healthcare benefits will be paid "only if a physician certifies and recertifies" that:

> (i) The individual needs or needed intermittent skilled nursing care . . . ;
>
> (ii) Home health services were required because the individual was confined to the home except when receiving outpatient services;
>
> (iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine, osteopathy, or podiatric medicine . . . ;
>
> (iv) The services were furnished while the individual was under the care of a physician

> who is a doctor of medicine, osteopathy, or podiatric medicine;
>
> (v) The physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of home health care. . . .

42 C.F.R. § 424.22(a)(i)-(v). The certification decision is documented in a Medicare "Home Health Certification and Plan of Care" ("Form 485") that the physician signs and provides to the home-healthcare provider so that it can bill Medicare for its services under Medicare Part A. *See* Pet. App. 2-3.

The physician must make this home-healthcare determination based on a "face-to-face" examination of the patient, the patient's medical records, and an in-home assessment of the patient—called an Outcome and Assessment Information Set ("OASIS")—and Form 485 Plan of Care created by the home-healthcare provider who examines the patient in his or her home. ROA.2695-98, 2729.

Dr. Hamilton or her supervised nurse practitioners personally examined every patient that she certified for home healthcare and reviewed their records. ROA.3754-56.[4]

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[4] The statutes allow for a different medical professional to complete the face-to-face encounter in the patient's home in

b) The Home-Healthcare Conspiracy

Around 2011, federal and state agents began investigating healthcare fraud related to Medicare claims submitted for home-healthcare services in the Houston area. UNITED STATES DEPT. OF JUSTICE, Houston Strike Force Operations (Sept. 4, 2020), https://www.justice.gov/criminal-fraud/houston-strike-force-operations. These investigations revealed that local HHAs were paying individuals to recruit Medicare patients to go to physicians' offices to be evaluated for home-healthcare services. These HHAs and recruiters paid patients if they were approved for home-health services, which the HHAs would then purportedly provide. The HHAs often falsified information on the OASIS and Form 485 documents they submitted to the physicians for certification.

Several of these HHA representatives admitted that they paid "patients" to obtain home-health certifications from Dr. Hamilton. ROA.2958-59, 3068-69, 3220-21. None testified that Dr. Hamilton falsified any information to Medicare or agreed to defraud anyone. Instead, several of the home-health agency owners and some of her patients admitted that they had included false information on the forms they gave to Dr. Hamilton. ROA.2987-90, 3062-63, 3096-98, 3252-54. Yet, as a result of the FBI's investigation of these individuals, Dr. Hamilton's office was raided, and she was swept into the larger investigation and related prosecutions.

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connection with the certification. 42 U.S.C. §§ 1395f(a)(2)(C), 1395n(a)(2)(A).

2. Procedural History

a) Proceedings Before the District Court

The case against Dr. Hamilton originally was tried in May 2019. When the jury could not agree upon a verdict after extended deliberations, the court declared a mistrial. ROA.2501.

The retrial took place a few months later. Four HHA owners and one marketer testified, all but one of whom had pled guilty to Medicare-fraud crimes, were awaiting sentencing, and hoping for leniency. ROA.2954-55, 3063-64, 3216-18, 3321. The three HHA-conspiracy witnesses each testified that they paid recruiters to hire patients to visit Dr. Hamilton's office for the sole purpose of obtaining home-health certifications. ROA.2958-59, 3068-69, 3220-21. They also testified that the detailed OASIS assessment forms they provided to Dr. Hamilton contained false information and that they did not reveal the fabricated information to Dr. Hamilton because they wanted her to certify their patients. ROA.2987, 2989-90, 3062-63, 3096-98, 3252, 3254.

