No. 08-

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA, *ex rel.*,
RICHARD FEINGOLD,

Petitioners,

v.

PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS, BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, and UNKNOWN DURABLE MEDICAL EQUIPMENT SUPPLIERS,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Eleventh Circuit's decision granting absolute immunity to Medicare Carriers, like the Defendants in this case, was correctly decided in view of the flatly contrary conclusion reached by the Tenth Circuit in *United States ex rel. Sikkenga v. Regence BlueCross BlueShield*, 472 F.3d 702 (10th Cir. 2006).

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The opinion of the Eleventh Circuit, dated May 20, 2008 is unpublished. (App. A) The district court order granting the respondents' motion to dismiss, dated January 30, 2007, is published. (App. B)

JURISDICTION

The district court had jurisdiction pursuant to 28 U.S.C. § 1331. The Court of Appeals had jurisdiction to review the district court's final judgment pursuant to 28 U.S.C. § 1291. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1), as the Eleventh Circuit denied a timely petition for rehearing on July 18, 2008, which is unpublished. (App. C)

STATUTES INVOLVED

Medicare's statutory immunity provision at issue in the case reads as follows:

> (1) No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by him under this section.
>
> (2) No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by him under this section if it was

> based upon a voucher signed by a certifying officer designated as provided in paragraph (1) of this subsection.
>
> (3) No such carrier shall be liable to the United States for any payments referred to in paragraph (1) or (2).

42 U.S.C. § 1395u(e) (1999)

The federal False Claims Act imposes liability, inter alia, on any person who

> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid.

31 U.S.C. § 3729(a)(1)&(2).

SUMMARY AND INTRODUCTION

The Defendants have been protected from a knowing violation of the Federal False Claims Act by a plainly incorrect interpretation of the immunity provisions of the federal Medicare law. More specifically, the Eleventh Circuit clearly, and wrongly, interpreted the immunity provisions of the Medicare law as providing absolute immunity to Medicare contractors, like the

Defendants, when both the statutory language and the applicable legislative history indicate that Medicare contractors are only to be provided immunity in the absence of "gross negligence or intent to defraud" the Medicare program. The error in statutory interpretation made by the Eleventh Circuit is amply demonstrated by the flatly contrary conclusion reached by the Tenth Circuit in its unanimous decision in *United States ex rel. Sikkenga v. Regence BlueCross BlueShield*, 472 F.3d 702 (10th Cir. 2006),[1] which was urged and supported by an Amicus Curie Brief filed by the United States Department of Justice. (Amicus Brief of the United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, July 22, 2005.)

The United States Department of Justice has recognized that the issue is "significant." (Amicus Brief of the United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, July 22, 2005 at 20 n.7.) Indeed, the potential loss to the taxpayers as a result of the Eleventh Circuit's obvious error goes far beyond the $40,000,000 at stake in this litigation. There can be little doubt that there have been billions of dollars illegally paid by Medicare contractors like the Defendants, and some estimates have placed the extent of Medicare fraud as high as seventy billion dollars each year. The taxpayers should not be expected to pay that bill, and obvious "bad actors" like the Defendants should not get a free pass for their actions.

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[1] While Judge Hartz dissented with part of the majority opinion, he concurred that Medicare contractors were not entitled to absolute immunity.

COURSE OF PROCEEDINGS AND DISPOSITION OF THE CASE

This case is a False Claims Action brought under Section 3729(a) of the federal False Claims Act. Counts III and IV of the Amended Complaint address Medicare claims illegally paid to suppliers by the Defendants acting collectively as an administrative agent for the Medicare Program. (R 70, Amended Complaint ("AC") ¶¶ 201, 205.) The Relator, Richard Feingold (hereinafter the "Relator" and/or "Feingold") undertook a personal investigation of fraudulent supplier claims for Female Urinary Collection Pouches, (hereinafter, "FUCPs") submitted to the Defendant Palmetto, a Medicare Part B payment agent (or "Carrier") (hereinafter "Palmetto" and/or "BCBS/SC") (collectively the "Defendants"). (R. 70, AC at ¶ 69, 70, 71). Feingold's investigation revealed that Palmetto had fraudulently approved over $40 million in such claims for FUCPs. (R. 126, AC at ¶ 113.) Beginning in 1994 Defendant Palmetto was the Durable Medical Equipment (DME) Regional Carrier for the South East Region (hereinafter, "DMERC"), and as such was reimbursed by Medicare for their payments to suppliers of DME including FUCPs.

By 1997 Palmetto was the only DMERC paying FUCP claims. (R 70, AC ¶¶ 116-122.) Almost all of the claims approved by Defendants for FUCPs since 1994 were illegally paid. (R 70, AC ¶ 124.)

