No. _____

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA & STATE OF INDIANA,
EX REL. CATHY OWSLEY,

Petitioner,

v.

FAZZI ASSOCIATES, INC., CARE CONNECTION OF CINCINNATI, LLC, GEM CITY HOME CARE, ASCENSION HOME CARE, AND ENVISION HEALTHCARE HOLDINGS, INC.

Respondents.

On Petition for a Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

PETITION FOR A WRIT OF CERTIORARI

Warner Mendenhall
THE LAW OFFICES OF WARNER MENDENHALL
190 North Union Street
Suite 201
Akron, OH 44304

Tejinder Singh
Counsel of Record
GOLDSTEIN & RUSSELL, P.C.
7475 Wisconsin Ave.
Suite 850
Bethesda, MD 20814
(202) 362-0636
tsingh@goldsteinrussell.com

Counsel for Petitioner

QUESTION PRESENTED

The question presented here is the same as the question presented in No. 21-462, *Johnson v. Bethany Hospice & Palliative Care, LLC*, and is the subject of an acknowledged multi-way circuit conflict:

Whether Federal Rule of Civil Procedure 9(b) requires plaintiffs in False Claims Act cases who plead a fraudulent scheme with particularity to also plead specific details of false claims.

PARTIES TO THE PROCEEDING

The parties to this proceeding are listed in the caption.

RELATED PROCEEDINGS

United States ex rel. Owsley v. Fazzi Associates, Inc., No. 1:15-cv-511 (S.D. Ohio Nov. 18, 2019)

United States ex rel. Owsley v. Fazzi Associates, Inc., No. 19-4240 (6th Cir. Oct. 13, 2021)

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The Sixth Circuit's precedential opinion (Pet. App. 1a-9a) is published at 16 F.4th 192. The district court's opinion (Pet. App. 10a-33a) is not in the *Federal Supplement* but is available at 2019 WL 6117299.

JURISDICTION

The Sixth Circuit entered judgment on October 13, 2021. Pet. App. 1a. This Court has jurisdiction under 28 U.S.C. § 1254.

RULES AND STATUTORY PROVISIONS

The relevant rule and statutory provisions are reproduced in the appendix at Pet. App. 67a-69a.

STATEMENT OF THE CASE

I. Legal Background

1. The False Claims Act (FCA) imposes civil liability on any person who knowingly presents, or causes to be presented, a false or fraudulent claim to the Government, or who makes or uses a false record or statement material to such a claim. 31 U.S.C. § 3729(a). The FCA is designed "to reach all types of fraud, without qualification, that might result in financial loss to the Government." *Cook County v. United States ex rel. Chandler*, 538 U.S. 119, 129 (2003) (quotation marks omitted).

The FCA's most common application is redressing health care fraud. In 2020, over 80% of FCA recoveries (over $1.8 billion) related to health care. U.S. Dep't of Justice, *Justice Department Recovers over $2.2 Billion from False Claims Act Cases in Fiscal Year 2020* (Jan. 14, 2021), https://www.justice.gov/opa/pr/justice-department-recovers-over-22-billion-false-claims-act-cases-fiscal-

year-2020. That percentage echoes numbers from previous years.

The FCA allows private citizens, known as *qui tam* relators, to sue for the Government, and keep a share of the recovery if successful. *See* 31 U.S.C. § 3730(b), (d). The *qui tam* provisions seek to "encourage any individual knowing of Government fraud to bring that information forward." S. Rep. No. 99-345, at 2 (1986). Since 1986, over 13,957 *qui tam* cases have been filed (over 600 each year since 2011), resulting in recoveries exceeding $46.5 billion. U.S. Dep't of Justice, *Fraud Statistics – Overview, October 1, 1986 – September 30, 2020*, at 3 (2021), https://www.justice.gov/opa/press-release/file/1354316/download.

2. This case involves alleged fraud regarding Government payments for home health services. Such services are coordinated through home health agencies, which arrange for the Government's homebound beneficiaries to receive extra care in their home. The Government pays for these services principally through Medicare, and also through Medicaid and other insurance programs.

The first step to billing the Government for home care is that a physician must approve a "plan of care" for the beneficiary. The plan of care identifies the beneficiary's needs, the reasonable and necessary services to address those needs, and the expected therapeutic outcomes. Frequently, a home health agency's staff (*e.g.*, nurses) will design the plan of care, and a physician will review the patient's documentation and approve the plan. *See* Pet. App. 46a.

The Government pays the agency for these services using a "prospective payments system." Pet. App.

2a (citation omitted). At the start of each "episode of care," which is a period not to exceed 60 days, the home health agency makes a "request for anticipated payment," or RAP, which the Government pays; at the end of the episode, the Government makes a residual final payment. *Id*. at 2a-3a.

The amount the Government pays "depends in large part on the patient's condition: the more care the patient needs, the larger the Medicare payments." Pet. App. 3a. To determine how much to pay for each beneficiary, the Government requires home health agencies to collect data called the Outcome and Assessment Information Set (OASIS). *Ibid.* OASIS data records each beneficiary's medical condition, physical capabilities, and expected therapeutic needs. It must be collected by a clinician (usually a registered nurse). And it must be collected periodically, beginning at the start of care, regularly at the end of episodes of care, and in conjunction with certain important events (*e.g.*, transfer or discharge). *Ibid.* The data on OASIS forms "must accurately reflect the patient's status at the time of assessment." 42 C.F.R. § 484.45(b). The data is translated into codes the Government uses to score the patient's condition, and thus determine payment amounts. Pet. App. 3a. The OASIS assessment is also used to create plans of care and RAPs, which are essential prerequisites to reimbursement. *Id*. at 3a-4a.

Under this payment scheme, home health agencies have an incentive to exaggerate beneficiaries' health problems. These exaggerations increase reimbursement without increasing the cost of care, padding agency profits. Unscrupulous providers go further, manufacturing fake illnesses to make the beneficiary population seem sicker than it is, or even

falsifying the prerequisites to home health care eligibility (*e.g.*, whether the patient is homebound).

II. Factual Background and Procedural History

1. Petitioner brought a *qui tam* action alleging that respondents presented (or caused to be presented) false or fraudulent claims for payment, made or used false records and statements material to those claims, and conspired to violate the FCA in violation of 31 U.S.C. § 3729. Specifically, petitioner alleges that respondents systematically and fraudulently altered OASIS data to make the beneficiary population of their home health agencies appear sicker than it actually was, thus increasing the amount the Government paid for care. Pet. App. 4a-5a, 48a.[1]

Petitioner's complaint explains that she is a registered nurse for over 40 years, with over 17 years of home health care experience. Pet. App. 36a. Starting in 2006, she worked as a Quality Assurance Nurse for respondent Care Connection of Cincinnati (CCC), a home health agency in Ohio. *Ibid*. There, petitioner reviewed patient assessment forms and completed plans of care for home health care beneficiaries. *Ibid*. CCC has a normal census of 1500 patients, over 60% of whom are insured by government health care plans, *e.g.*, Medicare. *Id*. at 37a.

CCC's parent company is respondent Evolution Health Care. Pet. App. 37a. Starting in 2014, Evolution Health has been in a joint venture with respondent Ascension Health to provide home health care

[1] This petition includes citations to petitioner's amended complaint (Pet. App. 34a-66a), included to illustrate the particularity with which petitioner alleged fraud.

services. *Id*. at 37a-38a. This joint venture outsources its medical coding to respondent Fazzi Associates, Inc., which holds itself out as the largest outsource coding service in the country. *Ibid*.

Starting in 2015, petitioner personally observed respondents manipulate OASIS data to make beneficiaries appear sicker than they were. Specifically, Fazzi, which has no direct contact with patients (and therefore is not conducting the OASIS assessments) was altering OASIS data by enhancing existing diagnosis codes and adding new codes not supported by medical documentation. Pet. App. 48a. Respondents CCC and Evolution Health used that altered data to complete plans of care and requests for payment, causing the Government to overpay for home health care. *Ibid.*

The complaint provides numerous representative examples of falsified records from 2015. For example, a registered nurse determined that a patient had a simple leg wound; Fazzi altered the diagnoses to include uncontrolled diabetes, hypertension, diabetic neuropathy, and morbid obesity—even though no medical documentation supported these diagnoses. Pet. App. 48a-49a. A Medicare Advantage patient with a leg ulcer was falsely diagnosed with malignant cancer of the larynx. *Ibid*. A Medicare patient who could walk and inject her own medicine was falsely described as non-ambulatory and unable to self-inject. *Ibid.* A Medicare patient who used a walker was falsely diagnosed as a paraplegic. *Ibid*. And the diagnosis of a Medicaid patient with a skin lesion was fraudulently upcoded to inability to walk and diabetes. *Id*. at 49a-50a. To comply with patient health privacy

laws, the complaint does not identify these patients by name. *Id*. at 49a n.2.

The complaint also provides examples from subsequent years. Registered nurse Rebecca Gumm assessed a patient on October 8, 2016, noting that the patient bathed independently and could walk unassisted. Pet. App. 54a-55a. Fazzi changed the answers to state the patient required intermittent assistance to bathe and needed supervision or assistance to walk. *Id*. at 55a. These changes materially altered the patient's health score.

The misconduct was not limited to Fazzi. Beginning in March 2015, CCC trained its workers how to falsify OASIS data during the initial assessments. Pet. App. 50a. For example, it instructed nurses to always say patients could not walk unassisted, even when they could. *Ibid*. These instructions brought CCC's intake procedures into line with Fazzi's fraudulent coding. *Ibid*.

The complaint details the alleged upcoding and petitioner's efforts to resolve the issues internally. Thus, it names supervisory employees petitioner contacted to discuss Fazzi's upcoding[2] and nurses who complained Fazzi altered codes to misrepresent patients' health conditions.[3] It provides dates of trainings and meetings in which the issues were discussed,

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[2] These included CCC supervisors Beverly Naber and Tamela Kuntzman, and Evolution Health's vice president Robert James and director of regional operations Sherry Flannery. Pet. App. 50a-51a, 55a-56a.

[3] The nurses were Bobbie Mechley, Rebecca Gumm, Carol Dieckman, Chasity Cundiff, Jenny Coy, and Debra Caylor. Pet. App. 53a-57a.

Pet. App. 51a, 53a, 55a-56a, 58a, and it details the reactions petitioner received, including being told by supervisors that "It is what it is," and that petitioner could "leave and get another job" if she was uncomfortable with Fazzi's coding decisions. *Id*. at 51a, 55a.

Petitioner alleged these fraudulent alterations to the OASIS data caused the Government to pay more for home health care. Specifically, petitioner was the "last set of eyes" reviewing plans of care before they were used to prepare RAPs. Pet. App. 47a. Thus, she saw fraudulent data immediately before that data was used by others to generate inflated claims for payment. *Ibid*.

Finally, petitioner learned through conversations with supervisors and review of documentation that other Evolution Health home health agencies were also using Fazzi for their coding, leading petitioner to believe and allege that similar upcoding was occurring across Evolution Health's entire system. Pet. App. 59a-60a.

2. The district court dismissed petitioner's complaint for failure to plead fraud with particularity under Federal Rule of Civil Procedure 9(b). The court held that under circuit precedent, a relator alleging a far-reaching fraudulent scheme "must provide a representative sample of false claims submitted to the government in order for her complaint to proceed to discovery." Pet. App. 23a. The court recognized that petitioner's complaint provided "details related to the alleged upcoding scheme," but concluded this information was insufficient because it "relate[d] to potential internal fraudulent conduct," and not to "the submission of a false claim for payment." *Id*. at 27a.

The district court held that this analysis foreclosed petitioner's claims for presenting or causing others to present false claims, Pet. App. 21a-27a, making or using false statements or records material to false claims, *id*. at 27a-29a, keeping overpayments, *id*. at 29a-30a, conspiring to violate the FCA, *id*. at 30a-31a, and violating state law, *id*. at 31a. The court also denied leave to amend. *Id*. at 31a-32a.

3. The Sixth Circuit affirmed. The court of appeals recognized that petitioner "alleged in considerable detail that she observed, firsthand, documents showing that her employer had used fraudulent data from Fazzi Associates, Inc. to submit inflated claims for payment to the federal and Indiana state governments." Pet. App. 2a. But the court nevertheless concluded that petitioner did not provide sufficient detail to allow respondents "to identify any specific claims—of the hundreds or likely thousands they presumably submitted—that she thinks were fraudulent. For that reason alone, her complaint fell short of the requirements of Civil Rule 9(b)." *Ibid*.

The Sixth Circuit described its legal rule as follows:

> [O]ur circuit has imposed a "clear and unequivocal requirement that a relator allege specific false claims when pleading a violation of" the Act. [*United States ex rel. Sheldon v. Kettering Health Network*, 816 F.3d 399, 411 (6th Cir. 2016)] (cleaned up). Thus, under Rule 9(b), "[t]he identification of at least one false claim with specificity is an indispensable element of a complaint that alleges a False Claims Act violation." *United States ex rel. Hirt v. Walgreen Co.*, 846 F.3d 879, 881 (6th

> Cir. 2017) (cleaned up). Rule 9(b) therefore "does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply that claims requesting illegal payments must have been submitted." *Sanderson v. HCA-The Healthcare Co.*, 447 F.3d 873, 877 (6th Cir. 2006) (cleaned up).

Pet. App. 6a.

Applying that rule, the Sixth Circuit concluded that even though petitioner's "allegations describe, in detail, a fraudulent scheme," they fail because they do not "identify a representative claim that was actually submitted to the government for payment," nor "otherwise allege facts—based on personal knowledge of billing practices—supporting a strong inference that *particular identified claims* were submitted to the government for payment." Pet. App. 6a-7a (quotation marks omitted).

Petitioner argued, and the Sixth Circuit accepted, that she has "personal knowledge of billing practices employed in the fraudulent scheme—namely, her knowledge of the OASIS codes that she says Fazzi fraudulently changed." Pet. App. 7a. But that knowledge was insufficient, the court held, because petitioner "did not allege facts that identify any specific fraudulent claims." *Ibid*. It was not enough to describe "upcod[ing]," even regarding patients on "Medicare," "Medicaid," or "Medicare Advantage" (*id.* at 8a); instead, the information needed to be specific enough to enable respondents "to pluck out—from all the other claims they submitted—the" ones petitioner alleged were false. *Id*. at 9a. The court also affirmed the dismissal of the claims against the respondents where petitioner did not work because petitioner had no

personal billing-related knowledge about them. *Ibid*. Finally, the Sixth Circuit concluded that the district court properly denied leave to amend. *Ibid*.

4. This petition followed.

REASONS FOR GRANTING THE WRIT

I. The Circuits Are Split Over What Rule 9(b) Requires in False Claims Act Cases

Certiorari should be granted to resolve a longstanding circuit split about how Rule 9(b) works in FCA cases.

The Sixth Circuit is one of five that adopt a more rigid approach to Rule 9(b), requiring relators to plead details of false claims in addition to details of fraudulent schemes. Seven circuits adopt a more flexible approach that allows the presentment of claims to be inferred from circumstances (including from a fraudulent scheme), and does not require details of claims.

This split "has resulted in different outcomes depending on where the suit is brought as to whether the case is allowed to proceed." Tricia L. Forte, *Resolving the Circuit Split: Pleading Healthcare Fraud with Particularity*, 25 Roger Williams U. L. Rev. 16, 17 (2020). Indeed, "[w]histleblowers and contractors have struggled for more than a decade with inconsistent standards across the country for bringing forward fraud allegations." *See* Jennifer Doherty, *Attys Hope for Clarity with Justices' Interest in Fraud Claims*, Law360 (Oct. 15, 2021), https://www.law360.com/articles/1426789/attys-hope-for-clarity-with-justices-interest-in-fraud-claims. And because this "Court has declined to address this issue and because there is no single test that courts can use to decide whether a complaint is

sufficient, courts have come to widely disparate decisions." Sara A. Smoter, Note, *Relaxing Rule 9(b): Why False Claims Act Relators Should Be Held to a Flexible Pleading Standard*, 66 Case W. Res. L. Rev. 235, 237 (2015); *see also* Brianna Bloodgood, *Particularity Discovery in Qui Tam Actions: A Middle Ground Approach to Pleading Fraud in the Health Care Sector*, 165 U. Pa. L. Rev. 1435, 1442 (2017) ("[T]he Supreme Court has yet to grant certiorari to resolve the circuit split.").

1. Seven circuits hold that specific details of false claims are not required, and that the existence of false claims can be inferred from circumstances, including from the existence of a scheme that naturally would lead to the submission of false claims.

