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Special Master

**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION**

UNITED STATES OF AMERICA *ex*
rel. BENJAMIN POEHLING,

Plaintiffs,

vs.

UNITEDHEALTH GROUP, INC., *et al.*,
Defendants.

Case No. CV 16-08697-FMO-PVCx

SPECIAL MASTER’S REPORT AND
RECOMMENDATION REGARDING
MOTION FOR SUMMARY
JUDGMENT AND MOTION FOR
PARTIAL SUMMARY JUDGMENT
(Dkt. Nos 614, 615 and related filings)

This Report and Recommendation is submitted to the Honorable Fernando M. Olguin, United States District Judge, pursuant to Federal Rule of Civil Procedure 53.

On August 6, 2024, Defendants UnitedHealth Group, Inc., et. al, (“United”) filed a Motion for Summary Judgment. Dkt. 615. The same day,

1 Plaintiff United States (“the government”) filed a Motion for Partial Summary
2 Judgment on the issue of whether materiality is an element of the second prong of
3 the reverse false claims provision of the False Claims Act (“FCA”), 31 U.S.C. §
4 3729(a)(1)(G). Dkt. 614. The parties filed a Joint Brief Regarding Cross Motions
5 for Summary Judgment. Dkt. 616. Each party also subsequently filed a
6 Supplemental Memorandum. The District Judge’s previous order directed the
7 briefing procedures for summary judgment motions. Relator did not file a
8 separate brief but participated in the oral argument.

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10 The Special Master has considered the briefs and exhibits submitted as well
11 as the arguments made at a hearing on January 15, 2025, during which the parties
12 addressed the Special Master’s “Tentative Ruling.” This Report and
13 Recommendation concludes that the government is lacking any evidence in
14 support of two essential elements of its False Claim Act (“FCA”) and related
15 common law claims, which are all premised on United’s alleged failure to return
16 federal funds to which it was allegedly not entitled. Accordingly, it is
17 recommended that United’s Motion for Summary Judgment be GRANTED and
18 the government’s Motion for Partial Summary Adjudication be DENIED. The
19 Special Master notifies the parties that, pursuant to Rule 53(f)(2), parties may file
20 a motion to adopt, modify or objections to this Report and Recommendation
21 within 14 days of the date of the Report, as set forth in the Court’s May 5, 2020
22 Order appointing the Special Master. The Court noted in its May 5, 2020 Order
23 that “The parties shall not include – and the court will not consider – any evidence
24 or argument that was not presented to the Special Master. The standard of review
25 the court will apply to any motion for review shall be governed by Federal Rule of
26 Civil Procedure 53(f).” (May 5, 2020 Order, Dkt. 395, ¶ 5).

I. BACKGROUND

A. United's Arguments In Support of its MSJ

United argues in support of its MSJ:

The [government] alleges that United improperly kept money it was paid to provide healthcare to Medicare Advantage (“MA”) members. But after years of litigation, [the government] has not reviewed a single medical record of United’s MA members—the *only* evidence that could establish whether United may have been overpaid. That failure dooms all of [the government]’s claims. Dkt. 616 at 9.

The Centers for Medicare and Medicaid Services (“CMS”) pays insurers like United and other MA plans to cover their members’ healthcare costs. These payments are based in part on the members’ medical conditions, with the basic goal of paying MA plans more for taking care of sicker patients. Most of the diagnoses United submits to CMS for payment come directly from doctors, who certify that the patients they have seen have the health conditions, represented by alphanumeric diagnosis codes, listed on insurance claims forms. But doctors often fail to identify all the medical conditions their patients have on claims forms because they are typically paid based on the services they perform, not their patients’ diagnoses. MA plans like United thus obtain some of their patients’ underlying medical records (or “charts”) and hire medical coders to review the charts to capture

1 additional diagnoses doctors may have missed in submitting claims
2 forms. Dkt. 616 at 9.

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4 [The government's] theory in this case is novel. Unlike a traditional
5 case of alleged "upcoding," [the government] does not contend that
6 United's coders falsely documented *any* medical conditions. Nor does
7 [the government] allege that United failed to convey accurately the
8 diagnoses doctors submitted to it. [The government] also does not
9 contend that there is anything inherently wrong with MA plans
10 reviewing medical charts to submit more complete diagnostic
11 information (which is an industry-standard practice). And [the
12 government] likewise does not contend that United has an obligation
13 to conduct audits of all the codes it receives from doctors, since MA
14 plans should be allowed to rely on doctors' certified codes—and no
15 one expects perfect coding accuracy in this payment system. Dkt. 616
16 at 9.

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19 [The government's] sole contention is instead that if United coders
20 who reviewed a chart did not identify a diagnosis code, then that
21 necessarily means that a doctor who previously certified and
22 submitted the same code on a claim form did so in error. Dkt. 616 at
23 9-10.

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26 The problem with [the government's] categorical theory is that it is
27 not supported by any evidence. For one, United's coders are unaware
28 of what codes doctors have previously submitted in claims forms and
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1 thus make no effort to validate those codes in performing chart
2 review. For another, [the government's] own coding expert concedes
3 that there are multiple reasons a United coder reviewing a chart might
4 fail to identify a diagnosis code that is actually present there. United's
5 coders could be unfamiliar with the doctor's handwriting or area of
6 specialization, could be missing pages of the medical record, might
7 have lacked sufficient time to complete the review, or might simply
8 have missed a diagnosis certified by a doctor because a record was
9 lengthy or complex. And, of course, as both sides' experts agree,
10 coders are human and make mistakes. The mere fact that United's
11 coders may identify different codes than those a doctor submits is not
12 *evidence* sufficient to allow a jury to conclude the doctor's office was
13 necessarily wrong in submitting the code. Dkt. 616 at 10.

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16 Accordingly, to meet its burden in opposing summary judgment, [the
17 government's] needed to offer *something* other than mere coding
18 differences to show that some or all of the 28 million doctor-certified
19 codes at issue are unsupported. One obvious approach would have
20 been to review some or all of the medical charts at issue. [The
21 government] could have hired an expert to review charts and offer an
22 opinion about the portion of the doctor-certified diagnosis codes that
23 are in fact not supported. Yet, after more than a decade of litigation in
24 a case in which [the government] seeks to punish United for billions
25 of dollars, [the government] has chosen instead not to review a *single*
26 chart—not even a sample—perhaps because it was afraid of what that
27 review would show. [The government] must now accept the
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1 consequences of that decision, which is that its experts are left
2 hopelessly unable to say which (if any) of the diagnosis codes at issue
3 are unsupported. Dkt. 616 at 10-11.
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5 **B. The Government's Opposition to United's MSJ**
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7 The government argues in opposition to United's MSJ:
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9 If a Medicare Advantage Organization (MAO) such as United
10 receives a diagnosis code from a provider, submits the diagnosis to
11 CMS for risk adjustment payment, and then later reviews the medical
12 record from that provider, and finds that code to be unsupported, the
13 organization surely cannot hold onto the payment it received for that
14 code without further inquiry. Yet that is the core of United's
15 argument. There is considerable evidence from which a jury can
16 reasonably conclude that the diagnosis codes at issue were
17 unsupported and resulted in overpayments, including United's own
18 Chart Review coders' review of the medical records, United's own
19 data, and the [government's] expert's calculation of the financial
20 impact of United's failure to delete those codes. There is binding
21 precedent from the Ninth Circuit in *United States ex rel. Swoben v.*
22 *United Healthcare Ins. Co.*, 848 F.3d 1161 (9th Cir. 2016) that MAOs
23 such as United have longstanding duties prohibiting them from
24 turning a blind eye to unsupported codes submitted for payment. Dkt.
25 616 at 12-13.
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1 A foundational principle of the MA program – unwavering since the
2 program’s inception – is that [MAOs] are paid only for diagnosis
3 codes that are supported by the beneficiary’s medical records
4 (supported codes). [MAOs] are not required to audit every single
5 diagnosis code they submit, but they have contractual and regulatory
6 duties – incorporated into every [MA] contract – to undertake due
7 diligence and make good faith efforts to ensure that the diagnosis
8 codes they submit to CMS are supported. CMS adopted the FCA
9 knowledge standard into those duties, meaning that an [MAO] must
10 exercise due diligence and conduct in good faith any audit of
11 provider-submitted data it chooses to conduct, and correct
12 unsupported diagnosis codes that have been submitted for payment
13 revealed by those audits. In this case, United obtained information
14 from its own internal auditing program (Chart Review) that diagnosis
15 codes that it had already submitted to CMS for payment were
16 unsupported. Rather than making a good faith effort to inquire as to
17 the accuracy of those codes and correct them as required by both
18 regulation and contract, it simply buried its head in the sand and did
19 nothing but keep the money. Dkt. 616 at 13.

