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When Can Opinions Be "False" and Result in False Claims Act Liability: Three Circuit Courts Provide Conflicting Guidance—Part II

By Robert S. Salcido*

Recently three circuit courts have considered when opinions can be false under the False Claims Act ("FCA"). Although the circuits disagree regarding whether plaintiff must establish "objective falsity" to assert an FCA violation, they agree that the common law provides guidance regarding when an opinion can be false under the FCA. In the first part of this two-part article, which appeared in the February 2021 issue of Pratt's Government Contracting Law Report, *the author discussed the background of the issue and U.S. Supreme Court precedent. In this second part of the article, the author explains the circuit split and offers key takeaways.*

ELEVENTH CIRCUIT'S DECISION IN *ASERACARE* APPLIES *OMNICARE'S* COMMON LAW TEST

In *AseraCare,* the U.S. Court of Appeals for the Eleventh Circuit considered the circumstances in which a certification can be considered "false" when the hospice provider certifies that the patient is "terminally ill," and clinicians can reasonably disagree regarding whether a patient is "terminally ill."

To establish its case, the government retained an expert physician to review a sample of claims to determine whether patients admitted to the hospice were terminally ill. Upon direct review of patients' medical records and clinical histories, the government's expert opined that 123 patients from a sample were ineligible for the hospice benefit at the time the defendant received reimbursement for their care.[31]

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31 938 F.3d 1278, 1285 (11th Cir. 2019). Specifically, in developing its case, the government began by identifying a universe of approximately 2,180 patients for whom defendant had billed Medicare for at least 365 continuous days of hospice care. *Id.* at 1284. The government then focused its attention on a sample of 223 patients from within that universe. *Id.* at 1284–85. Through direct review of these patients' medical records and clinical histories, the government's primary expert witness identified 123 patients from the sample pool who were, in his view, ineligible for the hospice benefit at the time the defendant received reimbursement for their care.

However, he conceded that he could not say the defendant's medical expert, who disagreed with him concerning the accuracy of the prognoses at issue, was necessarily wrong.[32]

Moreover, the government's expert never testified that, in his opinion, no reasonable doctor could have concluded that the identified patients were terminally ill at the time of certification.[33]

At the conclusion of trial, after the jury had heard the government's and the hospice's expert clinicians' divergent opinions regarding whether the patients were terminally ill, the district court provided the following instruction to the jury on falsity: "A claim is 'false' if it is an assertion that is untrue when made or used. Claims to Medicare may be false if the provider seeks payment, or reimbursement, for health care that is not reimbursable."[34]

Thus, under the court's instruction, the precise question before the jury was which doctor's interpretation of those medical records sounded more correct. In other words, in this battle of experts, the jury was to decide which expert it thought to be more persuasive, with the less persuasive opinion being deemed a "false" opinion.[35]

Under the court's falsity instruction, the jury ultimately found that the defendant had submitted false claims for 104 of the 123 patients at issue during the relevant time period.[36] Following the partial verdict in this first phase of

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Id. at 1285. Should it prevail as to this group, the government intended to extrapolate from the sample to impose further liability on the defendant for a statistically valid set of additional claims within the broader universe of hospice patients for whom the defendant received Medicare payments. *Id.* at 1285.

[32] *Id.* at 1287.

[33] *Id.*

[34] *Id.* at 1289. Prior to trial, the defendant moved the district court to bifurcate trial into two phases: Phase One would address the FCA's falsity element and Phase Two would address the FCA's remaining elements and the government's common-law claims. *Id.* at 1286. The district court granted the motion in light of its concern that evidence pertinent to the knowledge element of the FCA would confuse the jury's analysis of the threshold question of whether the claims at issue were "false" in the first instance. *Id.* at 1287. The court did allow in Phase One general testimony regarding the defendant's business practices and claims submission process during the relevant time period, but only to contextualize the falsity analysis and "afford[] the jury an opportunity to more fully understand the hospice process within [the defendant]." *Id.* at 1287. The court noted that such evidence was not, however, admissible to prove the falsity of the claims at issue. *Id.*

[35] *Id.* at 1288–89.