The Relator filed this Qui Tam False Claims Action under seal on March 31, 1999. The seal was partially

lifted, and on May 11, 2000 the Department of Justice sent the initial Complaint to the Defendants. (R 70, AC ¶ 140.) Only after being shown the Relator's initial Complaint did the Defendant Palmetto's conduct undergo a significant change. Specifically, Defendants went from approving almost all claims for FUCPs to immediately disapproving virtually all (over 99%) of the claims for FUCPs (HCPCS Code A4328) submitted to them for payment. (R 70, AC ¶ 140.) (In contrast, during the first six months of 2000 Defendant Palmetto had approved 95.5% of the claims for FUCPs submitted to it. (R 70, AC ¶ 141.)).

The Government declined to intervene on September 28, 2005. On January 20, 2006 an Amended Complaint was filed under seal. On March 1, 2006, the district court ordered the Amended Complaint to be unsealed. The Amended Complaint was served on the Defendants on March 2, 2006. On March 5, 2006, the Government again declined to intervene.

Counts I and III of the Amended Complaint were brought under 31 U.S.C. § 3729(a)(1). (R 70, AC ¶¶ 191, 199.) Counts II and IV were brought under 31 U.S.C. § 3729(a)(2). (R 70, AC ¶¶ 195, 203.) On April 17, 2006, the Defendants filed a Motion to Dismiss on multiple grounds. On January 30, 2007, the district court dismissed the case with prejudice without leave to amend. (R 126, District Court Order, Appendix B at 18.) The district court dismissed Counts III and IV on the basis of the absolute statutory immunity the district court concluded was required by the Medicare Law.

(R 126, District Court Order, Appendix B at 8-11).[2] A timely appeal followed on March 1, 2007.

On May 20, 2008 a Panel of the Eleventh Circuit determined that Counts III and IV of the Amended Complaint should be dismissed. (Appendix A.) The Panel

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[2] The district court also dismissed all Counts of the Amended Complaint as failing to satisfy the requirements of Fed. R. Civ. P. 9(b). (R 126, District Court Order at 17.) The district court stated that

> "[i]n his Complaint, consisting of 214 paragraphs over 116 pages, Feingold includes a wealth of information concerning the history of the FUCP scheme. He similarly provides allegations concerning the ways in which claims are processed and submitted from health care providers to carriers, and from carriers to the government. He fails, however to point so [sic] specific examples of fraudulent claims approved or submitted by Palmetto."

U.S. Ex Rel Feingold v. Palmetto, 477 F. Supp. 2d 1187, 1195 (S. D. Fla. 2007). However, the Amended Complaint did allege that the claims payment data obtained by Feingold from the government revealed that the total payments for FUCP claims authorized by Defendants in 1995 was more than 25 times the amount of money paid by Medicare under that Code in 1992 for the entire United States. (R 70, AC ¶ 114.). From the beginning of 1997 through the second quarter of 2000, Defendant Palmetto was virtually the only Medicare Durable Medical Equipment (DME) Regional Carrier in the country approving any payments for FUCPs, paying 99.9% of all such claims on behalf of the Medicare program. (R 70, AC ¶¶ 116-122.).Almost all of the claims approved by Defendants for FUCPs since 1994 were fraudulently paid. (R 70, AC ¶ 124.)

held that its decision was controlled by the absolute immunity previously established by another panel of the Eleventh Circuit in the earlier case of *United States ex rel. Body v. Blue Cross and Blue Shield of Ala., Inc.* 156 F.3d 1098 (11th Cir. 1998) ("*Body*").[3] On July 18, 2008 the Eleventh Circuit denied Petitioners Petition for Rehearing and Rehearing En Banc regarding the application of absolute immunity protection to the defendants with respect to Counts III and IV of the Amended Complaint. (Appendix C.)

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[3] The Eleventh Circuit Panel also held that Counts I and II of the Amended Complaint did not satisfy the requirements of Rule 9(b), but, unlike the district court, the Panel did not hold that Counts III and IV failed to satisfy the requirements of Fed. R. Civ. P. 9(b). In any case, the allegations of the Amended Complaint, which establish that Medicare paid out millions of dollars on false FUCP claims submitted by the Defendants, more than satisfies the requirements of Rule 9 (b). Moreover, this Court recently has held that

> "[w]hat Section 3729 (a)(2) demands is not proof that that the defendant caused a false record or statement to be presented or submitted to the Government but that the defendant made a false record or statement for the purpose of getting 'a false or fraudulent claim paid or approved by the Government.'"