22 As opposed to a “novel theory,” the FCA allegation in this case is
23 straightforward – United violated the second prong of the reverse false
24 claims provision, which imposes liability on a person who “knowingly
25 and improperly avoids . . . an obligation to pay. . . the Government.”
26 31 U.S.C. § 3729(a)(1)(G). To prevail, the government must show
27 only that United: (1) improperly avoided its obligation to pay CMS;
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1 and (2) did so knowingly. *See United States ex rel. Ormsby v. Sutter*
2 *Health*, 444 F. Supp. 3d 1010, 1055-56 (N.D. Cal. 2020). United’s
3 obligation to pay arises from independent, yet legally and factually
4 aligned, sources: (1) its regulatory and contractual duties, and (2) its
5 retention of an overpayment. And there is ample evidence that by
6 deliberately ignoring or recklessly disregarding the negative results of
7 its Chart Review, United knowingly and improperly avoided its
8 obligation and improperly retained billions of dollars. Dkt. 616 at 13-
9 14.
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11 **C. The Government’s Motion for Partial Summary Judgment**

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14 The government argues in support of its Motion for Partial Summary
15 Judgment:
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17 . . . To clarify the issues for trial, the [government] now seeks partial
18 summary judgment that, as a matter of law, materiality is not a
19 required element of establishing liability under the second prong of
20 the reverse false claim provision. Dkt. 616 at 93.
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22 The fact that materiality is not an element of the second prong of the
23 reverse false claim provision is clear from the structure of the
24 statutory text. As discussed below, Courts have recognized that the
25 text itself draws a meaningful distinction between the first prong –
26 which requires a “false record or statement *material* to an obligation”
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1 – and the absence of that same requirement within the second prong.
2 Dkt. 616 at 93-94.

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4 The seminal case on materiality under the False Claims act, *Universal*
5 *Health Services v. United States ex rel. Escobar*, did not address
6 materiality under the reverse false claim provision, but rather focused
7 on materiality with respect to affirmative false claims under 31 U.S.C.
8 § 3729(a)(1)(A). 579 U.S. 176, 181 (2016). Since *Escobar*, several
9 Courts have expressly held that materiality is not an element under the
10 second prong of the reverse false claim provision. For example, in
11 *United States ex rel. Ormsby v. Sutter Health*, an analogous case
12 involving allegations that defendants knowingly concealed or
13 improperly avoided their obligation to return overpayments to the
14 Medicare Advantage program by failing to delete unsupported
15 diagnosis codes, the Court held that there was no materiality element
16 under the second prong of the reverse false claim provision. 444 F.
17 Supp. 3d 1010, 1056 (N.D. Cal. 2020) (“The elements of a violation
18 under the second prong of the reverse-FCA provision are that the
19 defendant (1) concealed or improperly avoided or decreased an
20 obligation to pay the government and (2) did so knowingly. There is
21 no requirement under the second prong to show that the defendant
22 used a false record or statement or that a record or statement was
23 material.” (internal citations omitted)). Dkt. 616 at 94.
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D. United’s Opposition to The Government’s Motion for Partial Summary Judgment

United argues in opposition to the government’s motion:

. . . DOJ asks this Court to ignore the Supreme Court’s clear holding in another FCA case that “the common law could not have *conceived* of ‘fraud’ without proof of materiality.” *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 193 (2016) (emphasis added) (citation omitted). . . . Dkt. 616 at 95.

In *Escobar*, the Supreme Court addressed the materiality requirement in a provision of the affirmative FCA, 31 U.S.C. § 3729(a)(1)(A), which imposes liability on one who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.” That provision does not expressly include a materiality element. But the second affirmative FCA provision that follows *does*: Section 3729(a)(1)(B) imposes liability on one 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). Faced with this statutory structure, the Supreme Court had no hesitation holding that *both* provisions require a showing of materiality. *See* 579 U.S. at 190, 192-95. (Dkt. 616 at 96.)

The reverse FCA provisions at issue here directly parallel the structure of the affirmative FCA provisions in *Escobar*. The first reverse FCA

1 prong, just like one of the affirmative FCA provisions, includes an
2 express materiality requirement tied to a false statement—requiring a
3 “false record or statement material to an obligation.” 31 U.S.C. §
4 3729(a)(1)(G). But the second reverse FCA prong, like the other
5 affirmative FCA provision, does not. *See id.* The reasoning in *Escobar*
6 applies just as clearly to this parallel situation; even absent the express
7 inclusion of the word “material,” the second prong of the reverse FCA
8 necessarily includes a materiality requirement because of its
9 “commonlaw antecedents” and the inconceivability of common-law
10 fraud without a materiality requirement. 579 U.S. at 193 (citation
11 omitted). . . .

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14 DOJ incorrectly claims that “several Courts have expressly held that
15 materiality is not an element under the second prong of the reverse
16 false claim provision.” DOJ Mot., *supra* at 85. None of the cases cited
17 by DOJ hold any such thing. And counsel is aware of no other case
18 that does.

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20 (Dkt. 616 at 95-97, 99.)
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22 **II. UNITED'S MOTION FOR SUMMARY JUDGMENT**

23 24 **A. Legal Standard**

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27 “Rule 56(c) mandates the entry of summary judgment, after adequate time
28 for discovery and upon motion, against a party who fails to make a showing
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1 sufficient to establish the existence of an element essential to that party's case, and
2 on which that party will bear the burden of proof at trial.” *Celotex Corp. v.*
3 *Catrett*, 477 U.S. 317, 322 (1986). “A moving party without the ultimate burden
4 of persuasion at trial...has both the initial burden of production and the ultimate
5 burden of persuasion on a motion for summary judgment.” *Nissan Fire & Marine*
6 *Ins. Co., Ltd. v. Fritz Cos., Inc.*, 210 F.3d 1099, 1102 (9th Cir. 2000). A moving
7 party without the ultimate burden of persuasion at trial—usually, but not always, a
8 defendant—has both the initial burden of production and the ultimate burden of
9 persuasion on a motion for summary judgment. *Nissan*, 210 F.3d at 1102 (citing
10 10A Charles Alan Wright, Arthur R. Miller and Mary Kay Kane, *Federal Practice*
11 *and Procedure* § 2727 (3d ed.1998)).

12
13 In order to carry its initial burden of production, the moving party must
14 either produce evidence negating an essential element of the nonmoving party's
15 claim or defense or show that the nonmoving party does not have enough
16 evidence of an essential element to carry its ultimate burden of persuasion at trial.
17 *See Nissan*, 210 F.3d at 1102 (citation omitted)(emphasis added). If the moving
18 party carries that initial burden, “the burden then moves to the opposing party,
19 who must present significant probative evidence tending to support its claim[.]”
20 *Intel Corp. v. Hartford Acc. & Indem. Co.*, 952 F.2d 1551, 1558 (9th Cir. 1991)
21 (internal quotation marks omitted). Where a rational trier of fact, considering the
22 record as a whole, cannot find for the nonmoving party, there is no genuine issue
23 for trial. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587
24 (1986) (internal quotations omitted). If the evidence is merely colorable, or is not
25 significantly probative, summary judgment is appropriate. *Anderson v. Liberty*
26 *Lobby, Inc.*, 477 U.S. 242, 249 (1986)). “To survive summary judgment [in an
27 FCA case], the [nonmovant] must establish *evidence* on which a reasonable jury
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1 could find for the plaintiff.” *United States ex rel. Aflatooni v. Kitsap Physicians*
2 *Serv.*, 314 F.3d 995, 1001 (9th Cir. 2002) (citation and alterations omitted).

3
4 “[T]he mere existence of *some* alleged factual dispute between the parties
5 will not defeat an otherwise properly supported motion for summary judgment;
6 the requirement is that there be no *genuine* issue of *material* fact.” *Anderson*, 477
7 U.S. at 247–48 (1986) (emphasis in original). “If the evidence is merely
8 colorable, . . . or is not significantly probative, . . . summary judgment may be
9 granted.” *Id.* at 249. If the movant has identified an absence of a genuine dispute
10 of material fact, the nonmovant cannot rely only on the pleadings and must
11 designate specific facts showing that there is a genuine issue for trial as supported
12 by affidavits, depositions, answers to interrogatories, and admissions on file; this
13 is especially so when parties have had an opportunity for discovery. *See Celotex*
14 *Corp.*, 477 U.S. at 322-24.
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17 In deciding a motion for summary judgment, a court must view the
18 evidence in the light most favorable to the nonmoving party and draw all
19 justifiable inferences in its favor. *See Anderson*, 477 U.S. at 253. However, an
20 opposing party may not rely upon “mere allegations” or speculation to survive a
21 summary judgment motion. *See Nelson v. Pima Cmty. Coll.*, 83 F.3d 1075, 1081–
22 82 (9th Cir. 1996) (“[M]ere allegation and speculation do not create a factual
23 dispute for purposes of summary judgment.”).
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B. The Reverse False Claim Provision of The FCA and The Government's Allegations

The government alleges United violated the "reverse false claims" provision of the FCA, which makes liable anyone who “*knowingly conceals or knowingly and improperly* avoids or decreases an obligation to pay or transmit money or property to the Government.” 31 U.S.C. § 3729(a)(1)(G) (emphasis added). An “obligation” for purposes of a reverse false claim has been defined in the healthcare context to include a failure to report and return an “identified” overpayment within sixty days “after the date on which the overpayment was identified.” 42 U.S.C. §§ 1320a-7k(d)(1), (2), (3); 42 C.F.R. § 401.305(e).

Essentially, the government asserts that United wrongly kept money it should have returned to the government. The money at issue is alleged overpayments the government claims United received as a result of submitting allegedly invalid diagnosis codes in connection with the Medicare Advantage (“MA”) program. The fatal flaw in the government's case is the complete absence of evidence of such overpayments, an essential element of the government's claim.