[36] *Id.* at 1289.

trial, the defendant moved for judgment as a matter of law, arguing that the court had articulated the wrong legal standard in its jury instructions.[37]

The district court agreed, noting that it "became convinced that it had committed reversible error in the instructions it provided to the jury."[38] It ultimately concluded that proper jury instructions would have advised the jury of two "key points of law" that the court had not previously acknowledged: (1) that the FCA's falsity element requires proof of an objective falsehood, and (2) that a mere difference of opinion between physicians, without more, is not enough to show falsity.[39] The court ultimately concluded that the only way to cure the prejudice its instruction caused was to order a new trial.[40]

The Eleventh Circuit concurred with the district court that a mere reasonable disagreement among clinicians is insufficient to establish FCA falsity. The court noted that a government witness conceded that "two doctors using their clinical judgment could come to different conclusions about a patient's prognosis and neither be right or wrong."[41] The court concluded that under these circumstances the physician's judgment could not be false, ruling that a "properly formed and sincerely held clinical judgment is not untrue even if a different physician later contends that the judgment is wrong."[42]

In reaching this conclusion, the Eleventh Circuit cited to and relied upon the Supreme Court's decision in *Omnicare*.[43] In addition to adhering to *Omnicare's* general principle that a properly formed and sincerely held opinion is not untrue even if a different person contends that it is wrong, the *AseraCare* court also identified essentially the same factors that could render the opinion false.

For example, the court noted that the physician's opinion can be false if the plaintiff proves that the physician did not, in fact, subjectively believe that her patient was terminally ill at the time of certification.[44]

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[37] *Id.* at 1289–90.

[38] *Id.* at 1290.

[39] *Id.*

[40] *Id.*

[41] *Id.* at 1296.

[42] *Id.* at 1297.

[43] *Id.*

[44] *Id.*

The physician's opinion can also be false if it is at odds with verifiable facts such as when expert evidence proves that no reasonable physician could have concluded that a patient was terminally ill given the relevant medical records.[45]

The physician's opinion can also be false if the physician knows of no facts that would justify the opinion such as failing to review a patient's medical records or otherwise familiarize herself with the patient's condition before asserting that the patient is terminal because it fails to reflect clinical judgment.[46]

But the court concluded, by contrast, that a reasonable difference of opinion among physicians reviewing medical documentation *ex post* is not sufficient on its own to suggest that those judgments—or any claims based on them—are false under the FCA.[47]

The court acknowledged that compelling the plaintiff to establish objective falsity "will likely prove more challenging for an FCA plaintiff" than "to find an expert witness willing to testify to a contrasting clinical judgment regarding cold medical records." But ultimately, "if this is a problem, it is one for Congress or CMS to solve."[48]

NINTH CIRCUIT ESSENTIALLY APPLIES SAME COMMON LAW TEST AS DESCRIBED IN *ASERACARE*

In *Winter*, relator contended that defendants submitted Medicare claims falsely certifying that patients' inpatient hospitalizations were medically necessary.[49] The district court ruled that to prevail, plaintiff must show that defendant knowingly made an objectively false representation "so a statement that implicates a doctor's clinical judgment can never state a claim under the FCA because 'subjective medical opinions . . . cannot be proven to be objectively false.' "[50]

The U.S. Court of Appeals for the Ninth Circuit reversed, ruling that Congress imposed no requirement of proving an "objective falsity" and it could not engraft that requirement on to the statute.[51] The court concluded that a

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[45] *Id.*

[46] *Id.*

[47] *Id.*

[48] *Id.* at 1301.

[49] 953 F.3d at 1112.

[50] *Id.* at 1113.

[51] *Id.*

"doctor, like anyone else, can express an opinion that he knows to be false, or that he makes in reckless disregard of its truth or falsity."[52]

The court noted that CMS defines a "reasonable and necessary" service as one that "meets, but does not exceed, the patient's medical need," and is furnished "in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition . . . in a setting appropriate to the patient's medical needs and condition."[53]

The court noted that the Medicare program trusts doctors to use their clinical judgment based on "complex medical factors," but does not give them unfettered discretion to decide whether inpatient admission is medically necessary.[54] "The factors that lead to a particular clinical expectation must be documented in the medical record in order to be granted consideration."[55]

The court noted that because Congress did not define "false or fraudulent," it would presume that Congress "incorporated the common-law definitions including the rule that a statement need not contain an 'express falsehood' to be actionable."[56] As to false opinions, the court noted that under "the common law, a subjective opinion is fraudulent if it implies the existence of facts that do not exist, or if it is not honestly held."[57] The court noted that the FCA imposes liability for all "false or fraudulent claims" and "it does not distinguish between 'objective' and 'subjective' falsity of carve out an exception for clinical judgments and opinions."[58]

The court stated that the Eleventh Circuit's decision in *AseraCare* was not directly to the contrary.[59]

First, it noted that *AseraCare* did not conclude that all subjective statements are incapable of falsity.[60]

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[52] *Id.* (citation omitted).