Allison Engine Co. Inc., et al., v. U.S. ex rel. Sanders, 128 S. Ct. 2123 (2008). The millions of dollars in false claims submitted to the Government by the Defendants, and actually paid by the Government, based on the submissions of the Defendants, surely satisfies that requirement as well.

FACTS

The Amended Complaint alleges that the Defendants, acting as a Part B agent, or DMERC, for the federal Medicare Program, knowingly made fraudulent payments to Medicare suppliers for FUCPs from 1994 through the second quarter of 2000. The Relator's (Feingold's) first hand efforts revealed that FUCPs are virtually never ordered by physicians because they are more costly and less effective than indwelling catheters. FUCPs were subject to spillage and can result in an unsterile patient smelling of urine, whereas catheters avoid those problems. (R 70, AC ¶ 132.)

Feingold's investigation included requesting specific Medicare claims payment data from a Medicare employee concerning billing and payment for FUCPs. (R 70, AC ¶¶ 105, 106; R 126) Based upon his personal knowledge and experience, he was able to organize and analyze the requested information, and thereby confirm that the Defendant Palmetto was fraudulently approving patently false FUCP claims submitted to them for reimbursement from Medicare. (R 70, AC at ¶¶ 124, 128; See R 126.)

The data requested by the Relator revealed that during the last four months of 1994 alone Defendants approved claims to Medicare for over 1 million FUCPs, resulting in a loss to Medicare of over $7.4 million. (R 70, AC ¶113). That was especially disturbing in light of the fact that the Relator's investigation also had revealed that the only company making reimbursable FUCPs, Hollister, manufactured less than 20,000 FUCPs between 1993 and 1995. (R 70, AC ¶ 81.) The

claims payment data also revealed that the total payments for Code A4328 claims authorized by Defendants in 1995 was more than 25 times the amount of money paid by Medicare under that Code in 1992 for the entire United States. (R 70, AC ¶ 114.)

From the beginning of 1997 through the second quarter of 2000, Defendant Palmetto was virtually the only DMERC in the country approving any payments for FUCPs, paying 99.9% of all such claims on behalf of the Medicare program. (R 70, AC ¶¶ 116-122.) The Relator advised the Government of the Defendants' fraud and filed this action under seal on March 31, 1999. (R 70, AC ¶ 124.) The seal was partially lifted and on May 11, 2000, the Department of Justice sent the initial Complaint to the Defendants. Significantly, Defendants did not stop making payments for false claims for incontinence supplies until after the Government disclosed the contents of the Relator's initial Complaint to Defendants in May of 2000. (R 70, AC ¶ 140.) Immediately after being shown the Relator's Complaint, the Defendants did a complete about face and immediately began disapproving virtually all (almost 99%) of the FUCPs submitted to them for payment. (R 70, AC ¶ 140.)

After the Relator filed his initial Complaint, additional evidence of highly questionable claims processing activities by the Defendants came to light. See (R 70, Amended Complaint at ¶¶ 16-24). For example, one former employee of the Defendants provided a detailed affidavit describing Defendants' fraudulent claims processing activities. (R 70, Amended Complaint at ¶ 151). Moreover, one federal judge, presiding over a

different case where Palmetto authorized payment of over $140 million for patently fraudulent prosthetic claims, publicly commented that, given the Defendants' performance as a fiscal agent, "[i]t is unclear why Palmetto . . . is not a subject of the Government's investigation into criminal wrongdoing, in light of the overwhelming evidence covering months of losses in the millions." (R 70, Amended Complaint at ¶ 18).

REASONS FOR GRANTING THE PETITION

The Eleventh Circuit held that Palmetto, the DMERC, was protected by the absolute immunity established by an earlier Eleventh Circuit case involving a Part A Medicare Intermediary. Appendix A at 2, citing *United States ex rel. Body v. Blue Cross and Blue Shield of Ala., Inc.* 156 F.3d 1098, 1111 (11th Cir. 1998). Although the nature of the immunity addressing Medicare Part B Carriers (including the DMERCs) is contained in a separate statutory provision from the immunity addressing Medicare Part A Intermediaries, the language of the two statutory provisions is identical.

The *Body* Court reached its conclusion by contrasting the language of Subsection 1395h(i)(3) of the Medicare Law, the Subsection of the statute applicable to Part A Intermediaries, with the language of Subsections (1) and (2) dealing with the limited immunity provided to certifying officers and disbursing officers. As the *Body* Court stated,

> "[i]n contrast to the limited immunity accorded to certifying and disbursing officers, subsection 1395(i)(3) broadly states that the

> fiscal intermediaries themselves will not be liable to the government for any of the payments referred to in paragraphs (1) and (2) – that is, payments certified by certifying officers and disbursed by disbursing officers."