Medicare is a federal health insurance program established under the Medicare and Medicaid Act for the elderly and disabled administered by the Centers for Medicare and Medicaid Services (“CMS”). Dkt. 616-1 at D2. Medicare Part C, now known as the “[MA] program,” allows people to enroll in health insurance plans offered by private insurers (“Medicare Advantage plans”). *Id.* at D7.

1 CMS pays the MA plans a fixed amount per month for each member that
2 they insure, based in part on the relative health of the individual members. Dkt.
3 616-1. at D9. The MA program is intended to pay MA plans more per month for
4 the risk of insuring sicker beneficiaries. *Id.* at D15. The process by which CMS
5 pays MA plans based on the health status of their beneficiaries is commonly
6 referred to as “risk adjustment.” *See id.* at D10. CMS determines which members
7 are sicker by looking at the health conditions those members have, as represented
8 by diagnosis codes doctors submit through claims forms. *See id.* at D16-D18,
9 D21.

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11 Diagnosis codes are alphanumeric codes that represent a patient’s health
12 conditions. Dkt. 616-1 at D17. There are thousands of diagnosis codes that coders
13 can select when coding medical charts. *See JS* at D23-D24; Exs. D-18 at 658, D-
14 43 at 980. CMS groups diagnosis codes into Hierarchical Conditions Categories
15 (“HCCs”). *See* 42 C.F.R. § 422.2; Dkt. 616-1 at D16, D18. HCCs are made up of
16 groups of diagnosis codes that are related clinically and have similar cost
17 implications. Dkt. 616-1 at D18. For example, the diagnosis code for “type 2
18 diabetes mellitus without complications” and the diagnosis code for “other
19 specified diabetes mellitus without complications” map to the same HCC of
20 “diabetes without complications.” Dkt. 616-1 at D25-27. CMS will pay a MA plan
21 the same amount regardless of which of the two diagnosis codes is submitted. Dkt.
22 616-1 at D25-27, D29-D31. Similarly, diagnosis codes for numerous different
23 forms of malignant cancer (*e.g.*, bone, lung, liver) would all establish that a patient
24 has the health condition of “metastatic cancer and acute leukemia” (HCC7), and
25 any of those numerous diagnosis codes would lead to the same payment for a MA
26 plan member. Dkt. 616-1 at D28, D29-D31.
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1 After a patient visits a doctor, the doctor is expected to document the
2 encounter, including the patient's diagnoses, in a medical chart. Dkt. 616-1 at
3 D19. The doctor or the doctor's coder then identifies one or more diagnosis codes
4 that they determine match the conditions documented in the medical chart. *Id.* at
5 D20. The doctor then submits that information on a claim form to a MA plan (if
6 the beneficiary is in the MA program). *Id.* at D21. When submitting the claim
7 form, doctors certify that the information on the claim form, including diagnosis
8 codes, is correct. *Id.* at D22.

9 Doctors may fail to identify all diagnosis codes that are documented in a
10 medical record. To capture documented diagnosis codes missed by doctors (and
11 thereby increase the payment received from CMS), MA plans like United may
12 obtain and review patients' medical records to identify additional codes doctors
13 may have failed to include in submitting claim forms, which is referred to as a
14 "chart review." *See* Dkt. 616-1 at D41, D44.

15 United had a "chart review" program during the relevant time period.
16 United hired coders to review the available medical charts retrieved from the
17 doctors to identify diagnosis codes that were supported by documentation in those
18 charts. Dkt. 616-1 at D48. United's chart reviewers did not compare the diagnosis
19 codes identified through its chart reviews to diagnosis codes submitted by doctors
20 on the claim for that same date of service. *Id.* at D50. United's coders generally
21 reviewed medical charts in a "blind" manner, meaning a coder reviewing a
22 medical record did not know what diagnosis codes the doctor had submitted. *Id.*
23 at D51. For dates of service years 2014-2016, United also introduced a process
24 called "second-level review," in which certain charts that had already gone
25 through an initial blind chart review were assigned to a second coder to conduct
26 another blind review. *Id.* at D243.

1 MA plans are required to certify annually that the data they submit to CMS
2 is “accurate, complete, and truthful” based on the plans’ “best knowledge,
3 information, and belief.” 42 C.F.R. § 422.504(*l*); Dkt. 616-1 at D104. In January
4 2014, CMS proposed a rule, the proposed Medical Record Review Rule
5 (“MRRR”), that would have required MA plans (like United) conducting
6 retrospective chart reviews to design their chart review programs “to identify
7 errors in diagnoses submitted to CMS as risk adjustment data, regardless of
8 whether the data errors would result in positive or negative payment adjustment.”
9 Dkt. 616-1 at D117. In May 2014, CMS declined to finalize the MRRR. *Id.* at
10 D136.

11
12 The government alleges that United violated the reverse FCA provision by
13 knowingly and improperly retaining overpayments United allegedly received
14 based on unsupported diagnosis codes that United submitted to CMS. During
15 discovery, United’s first interrogatory asked the government to identify “every
16 Diagnosis Code You allege [United] ‘knowingly and improperly failed to delete . .
17 . or otherwise return to the Medicare Program [as an] overpayment.” Dkt. 616-1 at
18 D155; Ex. D-7. The government identified 27,937,651 diagnosis codes in
19 response to this interrogatory. Dkt. 616-1 at D156; Ex. D-11A.

20 In generating this list of nearly 28 million diagnosis codes that it contends
21 were unsupported by medical records, the government did not compare the
22 diagnosis codes submitted by United’s doctors against the underlying medical
23 records to identify unsupported diagnosis codes. Instead, according to the
24 government, its list represented “every diagnosis code . . . [United] submitted to
25 CMS to increase its risk adjustment payments, and then improperly failed to
26 delete when [United]’s own reviewers found no support for the diagnosis code in
27 the member’s medical records.” Dkt. 616-1 at D157, D158; Ex. 4-5. In other
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1 words, if United's coders did not identify a diagnosis code during chart review as
2 supported by a medical record, the government *assumes* the diagnosis code was,
3 in fact, not supported.

4 The government does not contend that all 28 million diagnosis codes it
5 identified in response to United's Interrogatory No. 1 resulted in overpayments to
6 United. The government's expert, Dr. Garthwaite, identified 1.97 million
7 diagnosis codes of the approximately 28 million allegedly unsupported diagnosis
8 codes that the government contends resulted in overpayments to United, and for
9 which the government seeks damages. Dkt. 616-1 at D164; Ex. D-57. Dr.
10 Garthwaite calculated that United's payments for the relevant time period would
11 have decreased by approximately \$2.1 billion had United deleted the
12 approximately 2 million diagnosis codes he identified. Ex. D-57 at 1446-47, 1480
13 ¶¶ 13-14, ¶ 86. Dr. Garthwaite admitted that he did not review any medical charts
14 to reach his opinions. Dkt. 616-1 at D165. In performing his analysis, Dr.
15 Garthwaite assumed a doctor's diagnosis code submitted by United to CMS to be
16 conclusively unsupported if not identified by a United coder during chart review.
17 *Id.* at D169. Dr. Garthwaite did not review any medical records or other evidence
18 to conclude that the codes were unsupported. Instead, he *assumed* they were
19 unsupported if they differed from codes found during United's Chart Review
20 process. *Id.*

21 22 23 **C. The Government Failed to Present Any Evidence On Two Essential** 24 **Elements of Its Claim** 25

26 The government cannot prevail on its claim that United knowingly and
27 improperly avoided an obligation to repay the government for an overpayment
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1 based on unsupported diagnosis codes if the evidence is insufficient for a jury to
2 reasonably conclude either that United submitted unsupported diagnosis codes to
3 CMS or that United acted with the requisite intent with respect to any alleged
4 overpayments. *See In re Oracle Corp. Sec. Litig.*, 627 F.3d 376, 387 (9th Cir.
5 2010) (“the nonmoving party must come forth with evidence from which a jury
6 could reasonably render a verdict”). The government has not met its burden. A
7 failure to present evidence on this essential element is fatal to the government’s
8 claims. *See Celotex Corp.*, 477 U.S. at 325 (“A complete failure of proof
9 concerning an essential element of the nonmoving party’s case necessarily renders
10 all other facts immaterial.”)
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12 13 **1. Lack of Evidence of Overpayments**

14 15 **A. Evidence that United's Coders Failed to Identify the Diagnosis** 16 **Codes Included on Claim Forms Certified by Patients' Doctors is** 17 **Insufficient to Support an Inference that the Doctors' Codes Were** 18 **Unsupported By Medical Records**

19 As the government concedes, no one (including Dr. Garthwaite, the
20 government's expert) has conducted any comparison of the diagnosis codes United
21 submitted to CMS against the underlying medical charts to identify which
22 diagnosis codes, if any, were not supported by patient medical charts. Instead, the
23 government identified approximately 28 million diagnosis codes that were: “(1)
24 submitted for payment by United; (2) *not found to be supported by United’s Chart*
25 *Review Coders’ review of the medical record linked to that submission*¹; and (3)
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28 ¹ The language in italics is the government's characterization of United's conduct,
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1 not deleted.” Dkt. 616 at p. 34 (emphasis added). The government failed to
2 present any evidence, however, to show the second element (in italics) in the
3 preceding sentence. The government’s expert witness, Dr. Garthwaite, merely
4 *assumed* (without reviewing any medical records) that these 28 million diagnosis
5 codes were unsupported, and his analysis that 1.97 million unsupported diagnoses
6 resulted in overpayments of approximately \$2.1 billion to United is based on that
7 assumption. Dkt. 616-1 at D164; Ex. D-57. The government’s Opposition relies
8 entirely on speculative assumptions, not supported by record evidence.