The three patients who formed the basis of Counts 3-5 of the indictment each testified to having been paid by recruiters to go to Dr. Hamilton's office to obtain home-healthcare certifications. ROA.3028-29, 3059-60, 3147-48, 3274-75. Each admitted that they signed forms certifying they needed home-healthcare, did not read the materials, and provided false information to Dr. Hamilton. ROA.3027-28, 3203-05, 3291-94; *see also* ROA.8372, 8572, 8588. They also signed detailed

patient-intake forms for Dr. Hamilton that described a number of serious health issues. ROA.3039, 7083-249, 3203-08, 7251-325, 7326-449. The jury acquitted Dr. Hamilton as to the substantive-fraud count based on one of these three patients and convicted her on the other two. ROA.725.

In the second trial, the Government also recalculated its "loss" allegedly attributable to Dr. Hamilton, using new gross billing amounts that were four times the $275,000 figure used in the indictment:[5]

Medicare Part B Claims for Home Health Patients
January 2012-August 2016
Yolanda Hamilton

Total Billed	Total Paid
$5,523,680.51	$1,002,622

ROA.6160.

The Government conceded that a number of Medicare claims that Dr. Hamilton submitted were not fraudulent. ROA.3789. But it included billings and payments for every Part B service she provided for every patient certified for home-health. ROA.3388. This number included procedures like cancer screenings, colonoscopies, and other services provided by Dr. Hamilton's practice that had nothing to do with home-health certification. ROA.3826.

[5] ROA.36.

The Government also attributed to Dr. Hamilton 100% of what the HHAs received from Medicare as a result of their billings:

Medicare Part A (Home Health Claims)
January 2012-August 2016
Yolanda Hamilton

Total Billed	Total Paid	# of Home Health Agencies	# of Claims
$14,295,886.74	$16,388,521.86	165	7,461

ROA.6161. Yet Dr. Hamilton did not receive a cent from these HHA billings. ROA.4118. Here too, the Government included thousands of patient claims for which it provided no evidence of fraudulent certification.

At sentencing, the Government again used the extrapolated loss data to assert an intended-loss amount calculation of $19,819,547.25 and asked for a 20-level increase in the base-level offense. ROA.6603, 6605.

Based on a total recommended offense level of 41, the Government sought 25 years of imprisonment and restitution of $19 million. ROA.6615. The district court was clearly troubled by the aggressiveness of this stance. Considering the evidence, the court remarked:

> Dr. Hamilton clearly is not a very real-organized person. She is not a financially astute person.

> Her practice was very badly conducted. But is she a guilty person?

ROA.4139-40. Nevertheless, the judge overruled all of Dr. Hamilton's objections to the Presentence Report, stating that he would make a variance in the restitution award to "take care of all of these objections." ROA.4074. Dr. Hamilton was sentenced to 60 months imprisonment and ordered to pay restitution of $9,500,000. Pet. App. 36a, 42a.

b) Proceedings Before the Fifth Circuit

Dr. Hamilton appealed the District Court's judgment to the United States Court of Appeals for the Fifth Circuit.

The Fifth Circuit held that: (i) the evidence was sufficient to support a finding that two of the patients presented by the Government at trial and certified for home healthcare were not actually "homebound," justifying the substantive fraud counts; and (ii) the District Court did not clearly err in including in Dr. Hamilton's loss calculation claims that the HHAs billed to Medicare Part A for home-healthcare services they provided to patients where Dr. Hamilton was the certifying physician. Pet. App. 12-18a, 25-31a.

REASONS FOR GRANTING THE WRIT

Certiorari is warranted because direction from this Court is critically needed to guide lower courts on

the proper standard for substantive fraud claims and the proper segregation of healthcare claims among fraud defendants.

(1) Expert testimony is required to rebut a medical doctor's certification that home-health services are medically necessary for a patient whom the doctor has physically examined and certified for such services.

The strategic decision to forego expert testimony on the medical necessity of Dr. Hamilton's certifications should have foreclosed the fraud claims. Medical necessity requires specialized knowledge—not the arguments of counsel and interpretations of lay witnesses. *E.g.*, FED. R. EVID. 701 (lay witnesses may not offer opinions "based on scientific, technical, or other specialized knowledge within the scope of Rule 702").