The Seventh Circuit recognizes that "much knowledge is inferential," and permits complaints to proceed if the allegation that false claims were submitted is a "plausible" inference from the scheme alleged. *United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 854 (7th Cir. 2009). Thus, in *Lusby*, an employee who alleged a fraudulent scheme to provide noncompliant products to the Government, but had never seen the defendant's actual bills and certifications of compliance, could proceed because it was reasonable to infer the defendant had certified its compliance when it sought payment. *See ibid*.

In subsequent cases, the Seventh Circuit has confirmed that "a plaintiff does not need to present, or even include allegations about, a specific document or bill that the defendants submitted to the Government." *United States ex rel. Presser v. Acacia Mental Health Clinic, LLC*, 836 F.3d 770, 777 (7th Cir. 2016) (citing *Lusby*, 570 F.3d at 853-54, and *Leveski v. ITT*

Educ. Servs., Inc., 719 F.3d 818, 839 (7th Cir. 2013)). Instead, when the defendant receives money from the Government, while violating conditions for payment, a court may infer the submission of false claims from the juxtaposition of those two facts.

Most recently, the Seventh Circuit reaffirmed that a relator can satisfy Rule 9(b) if his allegations "plausibly support[] the inference that [the defendant] included false information" in its communications with the Government, even if the allegations only provide "circumstantial evidence" of an FCA violation. *United States ex rel. Prose v. Molina Healthcare of Ill., Inc.*, 17 F.4th 732, 471 (7th Cir. 2021). That case, like this one, involved fraud in connection with a prospective payment regime (Medicaid managed care), and the relator—who was an outsider to the defendant company—had no firsthand knowledge of claims submitted to the Government.

The Fifth Circuit applies the same flexible rule. For example, in *United States ex rel. Colquitt v. Abbott Laboratories*, 858 F.3d 365, 371 (5th Cir. 2017), the court of appeals considered a case involving alleged kickbacks between a stent manufacturer and the hospitals and physicians that used the stents. The district court held that although the relator "had identified some specific hospitals and doctors that allegedly received kickbacks, he did not plead that any of these hospitals or doctors signed up to be Medicare providers or submitted certified claims for reimbursement for procedures using Abbott's stents." *Ibid*. The Fifth Circuit determined that this was "too rigid an application of Rule 9(b)," which is "context specific and flexible and must remain so to achieve the remedial purpose of the False Claims Act." *Id*. at 372 (quoting *United States ex*

rel. Grubbs v. Kanneganti, 565 F.3d 180, 190 (5th Cir. 2009)). The Fifth Circuit held that instead of requiring "the details of an actually submitted false claim," it was enough to allege "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *Ibid*. (quoting *Grubbs*, 565 F.3d at 190).

Applying this rule, the Fifth Circuit determined that the relator's allegations permitted "[a] strong inference that the named hospitals submitted claims to Medicare" because "[n]early every hospital in America participates in Medicare and would most likely have billed Medicare had they performed procedures using Abbott's stents on a person over age 65," a practice the complaint alleged was "common." *Colquitt*, 858 F.3d at 372. Given the nature of the scheme, probability and circumstantial evidence were enough to infer the existence of claims for payment.[4]

In *Grubbs*, the case quoted in *Colquitt*, the Fifth Circuit explained that emphasis on details of claims is misplaced because "[s]tating 'with particularity the circumstances constituting fraud' does not necessarily and always mean stating the contents of a bill. The particular circumstances constituting the fraudulent presentment are often harbored in the scheme," and not the bills themselves. 565 F.3d at 190. Thus, when "the logical conclusion of the particular allegations" in

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[4] The relator's claim in *Colquitt* failed for the independent reason that he did not allege the underlying scheme with particularity. *See* 858 F.3d at 371-72. That issue is not present here; as the Sixth Circuit acknowledged, petitioner's complaint failed for one "reason alone," which was the lack of specificity about claims—not the scheme. Pet. App. 2a.

a complaint is that "fraudulent bills were presented to the Government," the complaint survives Rule 9(b) even if it does not include details of the bills themselves. *Id*. at 192. The court also recognized that to require details about claims "at pleading is one small step shy of requiring production of actual documentation with the complaint, a level of proof not demanded to win at trial and significantly more than any federal pleading rule contemplates." *Id*. at 190.

The Ninth Circuit has "join[ed] the Fifth Circuit," and expressly rejected stricter approaches to Rule 9(b). *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir. 2010) (contrasting the Fifth Circuit's approach with that of the First, Sixth, Eighth, and Eleventh Circuits).

In *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 679 (9th Cir. 2018), the allegations were similar to the allegations here: the relator alleged that the defendant Medicare Advantage organizations contracted with a third party to assess their beneficiaries and code their conditions to determine reimbursement—and that the contractor's approach was to overstate the beneficiaries' health problems, thus increasing the amount of money the Medicare Advantage organizations could seek from the Government for those beneficiaries' care.

The Ninth Circuit held that even though the relator did not have firsthand knowledge that the false data was actually submitted to the Government, there was "ample circumstantial evidence from which to infer that the defendant organizations submitted [the contractor's] risk adjustment data and certified the data's validity." *Silingo*, 904 F.3d at 679. Even though it was "possible that some Medicare Advantage

organization, after paying for [the contractor's] services, might have discovered the fraud and then cut ties with the company and thrown out its data," the allegations were enough to support the contrary inference; indeed, the court held that "it would stretch the imagination to infer" that defendants paid for years for data that they never used. *Ibid*. (quoting *Grubbs*, 565 F.3d at 192) (alteration omitted).

More broadly, the Ninth Circuit has held that Rule 9(b) "does not require absolute particularity or a recital of the evidence," and therefore does not require a complaint to allege "a precise time frame, describe in detail a single specific transaction or identify the precise method used to carry out the fraud." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) (quotation marks omitted). Instead, if the complaint is specific enough to give the defendant notice of the allegations, and to dispel an inference that the allegations are spurious, it satisfies Rule 9(b). *See id.* at 1183 n.11.

The Third Circuit acknowledged a circuit split, and then joined the Fifth Circuit in holding that Rule 9(b) is satisfied if the plaintiff can allege "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153, 156 (3d Cir. 2014) (quoting *Grubbs*, 565 F.3d at 190, and contrasting the Fifth Circuit's approach with that taken by the Fourth, Sixth, Eighth, and Eleventh Circuits). In *Foglia*, the Third Circuit reaffirmed its precedent holding that it was unnecessary for a plaintiff to "identify a specific claim for payment at the pleading stage." *Ibid*. (quotation marks and emphasis omitted).

The Tenth Circuit has likewise adopted the flexible rule that "claims under the FCA need only show the specifics of a fraudulent scheme and provide an adequate basis for a reasonable inference that false claims were submitted as part of that scheme." *United States ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1172 (10th Cir. 2010). The court also "excuse[s] deficiencies that result from the plaintiff's inability to obtain information within the defendant's exclusive control," including details about claims and billing procedures. *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 745 (10th Cir. 2018). That is because "Rule 9(b) does not require omniscience; rather the Rule requires that the circumstances of the fraud be pled with enough specificity to put defendants on notice as to the nature of the claim." *Ibid*. (quotation marks omitted). Telling defendants what they already know is not essential to providing notice.

The D.C. Circuit has joined these "sister circuits in holding that the precise details of individual claims are not, as a categorical rule, an indispensable requirement of a viable False Claims Act complaint." *United States ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 126 (D.C. Cir. 2015).

The Second Circuit has "decline[d] to require that every *qui tam* complaint allege on personal knowledge specific identified false invoices submitted to the government." *United States ex rel. Chorches v. Am. Med. Response, Inc.*, 865 F.3d 71, 86 (2d Cir. 2017). Instead, a relator may allege "the actual submission of bills . . . on information and belief" if two conditions are met. *Id*. at 83. First, the billing information must be peculiarly within the defendant's knowledge and control. *See ibid*. Second, "the complaint must still adduce

specific facts supporting a strong inference of fraud," *i.e.*, it must plead the fraudulent scheme. *Ibid*. (quotation marks omitted).

The facts of *Chorches* resemble this one. There, an ambulance company was providing medically unnecessary ambulance runs, but having its emergency medical technicians (EMTs) falsely or misleadingly represent in Patient Care Reports (PCRs) that the patients were more sick or injured than they actually were so that the transportation appeared medically necessary (a prerequisite to reimbursement by Medicare). *See* 865 F.3d at 76-77. An EMT sued under the FCA: he personally knew of times he had been asked to falsify PCRs, but he did not have access to the bills presented to the Government, and so he alleged on information and belief that claims for payment had been submitted. *See id*. at 81. The district court dismissed the complaint on Rule 9(b) grounds, and the Second Circuit reversed.

The Second Circuit recognized first that the complaint alleged "that the bills or invoices actually submitted to the government were uniquely within [the defendant's] knowledge and control." *Chorches*, 865 F.3d at 83. It also held that there was "little dispute that insofar as [the defendant's] scheme of falsifying PCRs is concerned—as distinct from its subsequent submission of any claim for payment—the [plaintiff's complaint] 'state[s] with particularity the circumstances constituting fraud.'" *Ibid.* (quoting Fed. R. Civ. P. 9(b)) (last alteration in original). The complaint there identified a general scheme, as well as particular examples in which it was implemented. *See id.* at 83-84.

Against that backdrop, the Second Circuit held that the complaint adequately pleaded "that the false records were actually presented to the government for reimbursement." *Chorches*, 865 F.3d at 84. This was because it was "difficult to conceive of a reason why [the defendant] would go through the trouble of qualifying runs as medically necessary if not to claim reimbursement for them." *Id*. at 85. The court also recognized that the relator's complaint alleged "that between 40% and 70%" of the defendant's relevant business was reimbursed by the Government, which made it likely that "any systematic scheme for documenting fabricated medical necessity for ambulance services would indeed reach the governmental insurers." *Id*. at 85 & n.10. Even though it could "be hypothesized . . . that [the defendant] falsified PCRs for runs that were billed to payors other than Medicare, billed for a denial, or not billed at all," the court held that such a "conclusory defense of the underlying scheme [was] not persuasive at the pleading stage." *Id*. at 85 (quotation marks omitted).

The Second Circuit also made an important practical observation, which is that the defendant's billing procedures "made it virtually impossible for most employees to have access to all of the information necessary to certify on personal knowledge both that a particular invoice was submitted for payment and that the facts stated to justify the invoice were false." *Chorches*, 865 F.3d at 82. That is because the EMTs—who interacted with the patients—would know that the PCRs were false, but did not personally participate in billing; the billing department knew about particular bills, but had no reason to know that the PCRs were false (because it had no interaction with the

patients). *See ibid*. A rule requiring plaintiffs to allege details about both the scheme and the bills would thus allow fraudsters to stymie FCA enforcement by compartmentalizing relevant knowledge.

The Second Circuit also commented on the circuit split directly, opining that its rule was "clearly consistent with the approach taken by the Third, Fifth, Seventh, Ninth, Tenth, and D.C. Circuits, which have overtly adopted a 'more lenient' pleading standard." *Chorches*, 865 F.3d at 89. The alignment is not perfect because the Second Circuit's rule conditions the more flexible standard on the relevant facts being within the opposing party's knowledge, which other circuits do not.

Nevertheless, petitioner's complaint satisfies the Second Circuit's rule. Petitioner alleged with particularity a scheme to falsify OASIS forms and resulting plans of care—which is closely analogous to the *Chorches* relator's alleged scheme to falsify PCRs. Petitioner did not have access to bills, but that information is within respondents' control—and the fact that respondents were falsifying OASIS data gives rise to a strong inference that false claims were presented because the majority of respondents' patients are paid for by the Government, which expressly requires OASIS data to determine the amount of reimbursement. Thus, under the Second Circuit's rule, petitioner's complaint would have survived because it makes "plausible allegations . . . that lead to a strong inference that specific claims were indeed submitted and that information about the details of the claims submitted are peculiarly within the opposing party's knowledge." *Chorches*, 865 F.3d at 93.

Under the rule adopted in any of these circuits, petitioner's complaint easily would have survived. The reason to manipulate OASIS data is to ensure that the Government pays more for home health care. Thus, claims for payment can readily be inferred from a scheme to manipulate the data. Not only that, the complaint alleges that over 60% of CCC's patients were on Government health insurance rolls, Pet. App. 37a, and that CCC falsified over half of the OASIS data forms, *id*. at 60a, making it essentially impossible that CCC did not submit false claims for at least one patient whose care was paid for by the Government. In the circuits described above, those facts, combined with the details of the fraudulent scheme alleged in petitioner's complaint, would have satisfied Rule 9(b). The conflict is especially acute vis-à-vis *Chorches*—and also *Prose* and *Silingo*, which both involved prospective payment systems similar to home health care.

2. On the other hand, five circuits take a more rigid approach to Rule 9(b). Here, the Sixth Circuit accurately described its rule. Under Sixth Circuit precedent, even "where a relator pleads a complex and far-reaching fraudulent scheme with particularity," the relator must also "provide[] examples of specific false claims submitted to the government pursuant to that scheme." *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 501 F.3d 493, 510 (6th Cir. 2007). "[I]t is insufficient to simply plead the scheme;" the relator "must also identify a representative false claim that was actually submitted to the government." *Chesbrough v. VPA, P.C.*, 655 F.3d 461, 470 (6th Cir. 2011).

The Sixth recognizes an exception to the need to plead examples when the relator has personal billing-

related knowledge. *See United States ex rel. Prather v. Brookdale Senior Living Cmtys., Inc.*, 838 F.3d 750, 769-70 (6th Cir. 2016). But this exception is "narrow"; the general rule is that representative examples are required. *United States ex rel. Ibanez v. Bristol-Myers Squibb Co.*, 874 F.3d 905, 920 (6th Cir. 2017). The result in this case shows how narrow the Sixth Circuit's exception is: even though the court acknowledged that petitioner has "'personal knowledge of billing practices' employed in the fraudulent scheme," it nevertheless affirmed the dismissal of her complaint because her information did "not amount to an allegation of 'particular identified claims.'" Pet. App. 7a-8a.

The Eighth Circuit's rule is similar. In *United States ex rel. Joshi v. St. Luke's Hospital, Inc.*, 441 F.3d 552, 557 (8th Cir. 2006), the relator alleged "a systematic practice" of false billing for anesthesia services that, according to the relator, rendered every claim for payment false. The Eighth Circuit affirmed dismissal under Rule 9(b) because the relator failed to provide "representative examples of [the defendants'] alleged fraudulent conduct." *Ibid*.

Later, the Eighth Circuit slightly softened its rule, holding that representative examples are not always required. *See United States ex rel. Thayer v. Planned Parenthood of the Heartland*, 765 F.3d 914, 917 (8th Cir. 2014). Instead, when a relator is "able to plead personal, first-hand knowledge of [the defendant's] submission of false claims," that provides the requisite "reliable indicia that lead to a strong inference that claims were actually submitted." *Ibid*. (quotation marks omitted). Under this rule, relators who, by virtue of their job duties, have firsthand knowledge of a defendant's billing practices may sometimes succeed.

But other relators may not proceed unless they plead representative example claims. *See United States ex rel. Strubbe v. Crawford Cnty. Mem'l Hosp.*, 915 F.3d 1158, 1163, 1165 (8th Cir.) (holding that relators who were paramedics and EMTs "did not have access to the billing department," and so even though their complaint alleged a "wide-ranging fraudulent scheme," they did not allege the submission of false claims with the requisite particularity); *United States ex rel. Benaissa v. Trinity Health*, 963 F.3d 733, 740 (8th Cir. 2020) (holding that trauma surgeon could not satisfy Rule 9(b), and refusing to hold that inference of false claims was reasonable when the plaintiff alleged that over a quarter of a hospital's revenue came from Medicare, and that every claim submitted by certain physicians was false due to Stark Act and Anti-Kickback Statute violations).

The Eleventh Circuit also adopts a rigid approach to Rule 9(b). In *United States ex rel. Clausen v. Laboratory Corp. of America*, 290 F.3d 1301 (11th Cir. 2002), the court held that Rule 9(b) "does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government." *Id*. at 1311. Instead, the plaintiff must identify "actual, and not merely possible or likely, claims" for payment. *See id.* at 1313.

In *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1013 (11th Cir. 2005) (per curiam), the Eleventh Circuit elaborated that the submission of a fraudulent claim . . . must be pleaded with particularity and not inferred from the circumstances." The Eleventh Circuit

specifically rejected the argument "that a pattern of improper practices of the defendants leads to the inference that fraudulent claims were submitted to the government." *Ibid*. Thus, even though the plaintiff was an insider at the company who claimed to be "'aware' of the manner by which the defendants submitted fraudulent claims and had 'learned from his colleagues the national reach of the schemes,'" the court deemed his complaint inadequate because it did not show "that a specific fraudulent claim was in fact submitted to the government." *Id*. at 1013-14; *see also United States ex rel. Atkins v. McInteer*, 470 F.3d 1350, 1359 (11th Cir. 2006) (holding that when plaintiff described scheme in detail, including identifying "particular patients, dates and corresponding medical records for services that he contends were not eligible for government reimbursement," the claim still failed because the plaintiff was "not a billing and coding administrator responsible for filing and submitting the defendants' claims for reimbursement"—and therefore not privy to the submission of actual false claims); *United States ex rel. Sanchez v. Lymphatx, Inc.*, 596 F.3d 1300, 1302 (11th Cir. 2010) (per curiam) (finding complaint inadequate when relator claiming "direct knowledge of the defendants' billing and patient records" failed to provide "at least some examples of actual false claims") (quotation marks omitted).