[53] *Id.*

[54] *Id.* at 1114.

[55] *Id.* (quoting 42 C.F.R. 412.3(d)(1)(i)).

[56] *Id.* at 1117 (citation omitted).

[57] *Id.* (citing Restatement (Second) of Torts 525, 539).

[58] *Id.*

[59] *Id.* at 1118.

[60] *Id.* at 1118–19 (for example, *AseraCare* noted that a claim could be false if "the [doctor] does not actually hold that opinion" or simply "rubber-stamp[s] whatever file was put in front of him" if the opinion is "based on information that the physician knew, or had reason to know, was incorrect" or if "no reasonable physician" would agree with the doctor's opinion, "based on the evidence").

Second, *AseraCare* confined its decision to the hospice benefit which the court stated defers to whether a physician has based a recommendation for hospice treatment on a genuinely held clinical opinion whether a patient was terminally ill.[61]

The court concluded that a physician's certification that inpatient hospitalization was "medically necessary" can be false or fraudulent for the same reasons any opinion can be false or fraudulent. Like in *AseraCare*, the court noted that these "reasons include if the opinion is not honestly held, or if it implies the existence of facts—namely, that inpatient hospitalization is needed to diagnose or treat a medical condition, in accordance with accepted standards of medical practice—that do not exist."[62]

The court concluded that for purposes of Rule 12(b)(6), the relator adequately pled these factors.

For example, there was reason to conclude that the physicians may not have believed that an admission was necessary or that there was no factual foundation to conclude that an admission was necessary. The court observed, for instance, that relator, who was a former Director of Care Management at Gardens Regional Hospital, claimed that she observed that the admissions in the hospital spiked once owners of a nursing facility, which made referrals to the hospital, became co-owners of a management company that operated the hospital.[63]

The court noted that this reveals that defendants had a financial motive to falsify Medicare claims and pressure physicians to increase admissions when presumably the physicians would not otherwise believe that admission was necessary.[64]

The court also noted that relator's complaint identified 65 allegedly false claims in "great detail" and that the admissions failed to satisfy InterQual criteria that represents the "consensus of medical professionals' opinions," which presumably would also indicate that the physicians did not actually believe that admission was necessary.[65]

Finally, relator set forth anecdotal information that she confronted one doctor regarding the admissions, and he stated that hospital management

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[61] *Id.* at 1119.

[62] *Id.* (citation omitted).

[63] *Id.* at 1112, 1115.

[64] *Id.* at 1119–20.

[65] *Id.* at 1120.

pressured him into recommending patients for medically unnecessary inpatient admission, thereby indicating that physicians did not believe these admissions to be necessary or that there was no factual foundation to support the admission.[66]

The court pointed out that relator had alleged more than just a reasonable difference of opinion.[67] For example, she alleged that a number of the hospital admissions were for diagnoses that laboratory tests have disproven, and that several admissions were for psychiatric treatment, even though the hospital was not a psychiatric hospital—and one of those patients never even saw a psychiatrist.[68]

The court concluded that even if it were to discount relator's evaluation of medical records, these other facts would be sufficient to make her allegations of fraud plausible.[69]

Thus, ultimately, while the Ninth Circuit disagreed regarding whether the FCA required an objective falsehood, it ultimately applied the same common law rule regarding when an opinion can be false as the Eleventh Circuit did in *AseraCare*.

Namely, as a general matter, an opinion cannot be false unless the speaker implies the existence of facts that do not exist or if the opinion is not honestly held.

THIRD CIRCUIT INVOKES COMMON LAW BUT FAILS TO APPLY IT IN ANALYSIS REGARDING WHEN A "FALSE" OPINION IS ACTIONABLE

In *Druding*, relators alleged that defendant hospice admitted patients who were ineligible for hospice care and directed its employees to alter improperly those patients' Medicare certifications to reflect eligibility.[70] Relators retained an expert who opined based upon a medical record review that patients were inappropriately certified for hospice care 35 percent of the time.[71] In his view, any reasonable physician would have reached the same conclusion.[72]

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[66] *Id.*

[67] *Id.*

[68] *Id.* at 1120–21.