By requiring that only a physician can determine that home healthcare is medically necessary, the Medicare statute itself has made clear that the determination of medical necessity requires "scientific, technical, or other specialized knowledge." FED. R. EVID. 701, 702. At trial, the Government challenged Dr. Hamilton's "homebound" certifications for only three individual patients. Dr. Hamilton explained why she certified each of them for home healthcare, demonstrating that her certifications were based on:

- her years of medical training and experience;
- medical testing and diagnostic criteria;

- lengthy, detailed medical records, often from third parties, that included (in some cases, fraudulent) OASIS forms from home-healthcare providers detailing the severity of the patients' mobility and other restrictions; and
- her own observations of the patients from her examinations of them.

The Government countered this proof with lay witnesses—the patients, the HHA owners, and Dr. Hamilton's non-physician employees.

Without expert proof to rebut Dr. Hamilton's findings as a medical doctor and resulting certifications, the Government's healthcare fraud case is fatally deficient, and the convictions should have been set aside.

(2) Even if the Government established "fraud" as to the two patients it presented at trial, there was no basis for extrapolating from two patients to include all HHA Medicare Part A billings in the loss calculation.

The Government proved at most that home-healthcare services were not medically necessary for two of Dr. Hamilton's patients. It also stipulated that at least some of the patients that Dr. Hamilton certified as "confined to the home" actually needed home-healthcare services. ROA.3470-71, 3789. Without proof that these thousands of other patient claims the Government included in the loss calculation were also

fraudulent, the Government had no basis for any extrapolation.

The Government never urged that this case involved pervasive fraud that allows an "inference of fraud across the board" to establish that "all the claims were fraudulent." The court of appeals agreed: "The evidence of fraud here is less direct than in some of our previous cases." Pet. App. 15. Thus, the burden of proving the legitimate amounts billed never shifted to Dr. Hamilton.

The extrapolation from two patients to thousands of other patients resulted in millions of dollars in added loss calculations. That loss-calculation extrapolation is fatally defective and sets a dangerous precedent.

I. The Fifth Circuit Erred in Concluding That Lay Witnesses Could Establish a Lack of Medical Necessity for Home-Healthcare Services.

To establish healthcare fraud, the Government had to prove that Dr. Hamilton "falsely" certified patients as homebound for home healthcare. *See United States v. Hunter*, 628 Fed. App'x 904, 905 (5th Cir. 2015) (per curiam) (delineating elements of conspiracy to commit healthcare fraud and conspiracy to pay and receive kickbacks). In Medicare parlance, that means it had to demonstrate—beyond a reasonable doubt—that her certifications lacked medical necessity. The

Government not only failed to do so, it skirted the issue entirely.

Expert testimony is not always required to establish lack of medical necessity in Medicare fraud cases, but this is not a case where the lack of expert proof could be excused. There is no "smoking gun" proof of fraud that is easily understood by lay jurors—like substituting scooters for motorized wheelchairs, signing authorizations in blank, or billing for tests or procedures never provided.

Nor is this a case in which a physician certified patients as "homebound" without ever seeing or examining them. *See*, *e.g.*, *United States v. Njoku*, 737 F.3d 55, 62 (5th Cir. 2013) ("physician was paid to authorize plans of care despite not having examined the patients"); *United States v. Sanjar*, 876 F.3d 725, 745 (5th Cir. 2017) (physician "did not meet any of the patients in arriving at a diagnosis"); *United States v. Ramirez*, 979 F.3d 276, 278 (5th Cir. 2020) (physician certified patients "without *meeting* the patients, much less evaluating them") (emphasis in original); *United States v. Dailey*, 868 F.3d 322, 330 (5th Cir. 2017) (no evidence that physician "had any type of relationship" with certified patients; patients testified they had "no knowledge of [physician] and had never been his patient"); *see also* Pet. App. 15.