In *Carrel v. AIDS Healthcare Foundation, Inc.*, 898 F.3d 1267 (11th Cir. 2018), the Eleventh Circuit held that "even if the relator is an insider who alleges awareness of general billing practices, an accusation of underlying improper practices alone is insufficient absent allegations that a specific fraudulent claim was in fact submitted to the government." *Id*. at 1275

(cleaned up). Under the Eleventh Circuit's rule, it is not enough to allege a scheme to defraud; the plaintiff must also "allege with particularity that" the scheme resulted in "an actual false claim." *Id*. at 1277. Moreover, relators cannot "rely on mathematical probability to conclude that the [defendant] surely must have submitted a false claim at some point"; such allegations are, in the Eleventh Circuit's view, too speculative. *Ibid*.[5]

Most recently, the Eleventh Circuit held that a complaint failed to satisfy Rule 9(b) even when the plaintiffs alleged that all or nearly all of the defendant's patients were covered by Government insurance programs, that a large fraction of the patients were receiving care tainted by kickbacks (which would cause the resulting claims for payment to be false per se), and that Medicare claims data showed that the defendant was submitting claims for reimbursement for patients referred by the doctors who received kickbacks. *See Est. of Helmly v. Bethany Hospice & Palliative Care of Coastal Ga., LLC*, 853 F. App'x 496, 502 (11th Cir. 2021) (per curiam), *petition for cert. pending*, No. 21-462 (docketed Sept. 27, 2021). The Eleventh Circuit held that under its precedents, the only way to satisfy Rule 9(b) is to "allege specific details about false claims." *Ibid*. (quotation marks omitted). A

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[5] The Eleventh Circuit has held that when the plaintiff participated firsthand in the submission of false claims, she could proceed without representative examples. *See Carrel*, 898 F.3d at 1276. But even in this circumstance, the Eleventh Circuit requires "specific details about false claims." *Ibid*. (quotation marks omitted).

petition for a writ of certiorari seeking review of that decision is pending.

The First Circuit also holds that representative examples of false claims are required in most cases. *See United States ex rel. Karvelas v. Melrose-Wakefield Hosp.*, 360 F.3d 220, 233 (1st Cir. 2004), *abrogated on other grounds by Allison Engine Co. v. United States ex rel. Sanders*, 553 U.S. 662 (2008). It recognizes an exception, however, when the plaintiff alleges that the defendant caused a third party to submit false claims. *See United States ex rel. Nargol v. DePuy Orthopaedics, Inc.*, 865 F.3d 29, 38-39 (1st Cir. 2017). Under that exception, it is possible that petitioner's claims against Fazzi might have survived (because Fazzi caused CCC and other entities to present false claims), but the claims against CCC itself would not have.

The Fourth Circuit has yet another rule. It allows a complaint alleging the presentment of false claims to satisfy Rule 9(b) in two ways. First, the complaint can describe specific false claims in detail. *See United States ex rel. Nathan v. Takeda Pharms. N. Am., Inc.*, 707 F.3d 451, 456 (4th Cir. 2013). Second, the complaint can "allege a pattern of conduct that would necessarily have led to submission of false claims to the government for payment." *United States ex rel. Grant v. United Airlines Inc.*, 912 F.3d 190, 197 (4th Cir. 2018) (cleaned up). The possibility or even probability that the Government was billed is not enough; the fact must be certain.

3. In sum, there is an open and acknowledged circuit split about the right way to apply Rule 9(b) in FCA cases. Despite many opportunities to reach unanimity over the years, the circuits have not done so. The split is entrenched and calls out for this Court's review.

II. The Question Presented Is Important and Frequently Recurring

Certiorari should be granted because the question presented is important. *Qui tam* cases under the FCA are sufficiently frequent and important that this Court has repeatedly granted certiorari to resolve even relatively narrow and shallow splits. *See, e.g.*, *Cochise Consultancy, Inc. v. United States ex rel. Hunt*, 139 S. Ct. 1507 (2019) (resolving split about application of statute of limitations); *State Farm Fire & Cas. Co. v. United States ex rel. Rigsby*, 137 S. Ct. 436 (2016) (resolving split about consequences for violating requirement to keep case under seal); *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176 (2016) (resolving split about materiality); *Kellogg Brown & Root Servs., Inc. v. United States ex rel. Carter*, 575 U.S. 650 (2015) (resolving split about when a case is deemed "pending" for purposes of first-to-file bar).

The specific issue here is one of the most important ones affecting FCA practice. Rule 9(b) applies to every FCA complaint, hundreds of which are filed each year. *See* U.S. Dep't of Justice, *Fraud Statistics – Overview, October 1, 1986 – September 30, 2020*, at 3 (2021), https://www.justice.gov/opa/press-release/file/1354316/download (showing over 600 *qui tam* cases filed each year for the last ten years).

Compliance with Rule 9(b) is also one of the most frequently litigated defenses at the pleading stage of an FCA action. As the summary of circuit cases shows, this issue arises frequently, and it arises everywhere. And the circuit cases only hint at the amount of litigation. A Westlaw search for "'false claims' /p particularity" yields nearly 2,000 federal cases. A Westlaw

KeyCite search based on the FCA's liability provision, 31 U.S.C. § 3729, narrowed to "12(b) /p 9(b)" (to identify most cases in which a motion to dismiss raises Rule 9(b)), yields over 1,250 federal cases.

Such searches are not perfect fits for the universe of relevant cases, but they provide a useful approximation of the volume of cases in which this issue is relevant. And based on experience litigating in this field, it is safe to say that a Rule 9(b) defense is asserted in most motions to dismiss FCA cases. *See* Claire M. Sylvia, *The False Claims Act: Fraud Against the Government* § 10:59, Westlaw (database updated Apr. 2021) ("Pretrial motions challenging a complaint under Federal Rule 9(b) . . . have become standard practice."). The standard governing such motions is therefore extremely important to relators, the Government, and defendants.

III. This Case Is an Excellent Vehicle to Decide the Question

This case provides an ideal vehicle to decide the question presented because the application of Rule 9(b) is presented squarely and cleanly. It is the only issue, and the complaint's allegations bring the contrast between the circuits' rules into stark relief. Specifically, the Sixth Circuit acknowledged in its precedential decision that petitioner's complaint "describe[s], in detail, a fraudulent scheme," but held that Rule 9(b) requires plaintiffs also to identify "specific claims" for payment presented to the government. Pet. App. 6a-7a. The Sixth Circuit also refused to find that petitioner fell within the narrow exception for people with "personal knowledge of billing practices," because the knowledge she had did "not amount to an

allegation of particular identified claims submitted pursuant to the fraudulent scheme." *Id*. at 7a-8a (quotation marks omitted).

IV. The Decision Below Is Incorrect

Certiorari should also be granted because the decision below is incorrect. Rule 9(b) requires plaintiffs to plead the "circumstances constituting fraud" with "particularity." By requiring plaintiffs who plead a fraudulent scheme in detail also to plead the details of false claims, the Sixth Circuit—and the other four courts in its camp—impose an arbitrarily high burden on FCA relators that Rule 9(b) does not require.

The Fifth Circuit explained it well: "Stating 'with particularity the circumstances constituting fraud' does not necessarily and always mean stating the contents of a bill. The particular circumstances constituting the fraudulent presentment are often harbored in the scheme." *Grubbs*, 565 F.3d at 190. When, as here, a relator describes a fraudulent scheme in detail, and explains why that scheme logically would lead to claims being submitted, she has done what Rule 9(b) requires.

It is also wrong to require relators at the pleading stage already to have the details of specific false claims, *i.e.*, the evidence to support their allegations. As this Court has recognized, even when Rule 9(b) applies, so does Federal Rule of Civil Procedure 11(b)(3), which allows "pleadings based on evidence reasonably anticipated after further investigation or discovery." *Rotella v. Wood*, 528 U.S. 549, 560 (2000). In cases where the relator can allege the existence of a fraudulent scheme with particularity, and plausibly alleges that claims were submitted under that scheme, the

specific details of the claims are exactly the sort of information that ordinarily would be found later.

Similarly, the Sixth Circuit's refusal to infer the existence of false claims from circumstances finds no support in any pleading standard. Even later in a case, *i.e.*, at summary judgment or at trial, plaintiffs can prove their case with circumstantial evidence. Indeed, "[c]ircumstantial evidence is not only sufficient, but may also be more certain, satisfying and persuasive than direct evidence" in certain cases. *Desert Palace, Inc. v. Costa*, 539 U.S. 90, 100 (2003) (quotation marks omitted). When a plaintiff alleges a fraudulent scheme, the logical endpoint of which is the submission of false claims, that supports an inference that claims were, in fact, submitted. Otherwise, why bother devising and executing the scheme? Evidence of such a scheme would be sufficient evidence of false claims at summary judgment or trial; it should easily suffice at the pleading stage.

The Sixth Circuit's rigid requirement also has no logical relationship to the purposes of Rule 9(b), which are to provide defendants with notice of the charges against them, and to prevent spurious claims from moving forward. Here, respondents know exactly what they are accused of doing wrong: upcoding the diagnoses of home health beneficiaries in specific ways. The complaint even includes specific examples of fraud that petitioner has already identified to her supervisors, which means respondents at least know of those. Details about the related claims for payment would add nothing to that understanding.

Nor was dismissal necessary to ward off a spurious or speculative claim. Petitioner personally observed systematic misconduct and corroborated her

suspicions with multiple clinicians as well as her supervisors—all of whom are named in petitioner's complaint. Here, petitioner has done far more than the usual pre-filing investigation before bringing suit.

Finally, as explained by the majority of circuits, the Sixth Circuit's rule undermines the efficacy of the FCA. In most cases, relators will not have specific details of actual false claims—perhaps because the relator's role does not give them access to that information, or because the defendant has effectively concealed it. Requiring dismissal in all such cases will ensure that meritorious cases fail. Even worse, it will prevent many meritorious cases from ever being filed because relators and their counsel will know that they cannot meet the Sixth Circuit's artificially high pleading burden. The inevitable result is that more fraud on the Government will go unchecked.

V. The Court Should Consider Calling for the Views of the Solicitor General

If the Court does not grant certiorari outright, it should call for the views of the Solicitor General. The application of Rule 9(b) directly implicates the interests of the United States, which is the real party in interest in FCA cases.

This Court previously called for the views of the Solicitor General in *United States ex rel. Nathan v. Takeda Pharmaceuticals North America, Inc.*, No. 12-1349. There, the Government acknowledged that "lower courts have reached inconsistent conclusions about the precise manner in which a *qui tam* relator may satisfy the requirements of Rule 9(b)." U.S. Amicus Br. at 10. The Government thus acknowledged a split between courts that "correctly held that a *qui tam*

complaint satisfies Rule 9(b) if it contains detailed allegations supporting a plausible inference that false claims were submitted to the government, even if the complaint does not identify specific requests for payment"—and it rejected a "per se rule that a relator must plead the details of particular false claims," arguing that such a rule "is unsupported by Rule 9(b) and undermines the FCA's effectiveness as a tool to combat fraud against the United States." *Ibid*. The Government opined that if the disagreement among the lower courts "persists," then "this Court's review to clarify the applicable pleading standard may ultimately be warranted in an appropriate case." *Ibid*. The Government believed the case was "not a suitable vehicle" because the lower courts had thrown out the complaint on multiple grounds, so that the "suit could not go forward even under the pleading standard most favorable to relators." *Id*. at 11.

The conditions the Government cited all came to pass in this case. Here, the Sixth Circuit applied a rule the Government disparaged, in a case in which the matter was outcome-determinative. Accordingly, the Court should either grant certiorari, or at a minimum request the Government's views.

CONCLUSION

Certiorari should be granted.

Respectfully submitted,

Warner Mendenhall
THE LAW OFFICES OF
WARNER MENDENHALL
190 North Union Street
Suite 201
Akron, OH 44304

Tejinder Singh
Counsel of Record
GOLDSTEIN & RUSSELL, P.C.
7475 Wisconsin Ave.
Suite 850
Bethesda, MD 20814
(202) 362-0636
tsingh@goldsteinrussell.com

December 21, 2021

APPENDIX

APPENDIX A

**UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT**

No. 19-4240

RECOMMENDED FOR PUBLICATION
Pursuant to Sixth Circuit I.O.P. 32.1(b)

File Name: 21a0242p.06

UNITED STATES OF AMERICA, ET AL.,
EX REL. CATHY OWSLEY,

Relator-Appellant,

v.

FAZZI ASSOCIATES, INC.; CARE CONNECTION OF CINCINNATI; GEM CITY HOME CARE; ASCENSION HEALTH CARE; ENVISION HEALTHCARE HOLDINGS, INC.,
Defendants-Appellees.

Appeal from the United States District Court for the Southern District of Ohio at Cincinnati.

No. 1:15-cv-00511—Timothy S. Black, District Judge.

Argued: November 17, 2020

Decided and Filed: October 13, 2021

Before: KETHLEDGE, DONALD, and LARSEN, Circuit Judges.

* * *

OPINION

KETHLEDGE, Circuit Judge. Cathy Owsley—a nurse for defendant Care Connection, a company providing home-health care to Medicare patients—alleged in considerable detail that she observed, firsthand, documents showing that her employer had used fraudulent data from Fazzi Associates, Inc. to submit inflated claims for payment to the federal and Indiana state governments. She therefore sued both companies and some related entities under the False Claims Act and an Indiana statute. But Owsley's complaint provided few details that would allow the defendants to identify any specific claims—of the hundreds or likely thousands they presumably submitted—that she thinks were fraudulent. For that reason alone her complaint fell short of the requirements of Civil Rule 9(b). We therefore affirm the district court's dismissal of her claims.

I.

At the pleadings stage, we take Owsley's allegations as true. *See Norfolk Cnty. Ret. Sys. v. Cmty. Health Sys., Inc.*, 877 F.3d 687, 689 (6th Cir. 2017).

A.

Private home-healthcare agencies obtain payments from Medicare through a "prospective payment system." 42 U.S.C. § 1395fff(a); *United States ex rel. Prather v. Brookdale Senior Living Cmtys., Inc.*, 838 F.3d 750, 756 (6th Cir. 2016). These agencies provide "episodes" of care, for which Medicare normally pays

in two installments: an initial payment "made in response to a request for anticipated payment (RAP)" and a "residual final payment." 42 C.F.R. § 484.205(b)(1), (g).

The amount of each payment depends in large part on the patient's condition: the more care the patient needs, the larger the Medicare payments. For that reason, at the outset of a patient's treatment, a clinician (usually a registered nurse) conducts a "comprehensive assessment" of the patient. *Id.* § 484.55(b). As part of that assessment, the clinician collects data for a form called the Outcome and Assessment Information Set (OASIS)—which is the Centers for Medicare and Medicaid Services' standardized assessment of a patient's condition. *See id.* § 484.55(c)(8); 64 Fed. Reg. 3764, 3765 (Jan. 25, 1999). The OASIS form records many details about a patient, including his primary and other diagnoses and his ability to bathe and walk. *See* Ctrs. for Medicare & Medicaid Servs., OASIS-C1/ICD-10 Guidance Manual, ch. 3, at C-10, K-6, K-14 (2015). Those data ultimately take the form of codes enumerated by the Centers for Medicare and Medicaid Services (CMS). *See id.* ch. 1, at 8, ch. 3. The data on OASIS forms—and hence the codes—"must accurately reflect the patient's status at the time of assessment." 42 C.F.R. § 484.45(b).

A home-health agency uses the OASIS data to establish an "individualized plan of care" for the patient and to complete a request for anticipated payment. *See id*. § 484.60 (plan of care); Ctrs. for Medicare & Medicaid Servs., Medicare Claims Processing Manual, ch. 10, §§ 10.1.7, 10.1.10.3, 40.1 (2021) (use of OASIS data for RAP); 42 C.F.R. § 484.205(c) (same). At the end of an episode of care, the agency reassesses the patient's

condition and updates his OASIS form. *See* 42 C.F.R. § 484.55(d)(1). The agency then uses the updated OASIS data to complete its claim for residual payment. *See* Claims Processing Manual, ch. 10, § 40.2.