9 The government's brief repeatedly asserts that United received
10 overpayments for claims that were based upon "unsupported" codes. (*See e.g.*,
11 U.S. Supp. Memo., at 1, lines 2-5) (“ . . . [C]an the MAO turn a blind eye to
12 information from those reviews showing that diagnosis codes . . . were
13 unsupported?”]. The government, however, has failed to provide any evidence to
14 raise a triable issue of fact that any particular code was "unsupported." The
15 government never provided any evidence that showed a particular code lacked
16 support in a medical record. In fact, the government conceded that “there are a
17 number of reasons why a medical coder may not identify a diagnosis code
18 submitted on a claim form by a doctor.” (Defendant’s Statement of Undisputed
19 Facts, D55).

20 The government’s evidence establishes that United submitted certain
21 diagnosis codes to CMS and later submitted *additional* diagnosis codes that
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24

25 but there is no evidence in the record to show that United submitted diagnosis
26 codes unsupported by medical records. The Chart Review Coders did not review
27 the codes submitted by doctors. There is no evidence in the record that either the
28 doctors' codes or the Chart Review Coders' codes were unsupported by medical
29 records.

1 United's coders identified during chart review. The government has not, however,
2 presented evidence from which a jury could reasonably conclude that in any
3 particular instance of a discrepancy, much less in every instance, the code United
4 *initially* submitted was invalid. The government's theory assumes that United's
5 coders were always perfect in their coding and did not miss any codes supported
6 by a beneficiary's medical records. It is equally possible, however, based on the
7 evidence, that in any specific case, the diagnosis code certified by a medical
8 provider and submitted by United to CMS *was* supported by a medical record, and
9 the coder reviewing the record during chart review simply failed to independently
10 identify it.

11
12 The government points to the following as "ample evidence" from which a
13 jury could reasonably conclude that, if a coder did not identify a diagnosis code,
14 the diagnosis code was unsupported: "[t]he coders that United retained to review
15 medical records in Chart Review were certified, trained, and quality tested[;]" [the
16 coders] were instructed to identify "all the codes they found to be supported in the
17 medical records they reviewed[;]" and the coders "[r]eviewed many medical
18 records twice." Dkt. 616 at p. 50 (emphasis in original). The government also
19 notes that United on the coders' findings to submit new codes to CMS that United
20 had not previously submitted because not identified by doctors, possibly
21 increasing payment to United. *See id.* But the government failed to provide
22 evidence of a single actual instance where a medical record did not support a
23 code.

24
25 At the hearing before the Special Master on January 15, 2025, the
26 government and relator argued (for the first time) that they had enough evidence
27 to send the case to trial based on *testimony of United's coders* regarding their
28 training and thoroughness. *See* 1/15/25 Tr. at 70, 75-77. However, the
29

1 government failed to submit this evidence (*i.e.*, the testimony of United’s coders)
2 in opposition to United’s motion. The record contains no evidence of the actual
3 coders’ testimony. Instead, in the government’s Opposition, the government
4 argued that the testimony of its expert, Dr. Craig Garthwaite, was enough.
5 Specifically, the government relied on the testimony of Dr. Garthwaite who
6 disclaimed that he had, or would express at trial, any opinion as to the rate at
7 which the doctors’ diagnosis codes were unsupported by patient medical records,
8 but merely *assumed* that every diagnosis previously certified by a doctor but not
9 separately identified by a United coder was invalid. *See* JS at D169; Ex. D-57 at
10 1537. Dr. Garthwaite apparently focused on the government’s purported damages
11 as a result of the presumed overpayments. Dkt. 616 at 17-18, 26-27; 1/15/25 Tr.
12 at 49 (government asserting that “determining what the damages are is
13 determining what the overpayments were,” and that “Dr. Garthwaite was engaged
14 to” “estimate” that such overpayments “comes out to \$2.1 billion”). Apart from
15 Dr. Garthwaite’s testimony, the government relied on testimony from United
16 representatives (including two supervisors) regarding the manner in which United
17 conducted its blind chart review program. *Id.* at 22-26. However, the briefs, the
18 Statement of Uncontroverted Facts, and the government’s exhibits are missing any
19 evidence whatsoever from United’s coders.
20

21 The summary judgment record is devoid of evidence regarding the identity
22 of any United coders—particularly those coders who actually reviewed the charts
23 that would be relevant in this case—let alone any statements that those coders had
24 provided or would provide at trial. The government did not disclose these United
25 coders as witnesses in its Rule 26 disclosures nor were they disclosed in
26 interrogatory or other discovery responses. They were never deposed as witnesses.
27 *See* 1/15/25 Tr. at 75-76, 78-80. A party cannot present evidence at a hearing that
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1 it failed to present to the court in opposition. *See, e.g., Cambridge Elecs. Corp. v.*
2 *MGA Elecs., Inc.*, 227 F.R.D. 313, 327 (C.D. Cal. 2004) (noting that it was
3 improper for a party to rely on a deposition transcript that was not in the record
4 when opposing summary judgment but deciding that, in the alternative, summary
5 judgment was appropriate even if the testimony were considered); *Jain v. Trimas*
6 *Corp.*, 2005 WL 3439932, at *1-3 (E.D. Cal. Dec. 15, 2005) (striking the
7 declaration and all exhibits offered in support of a party's opposition to summary
8 judgment because neither the declarant nor the evidence had previously been
9 disclosed during written discovery or during Rule 26 disclosures).

10
11 In any event, even if the government had submitted testimony of United's
12 coders (including those coders who were directly involved in reviewing medical
13 charts), it is pure speculation to find that the United coders' testimony would have
14 supported the government's overpayment claim. At most, the record evidence
15 indicated the overall excellence of United's coders in reviewing patient charts
16 under limited time conditions. However, the mere fact that United's coders (who
17 were not themselves medical practitioners) may have been effective in identifying
18 codes still would not constitute evidence sufficient to allow a jury to conclude that
19 the doctor's office was necessarily wrong in submitting the original codes. As the
20 government's coding expert acknowledged, there are myriad reasons (including
21 the length, complexity, or completeness of a medical record under review) why
22 otherwise competent United coders might have identified additional diagnosis
23 codes while failing to identify a diagnosis code that was actually documented in a
24 patient's medical record. See JS at D55-D56, D58-D61.

25
26 As United noted, the government at best has identified an "unresolved
27 discrepancy" between the doctors' initial diagnosis codes and the United coders'
28 codes. (Dkt. 616 at p. 35; 1/15/25 Tr. at 21-22, 36, 45). But such a purported
29

1 discrepancy would not support an inference that the doctors' codes were
2 unsupported by the patient's medical record, however well trained the coders
3 might have been in conducting their task. Again, lack of sufficient support in the
4 medical records for the codes identified in the doctors' certified claim forms was
5 only one of the various possible reasons for the coders' failure to identify those
6 same codes. While the relator argued at the January 15, 2025 hearing that a jury
7 could infer that this was the reason for the "discrepancy" (see 1/15/25 Tr. at 70-
8 71), that argument misunderstands the law. "At summary judgment, [a] court
9 need not draw *all* possible inferences in [the nonmovant's] favor, but only all
10 *reasonable* ones." *Villiarimo v. Aloha Island Air, Inc.*, 281 F.3d 1054, 1065 n. 10
11 (9th Cir. 2002) (emphasis in original). Relator's argument also overlooked the
12 complete absence of this evidence in the record before the Special Master.

14 On the undisputed evidence submitted with the briefing, a jury could not
15 reasonably conclude that any, much less every, diagnosis code certified by a
16 medical provider and submitted by United to CMS but not identified by United's
17 coders in chart review is necessarily invalid. A jury "is permitted to draw only
18 those inferences of which the evidence is reasonably susceptible; it may not resort
19 to speculation." *Brit. Airways Bd. v. Boeing Co.*, 585 F.2d 946, 952 (9th Cir.
20 1978); *see also Intel Corp. v. Hartford Acc. & Indem. Co.*, 952 F.2d 1551, 1558–
21 59 (9th Cir. 1991) (affirming summary judgment for defendant where plaintiff
22 asked court to "infer" conclusions from evidence but the proposed inferences
23 "resemble[d] tenuous speculations rather than potentially valid conclusions that
24 could be grounded in evidence in the record."); *O.S.C. Corp. v. Apple Computer,*
25 *Inc.*, 792 F.2d 1464, 1467 (9th Cir. 1986) (evidence must be sufficient to permit a
26 finding in favor of the opposing party "based on more than mere speculation,
27 conjecture, or fantasy.") (internal quotation marks omitted). As United points out,
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29

1 coders conducting a blind retrospective chart review are not looking to confirm
2 the validity of diagnosis codes submitted by doctors. Undisputed testimony
3 confirmed that coders may themselves miss diagnosis codes supported by a
4 medical record for any number of reasons, including the time available for the
5 review, the completeness, legibility and clarity of the medical record
6 documentation, and simple human error. Dkt. 616 at p. 44-45. Furthermore, as
7 noted, the government's expert, Dr. Garthwaite, had no opinion about how many
8 codes were truly unsupported by medical records, and he ultimately testified that
9 only 1.97 million of the 28 million codes that differed from the codes identified by
10 United's chart reviewers purportedly unsupported diagnosis codes arguably
11 resulted in an overpayment and that 93 percent were not overpayments. *See* JS at
12 D183; Ex. D-65 at 1916-19.