And this is not a case in which any witnesses testified with direct knowledge that the defendant physician "had agreed to certify patients fraudulently or that [the defendant physician] was aware the patients

were not homebound, unlike in many healthcare fraud cases." Pet. App. 15; *see also United States v. Eghobor*, 812 F.3d 352, 362 (5th Cir. 2015) ("The government's primary witness . . . testified that Eghobor admitted patients into PTM by falsifying OASIS forms and Plans of Care."); *Njoku*, 737 F.3d at 63 ("[A co-conspirator] admitted to falsifying forms submitted to Medicare and said that other people she worked with, including Njoku, participated."); *United States v. Mesquias*, 29 F.4th 276, 280 (5th Cir. 2022) (co-conspirator medical directors "testified that the certifications for all six patients were either outright lies or based on fabricated medical records," which was alone sufficient to support conviction).

In stark contrast, Dr. Hamilton or her supervised nurse practitioners personally evaluated each patient that she certified and made tailored decisions for their care and treatment based on that evaluation and patient records. There is no allegation she paid any patients, and she did not prepare—but rather was given—falsified medical charts designed to convince her that the services were medically necessary. She did not sign blank forms, shred documents, or bill for tests that were irrelevant to her patients' health conditions or that were never performed. She accurately reported and receipted every payment she received. Consequently, the jury's decision turned entirely on whether it believed that Dr. Hamilton's medical-necessity determinations were medically sound. And the only testimony supporting the jury's findings was the testimony of lay witnesses who disagreed with Dr. Hamilton's

professional decisions about the medical necessity of home healthcare.

When a medical doctor certifies a patient for home healthcare after observing and examining the patient and the patient's medical records, that doctor's medical opinion and judgment regarding whether the patient is "confined to the home" should be accorded the medical respect recognized by the governing statutes. Where—as here—the ***statute requires*** a "physician" to certify a patient as "confined to the home" and a physician does so after examining the patient and related records, the Government should be required to provide expert testimony of equal fortitude to contradict the certification.

It would not be unusual or an undue burden to require the Government to provide expert testimony. Federal courts regularly consider expert testimony regarding what it means to be "homebound" and whether specific patients meet that definition. *See*, *e.g.*, *United States v. Barnes*, 979 F.3d 283, 306-09 (5th Cir. 2020) (medical expert could testify whether a patient needed home healthcare but could not testify whether patient qualified for home healthcare under Medicare regulations when he was not qualified as expert in regulations or questioned about regulations); *United States v. Gonzalez*, 566 Fed. App'x 898, 902 (11th Cir. 2014) (per curiam) (government provided expert testimony regarding qualifications for being "homebound" under Medicare regulations); *United States v. Terrero*, 571 Fed. App'x 778, 780-81 (11th Cir. 2014) (allowing expert testimony regarding whether patient was

"homebound" under the Medicare statute); *United States v. Okoroji*, No. 3:15-cr-00559-O, 2018 WL 8756434, at *3 (N.D. Tex. June 12, 2018) (permitting expert testimony regarding definition of "homebound" when defendant did not show that witness would use incorrect standard); *Munsen v. Wellmark, Inc.*, 257 F. Supp. 2d 1172, 1197 n.6 (N.D. Iowa 2003) (noting expert's definition of "homebound"—as unable to leave the home at all or for any period of time—was inconsistent with applicable definition); *United States v. Cholak*, No. 16-20048, 2017 WL 11408492, at *3 (E.D. Mich. June 6, 2017) (noting the testimony of a Medicare expert in the "overwhelming" evidence of defendant's guilt, including testimony that defendant requested home health prescriptions for patients who did not need or receive the services).