B.

Cathy Owsley was a Quality Assurance Nurse at Care Connection of Cincinnati, a home-health agency. In that role she reviewed OASIS forms and used them to complete plans of care. In 2014, Envision Healthcare Holdings acquired Care Connection and outsourced its OASIS coding to Fazzi Associates. Soon Owsley noticed that "Fazzi coders were altering OASIS data by enhancing existing diagnosis codes and adding new codes that were not supported by any medical documentation." Am. Compl. ¶ 36.

Owsley reported these concerns to several of her supervisors at Envision and Care Connection, repeatedly providing examples of specific patients whose OASIS data Fazzi had fraudulently changed (or "upcoded"). None of those supervisors took any action in response. One told her "[i]t is what it is"; another replied, "if you don't agree with this you can leave and get another job." *Id.* ¶¶ 42, 55. Meanwhile, Care Connection instructed nurses who had personally assessed patients' conditions to "agree to any changes Fazzi makes to the original answers to OASIS questions." *Id.* ¶ 57. Multiple nurses complained that Fazzi had inaccurately or fraudulently coded the condition of patients whom the nurses had assessed. *See id.* ¶¶ 57-59. But most nurses acquiesced. *Id.* ¶ 58.

According to Owsley, Fazzi fraudulently changed the coding on the OASIS forms for about half of Care Connection's patients. *Id.* ¶ 70. Owsley then used

those forms to complete patient plans of care; others at Care Connection used those same forms to complete requests for anticipated payment, which Care Connection would submit to Medicare the morning after Owsley had completed the patient's plan of care. *Id.* ¶ 34.

Owsley also alleged that this scheme extended beyond Care Connection. Envision controlled "dozens of home health agencies across the United States"—including Gem City and Ascension—and had outsourced coding for each of those agencies to Fazzi. *Id.* ¶¶ 66, 68. Owsley once observed the same pattern of fraudulent upcoding at Gem City. A physician had noted that the patient did not suffer from diabetes, chronic obstructive pulmonary disease, or apnea. *Id.* ¶ 67. But Fazzi changed the patient's OASIS form to report that the patient had each of those ailments. *Id.*

C.

Owsley thereafter sued Fazzi, Envision, Care Connection, Gem City, and Ascension on behalf of the United States and the State of Indiana, asserting various claims under the False Claims Act, 31 U.S.C. § 3729(a)(1)(A), (B), (C), (G), and a similar statute in Indiana, *see* Ind. Code § 5-11-5.7-2. The United States declined to intervene in the case. The district court later dismissed all of Owsley's claims, reasoning that her amended complaint had not pled the alleged fraudulent scheme with the particularity required by Civil Rule 9(b). This appeal followed.

II.

The question presented is whether Owsley's allegations satisfied Rule 9(b). That rule requires a plaintiff "to state with particularity the circumstances constituting fraud[.]" Fed. R. Civ. P. 9(b). "We review de

novo a district court's dismissal of a complaint for failure to plead with particularity under Rule 9(b)." *Chesbrough v. VPA, P.C.*, 655 F.3d 461, 467 (6th Cir. 2011).

All of Owsley's claims under the False Claims Act (and the Indiana statute) rest on the premise that the defendants knowingly submitted or caused to be submitted "a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A); Ind. Code § 5-11-5.7-2(a)(1). The quoted language "attaches liability, not to the underlying fraudulent activity or to the government's wrongful payment, but to the claim for payment." *United States ex rel. Sheldon v. Kettering Health Network*, 816 F.3d 399, 411 (6th Cir. 2016) (cleaned up). For that reason, our circuit has imposed a "clear and unequivocal requirement that a relator allege specific false claims when pleading a violation of" the Act. *Id.* (cleaned up). Thus, under Rule 9(b), "[t]he identification of at least one false claim with specificity is an indispensable element of a complaint that alleges a False Claims Act violation." *United States ex rel. Hirt v. Walgreen Co.*, 846 F.3d 879, 881 (6th Cir. 2017) (cleaned up). Rule 9(b) therefore "does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply that claims requesting illegal payments must have been submitted." *Sanderson v. HCA-The Healthcare Co.*, 447 F.3d 873, 877 (6th Cir. 2006) (cleaned up).

That in substance is what Owsley has done here. Owsley's allegations describe, in detail, a fraudulent scheme: Fazzi fraudulently upcoded patient OASIS data, which Care Connection then used to submit inflated requests for anticipated payment to CMS. The defendants respond that Care Connection required a

clinician—typically the nurse who performed the patient's assessment—to sign off on the final OASIS coding before that coding was used for a request for anticipated payment. But Envision and Care Connection told employees (including Owsley herself) to accept Fazzi's coding or leave the company. *See* Am. Compl. ¶ 55. And most nurses accepted "Fazzi's changes out of fear of losing their jobs." *Id.* ¶ 58. The idea that those same nurses nonetheless corrected all the fraudulent upcoding that Owsley allegedly observed is itself implausible.

But Owsley makes little effort in her complaint to "identify any specific claims" that Care Connection submitted pursuant to the scheme. *Sanderson*, 447 F.3d at 877. Owsley could have done that in one of two ways. The default rule is that a False Claims Act claimant must identify a "representative claim that was actually submitted to the government for payment." *United States ex rel. Ibanez v. Bristol-Meyers Squibb Co.*, 874 F.3d 905, 915 (6th Cir. 2017). Owsley did not do that here. Alternatively, a claimant "can otherwise allege facts—based on personal knowledge of billing practices—supporting a strong inference that *particular identified claims* were submitted to the government for payment." *Prather*, 838 F.3d at 771 (emphasis added).

Here, Owsley did allege "personal knowledge of billing practices" employed in the fraudulent scheme—namely, her knowledge of the OASIS codes that she says Fazzi fraudulently changed. *Id.*; Am. Compl. ¶ 70. But Owsley did not allege facts that identify any specific fraudulent claims. Her complaint instead describes several instances of upcoding from 2015:

> (a) A [Care Connection (CCC)] registered nurse evaluated Patient A and indicated on the OASIS form that this patient was being treated for a simple leg wound. However, Fazzi altered the diagnosis on the OASIS form to include uncontrolled diabetes, hypertension, diabetic neuropathy and morbid obesity. There was no medical documentation supporting these diagnoses.
>
> (b) A CCC registered nurse evaluated Patient B—a Medicare Advantage patient—and diagnosed her with a leg ulcer. Without any supporting documentation, Fazzi altered the diagnosis to include a malignant cancer of the larynx.
>
> (c) Another CCC Medicare patient—Patient C—is ambulatory and can self-inject insulin. Nevertheless, Fazzi altered the OASIS forms to indicate that she is non-ambulatory and cannot self-inject insulin.
>
> (d) Patient D, a CCC post-surgical patient on Medicare, utilizes the assistance of a hand-held walker. Fazzi upcoded her diagnosis to paraplegia.
>
> (e) Another CCC patient on Medicaid—Patient E—was treated for a skin lesion, but the diagnosis was fraudulently upcoded to non-ambulatory and diabetic.

Am. Compl. ¶ 38.

This information does not amount to an allegation of "particular identified claims" submitted pursuant to the fraudulent scheme. *Prather*, 838 F.3d at 771. Owsley identifies neither the dates on which she reviewed

the OASIS forms for these patients, nor the dates of any related claims for payment, nor the amounts of any of those claims. *Compare id.* at 769-70. That is not to say that our precedents require a plaintiff in one case to allege all the facts found sufficient in another; the facts of a particular case should not be mistaken for its rule. Instead, the touchstone is whether the complaint provides the defendant with notice of a specific representative claim that the plaintiff thinks was fraudulent. *See Sanderson*, 447 F.3d at 877; *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.*, 342 F.3d 634, 643 (6th Cir. 2003). And the diagnostic information in Owsley's complaint is simply not enough for Care Connection, Fazzi, or Envision reasonably to pluck out—from all the other claims they submitted—the five that Owsley was alluding to here. Her complaint therefore did not satisfy Civil Rule 9(b) as to those defendants.

B.

The district court was also correct to dismiss Owsley's claims against Gem City and Ascension. Owsley worked only at Care Connection, *see* Am. Compl. ¶¶ 6, 34, and did not allege that she regularly reviewed the OASIS forms of other defendant home-health agencies. She therefore lacked personal knowledge about the billing practices of those defendants.

Finally, the district court did not abuse its discretion when it denied Owsley leave to amend her complaint a second time. Owsley neither moved formally to amend nor proffered a proposed amended complaint. *See Begala v. PNC Bank, Ohio, Nat'l Ass'n*, 214 F.3d 776, 783-84 (6th Cir. 2000).

The district court's judgment is affirmed.

APPENDIX B

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

Case No. 1:15-cv-511
Judge Timothy S. Black

UNITED STATES OF AMERICA, ET AL.,

Plaintiffs,

v.

FAZZI ASSOCIATES, INC., ET AL.,
Defendants.

ORDER GRANTING THE MOTIONS TO DISMISS OF THE ENVISION DEFENDANTS AND DEFENDANT FAZZI ASSOCIATES (Docs. 42, 44), AND TERMINATING THIS CASE IN THIS COURT

This civil action is before the Court on Defendants Envision Healthcare Holdings, Inc., Care Connection of Cincinnati, Gem City Home Care, and Ascension Health (collectively, "Envision Defendants")'s motion to dismiss relator's amended complaint (Doc. 42) and the parties' responsive memoranda (Docs. 51, 53). Also before the Court is Defendant Fazzi Associates, Inc. ("Fazzi")'s separately filed motion to dismiss relator's amended complaint (Doc. 44) and the parties' responsive memoranda (Docs. 51, 54).

I. BACKGROUND

For purposes of Defendants' motions to dismiss, the Court must: (1) view the complaint in the light most favorable to Plaintiff, and (2) take all well-pleaded factual allegations as true. *Bickerstaff v. Lucarelli*, 830 F.3d 388, 396 (July 21, 2016).

Relator Cathy Owsley filed this *qui tam* lawsuit against the Envision Defendants and Fazzi on behalf of the United States and the State of Indiana pursuant to the False Claims Act ("FCA"), 31 U.S.C. § 3729, *et seq.* and the Indiana Medicaid False Claims and Whistleblower Protection Act ("Indiana FCA"). (Doc. 15). Owsley, a Quality Assurance Nurse for Care Connection of Cincinnati ("Care Connection"), alleges that Defendants are engaging in a nation-wide "upcoding" scheme, inflating patient data and submitting fraudulent Medicare, Medicaid, and CHAMPUS/TRICARE claims. (*Id.* at 1-2, ¶¶ 6, 68-69).

Care Connection and Gem City Home Care ("Gem City") are both "home-health agencies" and are subsidiaries of Evolution Health Care of Dallas ("Evolution"). (*Id.* at ¶ 8-9). Care Connection is located in Cincinnati, and Gem City has multiple locations in Ohio and Indiana. (*Id.*). Evolution, a division of Defendant Envision Healthcare Holdings, Inc ("Envision"), is a "healthcare services provider specializing in post-acute care management of patients with advanced illnesses and chronic disease." (*Id.* at ¶ 10). A separate, faith-based healthcare organization, Defendant Ascension Health Care, entered into a joint venture agreement with Evolution in September 2014 to provide home-healthcare services. (*Id.* at ¶ 11). Beginning in December 2014, Evolution outsourced its home-healthcare coding to Defendant Fazzi for all of its home-health agencies,

including Care Connection and Gem City. (*Id.* at ¶¶ 10, 35, 66, 68).

Home-health agencies, such as Care Connection and Gem City, evaluate whether patients are eligible for Medicare's home-health insurance, including whether the patient is home-bound. 42 C.F.R. § 484.55(a); (*Id.* at ¶ 23). The Medicare insurance may include part-time nursing care, physical and speech therapy, part-time home aide services, and medical equipment and supplies. (Doc. 15 at ¶ 23). The evaluations are conducted using a data-collection tool called Outcome and Assessment Information Set ("OASIS"), which measures a patient's medical condition, physical capabilities, and expected therapeutic needs. 42 C.F.R. § 484.55(c)(8); (*Id.* at ¶ 24, 26). Home-health agencies must submit the OASIS data to the Center for Medicare and Medicaid Services ("CMS") to "administer applicable payment rate methodologies." (Doc. 15 at ¶ 29). "The encoded OASIS data must accurately reflect the patient's status at the time of assessment." 42 C.F.R. § 484.45(b); (Doc. 15 at ¶ 32). According to Owsley, Care Connection's OASIS forms are submitted every nine weeks. (Doc. 15 at ¶ 70).

The OASIS data is used to generate a physician-ordered Plan of Care. (Doc. 15 at ¶ 26). The data is also used to determine a patient's "case mix assignment," which matches a patient with one of 153 Home Health Resource Groups ("HHRGS"), with each patient receiving a code "that is used by government healthcare programs to determine the rate of payment to the [home-health agency] for a given patient." (*Id.* at ¶ 27); *see also* 42 C.F.R. § 412.620(a)(3).

Medicare payments for home-health services are distributed via a "prospective payment system," with

an initial payment made based on an estimated cost of services rendered during a standard sixty-day "episode of care." (Doc. 15 at ¶ 29). The initial request is referred to as a "request for anticipated payment" ("RAP"). *See* 42 C.F.R. § 484.205(h). At the end of the sixty-day episode, Medicare makes a "residual final payment." 42 C.F.R. § 484.205(g). "The initial base rate may be subject to upward adjustment, such as where there is a 'significant change in condition resulting in a new case-mix assignment,' or downward adjustment, such as where the number of predicted therapy visits substantially exceeds the number actually performed." (Doc. 15 at ¶ 28).

In her position as a Quality Assurance Nurse with Care Connection since 2006, Owsley has reviewed completed OASIS forms and has used the OASIS data to complete Plans of Care. (*Id.* at ¶¶ 6, 34). Care Connection "uses information on the OASIS forms and Plans of Care to generate a[n] [RAP] form which serves as the basis for billings submitted to government health care programs." (*Id.*). Owsley alleges that in the course of her work reviewing OASIS data, she noticed that "Fazzi coders were altering OASIS data by enhancing existing diagnosis codes and adding new codes that were not supported by any medical documentation." (*Id.* at ¶ 36). She also observed that Fazzi was using outdated patient histories to alter the codes. (*Id.*). Owsley alleges that she "is the 'last set of eyes' that reviews the Plans of Care before the resulting RAP is produced." (*Id.* at ¶ 34). She further alleges that "RAPs are submitted to CMS the very next morning while the physician's signature on the Plan of Care is still pending." (*Id.*).

As part of this upcoding scheme, Care Connection has allegedly conducted training sessions with its healthcare workers, instructing them on how to falsify data when evaluating patients so as to match Fazzi's coding methods. (*Id.* at ¶¶ 40, 50). This training involved requiring nurses to watch videos created by Fazzi that are available online through the "Fazzi Academy." (*Id.* at ¶ 50). Representatives from four of Evolution's Indiana offices have also participated in training on Fazzi's coding methods. (*Id.* at ¶ 66).

Owsley raised her concerns regarding Fazzi's apparent upcoding multiple occasions to her then-supervisor, Beverly Naber, and also to Robert James, Evolution's then-Vice President of Midwest Operations. (*Id.* at ¶ 41). This included sending emails identifying examples of fraudulently altered OASIS data. (*Id.*). On one occasion, Owsley confronted James regarding Fazzi's upcoded diagnoses, to which James responded, "it is what it is." (*Id.* at ¶ 42). James also allegedly responded, "everybody else is using [Fazzi] and we have to as well." (*Id.* at ¶ 66). Owsley sent James a follow-up email with examples of fraudulent conduct pursuant to his request, however James did not respond. (*Id.*). Owsley also met in person with Naber and James who, on the one hand, promised to address her concerns, but, on the other hand, "instructed Ms. Owsley to submit the fraudulently altered data to government healthcare programs for payment." (*Id.* at 43).

Owsley provides the following examples of patients whose OASIS forms were allegedly altered "and then billed" to the United States:

> (1) A CCC registered nurse evaluated Patient A and indicated on the OASIS form that this patient was being treated for a simple leg

wound. However, Fazzi altered the diagnosis on the OASIS form to include uncontrolled diabetes, hypertension, diabetic neuropathy and morbid obesity. There was no medical documentation supporting these diagnoses.

(2) A CCC registered nurse evaluated Patient B—a Medicare Advantage patient—and diagnosed her with a leg ulcer. Without any supporting documentation, Fazzi altered the diagnosis to include a malignant cancer of the larynx.

(3) Another CCC Medicare patient—Patient C—is ambulatory and can self-inject insulin. Nevertheless, Fazzi altered the OASIS forms to indicate that she is nonambulatory and cannot self-inject insulin.