14 In seeking to prove the essential element of an overpayment by entirely
15 speculative circumstantial evidence (i.e., the "unresolved discrepancies" between
16 United's coders and a doctor (or a doctor's coder)), the government cannot prevail
17 by showing that the inference it draws is merely consistent with the government's
18 overpayment allegation. Without review of the medical records, a jury would be
19 required to speculate as to whether the diagnosis codes were actually incorrect. A
20 mere possibility of an overpayment is not enough for the government to carry its
21 burden for purposes of avoiding summary judgment. *Neely v. St. Paul Fire and*
22 *Marine Ins. Co.* 584 F.2d 341, 344 (9th Cir. 1978) (an opposing party's "mere
23 hope" that further evidence may develop prior to trial is an insufficient basis upon
24 which to justify denial of the [summary judgment] motion); *National Union Fire*
25 *Ins. Co. of Pittsburgh v. Argonaut Ins. Co.*, 701 F.2d 95, 97 (9th Cir. 1983) (the
26 mere possibility of a factual dispute cannot defeat summary judgment). At the
27 hearing on the motion, the government and relator expressed their intent to rely on
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29

1 the coders' testimony at trial (testimony never taken, disclosed, or provided during
2 the many years this case was pending) and argued that testimony would somehow
3 prove that the doctor's codes were unsupported. The "mere possibility" of the
4 coders' testimony cannot defeat the pending summary judgment motion.

5 The government also relies on *United States ex rel. Swoben v. United*
6 *Healthcare Ins. Co.*, 848 F.3d 1161 (9th Cir. 2016), but that decision is
7 distinguishable. The government's theory of liability (a "false certification"
8 theory) in *Swoben* differed from this case (a reverse false claim), and the Ninth
9 Circuit evaluated the claims only under pleading standards. *Swoben* involved an
10 FCA claim asserted in a pleading, not a reverse FCA claim on summary judgment.
11 In *Swoben*, the relator alleged in a complaint that the defendants' certifications
12 "based on best knowledge, information, and belief," regarding the accuracy,
13 completeness, and truthfulness of data submitted to CMS were false or fraudulent
14 statements, and the Ninth Circuit found that was sufficient for pleading purposes.
15 The government's theory in this case is markedly different from the one raised in
16 *Swoben*. The government claims that United knowingly and improperly retained
17 overpayments received as a result of unsupported diagnosis codes. Proving such a
18 claim necessarily requires proving that United *submitted unsupported diagnosis*
19 *codes* and retained overpayments due to those unsupported codes. There is no
20 evidence in the record to prove this claim.

21
22 *Swoben* addressed whether the plaintiff's allegations were sufficient to
23 *plead* a claim for violation of the FCA based on false certifications; not the
24 sufficiency of evidence to *prove* that a defendant submitted unsupported diagnosis
25 codes to CMS. *See Swoben*, 848 F.3d at 1167 (holding plaintiff "assert[ed] a
26 cognizable legal theory"). In fact, the Ninth Circuit stated that, "[b]y holding that
27 one-sided retrospective reviews *can* result in false certifications under
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29

1 §422.504(I), we do not suggest that they necessarily always do.” *Id.* at 1175. The
2 Ninth Circuit's observation highlights that such a claim still must be proved by
3 admissible evidence.

4 *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010 (N.D.
5 Cal. 2020), also cited by the government, similarly addressed only the sufficiency
6 of the pleadings. *Id.* at 1080-1081 (holding “[a]t the pleadings stage, the plaintiffs
7 sufficiently allege that [defendant medical providers] knowingly concealed or
8 avoided their obligations to pay the government”) (emphasis added).

9 *Swoben* and *Sutter* do not support the proposition that the government can
10 carry its burden on summary judgment simply by pointing to evidence that United
11 submitted diagnosis codes to CMS that United coders did not identify in chart
12 reviews. To meet its burden, the government needed to present evidence from
13 which a jury could reasonably conclude that the diagnosis codes United submitted
14 were invalid, *i.e.*, that codes were not supported by the related medical record. The
15 complete failure of any evidence on this essential element must result in summary
16 judgment for United.
17

18
19 The government's case depends entirely on speculation and assumptions
20 about what the codes found by the United coders actually mean. If a defendant's
21 alleged obligation to pay or return an overpayment to the government depends on
22 multiple assumptions, courts have found that it is only a "potential and contingent"
23 obligation and thus non-actionable under 31 U.S.C. Section 3729(a)(1)(G). *See*
24 *United States ex rel Barrick v. Parker-Migliolini Intl., LLC*, 878 F.3d 1224, 1230-
25 31 (10th Cir. 2017). Here, any purported overpayment depends on the assumption
26 that doctors provided unsupported codes because their codes were different than
27 the codes found during the Chart Review process. This is an assumption, however,
28
29

1 and there is no evidence to support it. Accordingly, there is no evidence of an
2 obligation or overpayment under the FCA. *See also U.S. ex rel Quinn v.*
3 *Omnicare, Inc*, 382 F.3d 432, 446 (3rd Cir. 2004) (without a clear obligation to pay
4 the government, there is no FCA liability). The Ninth Circuit reached a similar
5 conclusion recently in *United States ex rel. Lesnik v. ISM Vuzem d.o.o.*:

6
7 Given that the government has not “established” a duty to repay the
8 government any money, this case fits neatly into a line of cases
9 declaring that potential or contingent obligations to repay are not
10 enough to support a reverse false claim theory of relief. For example,
11 in *United States ex rel. Simoneaux v. E.I. duPont de Nemours & Co.*,
12 843 F.3d 1033 (6th Cir. 2016), the Sixth Circuit addressed a situation
13 where the relator claimed the defendant had violated the FCA by
14 failing to report sulfur dioxide leaks to the EPA, which the relator
15 claimed was a knowing concealment of an obligation to pay money
16 (fines) to the government. *Id.* at 1034 . . . “For FCA liability to
17 attach,” the Sixth Circuit concluded, “there must be an established
18 duty to pay.” *Id.* at 1039, quoting 31 U.S.C. § 3729(a)(1)(G). “Where
19 ... a regulatory penalty has not been assessed and the government has
20 initiated no proceeding to assess it, there is no established duty to
21 pay.” *Id.*¹⁵ *Accord Carlisle v. Daewon Kangup Co.*, No. 3:15-cv-565,
22 2018 WL 2336757, at *2 (M.D. Ala. May 23, 2018) (potential
23 penalties a defendant owed, which would be based on the exercise of
24 administrative discretion, are not “obligations” that support a reverse
25 false claim theory).
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1 *United States ex rel. Lesnik v. ISM Vuzem d.o.o.*, 112 F.4th 816, 821 (9th Cir.
2 2024). The Ninth Circuit recognized that a reverse False Claims Act claim
3 requires more than a possible or contingent obligation to repay the government.
4 The complete failure to provide any evidence of an actual reverse false claim –
5 i.e., overpayment to United based on a code that is not supported by a medical
6 record – compels summary judgment for United.

7
8 **B. CMS RADV Audit Data Undercuts The Government’s Theory that**
9 **Coding Discrepancies Prove Unsupported Codes.**
10

11
12 Any presumption that a diagnosis code not identified by United’s coders in
13 chart review is necessarily invalid is also rendered questionable by data from
14 audits conducted by the government.

15 CMS conducts periodic audits of MA plans, which are called RADV audits.
16 Dkt. 616-1 at D71. To conduct RADV audits, CMS selects a sample of a MA
17 plan’s members. *Id.* at D74. MA plans then submit medical charts for those
18 sampled members, which CMS reviews. *Id.* at D75-76.

19 CMS conducted RADV audits on certain United contracts for 2011-15, at
20 least 4 of the 9 years at issue in this case. Dkt. 616-1 at D81, D83, D88. Through
21 such audits, CMS reviewed medical records relating to roughly 6,500 of the 28
22 million diagnosis codes submitted by United that the government claims were
23 unsupported. *Id.* at D184. CMS coders found that approximately 89% of those
24 roughly 6,500 codes had support in patients’ medical records. Exs. D-64, D-63.

25
26 The government disputes the relevance of the RADV data and argues that
27 this evidence is statistically insignificant because the RADV audit involved only a
28 small portion of the 28 million diagnosis codes that the government contends were
29

1 unsupported. Dkt. 616 at 29-30. Nonetheless, it is meaningful that the
2 government's *own auditors* found support in medical records for diagnosis codes
3 that the government has alleged were unsupported based solely on such codes not
4 having been coded during United's chart review. These findings undercut the
5 government's theory that any diagnosis code submitted by United to CMS but not
6 identified by coders in chart review is presumptively invalid.