Here, the Government presented a witness who had relevant expertise in reviewing patient files to determine whether the documentation supported a finding of medical necessity. This witness admitted she could have conducted an audit of Dr. Hamilton's files. But the Government did not ask her to review any patient files for medical necessity. Nor did it offer an audit of Dr. Hamilton's patient files, much less a physician to counter her certification decisions. By not offering its own expert on medical necessity, the Government precluded defense counsel from eliciting favorable testimony on cross-examination. To top it off, the Government also convinced the district judge to exclude Dr. Hamilton's own medical expert. Consequently, this jury had no expert guidance at all in

deciding whether Dr. Hamilton's treatment decisions—based on personal observations accompanied by review of patient records—were medically necessary. The Fifth Circuit should have vacated Dr. Hamilton's convictions for healthcare fraud.

II. The Fifth Circuit Should Not Have Sanctioned a Loss Calculation That Impermissibly Extrapolated Thousands of Claims From Two Patients.

The indictment alleged that Dr. Hamilton was paid $274,540.17 by Medicare for Part B claims falsely certifying patients for home-healthcare services. ROA.36. The jury found that the Government proved two counts of Medicare fraud based on the testimony of two of Dr. Hamilton's patients and failed to prove fraud for a third patient. ROA.725. However, at sentencing the Government attributed to Dr. Hamilton a loss calculation of over $16 million for Medicare Part A claims that were billed and collected by the HHAs—and for which Dr. Hamilton did not receive ***any*** compensation.[6]

The Government stipulated that at least some of Dr. Hamilton's home-healthcare certifications were not fraudulent. But its loss calculation included the

[6] Although the Government's "kick-back" claims were based on an alternative legal theory, they do not independently support extrapolation of the loss calculation to include all claims billed by the HHAs because the Government did not prove that the $60 fee was a kickback for each of her HHA certifications—as opposed to a co-pay for services Dr. Hamilton provided in the office visit.

HHA billings for ***every*** patient Dr. Hamilton certified for home health care, despite its stipulation that at least some of those patients needed home-healthcare.

These numbers were calculated by the Government's "certified fraud examiner" to include all of the HHAs' billings for any patient Dr. Hamilton certified for home healthcare. But the Government made a strategic decision not to audit Dr. Hamilton's patient files to prove a lack of medical necessity, instead relying solely on the three patients presented as witnesses—and Dr. Hamilton was acquitted for one of those three patients.

Thus, the Government was effectively permitted to extrapolate from the experiences of ***two*** patients to almost ***7,500*** claims billed by and paid to the HHAs. The Government never attempted to prove that any of these other Form 485 certifications were for "medically unnecessary [services] or otherwise out of compliance with Medicare regulations." Pet. App. 31. Because it never substantiated fraud in Dr. Hamilton's other certifications, the Government failed to carry its burden of establishing that these payments should be included in the loss calculation. *See United States v. Jones*, 475 F.3d 701, 707 (5th Cir. 2007) (finding "government failed to meet its burden of proof to establish the amount of loss suffered by Medicare as a result of [defendants'] criminal behavior").

Fifth Circuit cases have sanctioned an analogous extrapolation exercise—shifting the burden of proof to the defendant to segregate between legitimate and

fraudulent claims—when there is an "inference of fraud across the board" to establish that "all the claims were fraudulent." *See United States v. Martinez*, 921 F.3d 452, 473 (5th Cir. 2019); *accord United States v. Hebron*, 684 F.3d 554, 563 (5th Cir. 2012) (Where the fraud is so pervasive that separating legitimate from fraudulent conduct "is not reasonably practical, the burden shifts to the defendant to make a showing that particular amounts are legitimate."). The District Court never made that finding. Nor could the Government do so in light of its stipulation that not all of Dr. Hamilton's home-healthcare certifications were fraudulent. Thus, there is no basis for presuming that all of the claims were fraudulent. *See also* Pet. App. 15 ("The evidence of fraud here is less direct than in some of our previous cases."). Without evidence of fraud in any of the thousands of other patient files, the Government never proved "pervasive" fraud, which would have been necessary to shift the burden to Dr. Hamilton to show otherwise.