(4) Patient D, a CCC post-surgical patient on Medicare, utilizes the assistance of a handheld walker. Fazzi upcoded her diagnosis to paraplegia.

(5) Another CCC patient on Medicaid—Patient E—was treated for a skin lesion, but the diagnosis was fraudulently upcoded to nonambulatory and diabetic.

(*Id.* at ¶ 38).

Owsley also provides one example of Fazzi altering the OASIS data of a Gem City Patient. (*Id.* at ¶ 67). More specifically, she alleges that Gem City patient, "Patient H," received minor surgery to remove a cyst, with her primary physician noting that the patient did not suffer from diabetes, COPD, apnea, or other specified diseases. However, Fazzi altered the OASIS form to list several diseases, including diabetes

and apnea, "which were not supported by any medical documentation." (*Id.*). Further, Owsley believes the upcoded diagnoses have caused patients to receive unnecessary procedures. For example, patients coded as diabetic by Fazzi without a medical basis, such as "Medicare Patient F," received an A1C lab test unnecessarily. (*Id.* at ¶¶ 44-45).[1]

Owsley explains that the inflation of OASIS data coincides with an effort by the Defendant home-health agencies to inflate their "Star Ratings." (*Id.* ¶¶ 46-62). The Center for Medicare and Medicaid Services operates a website that displays Star Ratings for home-health agencies based on health outcome improvements, such as improvement in ambulation and improvement in pain interfering with activities. (*Id.* at ¶ 48). The Star Ratings serve as "an additional tool to support consumers' health care decision-making." (*Id.* at ¶ 47). The ratings are calculated based on OASIS data and other Medicare claims data. (*Id.*). Care Connection nurses are incentivized to boost the agency's Star Rating, with Care Connection offering a $500 bonus if the rating has improved by the end of the year. (*Id.* at ¶ 52).

When reviewing OASIS data, Owsley is able to see the data before and after Fazzi's coding changes and she has observed changes to the data that specifically affect Care Connection's Star Rating. (*Id.* at ¶¶ 35, 53). Owsley provides examples of Fazzi coders changing eight answers to OASIS questions (that affected the

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[1] In her consolidated response brief, Owsley concedes (and abandons) any claims related to the allegations in her first amended complaint based on allegedly improper physical therapy services. (Doc. 51 at 6 n.1).

Star Rating) for "Patient G," indicating that Patient G was in a worse condition than originally assessed by a nurse. (*Id.* at ¶ 54).[2]

When Owsley raised the issue of Fazzi changing answers affecting the Star Rating to her supervisor, Tamela Kunztman, Kunztman allegedly responded, "[w]e can report this, but if you don't agree with this you can leave and get another job." (*Id.* at ¶ 55). Further, in a meeting between Owsley, a colleague, and Sherry Flannery, the Director of Regional Operations for Evolution Health, about the Start Ratings scheme, Flannery "told them that the Star Ratings assessments must show improvement by the time the patients are discharged," which Owsley and her colleague took to mean that the patients must be given inflated scores in their initial assessment. (*Id.* at ¶ 56). Owsley also documents several specific examples of nurses voicing their opposition to Fazzi's coding alterations, with one nurse stating, "I am not spending anymore of my personal time to change back my answers to the actua[l] and true assessment as I originally documented. This guy is not any of the answers that Fazzi changed to. Why do they have to change them? They should just make recommendations. Somehow this has to be Medicare fraud." (*Id.* at ¶ 58). Another nurse stated, "we have been instructed to let you all do the coding . . . . I fill in the physical assessment and I have changed back 1830 and 1860 because it is what I assessed . . . . So please ask us to consider changing an[y]

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[2] For example, Owsley states that Nurse Gumm, in her initial assessment, coded Patient G as "able to bathe self independently" – and, thereafter, Fazzi coder, Maryia Dabrynets, changed the answer to "able to bathe with intermittent assistance of a person." (Doc. 15 at ¶ 54).

response [and] not change the assessment to fit your needs." (*Id.* at ¶ 59).

Based on these allegations, Owsley asserts the following claims: (1) knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A) ("presentment claim"), (2) knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim in violation of 31 U.S.C. § 3729(a)(1)(B) ("false record claim"), (3) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government in violation of 31 U.S.C. § 3729(a)(1)(G) ("reverse false claim"), (4) conspiracy to commit a violation of subparagraphs (A), (B), or (G) ("conspiracy claim"), and (5) violation of the Indiana FCA. (*Id.* at ¶¶ 71-90).

Owsley filed her first amended complaint on March 7, 2017. (Doc. 15). The United States declined to intervene on April 6, 2018. (Doc. 22). The Envision Defendants and Fazzi have each moved to dismiss the first amended complaint in its entirety. (Docs. 42, 44). The motions are fully briefed and ripe for review. For the reasons stated below, the Court will grant Defendants' motions to dismiss and will dismiss Owsley's first amended complaint with prejudice.

II. STANDARD OF REVIEW

A motion to dismiss pursuant to Federal Rule of Civil Procedure 12(b)(6) operates to test the sufficiency of the complaint and permits dismissal of a complaint

for "failure to state a claim upon which relief can be granted." To show grounds for relief, Federal Rule of Civil Procedure 8(a) requires that the complaint contain a "short and plain statement of the claim showing that the pleader is entitled to relief."

Pleadings offering mere "'labels and conclusions' or 'a formulaic recitation of the elements of a cause of action will not do.'" *Bell Atl. v. Twombly*, 550 U.S. 544, 555 (2007). In fact, in determining a motion to dismiss, "courts 'are not bound to accept as true a legal conclusion couched as a factual allegation[.]'" *Id*. at 555 (citing *Papasan v. Allain*, 478 U.S. 265 (1986)). Further, "[f]actual allegations must be enough to raise a right to relief above the speculative level[.]" *Id.* Accordingly, "[t]o survive a motion to dismiss, a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Iqbal*, 556 U.S. at 678. A claim is plausible where a "plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Id.* Plausibility "is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Id.* "[W]here the well-pleaded facts do not permit the court to infer more than the mere possibility of misconduct, the complaint has alleged—but it has not 'show[n]'—'that the pleader is entitled to relief,'" and the case shall be dismissed. *Id.* (citing Fed. R. Civ. P. 8(a)(2)).

In addition, claims brought under the FCA are subject to Federal Rule of Civil Procedure 9(b)'s heightened pleading requirement that "a party . . . state with particularity the circumstances constituting fraud." *United States ex rel. Prather v. Brookdale*

Senior Living Cmtys., Inc., 838 F.3d 750, 760 (6th Cir. 2016). Rule 9 should not be read to "reintroduce formalities to pleadings" and operates in conjunction with Rule 8's requirement of a "short and plain statement of the claim." *United States ex rel. Sheldon Kettering Health Network*, 816 F.3d 399, 408 (6th Cir. 2016) (citing *United States ex rel. Bledsoe v. Cmty. Health Sys.*, 501 F.3d 493, 503 (6th Cir. 2007)). The "overarching purpose" of Rule 9(b) is to "ensure that [the] defendant possesses sufficient information to respond to an allegation of fraud." *Id.* (citing *United States ex rel. SNAPP, Inc. v. Ford Motor Co.*, 532 F.3d 496, 504 (6th Cir. 2008)).

At a minimum, a relator must allege the "time, place, and content of the alleged misrepresentation on which the injured party relied." *Bledsoe*, 501 F.3d at 505. "A relator cannot meet this standard without alleging which specific false claims constitute a violation of the FCA." *Id.* "Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally." *Chesbrough v. VPA., P.C.*, 655 F.3d 461, 466 (6th Cir. 2011). Like in any other case, "[i]n the *qui tam* context, 'the Court must construe the complaint in the light most favorable to the plaintiff, accept all factual allegations as true, and determine whether the complaint contains enough facts to state a claim to relief that is plausible on its face.'" *United States ex rel. Ibanez v. Bristol-Myers Squibb Co.*, 874 F.3d 905, 914 (6th Cir. 2017) (quoting *SNAPP*, 532 F.3d at 502).

III. ANALYSIS

As stated above, Relator Owsley asserts presentment and false record claims under 31 U.S.C. §§ 3729(a)(1)(A)-(B) for knowingly presenting, or

causing to be presented, a false or fraudulent claim for payment or approval, and for knowingly making, using, or causing to be made or used, a false record . . . material to a false or fraudulent claim, respectively. (Doc. 15 at ¶¶ 71-75). Owsley also asserts a "reverse false claim" under § 3729(a)(1)(G), and a conspiracy claim under § 3729(a)(1)(C), as well as claims under the Indiana FCA. (*Id.* at ¶¶ 76-90). The Envision Defendants and Fazzi have separately moved to dismiss Owsley's First Amended Complaint, arguing, among other things, that Owsley has failed to plead FCA violations with adequate specificity under Rule 9(b). (Doc. 41 at 6-17; Doc. 44 at 16-28).

A. Relator fails to plead presentment under § 3729(a)(1)(A) with particularity

To assert a "presentment claim" under § 3729(a)(1)(A) of the FCA, a realtor must allege with specificity that the defendant "knowingly present[ed], or caus[ed] to be presented, a false of fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A). This "requires proof that the alleged false of fraudulent claim was 'presented' to the government." *United States ex rel. Marlar v. BWXT Y-12, LLC*, 525 F.3d 439, 445 (6th Cir. 2008). A heath care provider is not liable under the FCA for mere "disregard of Government regulations or improper internal policies;" rather, liability attaches when "as a result of such acts, the provider knowingly asks the Government to pay amounts it does not owe." *Prather*, 838 F.3d at 768 (quoting *Sanderson v. HCA—The Healthcare Co.*, 447 F.3d 873, 877 (6th Cir. 2006)); *see also Sanderson*, 447 F.3d at 878 (describing the fraudulent claim as "the *sine qua non* of a False Claims Act violation") (quoting *United States ex rel. Clausen v. Lab. Corp. of Am.*, 290 F.3d

1301, 1311 (11th Cir. 2002)). In other words, a relator must do more than "describe a private scheme in detail" and 'then . . . allege simply . . . that the claims requesting illegal payments must have been submitted, were likely submitted or should have been submitted to the Government." *United States ex rel. Hockenberry v. OhioHealth Corp.*, No. 16-4064, 2017 WL 4315016, at *2 (6th Cir. April 14, 2017) (quoting *Sanderson*, 447 F.3d at 877).

Moreover, "[w]here a relator pleads a complex and far-reaching fraudulent scheme," to meet the pleading requirement of Rule 9(b), she must provide "examples of specific false claims submitted to the government pursuant to that scheme." *Ibanez*, 874 F.3d at 914 (quoting *Prather*, 838 F.3d at 768). "Although the relator does not need to identify *every* false claim submitted for payment, [s]he must identify with specificity 'characteristic examples that are illustrative of the class of all claims covered by the fraudulent scheme.'" *Chesbrough*, 655 F.3d at 470 (quoting *Bledsoe*, 501 F.3d at 511).

The fraudulent scheme alleged in Relator's Second Amended Complaint is far-reaching. Owsley asserts that following a joint venture agreement between Evolution and Ascension in September 2014, Evolution outsourced coding for its home-health agencies, including Care Connection and Gem City to Fazzi. (*Id.* at ¶¶ 10, 11, 35, 66, 68). Based on her observations as a Quality Assurance Nurse for Care Connection, Owsley alleges that Fazzi systematically "upcoded" patient OASIS data which "serves as the basis for billings submitted to government healthcare programs." (*Id.* at ¶¶ 34, 53). This "nationwide" scheme to over-bill the government allegedly occurred from at least December

2014 up through the present, with Owsley "continu[ing] to observe fraudulent diagnoses almost every day." (*Id.* at ¶¶ 1, 70). Owsley estimates that "nearly half" of all OASIS forms contain fraudulently altered data. (*Id.* at ¶ 70). In light of these extensive allegations, Owsley must provide a representative sample of false claims submitted to the government in order for her complaint to proceed to discovery.

Owsley effectively concedes in her consolidated response brief that she has not directly identified an example of a fraudulent bill that was submitted to the government. Rather than rebut this argument by Defendants, Owsley focuses exclusively on her argument that the Court should apply the "relaxed" *Prather* standard discussed below. In her position at Care Connection, Owsley reviewed OASIS data and Plans of Care, but was not involved in the actual submission of RAPs or "claims" to the government.[3] *See Prather*, 838 F.3d at 766 ("[RAPs] . . . constitute 'claims' for purposes of the False Claims Act . . ." and "are treated similarly to requests for final payment"); *see also id.* at 768 (finding that relator failed to plead submission of a specific RAP despite providing detail regarding the fraudulent scheme and patient documentation for submission of payment to Medicare); (Doc. 15 at ¶ 34). Owsley provides examples of allegedly altered OASIS data but then states in a conclusory manner that the forms were "billed by Defendants to the United

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[3] A "claim" is defined by the FCA as "any request or demand . . . for money . . . that—(i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor . . . or other recipient, if the money . . . is to be spent or used on the Government's behalf or to advance a Government program or interest . . ." 31 U.S.C. § 3729(b)(2)(A).

States." (Doc. 15 at ¶ 38). She does not attach or identify a RAP or request for final payment, or otherwise identify an actual claim.

However, Owsley is correct that the Sixth Circuit permits an FCA claim to proceed without the identification of an actual bill or invoice in limited circumstances where the relator demonstrates "a strong inference that specific false claims were submitted for payment" "by pleading specific facts based on her personal billing-related knowledge." *Prather*, 838 F.3d at 773; *see also Ibanez*, 874 F.3d at 915. In *Prather*—the first and only Sixth Circuit case to find the "strong inference" standard met—the relator provided four specific examples of patients, including the approximate dates of the episode of care, an allegation that the RAPs and requests for final payment were submitted (sometimes giving dates of submission for one or both), and the amount of the requested final payment. *Id.* at 769-70. In addition, Prather included an exhibit listing hundreds of patients, including the dates of the treatment episode, the specific home-health provider, and the specific community in which each patient lived. *Id.* at 770. The Sixth Circuit also considered the unique circumstances surrounding the relator's allegations. Prather was hired for the specific purpose of working through a backlog of Medicare claims, and she described her responsibilities as reviewing final claims in anticipation of the billing department's submission of the claims to Medicare. *Id.* Furthermore, Prather received confirmation from the billing department that the final claims she reviewed were submitted. *Id.*

In the instant case, Owsley, employed as Quality Assurance Nurse, reviews OASIS data and is "the last set of eyes" to review Plans of Care "before the

resulting RAP is produced." (Doc. 15 at ¶ 34). Thus, like Prather, Owsley reviews documentation related to the submission of claims to Medicare; but, unlike Prather, Owsley does not review "final claims" prior to their submission to the billing department. Owsley states that after her review of the Plans of Care, "the RAP is produced." (*Id.*). However, she fails to allege who produces the RAP (*i.e.*, the billing department) and does not allege anywhere in the complaint that she personally reviews or has access to the RAPs—which constitute "claims" under the FCA. In addition, unlike Prather, Owsley does not allege she is notified when claims related to the documentation she reviews are actually submitted. Owsley states that RAPs are submitted the morning following her review of the Plans of Care, but she does not provide a factual basis for this allegation, such as communication with billing department employees. *See Marlar*, 525 F.3d at 446 (rejecting presentment claim where relator alleged "on information and belief" that fraudulent claims were submitted to the government). Thus, although Owsley alleges "firsthand knowledge of how Care Connection bills government health programs," she has not provided important factual details connecting her role reviewing OASIS data and Plans of Care to the actual submission of claims to Medicare or any other government entity.

Moreover, Owsley's examples of patients whose OASIS data were allegedly altered "and then billed by Defendants to the United States" are significantly less detailed than the examples provided by the relator in *Prather*. Owsley provides five examples of Care Connection patients and one example of a Gem City patient whose diagnoses were allegedly "upcoded" by

Fazzi. (Doc. 15 at ¶¶ 38, 67). The patients are not identified in any way, such as by initials, and unlike the samples in *Prather*, there are no specified dates of either the episodes of care or the submission of RAPs or final claims for payment. Owsley simply notes a change in diagnosis made by Fazzi, for example "ambulatory and can self-inject insulin" to the opposite, "non-ambulatory and cannot self-inject insulin." (*Id.*). In some, but not all of the examples, Owsley asserts the changes were made "without any supporting documentation." (*Id.*). Owsley also states Fazzi fraudulently coded "Patient F" as diabetic with "no medical basis for this diagnosis," which resulted in Care Connection performing an unnecessary test associated with the diabetes diagnosis. (*Id.* at 45). A further example involving "Patient G," includes the name of the nurse who performed the initial assessment, the date of the assessment, and the name of the Fazzi coder who allegedly fraudulently upcoded Patient G's diagnoses. (*Id.* at 54). However, each of Owsley's examples lack details related to the submission of a claim to Medicare, such as the date the claim was submitted or the amount of the payment requested.