7
8 **C. The Government Had A Full Opportunity to Develop Evidence**
9 **to Support its Claims.**
10

11
12 The allegation that United submitted unsupported diagnosis codes resulting
13 in overpayments is a crucial element of the government's reverse FCA claim, on
14 which the government has the burden of proof at trial. Before even filing its
15 complaint, the government was required to conduct a reasonable investigation of
16 the facts and to have a reasonable belief that it could prove this element of its
17 claim. This litigation has been pending for more than a decade, and the
18 government has had ample opportunity to develop evidence in support of its
19 theories. It has not done so.

20 The government's argument that it was precluded from obtaining evidence
21 during discovery because United "refused" to produce medical records is not
22 supported by the record. United "offered to produce to the government every
23 medical record in United's possession that United reviewed as part of its chart
24 review program, to allow the government to determine for itself which of the
25 codes on its list are or are not supported. The government rejected this offer."
26 Dkt. 419 at 9-10.
27
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29

1 This discovery issue is addressed in the Special Master's Order dated May
2 28, 2021. In that Order, the Special Master noted:

3
4 Interrogatory 14 asked UnitedHealth to, with respect to every
5 diagnosis code on the government's list, (a) identify which code is
6 supported by a medical record and (b) identify every medical record
7 review that UnitedHealth conducted. (MTC at 5-7). Request 147
8 requests all medical records associated with the diagnosis codes on the
9 government's list. (Id. at 7). In response to Interrogatory 14,
10 UnitedHealth objected on the grounds that "this Interrogatory is an
11 improper contention interrogatory that impermissibly seeks to shift the
12 burden of proving an essential element of the government's False
13 Claims Act case on to UnitedHealth and seeks expert opinion." (Id. at
14 8). In response to Request 147, UnitedHealth stated: "Based upon its
15 General and Specific Objections, UnitedHealth does not intend to
16 produce documents responsive to this Request." *At the meet and*
17 *confer on this issue, UnitedHealth indicated that it would produce*
18 *the responsive medical records in its possession. This production,*
19 *however, would require a production of approximately 21 million*
20 *charts and take 8 months to produce.* This proposal did not resolve
21 the discovery dispute.
22
23

24 (Dkt. 419, Order Denying Motion To Compel Without Prejudice at 2-3)(emphasis
25 added). The government declined United's offer to produce the 21 million medical
26 records, apparently due to the volume of records at issue. However, the
27 government was responsible for placing that volume of records in dispute.
28
29

1 The government fails to explain why it could not review even a sampling of
2 the medical records. According to United, this is the procedure the government
3 has followed in other FCA cases. The government has failed to provide any
4 explanation for its choice to avoid any kind of review of medical records to
5 determine whether the records supported the listed codes.

6 Instead, the government has repeatedly attempted to shift the burden to
7 United to *disprove* the government's allegations. Rather than review medical
8 records itself, the government served discovery asking United to identify which of
9 the approximately 28 million diagnosis codes, if any, *United* contends *were*
10 *supported* by medical records and to produce the medical records providing such
11 support. While United objected primarily to the breadth and scope of the
12 discovery request, and to conducting the comparison work on the government's
13 behalf, the meet and confer correspondence, as well as the Special Master's order,
14 revealed United's willingness to turn over the medical records to the government.
15 The government rejected this offer. The government's presentation of this issue
16 in its Opposition is incomplete, as it does not discuss the record evidence
17 demonstrating that United agreed to turn over medical records.
18

19 The Special Master's May 28, 2021 order denied without prejudice the
20 government's motion to compel United to respond to such burdensome discovery.
21 Dkt. 419. The Special Master found that responding to the interrogatory "would
22 impose a tremendous burden on the responding party to prepare an answer that
23 does not currently exist." *Id.* at 4. The Special Master also found that "[o]nly an
24 expert—or someone with specialized knowledge—could do a fair comparison of
25 the medical records and the diagnosis codes to determine if the medical record
26 supported the code." *Id.* at 4-5. Accordingly, the Special Master denied the
27 motion without prejudice. The Special Master found that the government could
28
29

1 “renew” the request “if the requested documents are relevant to [United’s]
2 defenses asserted at a later phase of the action.” (*Id.* at 10.). Nothing in this
3 discovery order, however, prevented the United States from requesting or
4 reviewing *a sampling* of the medical records. The government has never
5 explained why it would not undertake a review of the medical records itself or a
6 subset of the medical records. The government never explained why it would
7 only be satisfied by production of millions of records and by having United
8 perform the necessary comparison work.

9
10 On March 22, 2024, after United provided the report of its expert, Mr.
11 Timothy Renjilian, the government brought an untimely motion to compel, again
12 seeking to compel United to respond to its interrogatory and to produce the
13 millions of medical records supporting any codes United contends were
14 supported. As noted, the government sought to shift its burden of investigating its
15 contentions to United by requiring United to disprove the government's
16 allegations. Nothing, however, stopped the government from conducting this
17 investigation on its own.

18 The Special Master denied the government’s motion, again noting that the
19 burden of reviewing the medical records could not be shifted to United. The
20 Special Master explained that Mr. Renjilian did not review nor rely on any
21 medical records in reaching his opinion (i.e., that data from CMS’s own RADV
22 audits undercut the government’s theory), and therefore the medical records the
23 government sought to compel were not discoverable as expert reliance materials.
24 Nor had the government shown any other justification for requiring United to
25 undertake the costly and burdensome collection and expert analysis of millions of
26 medical records to *disprove* the government’s claims that certain diagnosis codes
27 were unsupported by medical records.
28
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1 The government “must present affirmative evidence” to defeat summary
2 judgment and was unable to do so, despite having had “a full opportunity to
3 conduct discovery.” *Anderson*, 477 U.S. at 257. The government did not review
4 any medical records, did not designate any expert to compare diagnosis codes
5 submitted by United against patient charts to identify unsupported diagnosis
6 codes, and thus lacks evidence of any overpayments, which is an essential element
7 of its claim. Summary judgment for United is therefore appropriate. *See United*
8 *States ex rel. Kelly v. Serco, Inc.*, 846 F.3d 325, 335 (9th Cir. 2017) (granting
9 summary judgment where plaintiff failed to establish “an essential element” of
10 false records claim); *In re Oracle Corp. Sec. Litig.*, 627 F.3d at 387 (affirming
11 summary judgment for defendant where plaintiffs “had not developed evidence
12 sufficient to allow a jury to reasonably conclude” an essential element of
13 plaintiffs’ claim).
14

15
16 **2. Lack of Evidence of Knowing and Improper Avoidance of United’s**
17 **Obligations With Respect to the Alleged Overpayments**
18

19 United is also entitled to summary judgment on the reverse FCA claim on
20 the alternative ground that the government has failed to present any evidence
21 showing that United “knowingly and improperly avoid[ed]” its obligation to repay
22 the alleged overpayments.
23

24 The government advances the position that mere avoidance of an obligation
25 to repay money to the government is enough to create liability under the FCA,
26 without the need to prove any deceptive conduct. *See* Dkt. 616 at 78-80. As
27 discussed below, the Special Master agrees with United that the government’s
28 position cannot be reconciled with the relevant statutory language, which requires
29

1 United to have knowingly “conceal[ed]” or “improperly avoid[ed]” such a
2 payment obligation. 31 U.S.C. § 3729(a)(1)(G). In addition, the government’s
3 position is incompatible with the Supreme Court’s recognition in *Escobar* that the
4 FCA is an anti-fraud statute that imports common-law fraud concepts. *Escobar*,
5 579 U.S. at 186-87. *See also United States ex rel. Schutte v. SuperValu, Inc.*, 598
6 U.S. 739, 750-51 (2023) (recognizing that the “FCA is largely a fraud statute,”
7 and that, therefore, “[i]n the absence of statutory text to the contrary,” courts
8 should interpret the FCA as incorporating “the well-settled meaning of such a
9 common-law term”). The holdings in *Escobar* and *SuperValu* conflict with the
10 government’s view that the violation of a regulatory or contractual requirement is
11 enough to create liability under the FCA, and that the FCA does not require
12 conduct that is designed to deceive or mislead the government regarding a party’s
13 entitlement to a payment.
14

15 “The disregard of a federal regulation, by itself, does not create liability
16 under the [FCA].” *U.S. ex rel Drakeford v. Tuomey*, 792 F.3d 364, 379-81 (4th
17 Cir. 2015). Instead, a reverse FCA claim requires proof that the defendant
18 engaged in conduct that deceived the government about an obligation to repay
19 funds. Specifically, the reverse FCA requires, at minimum, a showing of one of
20 the following: (1) a knowingly false statement or record that is material to a
21 repayment obligation; (2) knowing concealment of a repayment obligation; or (3)
22 knowing and improper avoidance of a repayment obligation. *See* 31 U.S.C. §
23 3729(a)(1)(G).
24

25 This requirement means that, like the rest of the FCA, the reverse FCA
26 creates liability for fraud. *See Olson v. Fairview Health Servs. of Minn.*, 831 F.3d
27 1063, 1073-74 (8th Cir. 2016) (referring to the reverse FCA as “one of seven
28 substantive provisions imposing liability for fraud against the government,” and
29

1 holding that the FCA's punitive sanctions are an “unreasonable levy” for parties
2 liable “only [for] ‘knowingly’ receiving an overpayment from the government . . .
3 If there is no allegation of fraudulent conduct under the FCA, then there can be no
4 reverse liability under § 3729(a)(1)(G).”).