Though not her burden to disprove any basis for this extrapolation, Dr. Hamilton presented a patient witness who testified without contradiction that she needed the home-healthcare services Dr. Hamilton certified.[7] This evidence, coupled with the Government's stipulation that Dr. Hamilton provided medically-necessary certifications, is proof that ***not all*** of Dr.

[7] Dr. Hamilton attempted to present several more patient witnesses who came to the courthouse, but the District Court only permitted the one to testify because the Government stipulated that not all of her patients were not homebound. ROA.3470-75.

Hamilton's certifications could be considered "relevant conduct" sufficient to add to the loss calculation. *See United States v. Bernegger*, 661 F.3d 232, 242 (5th Cir. 2011) (citations omitted) (For "acts to constitute relevant conduct the conduct must be criminal." Thus, "[b]efore a court may attribute losses to a defendant's fraudulent conduct, there must be some factual basis for the conclusion that th[o]se losses were the result of fraud." (citation and internal quotation marks omitted)).

What ***is*** in the record refutes any suggestion that these thousands of claims should be included in the loss calculation. No state or federal regulator has questioned the medical necessity of Dr. Hamilton's treatment, certifications, or associated billings. ROA.3607-08, 3748, 3781-82. Dr. Hamilton was never told by Medicare that her assessments were insufficient or that her charges constituted overpayment. ROA.3781-82. The only audit conducted on another aspect of her practice ***confirmed*** the medical necessity of her billings. ROA.3518-21, 3529, 3534, 6943-55. No burden shifting could properly have occurred here, because the Government conceded that some of Dr. Hamilton's certifications were medically necessary, and neither the Government, nor the District Court, nor the Court of Appeals, considered this a pervasive fraud case. Therefore, the Government was required to prove the basis for the extrapolation, and it failed to do so.

The Government's failure to prove a lack of medical necessity for any of Dr. Hamilton's certifications, *see* part I, *supra*, means that it cannot attribute any of the

HHA's Part A billings to this loss. In fact, any billings for patients properly certified by Dr. Hamilton should ***reduce*** the amount of the loss calculation. *See*, *e.g.*, *United States v. Mahmood*, 820 F.3d 177, 192 (5th Cir. 2016) (loss improperly calculated when the defendant met his burden to show that the hospital rendered legitimate services that Medicare would have paid for); *cf. United States v. Dehaan*, 896 F.3d 798, 808 (7th Cir. 2018) (refusing to reduce loss amount by value of services provided to patients fraudulently certified as homebound even if patients were in fact homebound when physician conceded he certified patients as homebound when they were not and admitted to fraudulent certifications).

The Fifth Circuit should not have permitted the Government to extrapolate from the certifications of three patients—one of whom the jury found not to be fraudulent—to the HHA Part A billings for every patient that she certified.[8]

[8] The Fifth Circuit suggests that this was "harmless error" because the 60-month sentence would have been "well below the Guidelines range even if the loss amount had excluded *all* of the Medicare Part A claims." Pet. App. 32-33 (emphasis in original). But that conclusion is not warranted on this record. By eliminating a 20-point increase for the $16 million received by the HHAs, the district court would have had the opportunity to order probation and a much smaller amount of restitution, if any.

CONCLUSION

For the reasons stated above, this Court should grant the petition.

Respectfully submitted,

MARCY HOGAN GREER
Counsel of Record
ANNA M. BAKER
ALEXANDER DUBOSE & JEFFERSON LLP
515 Congress Avenue, Suite 2350
Austin, Texas 78701-3562
(512) 482-9300
mgreer@adjtlaw.com
abaker@adjtlaw.com

KEVIN H. DUBOSE
ALEXANDER DUBOSE & JEFFERSON LLP
1844 Harvard Street
Houston, Texas 77008-4342
(713) 523-2358
kdubose@adjtlaw.com

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