Without details related to the billing process, Owsley has failed to demonstrate a "strong inference" that Defendants submitted claims for payment to the government for the specific, identified patients. *See, e.g.*, *United States ex rel. Holloway v. Heartland Hospice, Inc.*, No. 3:10-cv-1875, 2019 WL 2611077, at *13 (N.D. Ohio June 26, 2019) (finding relator who reviewed claims prior to submission to Medicare failed to demonstrate a "strong inference" that a false claim was actually submitted due to a lack of detail *related to claims for payment* such as amounts billed or

Medicare certification dates). In *United States ex rel. Crockett v. Complete Fitness Rehabilitation, Inc.*, the Sixth Circuit found that a relator who was exposed to allegedly inflated patient coding that formed "the very basis" of Medicare billing, failed to demonstrate a strong inference that a fraudulent claim was submitted, due to a lack of detail related to the billing process. 721 F. App'x 451, 458-59 (6th Cir. 2018). This was despite the fact that the relator provided emails reflecting pressure from her supervisors to upcode patient diagnoses and provide lengthier therapy sessions. *Id.* at 454-55. In *Crockett*, the relator was arguably further removed from the billing process than Owsley, as, in that case, the relator's employer billed a separate company for services it provided, which then prepared and submitted bills to Medicare. *Id.* at 454. Yet, the principle remains: detailed factual allegations regarding internal fraudulent conduct are insufficient to mount an FCA claim.

Although Owsley provides details related to the alleged upcoding scheme, including her brushed-off attempts to alert her supervisors, Fazzi's coding training program, and the correlation between upcoding and the home-health agencies' Star Ratings—these details relate to potential internal fraudulent conduct and do not assist Owsley in demonstrating the submission of a false claim for payment. Accordingly, Owsley has failed to plead with the level of specificity required by Rule 9(b) that a specific claim was submitted to the government.

B. Relator's remaining FCA and state claims fail

Owsley has similarly failed to adequately plead her false record claim under § 3729(a)(1)(B), reverse

false claim under § 3729(a)(1)(G), and conspiracy claim under § 3729(a)(1)(C).

Section 3729(a)(1)(B) of the FCA holds liable any person who "knowingly makes, uses, or causes to be made or used a false record or statement material to *a false or fraudulent claim*." (emphasis added). Although the Supreme Court in *Allison Engine Co. v. United States ex rel. Sanders*, 553 U.S. 662, 671 (2008), held that "presentation" of a false statement or record to the government is not an element of a false records claim under § 3729(a)(1)(B), the Sixth Circuit has since clarified that this does not "relieve [a relator] of the need to plead a connection between the alleged fraud and *an actual claim made to the government*."[4] *Chesbrough*, 655 F.3d at 472-73 (emphasis added). "The alleged connection must be evident." *Ibanez*, 874 F.3d at 916. For example, in *Ibanez*, the Sixth Circuit found the connection between the allegedly false statement and claim made to the government "too attenuated to establish liability" where the relator failed to plead a false claim either directly or under the *Prather* standard. *Id.* at 915-16. This was even after the realtor proposed amending the complaint to add data showing some claims were submitted to government programs, because the relator failed to tie *those particular claims*

[4] Congress amended § 3729(a)(1)(B), formerly codified at § 3729(a)(2), as part of the Fraud Enforcement and Recovery Act, Pub. L. No. 111-21, 123 Stats. 1617 (2009). The change removed the intent requirement in response to *Allison Engine*. Section 3729(a)(2) used to read: "knowingly makes, uses, or causes to be made or used, a false record or statement *to get* a false or fraudulent claim paid or approved by the Government." The amendment removed the phrase "to get" and replaced it with the current materiality requirement. *See Chesbrough*, 655 F.3d at 467 n.2.

to the alleged false statements. *Id.* at 922; *see also Kettering*, 816 F.3d at 407, 411-14 (denying false statement claim where relator failed to sufficiently plead a false claim).

Thus, because Owsley has failed to plead a false claim with specificity, it follows that she has not demonstrated a connection between the examples of upcoded data to an actual claim made to the government. As discussed *supra*, although Owsley documents multiple instances of what she considers to upcoding, she does not plead with specificity the existence of a false claim based on the allegedly fraudulent data. Consequently, her false record claim pursuant to § 3729(a)(1)(B) is subject to dismissal.

Without pleading a false claim with specificity, Owsley's "reverse false claim" under § 3729(a)(1)(G), and conspiracy claim under § 3729(a)(1)(C), also fail, as both claims rely on an assumption that false claims were submitted to the government. *Crockett*, 721 F. App'x at 459. A reverse false claim under § 3729(a)(1)(G) imposes liability when a person accepts an overpayment from the government and fails to refund the difference. This section does not expressly require "presentment" of a claim, but it does require either evidence that the defendant knowingly failed to remit an overpayment or "proof that the defendant made a false record or statement at the time the defendant owed to the government an obligation." *Chesbrough*, 655 F.3d at 473. A relator cannot demonstrate this by merely stating "that the defendant is obligated to repay all payments it received." *Id.*

Owsley's first amended complaint alleges that "Defendants knew they had received millions of dollars in home health . . . payments that were fraud-

ulently inflated by false patient OASIS assessment information," yet "took no action to . . . repay or refund those payments . . . ." (Doc. 15 at ¶ 25). Thus, Owsley's theory "requires the assumption that the United States actually received, much less paid, any overstated bills" from Defendants. *Crockett*, 721 F. App'x at 459. Owsley has not identified a fraudulent bill to the government, and thus cannot demonstrate a "concrete obligation" owed to the government. Nor does she allege facts demonstrating overpayment. Accordingly, her reverse false claim is insufficiently pleaded. *Id.* (citing *Chesbrough*, 655 F.3d at 473); *see also Ibanez*, 874 F.3d at 917 (finding "[r]elators do not plead facts that show defendants received overpayment, must less that they retained it.").

Owsley's final FCA claim, conspiracy to violate the FCA under § 3729(a)(1)(C), similarly fails. Under § 3729(a)(1)(C), a realtor must allege a "request or demand intended to be paid by the government." *Crockett*, 721 F. App'x at 459. As previously established, Owsley has not shown that Defendants made a claim for payment to the government. It follows that she has not identified a "request or demand" for payment, and as a result, she has not demonstrated this element of an FCA conspiracy claim. *Id.*

In addition, to plead conspiracy under the FCA, a realtor must allege facts showing there was a plan or agreement "to commit a violation of" the FCA. "[I]t is not enough for relators to show there was an agreement that made it *likely* there would be a violation of the FCA; they must show an agreement was made in order to violate the FCA." *Ibanez*, 874 F.3d at 917. Owsley does not identify an agreement to violate the FCA.

The first amended complaint alleges Ascension and Envision entered a joint-venture agreement in September 2014 "to provide home health care services," and Owsley alleges that soon after this agreement, Evolution "directed [Care Connection] to outsource all OASIS coding reviews to Fazzi." (*Id.* at ¶¶ 35, 68). Owsley further states that she believes that Evolution Health is using Fazzi for each of its home-health agencies. (*Id.* at ¶ 68). However, Owsley does not allege that the joint-venture agreement between Evolution Healthcare Holdings and Ascension, nor the contract with Fazzi, was entered into for the purpose of violating the FCA. Nor do the facts alleged support an inference of such an agreement. Therefore, Owsley's conspiracy claim, like her other three FCA claims, is insufficiently pleaded.

Finally, Owsley also asserts fraud claims under the Indiana FCA. (Doc. 15 at ¶¶ 85-90). Because the Indiana FCA parallels the federal FCA, the analysis addressing the federal FCA claims is "equally applicable" to the state claims. *United States ex rel. York Howze v. Sleep Ctrs. Fort Wayne, LLC*, No. 1:11-cv-35, 2016 WL 1358457, at *1 n.1 (N.D. Ind. Apr. 6, 2016). As such, Owsley's claims under the Indiana FCA are also subject to dismissal.

IV. DISMISSAL WITH PREJUDICE

Defendants request that the Court dismiss Relator's complaint with prejudice. Generally, "a district court 'should freely give leave to amend when justice so requires.'" *United States ex rel. Roycroft v. Geo Grp., Inc.*, 722 F. App'x 404, 408 (6th Cir. 2008). However, "the district court must have before it the substance of the proposed amendment to determine whether

'justice so requires.'" *Id.* Moreover, a court need not permit amendment "under . . . circumstances [that] would encourage delay and bad faith." *Glazer v. Chase Home Fin., LLC*, 704 F.3d 452, 458-59 (6th Cir. 2013). One such circumstance is "where a party in its response to a defendant's motion to dismiss seeks leave to amend only in the event the Court finds the original complaint deficient." *United States ex rel. Kustom Prods. v. Hupp & Assocs.*, No. 2:15-cv-3101, 2017 WL 2021512, at *6 (citing *Begala v. PNC Bank, Ohio, Nat'l Ass'n*, 214 F.3d 776, 783 (6th Cir. 2000)).

Owsley previously filed an amended complaint, and in her response brief, Relator seeks a second opportunity to amend the complaint, should the Court find her first amended complaint deficient. (Doc. 51 at 23). Thus, rather than seek leave to amend her complaint in response to Defendants' motions to dismiss, Owsley seeks leave only on the condition that her existing complaint is found to be deficient. The Court is also left to decide whether a second opportunity to amend the complaint is appropriate without the benefit of reviewing a proposed amended complaint. Accordingly, Owsley's request for leave to amend her complaint is denied.

V. CONCLUSION

Based on the foregoing, Defendants' motions to dismiss (Docs. 42, 44) are **GRANTED**, and Plaintiff's complaint (Doc. 15) is **DISMISSED with prejudice**. The Clerk shall enter judgment accordingly, whereupon this case is **TERMINATED** in this Court.

IT IS SO ORDERED.

Date: 11/18/19 /s/____________________

Timothy S. Black
United States District Judge

APPENDIX C

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

Case No. 15-cv-511

FILED UNDER SEAL
PURSUANT TO 31 U.S.C. § 3730(b)(2)

UNITED STATES OF AMERICA; STATE OF INDIANA; *EX REL.* CATHY OWSLEY,

Plaintiffs,

v.

FAZZI ASSOCIATES, INC.; CARE CONNECTION OF CINCINNATI; GEM CITY HOME CARE; ASCENSION HEALTH CARE; ENVISION HEALTHCARE HOLDINGS, INC.,
Defendants.

AMENDED *QUI TAM* COMPLAINT

This is an action brought by Plaintiff/Relator Cathy Owsley on behalf of the United States of America pursuant to the False Claims Act, 31 U.S.C. § 3729, *et seq.* (the "FCA"), and the State of Indiana pursuant to the Indiana Medicaid False Claims and Whistleblower Protection Act (the "IMFCWPA"), 5-11-5.7, *et seq* (as amended through P.L. 109-2014). In support thereof, Relator alleges as follows:

1. From at least December 2014 through the present, Fazzi Associates, Inc. and Envision Healthcare Holdings through its partner Ascension Health Care, and through its subsidiaries, Care Connection of Cincinnati, and Gem City Home Care (collectively "Defendants"), have engaged in a scheme to defraud the United States and the State of Indiana by knowingly submitting and/or causing to be submitted false and/or fraudulent claims, and retaining overpayments from government healthcare programs, including Medicare, Medicaid, and TRICARE.

2. Specifically, Defendants altered or falsified patient assessments to inflate Outcome and Assessment Information Set ("OASIS") scores in order to qualify for higher reimbursement amounts from government healthcare programs. As explained below, OASIS data are used for multiple purposes including calculating several types of quality reports which are provided to home health agencies to help guide quality and performance improvement efforts.

3. Consequently, Defendants knowingly billed, or caused to be billed, government healthcare programs for services which were based on falsified patient assessments and diagnoses. In some cases, falsified patient assessments and diagnoses of diabetes have caused unnecessary procedures to be performed on patients, raising the concern that Defendants' fraudulent conduct is compromising patient safety.

4. The FCA and IMFCWPA provide that any person who knowingly submits or causes to be submitted to the government or recipients of federal funds a false or fraudulent claim for payment or approval is liable for a civil penalty of between $10,781.40 and $21,562.80 for each such claim, and three times the

amount of the damages sustained by the government. The FCA permits persons having information regarding a false or fraudulent claim against the government to bring an action on behalf of the government and to share in any recovery. The complaint must be filed under seal, without service on the defendant. The complaint remains under seal while the government conducts an investigation of the allegations in the complaint and determines whether to join the action.

5. Pursuant to the FCA and IMFCWPA, Plaintiff/Relator seeks to recover on behalf of the United States and the State of Indiana, damages and civil penalties arising from Defendants' overcharging of Medicare, Medicaid, and CHAMPUS/TRICARE by: (1) falsifying patient assessments and diagnoses to qualify for higher reimbursement rates; (2) billing for services not rendered or medically unnecessary; and (3) retaining known overpayments.

PARTIES

6. Relator Cathy Owsley is a resident of Ft. Thomas, Kentucky. She was licensed as a registered nurse by the State of Ohio on March 30, 1979 and has been continually licensed since that date. Ms. Owsley has 17 years of home healthcare experience. Since 2006, she has worked as a Quality Assurance Nurse for Care Connection of Cincinnati. She is responsible for reviewing patient assessment forms and completing Plans of Care that are initiated by the assessing clinician and must be signed by a physician. In addition, in this capacity, she has firsthand knowledge of how Care Connection bills government healthcare programs based on the Plans of Care she reviews.

7. Defendant Fazzi Associates, Inc. ("Fazzi") is located in Northampton, Massachusetts and specializes in the coding of home care and hospice medical services. Fazzi holds itself out as the largest outsource coding service in the country.

8. Defendant Care Connection of Cincinnati ("CCC" or "Care Connection") is a home health agency located in Cincinnati, Ohio. Its parent company is Evolution Health Care of Dallas, Texas, a division of Defendant Envision Healthcare Holdings, Inc. CCC has a normal census of 1500 patients, more than 60% of whom are insured by government health care plans.

9. Defendant Gem City Home Care ("Gem City") is a home health agency with locations in Dayton, Ohio; Columbus, Ohio and Indianapolis, Indiana. Its parent company is Evolution Health, a division of Defendant Envision Healthcare Holdings, Inc. Together, CCC and Gem City provide home nursing services in 53 counties in Ohio and Indiana.

10. Defendant Envision Healthcare Holdings, Inc. ("Envision") was formed in January 2005 as Emergency Medical Services Corporation. Envision provides a broad range of healthcare solutions, ranging from medical transportation to hospital encounters to comprehensive care alternatives. Envision issued an initial public offering in late 2005, and on that date, merged with a private equity firm. In 2012, Envision created a division called Evolution Health, which is a healthcare services provider specializing in post-acute care management of patients with advanced illnesses and chronic disease with annual revenues of $4 billion. Evolution Health is headquartered in Dallas, Texas, with more than 1,100 employees managing a daily census of more than 11,000 patients. Envision will

hereinafter be referred to as "Evolution Health." Evolution Heath has outsourced its home healthcare coding to Defendant Fazzi for all of its home healthcare agencies.

11. Defendant Ascension Health is a faith-based healthcare organization and is a direct subsidiary of Ascension, the largest non-profit health system in the United States. It is headquartered in Edmundson, Missouri. In September 2014, Ascension Health and Evolution Health entered a joint venture agreement to provide home health care services. Pursuant to this agreement, Evolution Health is Ascension Health's "exclusive partner" in the provision of home health care services. Both parties to the agreement anticipated annual revenues to be between $75 and $100 million.

JURISDICTION AND VENUE

12. This action arises under the False Claims Act, 31 U.S.C. §§ 3729-3732, and the Indiana Medicaid False Claims and Whistleblower Protection Act, IC 5-11-5.5. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1345, 28 U.S.C. § 1367 and 31 U.S.C. § 3732(a), which confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730. Additionally, 31 U.S.C. § 3732(b) confers jurisdiction on this Court for state-law claims that arise under the same transactions or occurrences as the action brought under 31 U.S.C. § 3730.

13. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b)-(c) and 31 U.S.C. § 3732(a) because Defendants can be found in, reside in, or have transacted business in the Southern District of Ohio, and many of the alleged acts occurred in this District.

14. Ms. Owsley is an original source as defined by the False Claims Act in 31 U.S.C. § 3730(e)(4)(B). She has made voluntary disclosures to the United States and the State of Indiana prior to the filing of this lawsuit and this Amended Complaint as required by 31 U.S.C. § 3730(b)(2).