5 The mere retention of overpayments may deprive the government of funds
6 it is owed, but that is not fraud. “Bad math is no fraud, [and] proof of mistakes is
7 not evidence that one is a cheat.” *Owens*, 612 F.3d at 734 (citing *Hagood v.*
8 *Sonoma County Water Agency*, 81 F.3d 1465, 1478 (9th Cir. 1996) (internal
9 quotations omitted). Holding otherwise would “push the FCA beyond its proper
10 boundaries [and] invite the prospect of pervasive litigation that would discourage
11 many perfectly honest companies from wanting to do business with the United
12 States.” *Id.* Courts must guard against this outcome by treating the reverse FCA
13 as the fraud statute that it is. Understanding the reverse FCA as a fraud provision
14 “comports with the punitive nature of liability that the FCA imposes,” and with
15 the United States Supreme Court's admonition that the FCA is not an “all-purpose
16 antifraud statute.” *Olson*, 831 F.3d at 1074 (citation and quotation marks
17 omitted). “If the FCA is not meant to cover all types of fraud, it would be
18 unreasonable to assume it covers both fraudulent and nonfraudulent conduct.” *Id.*

20 The reverse FCA's text enshrines this requirement by requiring that, even in
21 the absence of “knowing[] conceal[ment]” of a repayment obligation, a plaintiff
22 show knowing and “improper[]” avoidance of a repayment obligation. 31 U.S.C.
23 § 3729(a)(1)(G) (emphasis added). Black's Law Dictionary defines “improper” as
24 “1. Incorrect; unsuitable or irregular. 2. *Fraudulent or otherwise wrongful.*”
25 Improper, Black's Law Dictionary (11th ed. 2019) (emphasis added). This
26 language makes clear that deception is a requirement for reverse FCA liability no
27 matter which precise formulation in Section 3729(a)(1)(G) is invoked to describe
28
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1 the conduct in question. Congress recognized this requirement when, in expanding
2 the statute's definition of “obligation” to include “the retention of an
3 overpayment,” it made clear that only overpayments of which the government is
4 unaware would be actionable: “[T]he violation of the FCA for receiving an
5 overpayment may occur once an overpayment is knowingly and improperly
6 retained, without notice to the Government about the overpayment.” S. Rep. No.
7 111-10, 2009 WL 787872, at *15 (Mar. 23, 2009); *see also* 155 Cong. Rec.
8 S4531, 2009 WL 1077017, at S4539-4540 (Apr. 22, 2009) (Sen. Jon Kyl noting
9 that “knowing and improper” means of retaining an overpayment “must be means
10 that are malum in se—that is, means that are inherently wrongful and constitute an
11 independent tort”).

12
13 Because the FCA—including the reverse FCA—is a fraud statute and fraud
14 as a common-law concept requires that the defendant's actions induce detrimental
15 reliance by the plaintiff (*see Glaser v. Enzo Biochem, Inc.*, 464 F.3d 474, 476-77
16 (4th Cir. 2006)), the problem with the government's allegations is that the
17 government knew of the very chart review practices of which it now claims
18 United prevented it from learning, and thus the government cannot have been
19 duped into relying on any action or inaction by United in determining whether it
20 had been the victim of overpayments.

21 Thus, the impropriety of a defendant's retention of an overpayment cannot
22 be grounded in the mere fact of the defendant having received the overpayment, or
23 even of being obligated to return it. Otherwise, the requirement of “improper”
24 conduct would introduce circularity and surplusage into a statute where Congress
25 clearly intended nothing of the kind. *Cf. Nat'l Ass'n of Mfrs. v. Dep't of Def.*, 583
26 U.S. 109, 128 (2018) (“Absent clear evidence that Congress intended this
27 surplusage, the Court rejects an interpretation of the statute that would render an
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entire subparagraph meaningless. As this Court has noted time and time again, the Court is ‘obliged to give effect, if possible, to every word Congress used.’”) (citation omitted).

The only contrary authority cited by the government that seemingly supports its position that neither concealment nor deception is required to establish a reverse FCA claim is *Kane ex rel. United States v. Healthfirst, Inc.*, 120 F. Supp. 3d 370 (S.D.N.Y. 2015). Dkt. 616 at 33, 60, 61, 79. In *Kane*, the district court concluded that for a reverse FCA claim, “avoiding” an obligation to pay occurs when a party is put on notice of a potential overpayment issue, is legally obligated to address it as a matter of regulatory or contractual requirements and does nothing. *See Kane*, 120 F. Supp. 3d at 388, 390-91, 394. However, setting aside the fact that *Kane* is not binding authority in this case, that decision is also inapposite because: (i) it focused only on the statutory term “avoid[]” and never addressed the meaning of the additional terms “conceal[]” and “improper[]”, and consequently it effectively read the latter terms out of the reverse FCA provision, which *Kane* nevertheless characterized as part of the FCA’s “robust anti-fraud scheme” (see *id.* at 390); and (ii) *Kane* was decided prior to *Escobar*, which, as discussed, eliminated any notion that mere notice of a potential regulatory or contractual violation is enough to support liability under the FCA.

The government has failed to allege any sort of deception on the part of United with respect to its alleged failure to return overpayments. It does not allege that United made a false statement material to a repayment obligation. Nor does the government contend that United actively concealed any such obligation. In relying upon only the “knowing and improper avoidance” formulation of reverse FCA liability, the government must establish that United knew it had received overpayments and acted in a way that kept the government from learning

1 of the overpayments. The government does not allege that United did any such
2 thing. Nor could it. To the contrary, the government was aware of United's claim
3 procedures as early as April of 2014, when United and CMS met regarding the
4 government's proposed new code verification rule. *See* 1/15/25 Tr. 89-103.

5 While the parties disagree about what was discussed at that 2014 meeting
6 (*see* Tr. 1/15/25 Tr. at 89), even construing all facts in favor of the government, it
7 is undisputed that United *requested* this 2014 meeting with the Director of CMS,
8 the Deputy Director of CMS, and other leaders of the agency to discuss United's
9 claim verification process and the impact of the proposed new rule. *See id.* at 92.
10 United's initiation of a meeting with CMS on this topic is the opposite of
11 concealment. The evidence thus supports United's position that it in no way
12 sought to withhold information about its chart review program from CMS when
13 submitting diagnoses for payment, and that United also sought guidance from
14 CMS regarding the agency's expectations.
15

16 United also submitted evidence of annual correspondence with CMS and
17 bid documents after the 2014 meeting in which United disclosed the nature of its
18 chart review program and the fact that that program was not designed to confirm
19 the validity of diagnosis codes submitted by doctors. *See* Dkt. 616 at 76; 1/15/25
20 Tr. at 109-11; Exs. P-1D and P-1E (emails between United's CEO in charge of
21 Medicare and CMS's deputy director wherein United informed CMS that United
22 "did not use our [chart review] process to determine whether diagnosis codes
23 submitted through claims are unsupported in the medical record," but that United
24 "do[es] have a quality assurance process that deletes codes initially identified
25 during chart review and that are later determined to be unsupported"); Ex. D-25
26 (United's annual bid documents informing CMS that United "has decided to cease
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1 one of its prior processes that identified and deleted certain diagnosis codes
2 through the medical record review process”).

3 For example, on June 26, 2015, United included the following paragraph in
4 an email to Sherri Rice at CMS:

5
6 CMS issued a proposed rule last year that would have required
7 MA plans to design any medical record reviews to determine the
8 accuracy of risk adjustment diagnoses associated with those records.
9 In May 2014, CMS withdrew the proposed rule. During our
10 conversations last year before the proposed rule was withdrawn, CMS
11 confirmed to us that the proposed requirements would not apply until
12 the effective date of the rule, and that MA plans were thus not
13 required to design their medical record reviews to determine the
14 accuracy of risk adjustment diagnoses. As we discussed last year, we
15 previously had a process through which we reviewed certain medical
16 records to determine the accuracy of risk adjustment diagnoses and
17 submitted appropriate deletes. Based on our conversations with CMS
18 last year, CMS’s withdrawal of the proposed rule, and CMS’s ongoing
19 consideration of a FFS Adjuster to address diagnoses not supported by
20 a medical record in the context of RADV, we ended this process and
21 informed you of that decision. That decision remains operative for
22 2013 dates of service. In particular, we did not use our previous
23 process to determine whether diagnosis codes submitted through
24 claims are unsupported in the medical record. We do have a quality
25 assurance process that deletes codes initially identified during chart
26 review and that are later determined to be unsupported.
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1 (Dkt. 618-2, Exhibit D-21). A similar email was sent in 2016, and United made
2 similar disclosures in bid documents to CMS during the relevant time period.