[69] *Id.*

[70] 952 F.3d at 91.

[71] *Id.*

[72] *Id.* at 94.

Defendant's expert disagreed and opined that a reasonable physician would have found that all of the patients were hospice-eligible on each occasion.[73]

At summary judgment, the district court ruled for defendant finding that a mere difference of opinion between experts regarding the accuracy of the prognosis was insufficient to create a triable dispute of fact as to the element of falsity.[74]

The U.S. Court of Appeals for the Third Circuit reversed.

It rejected the district court's holding that a "mere difference of opinion" is insufficient to show FCA falsity. It found that a mere "difference of medical opinion is enough evidence to create a triable dispute of fact regarding FCA falsity."[75] It also concluded that the district court's "objective" falsity standard improperly conflates the elements of falsity and scienter.[76]

But the Third Circuit's decision in *Druding* contains two clear flaws.

First, while invoking the common law, it did not apply the common law standard to determine when opinions can be false.

Second, while stating that the Eleventh Circuit in *AseraCare* wrongfully conflated the FCA's falsity and knowledge elements, the Third Circuit then proceeded to conflate the knowledge element with falsity and effectively wrote the FCA's falsity element out of the statute.

As to the falsity element, since Congress did not define what makes a claim "false" or "fraudulent," the court looked to common law to fill the gap but did not apply it to the facts.[77] For example, the court noted that the common law recognized that opinions can be false.[78]

However, the court did not identify any evidence that:

(1) The speaker (either the doctors making the certification or the defendant's expert) does not actually hold the opinion;

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[73] *Id.* at 91.

[74] *Id.*

[75] *Id.* at 100. *See also id.* at 101 ("We therefore find that a physician's expert testimony challenging a hospice certification creates a triable issue of fact for the jury regarding falsity").

[76] *Id.* at 95.

[77] *Id.*

[78] *Id.* (citing Restatement (Second) of Torts §§ 525, 539 that "an opinion many be false when the speaker makes an express statement contrary to the opinion he or she actually holds"). Also, like the Eleventh Circuit in *AseraCare*, it cited to the Supreme Court's decision in *Omnicare*, but unlike the *AseraCare* court, did not apply its rule.

(2) The opinion contains an embedded fact which is false;

(3) The speaker knows facts that would preclude such an opinion; or

(4) The speaker does not know facts that would justify the opinion.

As the Supreme Court noted in *Omnicare*, in applying the common law rule, a sincere statement of pure opinion, as a general matter, is not an "untrue statement of material fact" even if the speaker is ultimately wrong.[79] The Third Circuit did not apply this principle.

As to conflating falsity and knowledge, the Third Circuit asserted that the trial court wrongfully conflated falsity with knowledge because the district court noted, in rejecting relators' claim, that relators failed to establish evidence that any physician lied or certified a patient as hospice-eligible whom that physician believed was not hospice-eligible.[80]

But, rather than conflate the falsity and knowledge elements, the district court correctly segregated the falsity and knowledge element because when determining whether an opinion is false, under the common law, the common law looks to the speaker's intent. For example, did the speaker know the opinion was false? Did the speaker know that no facts supported the opinion? Did the speaker know that material facts undermined the opinion?

By contrast, the Third Circuit's ruling conflates the falsity and knowledge elements and undermines the Supreme Court's ruling in *Omnicare*. It undermines *Omnicare* because by ruling that falsity can be determined by merely an after-the-fact battle between two clinicians who reasonably disagree, *Omnicare's* principle that an honestly held opinion without more cannot be false is subverted.[81]

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[79] *See id.*, 575 U.S. at 186.

[80] 952 F.3d at 96. The Third Circuit unscored that the falsity and knowledge elements must be kept separate: "we make clear that in our Court, findings of falsity and scienter must be independent from one another for purposes of FCA liability." *Id.* at 100. As noted in detail below, its rule fails to achieve this objective.