Id.

In contrast, however, in reversing a district court dismissal based entirely on the *Body* decision, the U.S. Court of Appeals for the Tenth Circuit addressed precisely the same immunity question and reached precisely the opposite conclusion.[4] *United States ex rel. Sikkenga v. Regence BlueCross BlueShield,* 472 F.3d 702, 709-711 (10th Cir. 2006). According to the Tenth Circuit (and the U.S. Department of Justice) the statutory language is unambiguous. *Sikkenga,* 472 F.3d at 710; Amicus Brief of United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah,* at 7. "Correctly read, the payments referred to and incorporated by Section 1395u(e)(3) are payments made 'in the absence of gross negligence or intent to defraud the United States.'" *Id.*; See Amicus Brief of the United States Department of Justice in *United States ex rel Sikkenga v. Regence Blue Cross Blue Shield of Utah,* July 22, 2005, at 11.

There can be no question that *Body* was wrongly decided. Even if it could be argued that the statutory language is itself ambiguous, the legislative history plainly demonstrates that the Tenth Circuit's reading

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[4] *Body* construed a different section of the Medicare Act. However, the language of both sections is identical.

is correct. In the House Conference Report accompanying the passage of Section 1395u(e)(3), "the committee stated that *this provision provides carriers with 'the same immunity from liability for incorrect payments as would be provided their certifying and disbursing officers.*' H.R. Rep. No. 89-682, at 37 (1965) (Conf. Rep.) *as reprinted in* 1965 U.S.C.C.A.N. 1943, 2231." *Sikkenga*, 472 F.3d at 710-711 (emphasis added).

The Tenth Circuit explained that

> "[t]o the extent that our disagreement with the Eleventh Circuit can be said to evince ambiguity in the statute we find support for our interpretation in the legislative history of this provision. In the House Conference Report accompanying the passage of § 1395u(e) (3), the committee stated that this provision provides carriers with 'the same immunity from liability for incorrect payments as would be provided their certifying and disbursing officers. Thus, the legislative history unequivocally resolves any ambiguity that might exist because of the statute's poor grammatical structure. The immunity available . . . [to a] Medicare carrier under § 1395u(e)(3) is coextensive with that of its certifying and disbursing officers-in other words, the immunity excludes cases involving fraud and gross negligence." *Sikkenga*, 472 F.3d at 710-711 (internal citations, and quotations omitted).

The statutory language contained in a subsequent legislative enactment applicable to conduct undertaken subsequent to Oct. 1, 2005 explicitly reaffirms the statement of the contemporaneous legislative history cited by the Tenth Circuit. Specifically, Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which took effect on October 1, 2005 eliminated any possible ambiguity contained in the earlier enactment by explaining that "no Medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer *unless, in connection with such payment, the Medicare administrative contractor acted with reckless disregard of its obligations under its Medicare administrative contract or with intent to defraud the United States.*" Medicare Prescription Drug Improvement, and Modernization Act of 2003, § 911(d), Pub. L. No. 108-173, 117 Stat. 2066 (codified at 42 U.S.C. § 1395kk-1 (2003)) (emphasis added). The provision then goes even further stating that "[n]othing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of Title 31, United States Code." *Id.* Thus, Section 911(d)(3)(A) unambiguously provides that Medicare Contractors are to be granted only the same limited liability as certifying and disbursing officers, no more and no less. Medicare Prescription Drug, Improvement, and Modernization Act of 2003 § 911(d).[5]

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[5] As a result of this later statute, Medicare contracting agents like the Defendant Palmetto are subject to legal challenge for any improper payments made to suppliers after October 1, 2005 to the extent those payments are made intentionally or recklessly.

Importantly, the comments of the bill's manager, Senator Grassley, on the Senate floor prior to passage of the 2003 amendment plainly indicate that the purpose of the amendment was to clarify, not change, existing law. 149 Cong. Rec. 15606 (2003). As Senator Grassley explained,

> "[t]he language contained in section 911 of the conference agreement clarifies that Medicare administrative contractors are not liable for inadvertent billing errors but, *as in the past*, are liable for all damages resulting from reckless disregard or intent to defraud the United States. . . . This legislation makes it clear that the False Claims Act continues, *as in the past*, to remain available as a remedy for fraud against Medicare by certifying officers, disbursing officers, and Medicare administrative contractors alike and that Medicare contractors are subject to administrative, as well as trust fund, damages."