REGULATORY OVERVIEW

The Federal and State False Claims Acts

15. The False Claims Act, as amended by the Fraud Enforcement and Recovery Act of 2009, Pub. L. No. 111-21[1] provides, in relevant part:

> **Liability for Certain Acts.** (1) **In General** – Subject to paragraph (2), any person who –(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; . . . or (G) knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, is liable to the United States for a civil penalty of not less than [$5,500] and not more than [$11,000] . . . plus 3 times the

[1] The FCA was further amended on March 23, 2010 by the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. 111-148, 124 Stat. 119. PPACA did not impact the portions of the FCA quoted here.

amount of damages which the Government sustains because of the act of that person.

31 U.S.C. § 3729(a)(1).

Actions by Private Persons. (1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government.

31 U.S.C. § 3730(b)(1).

16. Additionally, the State of Indiana has passed False Claims Act legislation which closely mirrors the Federal FCA. Defendants' acts alleged herein constitute a violation of the Indiana False Claims and Whistleblower Protection Act, IC 5-11-5.7.

17. Ms. Owsley seeks to recover damages and civil penalties in the name of the United States of America and the State of Indiana arising from the false statements and claims for payment made by Defendants to the United States and the State of Indiana. Specifically, the false statements and claims involve "upcoding" home health prospective payment data by fraudulently manipulating and altering patient assessments and diagnoses in order to inflate prospective payments.

Duty to Report and Return Overpayments

18. The Medicare and Medicaid program integrity provisions, 42 U.S.C. § 1320a-7k(d), state as follows:

(d) Reporting and returning of overpayments

(1) In general

If a person has received an overpayment, that person shall--

(A) Report and return the overpayment to the Secretary, the State, an intermediary, a carrier, a contractor, as appropriate, at the correct address; and

(B) Notify the Secretary, State, intermediary, carrier, or contractor to whom the overpayment was returned in writing of the reason for the overpayment.

(2) Deadline for reporting and returning overpayments

An overpayment must be reported and returned under paragraph (1) by the later of—

(A) The date which is 60 days after the date on which the overpayment was identified; or

(B) The date any corresponding cost report is due, if applicable.

(3) Enforcement

Any overpayment retained by a person after the deadline for reporting and returning the overpayment under paragraph (2) is an obligation (as defined in section 3729(b)(3) of Title 31) for purposes of section 3729 of such title.

GOVERNMENT HEALTHCARE PROGRAMS

19. The Medicare Program ("Medicare") is a health insurance program administered by the Government of the United States that is funded by

taxpayer revenue. Medicare is directed by the United States Health and Human Services Department ("HHS"). Medicare was designed to assist participating states in providing medical services, durable medical equipment and prescription drugs to persons over 65 years of age and certain others.

20. The Medicaid Program ("Medicaid") is a health insurance program administered by state governments and is funded by State and Federal taxpayer revenue. It is overseen by HHS. Medicaid was designed to assist participating states in providing medical services, durable medical equipment and prescription drugs to financially-needy individuals who qualify for Medicaid.

21. CHAMPUS/TRICARE is a federally-funded program that provides medical benefits to (a) the spouses and unmarried children of (1) active duty and retired service members and (2) reservists who were ordered to active duty for thirty days or longer; (b) the unmarried spouses and children of deceases service members; and (c) armed forces retirees.

22. Whenever appropriate, Medicare, Medicaid and CHAMPUS/TRICARE will be collectively referred to as "government healthcare programs."

MEDICARE AND MEDICAID HOME HEALTH COVERAGE

23. Through the Medicare program administered by Center for Medicare and Medicaid Services ("CMS"), the United States provides health insurance to eligible citizens. 42 U.S.C. §§ 1395, et. seq. As part of its coverage, Medicare pays for some "home health services" for qualified patients. In order to qualify for home health care reimbursement under Medicare, a

patient must: (1) be homebound – i.e., the patient is generally confined to her home and can leave only with considerable effort; (2) need part-time skilled nursing services or speech therapy, physical therapy, or continuing occupational therapy as determined by a physician; and (3) be under a plan of care ("Plan of Care") established and periodically reviewed by a physician and administered by a qualified home health agency (HHA). 42 U.S.C. 1395(f). When a patient qualifies, government healthcare programs will pay for: (1) part-time skilled nursing care; (2) physical, occupational, or speech therapy; (3) medical social services (counseling); (4) part-time home health aide services; and (5) medical equipment and supplies. *Id*.

24. Upon a physician's referral, an HHA is required to make an initial assessment visit and perform a comprehensive assessment encompassing the patient's clinical, functional, and service characteristics. 42 C.F.R. §484.55. Accordingly, a registered nurse must evaluate the patient's eligibility for Medicare home health care, including homebound status, and must determine the patient's care needs using the Outcome and Assessment Information Set ("OASIS") instrument. (*Id*.). OASIS data are collected at the following time points: (1) start of care; (2) resumption of care following inpatient facility stay; (3) recertification within the last five days of each 60-day recertification period; (4) other follow-up during the home health episode of care; (5) transfer to inpatient facility; (6) discharge from home care; and (7) death at home. All of these assessments, with the exception of transfer to inpatient facility and death at home, require the clinician to have an in-person encounter with the patient during a home visit.

25. CMS guidance specifically states the comprehensive assessment and OASIS data collection are to be conducted by a registered nurse (RN) or any of the therapists, including physical therapist (PT), speech language pathologist/speech therapist (SLP/ST), or occupational therapist (OT). A licensed practical nurse or licensed vocational nurse (LPN/LVN), physical therapy assistant (PTA), occupational therapy assistant (OTA), medical social worker (MSW), or aide may not complete OASIS assessments.

26. The OASIS diagnostic items describe the patient's observable medical condition (clinical), physical capabilities (functional), and expected therapeutic needs (service). Because the OASIS data form the basis of the physician-ordered Plan of Care, CMS guidance states "there should be congruency between documentation of findings from the comprehensive assessment and the Plan of Care."

27. Based upon the OASIS information – and in turn upon the expected cost of caring for the patient – the patient's "case mix assignment" is determined and the patient is assigned to one of 153 Home Health Resource Groups ("HHRGs"). The patient's HHRG assignment and other OASIS information are represented by a Health Insurance Prospective Payment System (HIPPS) code that is used by government healthcare programs to determine the rate of payment to the HHA for a given patient. Consequently, the truthfulness and accuracy of all data in the OASIS form is material to the government's decision to pay for home services.

28. Once the HHA has submitted the patient's OASIS information, partial payment is made based on a presumptive 60-day episode. In order to continue

receiving covered care for another 60-day episode, the patient must be re-certified by a physician within the final five days of the initial episode as requiring and qualifying for home health care, and a new comprehensive assessment must be performed. The initial base rate may be subject to upward adjustment, such as where there is a "significant change in condition resulting in a new case-mix assignment," or downward adjustment, such as where the number of predicted therapy visits substantially exceeds the number actually performed. Throughout the patient's episode, the HHA is required to maintain clinical notes documenting the patient's condition and the health services performed.

29. Government healthcare programs pay for home health care by way of a Prospective Payment System ("PPS"). 42 C.F.R. § 484. The PPS is based on a "national prospective 60-day episode payment," a rate based on the average cost of care over a 60-day episode for the patient's diagnostic group. The OASIS assessment data is used for the calculation of the national prospective 60-day episode payment. An HHA must submit to CMS the OASIS data described at § 484.55 (*see* ¶24, above) in order for CMS to administer applicable payment rate methodologies.

30. Government expenditures on home health care have risen dramatically in the last decade. According to a report by the Medicare Payment Advisory Commission, HHAs, as an industry, currently enjoy an average profit margin of nearly 16%. In light of the explosive growth in profits to private companies and cost to Medicare, abuse of the home health system has been identified by CMS as a major concern. In March, 2009, the Government Accountability Office published a

report entitled "Improvements Needed to Address Improper Payments in Home Health." The GAO reported findings that the startling rise in home health spending was caused in part by fraud on the part of HHAs, including upcoding or overstating the severity of a patient's condition and billing for medically unnecessary treatments.

ALLEGATIONS

Defendants Knowingly Falsified Patient Assessments and Diagnoses in Order to Receive Higher Reimbursement Amounts from Government Healthcare Programs

31. Government healthcare programs' home health Prospective Payment System is intended to cover the projected cost of patient care. To that end, government healthcare programs require that an HHA registered nurse make an initial visit to each patient and perform a comprehensive assessment using the OASIS instrument. Medicare's prospective payment for that patient is then tied to the type and intensity – and therefore cost – of care that will be required. For example, a patient who is bedridden requires more care – and is reimbursed at higher rates – than a patient who can walk. Similarly, some conditions, (for example, strokes) may require extensive, costly, physical and occupational therapy, whereas others, such as minor wound care, may require only limited skilled nursing care and instruction.

32. The admitting HHA nurse is responsible for developing a physician-approved Plan of Care based on the patient's clinical diagnosis and observable characteristics. All encoded OASIS data must accurately reflect the patient's status at the time of assessment.

42 CFR 484.20(b). Based on the OASIS codes reported by the HHA, the patient is placed in one of 153 HHRGs and associated with one of 640 HIPPS codes that are designed to provide the most accurate payment for each patient.

33. With the goal of fraudulently placing patients in higher-value groups and boosting Medicare payments, Defendants systematically manipulate the PPS by altering and manipulating the OASIS data to falsely represent that the patient is in worse condition that he/she is. These false assessments and manipulated OASIS data directly increase the reimbursement amount government healthcare programs pay to the Defendant home health agencies. Thus, government healthcare programs are routinely billed for, and pay for, patient conditions which are exaggerated or, in some instances, fictitious.

34. Throughout her employment as Quality Assurance nurse with Care Connection of Cincinnati in 2006, Ms. Owsley has reviewed executed OASIS forms and utilized the information provided to complete Plans of Care. CCC uses information on the OASIS forms and Plans of Care to generate a Requested Anticipated Payment ("RAP") form which serves as the basis for billings submitted to government healthcare programs. In her current position at CCC, Ms. Owsley is "the last set of eyes" that reviews the Plans of Care before the resulting RAP is produced. The RAPs are submitted to CMS the very next morning while the physician's signature on the Plan of Care is still pending. As shown below, while Ms. Owsley is aware that the Plans of Care and RAPs contain altered patient assessments and falsified diagnoses and are, therefore, fraudulent, her supervisors have specifically

instructed her to not change any of the information contained on either the OASIS forms or Plans of Care.

35. As alleged above (*see* ¶10), Ascension Health and Evolution Health entered a joint venture agreement in September 2014 to provide home health care services. In December 2014, Evolution Health directed CCC to outsource all OASIS coding reviews to Fazzi. Fazzi has no contact with any patients and is neither authorized nor legally permitted, to manipulate OASIS data. Though her job responsibilities changed as a result of Fazzi's involvement, Ms. Owsley remains responsible for reviewing OASIS data and completing the Plans of Care after the field clinician assesses the patient. Consequently, Ms. Owsley is able to review Fazzi's fraudulent altering of OASIS data.

36. Ms. Owsley quickly realized that Fazzi coders were altering OASIS data by enhancing existing diagnosis codes and adding new codes that were not supported by any medical documentation. She additionally observed that, although federal regulations require coding be based upon the status of the patient at the time of the evaluation, Fazzi violates these regulations by using outdated patient history to justify alterations.

37. CCC and Evolution Health's other home health agencies then use the fraudulently altered OASIS data to complete Plans of Care, which as described above, become the basis of payment by government healthcare programs to Evolution Health.

38. Ms. Owsley has personal knowledge of several specific examples of this fraudulent conduct. The following are a representative sample of 2015 Medicare/Medicaid patients whose OASIS forms have been

altered, and then billed by Defendants to the United States.

(a) A CCC registered nurse evaluated Patient A[2] and indicated on the OASIS form that this patient was being treated for a simple leg wound. However, Fazzi altered the diagnosis on the OASIS form to include uncontrolled diabetes, hypertension, diabetic neuropathy and morbid obesity. There was no medical documentation supporting these diagnoses.

(b) A CCC registered nurse evaluated Patient B—a Medicare Advantage patient—and diagnosed her with a leg ulcer. Without any supporting documentation, Fazzi altered the diagnosis to include a malignant cancer of the larynx.

(c) Another CCC Medicare patient—Patient C—is ambulatory and can self-inject insulin. Nevertheless, Fazzi altered the OASIS forms to indicate that she is non-ambulatory and cannot self-inject insulin.

(d) Patient D, a CCC post-surgical patient on Medicare, utilizes the assistance of a hand-held walker. Fazzi upcoded her diagnosis to paraplegia.

(e) Another CCC patient on Medicaid—Patient E—was treated for a skin lesion, but the diagnosis

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[2] Patient specific information has been redacted from this Complaint pursuant to the Health Insurance Portability and Accountability Act. In accordance with federal law, Relator has provided copies of the relevant medical documentation pertaining to each of the patients described in this Complaint to the appropriate government agencies.

was fraudulently upcoded to non-ambulatory and diabetic.

39. CCC, with assistance from Fazzi, knowingly altered OASIS forms as described above and created Plans of Care which reflected the falsifications. These Plans of Care became the basis for government payment to CCC.

40. Beginning in March 2015, CCC began conducting training sessions with its healthcare workers to teach them how to falsify OASIS data when initially evaluating patients, so as to match Defendant Fazzi's coding methods in order to later justify fraudulent upcoding. Specifically, during zone meetings, CCC instructs its registered nurses to falsify answers to an OASIS form question pertaining to ambulation (MO1860), by selecting an answer that indicates that the patient cannot walk without the assistance of another person at all times. CCC requires its nurses choose this answer even if the patients can walk without any assistance at all. These fraudulent answers result in higher reimbursement amounts from government healthcare programs. In addition, Ms. Owsley's (now former) supervisor, Beverly Naber, has distributed written handouts at these zone meetings which confirm that Fazzi is using old and outdated evaluations and multiple clinicians' evaluations to justify changing the assessing clinician's OASIS answers.

41. After she discovered Defendants' fraud, Ms. Owsley immediately expressed her concerns to her then-supervisor, Beverly Naber, and to Robert James, Evolution Health's then-Vice President of Midwest Operations. Specifically, Ms. Owsley sent Naber and James several emails identifying examples of Fazzi's fraudulent upcoding and explaining why it was

unlawful. For example, in late April 2015, Ms. Owsley emailed James advising him that Fazzi had altered an OASIS form to falsely represent a diagnosis of pancreatic cancer, even though the patient did not have pancreatic cancer. James did not respond to the email.

42. In late April 2015, Ms. Owsley directly reported to James that Fazzi was fraudulently diagnosing Medicare patients with fractures that, in some cases, occurred more than 20 years earlier. James replied "It is what it is." He then requested Ms. Owsley to email examples of fraudulent upcoding involving previous fractures. Ms. Owsley complied with the request, but James never responded.

43. Ms. Owsley has had in-person meetings with both Naber and James where she has explained that Defendants are defrauding government healthcare programs by fraudulently altering patient data. While Ms. Owsley's supervisors promised her that they would address her concerns, the fraud has continued. Despite being informed that Defendants are violating federal law, both Naber and James instructed Ms. Owsley to submit the fraudulently altered data to government healthcare programs for payment.

44. Upon information and belief, Ms. Owsley believes these fraudulent diagnoses have resulted in unnecessary procedures being performed on patients, which she believes could compromise the safety of those patients. Specifically, in 2015, CMS required all HHAs to perform "A1C" lab tests on all diabetic patients in order to be eligible for government reimbursement.

45. Because Defendants falsely diagnosed patients as diabetic, patients unnecessarily underwent

the A1C lab test so that CCC could receive reimbursement from Medicare. For example, Fazzi falsely coded Medicare Patient F as diabetic, even though there is no medical basis for this diagnosis. As a result, CCC performed the A1C test on her in order to receive the higher reimbursement amount associated with a diabetes diagnosis.

Defendants Are Altering Patient Assessments to Fraudulently Boost "Star Ratings"

46. Defendants have devised a scheme to inflate its "Star Ratings" score to prospective customers who are in the market for home health care. As noted above, government healthcare programs determine reimbursement amounts based on the need of the patient at the time of assessment. Accordingly, fraudulently boosted "Star Ratings" scores cause government healthcare programs to reimburse the Defendant home health agencies at higher amounts than is medically necessary or justified.

47. In order to provide consumers a "convenient source of authoritative information on provider quality," CMS has established the Home Health Compare (HHC) website to assist consumers when choosing a home health care provider. As part of this outreach, CMS has created a "star ratings" system which will "summarize some of the current measures of health care provider performance[.]" CMS intends for these star ratings to serve as "an additional tool to support consumers' health care decision-making."