[81] Perhaps recognizing this flaw, the Third Circuit appears to seek to sidestep this issue—regarding when clinical opinions can be false—by asserting that this case is really a legally false claim case, and not a factually false claim case. Specifically, the court noted that the issue is whether defendant adhered to the regulatory requirement that the clinical information and documentation must support the prognosis. *Id.*, 952 F.3d at 100. But the analysis of whether the physician's clinical opinion that the patient is terminally ill can be false (a factually false issue) is no different from the analysis of whether the physician's clinical opinion that the documentation supports her opinion that the patient is terminally ill can be false under the regulation (the legally false issue). The court's analysis of factual falsity versus legal falsity, in this context, is merely a distinction without a difference. The falsity issue still revolves around whether the common law

Moreover, falsity and knowledge are conflated because there would be substantial risk that a juror's perception of whether the underlying claim is false could be tainted merely because the juror hears evidence that the facility had flawed policies and procedures. For example, as the district court and Eleventh Circuit feared in *AseraCare*, a juror could find a claim to be false—even though evidence existed in the medical record that the patient was terminally ill—because the juror heard evidence that the hospice defendant had flawed procedures and policies to determine whether the patient was terminally ill in the first instance.[82]

The existence of flawed policies does not render a particular medical claim to be false if the medical evidence shows that the patient was in fact terminally ill.

Thus, while ostensibly the Third Circuit designed its rule to avoid conflation of falsity and knowledge, its ruling provided substantial risk that such conflation would occur in practice.

Additionally, it potentially writes the falsity element out of the statute to the extent plaintiff's knowledge evidence clouds the jury's perception of whether the underlying opinion is a false opinion in the first instance.

TAKEAWAYS FROM DEVELOPING CASE LAW

There are countless examples of FCA certifications that require ultimately an opinion or exercise of discretion. These range from opining on whether a service is medically necessary, whether sufficient documentation exists to support a claim and whether the compensation paid to physicians is set at fair market value for purposes of the Stark law.

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criteria for when opinions can be false are satisfied and here the court did not provide any grounds for why the medical record documentation was not sufficient to support the physicians' clinical opinion that the patient was terminally ill.

[82] *See AseraCare*, 938 F.3d at 1287 (noting that the district court bifurcated the falsity and knowledge elements "in light of its concern that evidence pertinent to the knowledge element of the FCA would confuse the jury's analysis of the threshold question of whether the claims at issue were 'false' in the first instance. The court noted that, while 'pattern and practice' evidence showing deficiencies in AseraCare's admission and certification procedures could help establish AseraCare's *knowledge* of the alleged scheme to submit false claims—the second element of the government's case—the *falsity* of the element of the claims 'cannot be inferred by reference to AseraCare's general corporate practices unrelated to specific patients' "). The Eleventh Circuit agreed with this general approach. *See id.* at 1305 (noting on remand that the government must be able to link its knowledge evidence to the specific false claims to establish both elements). The Court in *Omnicare* also endorsed the principle that a reckless truth does not result in liability if the underlying representation is true. *See id.*, 575 U.S. at 185, n. 2 ("if our CEO did not believe that her company's TVs had the highest resolution on the market, but (surprise!) they really did, § 11 would not impose liability for her statement").

In resolving whether these certifications are false, the Supreme Court's decision in *Omnicare* and the Eleventh Circuit's decision in *AseraCare* provide a framework, grounded in the common law, to resolve when opinions can be false at the pleading stage, at summary judgment and during an internal audit when deciding whether an overpayment obligation exists.

At the pleading stage, plaintiff alleging a false opinion must plead plausible facts with sufficient factual content that allows the court to draw the reasonable inference that the defendant is liable by asserting how the defendant knew that the opinion is false, knew that facts precluded that opinion or does not know facts that would justify the opinion.[83]

Similarly, at the summary judgment stage, the plaintiff must offer concrete evidence from which a reasonable juror could return a verdict in plaintiff's favor that the defendant knew that the opinion is false, knew that facts precluded that opinion or does not know facts that would justify the opinion.

Finally, when conducting an internal audit, a company will know that it does not have an overpayment obligation regarding an opinion unless there is clear evidence that the person rendering the opinion did not believe that opinion, knew that facts precluded that opinion or did not know facts that would justify the opinion.

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[83] As the Supreme Court noted in *Omnicare*, this pleading standard would require that, at a minimum, plaintiff assert more than simply that the opinion is wrong, but must call into question the speaker's basis for offering the opinion. 575 U.S. at 194. Specifically, the plaintiff should identify the particular (and material) facts going to the basis for the speaker's opinion such as facts about the inquiry the speaker did or did not conduct or the knowledge she did or did not have, whose omission makes the opinion statement at issue misleading to a reasonable person reading the statement fairly and in context. *Id.* As the Court concluded, this "is no small task." *Id.*