Id. (emphasis added).

In light of the clear congressional policy against absolute immunity for Medicare contractors like the Defendants, it makes no sense to deprive the government and the taxpayers of an opportunity to recoup the fruits of the Defendants' fraud by granting them absolute immunity. "The Eleventh Circuit's decision in *Body* is wrong. . . ." Amicus Brief of the United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, at 15. It should be reversed. Neither Part A Intermediaries nor Part B Carriers should be granted absolute statutory immunity when they recklessly or intentionally pay fraudulent claims.

Unless the Eleventh Circuit's Opinion is reversed, the federal government will be prevented from recovering the more than $40,000,000 in fraudulent payments that the Defendants made for FUCPs on behalf of the Medicare program. (R 126, AC ¶ 113.) Nor is the problem confined only to fraudulent payments for FUCPs, or self-correcting as a result of the statutory provision that became effective as of October 1, 2005. Indeed, the United States Department of Justice has recognized that, not withstanding the new statute, the issue of Medicare contractor liability "remains significant." (Amicus Brief of the United States Department of Justice in *United States ex rel. Sikkenga v. Regence Blue Cross Blue Shield of Utah*, July 22, 2005 at 20 n.7.)

In that regard, the significance of the Eleventh Circuit's incorrect interpretation of the applicable statute goes far beyond the $40,000,000 that will be lost to the federal government in this case, because historically Medicare fraud has been rampant, and many Medicare Carriers and Intermediaries, including DMERCs like the Defendants, have done precious little to identify or alleviate that fraud, particularly as it related to fraudulent claims for DME. In fact, the Medicare program has been the perfect target for fraud precisely because its agents (the Intermediaries and Carriers like the Defendants in this case) did so little to investigate. As one recent investigative story from National Public Radio ("NPR") explained:

> [I]t's a trusting system, set up to serve honest physicians — with few safeguards designed to weed out false claims. Also, most claims are paid automatically, so there's little or no person-to-person contact.

> The companies Medicare hires to handle its claims say they are working to improve fraud detection. But their main mission is not to root out fraud; it is to pay claims quickly and smoothly. ("Medicare Fraud Acute in South Florida," by Greg Allen, NPR Legal Affairs, October 11, 2007.)

As a recent report of the Office of Inspector General of the Department of Health and Human Services ("Medical Review of Claims For The Fiscal Year 2006 Comprehensive Error Rate Testing Program," Department of Health and Human Services, Office of Inspector General, August 2008 ("OIG Report")) noted, the Medicare program itself has acknowledged that Medicare made approximately $700,000,000 in improper Medicare payments for DME during the fiscal year beginning October 1, 2005, the first year that the new statute was in effect. (See OIG Report at 2). There is no reason to believe that fraudulent payments were any less prevalent during prior years. In fact, precisely the opposite is true. As the head of Program Integrity for the Medicare program explained in another recent NPR feature, "until recently CMS (the Medicare program) didn't actually look for fraud." ("Feds Fight Rampant Medicare Fraud in South Florida," by Greg Allen, NPR Legal Affairs, November 6, 2007 at 2.)

Moreover, the Inspector General's recent Report emphasized that the Medicare program's estimate of improper DME payments was significantly understated. (*See* OIG Report at 5). According to the Inspector General's Report, the actual error rate for DME payments alone during FY 2006 was almost four times

the rate acknowledged by the Medicare program itself, or approximately $2.8 billion. (See OIG Report at 5.) In reacting to the Inspector General's Report the Ranking Member of one congressional subcommittee singled out the Defendant Palmetto by name as an entity in need of additional oversight. (See September 3, 2008 Press Release of Senator Norm Coleman (http:hsgac.senate.gov/public/index.cfm?FuseAction=PressReleases.Detail&PressRelease_id=a73d82d9-523a-42d7-85b9-63cafb421965&Affiliation=R).)

Of course, Medicare fraud relating to DME is likely to be merely the tip of the iceberg. Some comprehensive estimates of Medicare fraud suggest that the total annual losses to the Medicare program could be far more than the $2.8 billion annual loss related to DME fraud estimated by the Inspector General, and, in fact, could be as high as $70 billion annually. (*See* "Medicare Fraud Acute in South Florida," by Greg Allen, NPR Legal Affairs, October 11, 2007 at 3.) Neither the government, nor the taxpayers should be expected to pay for losses that enormous. Plainly, those responsible, the agents of the Medicare program, Carriers and Intermediaries like the Defendants, should not be granted a free pass with respect to conduct that otherwise would be violative of the federal False Claims Act.

CONCLUSION

For the foregoing reasons the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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