48. All Medicare-certified HHAs are potentially eligible to receive a Quality of Patient Care Star Rating (hereafter "Star Rating"). The Star Rating is based on OASIS assessments and Medicare claims data and

utilizes a methodology that comprises a number of factors, including several "outcome quality measures." According to CMS, these Outcome Measures include: (1) improvement in ambulation; (2) improvement in bed transferring; (3) improvement in bathing; and (4) improvement in pain interfering with activities.

49. Thus, there are numerous questions on the OASIS assessment which directly affect an HHA's Star Rating. These assessment questions are coded at certain levels, with higher levels (such as "4" or "5") indicating an assessment which requires the most medical attention and assistance and "0" requiring the least.

50. CCC alters patient assessments to falsely inflate its Star Ratings. Beginning in March 2015, CCC began conducting training sessions with its healthcare workers to teach them how to enter OASIS data when initially evaluating patients. As part of this training, CCC requires its registered nurses to watch training videos created by Fazzi, which are made available online through the "Fazzi Academy." One video instructed nurses to answer question M2020 (oral medications) to indicate that patients were unable to take their own medications simply because they were homebound and, therefore, not able to drive themselves to a pharmacy.

51. At a 2015 zone meeting, Beverly Naber instructed registered nurses to falsify answers to an OASIS form question pertaining to ambulation (M1860) by selecting an answer that indicates that the patient cannot walk without the assistance of another person at all times irrespective of whether the answer was accurate. In April 2015, Ms. Owsley reviewed a patient evaluation completed by Bobbie Mechley, a home health care registered nurse who evaluated a patient

and stated that she needed "someone at all times for ambulation." Ms. Owsley noted that the patient evaluation did not match this diagnosis, and expressed her concern to Mechley. Mechley responded via email "I put her down as needing stand by assist [sic] because in the last zone meeting they recommended that we do this [for] patients getting therapy that aren't using a cane/walker."

52. Along with the mandatory training sessions described above, CCC is incentivizing its employees to fraudulently boost its Star Ratings by creating a bonus plan whereby nurses can receive an extra $500 if CCC's Star Ratings improve by the end of the calendar year. This combination of training videos and incentive plans has resulted in patient assessments being altered on nearly a daily basis.

53. As part of her quality assurance responsibilities, Ms. Owsley is able to view "audit trails" for each OASIS form. These audit trails specifically identify which questions relate to Star Ratings by designating them as "star" questions. In viewing the audit trails, Ms. Owsley is able to see both the original scores for these Star Ratings questions (as recorded by the nurse providing the assessment) and the changes that Fazzi then makes to the scores. Inevitably, Fazzi's changes always result in a higher score. Ms. Owsley has observed dozens of patient-specific examples where Fazzi has changed answers to Star Ratings questions after the nurse has completed the patient assessment.

54. For example, Ms. Owsley reviewed the OASIS audit trail for Patient G. Registered Nurse Rebecca Gumm performed the assessment of this patient on October 8, 2016 and noted that in response to OASIS question M1830 (bathing), the patient was "able

to bathe self independently." Yet, Fazzi Coder Maryia Dabrynets changed this answer to "able to bathe with intermittent assistance of a person." As a result of this change, the designated value for OASIS question M1830 increased from a "0" to a "2", which indicates the patient is in worse condition than s/he actually is. Similarly, RN Gumm noted that in response to OASIS question M1860 (ambulation), the same patient was "able to independently walk on even and uneven surfaces and negotiate stairs with or without railings." However, Fazzi changed this answer to "able to walk only with the supervision or assistance of another person at all times." As a result of this change, the designated score value for OASIS question M1860 increased from a "0" to a "3." Both the M1830 and M1860 questions are designated as "Star" questions on the OASIS audit trail. In total, Fazzi changed answers to eight (8) OASIS questions for this patient.

55. Ms. Owsley informed her supervisor, Tamela Kunztman, that Fazzi was changing answers to Star Ratings questions for dozens of patients. When Kuntzman asked Ms. Owsley to provide her with an example, she emailed Kuntzman a detailed description of how Fazzi changed the answers for a specific patient. Kuntzman did not reply. When Ms. Owsley later followed up with Kuntzman about her concerns at a meeting, Kuntzman responded "We can report this, but if you don't agree with this you can leave and get another job."

56. In a November 14, 2016 meeting, Ms. Owsley and Carol Dieckman, a quality assurance nurse, spoke with Sherry Flannery, Director Regional Operations for Evolution Health, about the scheme to boost CCC's Star Ratings. Flannery told them that the Star Ratings

assessments must show improvement by the time the patients are discharged. Both Ms. Owsley and Dieckman understood this to mean that the initial assessments must be scored higher than is medically justified so that by the time the patients are discharged, the assessments will indicate the patients had improved while under the care of CCC. As explained below, these fraudulent answers result in higher reimbursement amounts from government healthcare programs.

57. CCC instructs nurses who perform patient assessments to accept and agree to any changes Fazzi makes to the original answers to OASIS questions. Many of these nurses have shown reluctance to change any answers and have voiced their concerns to their supervisors and to Ms. Owsley. For example, in an email to her supervisors, RN Chasity Cundiff explained that she is being asked to change answers to questions pertaining to care of a patient's wounds. Cundiff stated in the email that she cannot change the answers as instructed because "it would be false documentation."

58. Ms. Owsley has observed that most nurses acquiesce to Fazzi's changes out of fear of losing their jobs, while others are too busy to correct Fazzi's changes to match the original patient assessments. For example, Registered Nurse Jenny Coy, in response to changes Fazzi made to her patient assessment, provided notations in the OASIS documentation where she requested that Ms. Owsley "audit all of my charts" and indicated that "I am not spending anymore of my personal time to change back my answers to the actua[l] and true assessment as I originally documented. This guy is not any of the answers that Fazzi changed to. Why do they have to change them? They should just

make recommendations. Somehow this has to be Medicare fraud."

59. Another RN, Debra Caylor, was equally blunt when, in response to Fazzi changing her patient assessment, told Fazzi that "we have been instructed to let you all do the coding to ensure proper and accurate codes. I fill in the physical assessment and I have changed back 1830 and 1860 because it is what I assessed, not because you feel the need to support your codes. So please ask us to consider changing an[y] response not change the assessment to fit your needs."

60. Prior to December 2014—when CCC (at Evolution Health's direction) began outsourcing its coding practices to Fazzi—RNs rarely designated a patient with higher OASIS scores for Star Ratings questions. Ms. Owsley has been observing higher scores for these questions since 2015, and the nurses performing the assessments repeatedly admit that they are now scoring the patients higher because they have been instructed to do by their supervisors.

61. Again, under the prospective payment system ("PPS"), Medicare pays home health agencies a predetermined base payment which is adjusted for the health condition and care needs of the patient. The adjustment for the health condition, or clinical characteristics, and service needs of the beneficiary is referred to as the case-mix adjustment. The home health PPS will provide HHAs with payments for each 60-day episode of care for each beneficiary.

62. When CCC and Fazzi alter patient assessments, this generates Plans of Care which are fraudulent because they are based on altered and incorrect assessments. These Plans of Care result in higher

reimbursement amounts from government healthcare programs than are medically and legally justified, since the reimbursement amounts are determined by the needs of the patient at the time of assessment.

CCC is Fraudulently Billing Government Healthcare Programs for Therapy Services it Never Provided

63. Government healthcare programs require HHAs to perform periodic reassessments on their patients who are in need of therapy services, such as occupational, speech or physical therapy. Medicare regulations require that these services only be performed by a licensed therapist.

64. CCC often contracts with licensed therapists who can perform the required assessments. In her role as quality assurance nurse, Ms. Owsley has observed patient files which indicate that reassessments have been performed. However, the patient files indicate that reassessments have been performed by Danielle Reynolds. Ms. Reynolds is a patient scheduler and not a licensed therapist.

65. Consequently, Ms. Owsley believes that CCC is fraudulently receiving payment from government healthcare programs for therapy services that were either not performed or were not performed by a licensed therapist as required by Medicare guidelines.

Evolution Health and Fazzi Are Engaged in a Nationwide Scheme to Defraud Government Healthcare Programs

66. Evolution Health and Fazzi are defrauding government healthcare programs as to all Evolution Health facilities nationwide. In March 2015, a

representative of four of Evolution Health's Indiana home health care agencies attended a training session at the CCC office where Ms. Owsley is employed. The purpose of the training was to familiarize the representative with both Fazzi's review methods and how the quality assurance nurses would complete the Plans of Care (based on Fazzi's review) for the Indiana offices. When Ms. Owsley spoke directly with Evolution Health Vice President Bob James regarding her concerns that Fazzi was altering OASIS data, James responded by saying that "we have to use Fazzi. Everybody else is using them and we have to as well." In a January 25, 2017 conversation with Brandy Kilmer, one of Ms. Owsley's supervisors, Kilmer confirmed that Evolution Health has outsourced the coding practices of each of its home health agencies to Fazzi.

67. Ms. Owsley has reviewed documentation establishing that Fazzi is improperly altering OASIS forms for patients at Defendant Gem City Home Care. For example, Patient H, a Gem City Home Care Medicaid patient, received minor surgery to remove a cyst. Her primary physician specifically noted that the patient does not suffer from diabetes, COPD, apnea, and certain other diseases. In spite of this notation, Fazzi altered the OASIS form to include diabetes, sickle-cell anemia, airway obstruction, congestive heart failure, esophageal reflux, apnea, depressive disorder and other conditions which were not supported by any medical documentation.

68. Based on this information, including the fact that CCC outsourced its coding practices to Fazzi as soon as Evolution Health took control of CCC in September 2014 (see, supra, ¶9), Ms. Owsley believes that Evolution Health is using Fazzi system-wide for each

of its home health agencies. According to its website, Evolution Health operates Defendants Care Connections of Cincinnati, Gem City Home Care, and Ascension Health, along with home health care companies Guardian Healthcare and Millennium Home Care. As such, Evolution Health exercises operational control of dozens of home health agencies across the United States.

69. As a result of this nationwide fraudulent scheme, Defendants place their patients in more lucrative HHRGs that do not accurately reflect the types of care or therapies the patients require. In so doing, the Defendant home health agencies falsely represent to the United States that they are performing certain care that is prescribed and medically necessary, when in fact it is not. Consequently, the United States pays for services that are not part of the patient's legitimate Plan of Care and may in fact be contrary to the patient's true physician-diagnosed condition.

70. Ms. Owsley continues to observe fraudulent diagnoses almost every day. OASIS forms are submitted every nine weeks. Ms. Owsley estimates that Defendants fraudulently alter nearly half of all OASIS forms. Ms. Owsley further estimates that each fraudulently altered OASIS form results in a $3,000 increase. To date, Ms. Owsley calculates that CCC alone has fraudulently billed government healthcare programs in excess of $2.7 million. To her knowledge, Evolution Health has not refunded any payments to government healthcare programs.

COUNT I

VIOLATION OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729(A)(1)(A-B)

71. Ms. Owsley realleges and incorporates paragraphs 1 through 70 as though fully set forth herein.

72. This is a civil action brought by Ms. Owsley on behalf of the United States against Defendants under the Federal False Claims Act, 31 U.S.C. § 3729-33.

73. Under the False Claims Act, 31 U.S.C. § 3729(a)(1), as amended on May 20, 2009, Defendants have violated:

i. 31 U.S.C. § 3729(a)(1)(A) by knowingly presenting, or causing to be presented, a false or fraudulent claim for payment or approval; and/or

ii. 31 U.S.C. § 3729(a)(1)(B) by knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim.

74. Government healthcare programs, unaware of the falsity of the claims and/or statements made or caused to be made by Defendants, and in reliance on the accuracy of these claims and/or statements, paid for purported medical services performed for patients insured by federally-funded health insurance programs, including Medicare, Medicaid and CHAMPUS/TRICARE. Had the United States known that the bills presented by Defendants were false and/or fraudulent, payment would not have been made for such claims.

75. Defendants' unlawful conduct is continuing in nature and has caused the United States to suffer damages.

COUNT II

VIOLATION OF THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729(A)(1)(G)

76. Ms. Owsley realleges and incorporates paragraphs 1 through 70 as though fully set forth herein.

77. Through the acts described above, Defendants intentionally and knowingly failed to remit funds paid by government healthcare programs for services never rendered by Defendants. Defendants knew they had received millions of dollars in home health PPS payments that were fraudulently inflated by false patient OASIS assessment information, yet Defendants took no action to satisfy their obligations to the United States to repay or refund those payments and instead retained the funds and continued to bill the United States.

78. Under the False Claims Act, 31 U.S.C. § 3729(a)(1), as amended on May 20, 2009, Defendants have violated 31 U.S.C. § 3729(a)(1)(G) by knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government.

79. Defendants' fraudulent concealment and intentional failure to report funds that were improperly received from government healthcare programs constitutes an unlawful avoidance of an obligation to pay money owed to the United States.

80. Defendants' unlawful conduct is continuing in nature and has caused the United States to suffer damages.

COUNT III

CONSPIRACY TO VIOLATE THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729(A)(1)(C)

81. Ms. Owsley realleges and incorporates paragraphs 1 through 70 as though fully set forth herein.

82. Under the False Claims Act, 31 U.S.C. § 3729(a)(c), as amended on May 20, 2009, Defendants have violated conspired to commit a violation of subparagraph (A), (B), or (G) by:

i. by conspiring to knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval; and/or

ii. by conspiring to knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim.

83. Government healthcare programs, unaware of the falsity of the claims and/or statements made or caused to be made by Defendants, and in reliance on the accuracy of these claims and/or statements, paid for purported medical services performed for patients insured by federally-funded health insurance programs, including Medicare, Medicaid and CHAMPUS/TRICARE. Had the United States known that the bills presented by Defendants were false and/or fraudulent, payment would not have been made for such claims.

84. Defendants' unlawful conduct is continuing in nature and has caused the United States to suffer damages.

COUNT IV

VIOLATION OF THE INDIANA MEDICAID FALSE CLAIMS AND WHISTLEBLOWER PROTECTION ACT IC 5-11-5.5, *et seq.*

85. Ms. Owsley realleges and incorporates paragraph 1 through 70 as though fully set forth herein.

86. This count sets forth claims for treble damages and forfeitures under the Indiana False Claims and Whistleblower Protection Act.

87. Through the acts described above, Defendants knowingly cause to be presented to the Indiana Medicaid Program fraudulent claims, records, and statements in order to obtain reimbursement for services not rendered.

88. Defendants knowingly violated:

i. IC 5-11-5.7-2(b)(1) by knowingly or intentionally presenting a false claim to the state for payment or approval;

ii. IC 5-11-5.7-2(b)(2) by knowingly or intentionally making or using a false record or statement to obtain payment or approval of a false claim from the state; and/or

iii. IC 5-1—5.7-2(b)(6) by knowingly or intentionally making or using a false record or statement to avoid an obligation to pay or transmit property to the state.

89. Defendants knowingly presented false claims for payment to the State of Indiana. The State of Indiana, unaware of the falsity of these claims, approved, paid and participated in payments made by the State of Indiana Medicaid Program for claims that otherwise would not have been allowed.

90. Defendants' unlawful conduct is continuing in nature and has caused the State of Indiana to suffer damages.

PRAYER

WHEREFORE, Cathy Owsley, on behalf of the United States and the State of Indiana, requests:

a. This Court entered an order determining that Defendants violated the Federal and State False Claims Act by billing Government Payors for services not rendered and unlawfully retaining overpayments;

b. Defendants pay an amount equal to three times the amount of damages the United States and the State of Indiana have sustained because of Defendants' actions, plus a civil penalty against Defendants of not less than $10,781.40 and not more than $21,562.80 for each violation of the Federal and Indiana False Claims Acts;

c. Defendants cease and desist from violating the Federal and State False Claims Acts;

d. Ms. Owsley be awarded all costs of this action, including attorneys' fees, expenses, and costs pursuant to the Federal and Indiana False Claims Acts;

e. Ms. Owsley be award a relator's share of any recovery as provided by the Federal and Indiana False Claims Acts; and

f. The United States, the State of Indiana and Ms. Owsley be granted all such other relief as the Court deems just and proper.

DATED: March 7, 2017

Respectfully submitted,

s/____________________

FREDERICK M. MORGAN

* * *

APPENDIX D

Federal Rule of Civil Procedure 9 provides in relevant part:

Rule 9. Pleading Special Matters

* * *

(b) Fraud or Mistake; Conditions of Mind. In alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally.

* * *

The False Claims Act provides in relevant part:

31 U.S.C. § 3729. False claims

(a) LIABILITY FOR CERTAIN ACTS.—

(1) IN GENERAL.—Subject to paragraph (2), any person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104-410[1]), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) REDUCED DAMAGES.—If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about

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[1] So in original. Probably should read "Public Law 101-410".

the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation,

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) COSTS OF CIVIL ACTIONS.—A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

* * *