3 While CMS did not endorse United's chart review program following the
4 2014 meeting (*see* Dkt. 616 at 80; Exs. P-1D, P1-E, P1-F), there is no question
5 that United disclosed its medical record review practices to the CMS
6 representatives that it regularly corresponded with. In short, not only was there no
7 evidence of deception as required to establish reverse FCA liability for the
8 "improper" avoidance of an obligation to repay the government, but the evidence
9 presented actually showed that United was seeking guidance from the agency and
10 transparent about its practices. Nothing United allegedly did or did not do
11 prevented the government from acquiring knowledge of United's medical record
12 review program. There simply was no fraud.
13

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15 **3. The Government's Common Law Claims Also Fail For Lack of**
16 **Evidence of an Overpayment Based on Unsupported Codes.**
17

18 Like its reverse FCA claim, the government's common law claims for
19 payment by mistake and unjust enrichment fail because the government has not
20 carried its burden to present evidence of an overpayment based on unsupported
21 diagnosis codes. As a result, the government cannot prevail on its common law
22 claims because these claims necessarily also require it to prove that United
23 received payments from the government to which United was not entitled.
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III. THE GOVERNMENT'S MOTION FOR PARTIAL SUMMARY JUDGMENT

A. The Government's Contentions

The government seeks partial summary judgment on the issue that materiality is not a required element of establishing liability under the second prong of the reverse false claim provision. Dkt. 616 at 93-94. That prong applies to a person who “knowingly and improperly avoids . . . an obligation to pay . . . the [g]overnment.” 31 U.S.C. § 3729(a)(1)(G). The government argues that it is clear from the structure of the statutory text of the provision that materiality is not a required element of such a reverse FCA claim. It contends courts have recognized that the text draws a meaningful distinction between the first prong – which requires a “false record or statement *material* to an obligation” – and the absence of that same requirement within the second prong. *See* Dkt. 616 at 92-94.

The government argues that the seminal case on materiality under the FCA, *Universal Health Services v. United States ex rel. Escobar*, 579 U.S. 176 (2016), did not address materiality under the reverse false claim provision, but rather focused on materiality with respect to affirmative false claims under 31 U.S.C. § 3729(a)(1)(A). *See* Dkt. 616 at 93-4 (citing *Escobar*, 579 U.S. at 181). The government argues that since *Escobar*, a number of district courts both in the Ninth Circuit and in other circuits have expressly held that materiality is not an element under the second prong of the reverse-FCA provision.

B. United's Opposition

United opposes the motion on the grounds that the government's argument ignores the Supreme Court's holding in *Escobar* that "the common law could not have *conceived* of 'fraud' without proof of materiality." *Escobar*, 579 U.S. at 193 (emphasis added) (citation omitted). United argues that not only is materiality a cornerstone element of fraud, but the text, structure, and history of the reverse FCA all require its "rigorous materiality requirement" to be enforced. *Escobar*, 579 U.S. at 181.

To the extent that materiality is an element of any reverse-FCA claim—including a claim brought under the second prong of the FCA's reverse provision—United contends that CMS did not consider United's failure to delete or investigate diagnosis codes that doctors had certified and submitted to United, but that United's coders did not independently identify during their blind chart review, to be *material* to CMS's decision to pay United on the basis of those codes. United points to the fact that CMS knew about the process used by United in submitting codes for years and yet continued to pay United anyway. See Dkt. 616 at 103.

C. Fraud Claims Require Materiality

As previously discussed, the Supreme Court has recently reaffirmed, "the text of the FCA" "tracks the common law" "for claims of fraud . . . because . . . the FCA is largely a fraud statute." *SuperValu Inc.*, 598 U.S. at 750 (citing *Escobar*, 579 U.S. at 187-88 & n.2). In addition, the Ninth Circuit has recognized

1 that “[t]he [FCA’s] ‘reverse false claims’ provision does not eliminate or
2 supplant the FCA’s false claim requirement.” *Serco, Inc.*, 846 F.3d at 336
3 (quoting *Cafasso v. Gen Dynamics C4 Sys., Inc.*, 637 F.3d 1047, 1056 (9th Cir.
4 2011)). Rather, that provision “expands the meaning of a false claim to include
5 statements to avoid paying a debt or returning property to the United States.”
6 *Cafasso*, 637 F.3d at 1056. In particular, the FCA’s reverse false claims provision
7 “attempts to provide that fraudulently reducing the amount owed to the
8 government constitutes a false claim.” *Id.* (internal citation and quotation marks
9 omitted). This view of a reverse false claim as a type of false claim that is
10 intended to prevent fraud upon the government indicates that a materiality element
11 is applicable to reverse false claims, including the one asserted by the government
12 in this case.
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14
15 As noted in the *Ormsby* decision, the FCA defines materiality as “ ‘having a
16 natural tendency to influence, or be capable of influencing, the payment or receipt
17 of money or property.’ ” *Ormsby*, 444 F. Supp. 3d at 1055 (quoting *Escobar* at
18 1213; 31 U.S.C. § 3729(b)(4)). “Although the requirement is ‘demanding,’ the
19 Supreme Court has held that there is not a bright-line test for determining whether
20 the FCA’s materiality requirement has been met.” *Id.* (citing *Escobar*). “Instead,
21 the Supreme Court has given a list of relevant, but not necessarily dispositive,
22 factors in determining whether the false claims were material, such as whether
23 the government decided ‘to expressly identify a provision as a condition of
24 payment.’ ” *Id.* (quoting *Escobar*, 136 S. Ct. at 2003). “ ‘Likewise, proof of
25 materiality can include, but is not necessarily limited to, evidence that the
26 defendant knows that the government consistently refuses to pay claims in the
27 mine run of cases based on noncompliance with the particular statutory,
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1 regulatory, or contractual requirement.’ ” *Id.* (quoting *Escobar*, 136 S. Ct. at
2 2003). “ ‘Conversely, if the government pays a particular claim in full despite its
3 actual knowledge that certain requirements were violated, that is very strong
4 evidence that those requirements are not material.’ ” *Id.* (quoting *Escobar*, 136 S.
5 Ct. at 2003). “ ‘Or, if the government regularly pays a particular type of claim in
6 full despite actual knowledge that certain requirements were violated, and has
7 signaled no change in position, that is strong evidence that the requirements are
8 not material.’ ” *Id.* (quoting *Escobar*, 136 S. Ct. at 2003–04). *Escobar* does not
9 directly address reverse false claims provisions, but the decision’s emphasis on the
10 significance of the materiality element cannot be ignored.

11
12 The reverse FCA provision, 31 U.S.C. § 3729(a)(1)(G), imposes liability
13 on one who “knowingly makes, uses, or causes to be made or used, a false record
14 or statement material to an obligation to pay or transmit money or property to the
15 Government, or knowingly conceals or knowingly and improperly avoids or
16 decreases an obligation to pay or transmit money or property to the
17 Government[.]” 31 U.S.C. § 3729(a)(1)(G). The government invokes the “second
18 prong” of this provision, alleging that United has knowingly concealed and
19 avoided United’s obligation to return MA overpayments. The government further
20 maintains that no materiality requirement applies to such a reverse false claim and
21 argues that neither *Escobar* nor any other binding authority addressed this second
22 prong when discussing materiality.

23
24 However, while it is true that *Escobar* did not address the reverse false
25 claims provision, *Escobar* and subsequent Ninth Circuit cases recognize that, like
26 the FCA as a whole, its reverse false claims provision incorporates the elements of
27 common law fraud (although the provision expands the notion of what constitutes
28 a “false claim” under the statute). Accordingly, a materiality element must apply
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1 to that provision, regardless of which of its two prongs is the basis for the
2 government's claim in a given case, because of the inconceivability of fraud
3 absent a materiality element. *See e.g., Neder v. U.S.*, 52 U.S. 1, 22-23 (1999)
4 (materiality is an element of fraud because the well-settled meaning of fraud at
5 common law involves the concealment of a material fact); *Cox v. Continental*
6 *Cas. Co.*, 703 Fed. Appx. 491, 495 (9th Cir. 2017) ("fraud requires materiality").
7

8 The cases cited by the government do not thoroughly analyze this issue.
9 For example, the *Ormsby* decision recites that the second prong of the reverse
10 FCA provision does not require proof of a material false record or statement, but
11 *Sutter* omits any real discussion or analysis of this issue and relies, in part, on
12 authority outside the Ninth Circuit. *See Ormsby*, 444 F. Supp. 3d at 1056; *see*
13 *also United States ex rel. Jacobs v. Pac. Dermatology Inst., Inc.*, 2022 WL
14 17401522, at *13 (no analysis of the issue); *United States ex rel. Frey v. Health*
15 *Management Systems, Inc.*, 2021 WL 4502275, at *7 (same); *United States ex rel.*
16 *Little v. Shell Exploration & Production Co.*, 2017 WL 4742917, at *29 n.260
17 (noting the parties' agreed that the pre-FERA version of the FCA applied). Other
18 decisions, including one in this litigation, have noted that under *Escobar*, "a claim
19 must be based on a violation [of the FCA] that is likely to affect whether and how
20 much the Government would have paid to a defendant." *See United States ex rel.*
21 *Poehling v. UnitedHealth Grp., Inc.*, 2018 WL 1363487, at *11 (C.D. Cal. Feb.
22 12, 2018) (recognizing that *Escobar* did not distinguish claims brought under §
23 3729(a)(1)(A) from claims brought under § 3729(a)(1)(G) when discussing the
24 FCA's materiality requirement, and that *Escobar* had no reason to address §
25 3729(a)(1)(G) since the case concerned only § 3729(a)(1)(A)).
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1 As this discussion indicates, both the statute's language and history
2 indicate that a "false claim"—which includes a reverse false claim—is not limited
3 to false statements but covers any attempt to fraudulently reduce or avoid the
4 amount owed to the government. This includes a defendant's attempt to
5 knowingly conceal or improperly avoid an obligation to return overpayments to
6 the MA program. The government provides no reason to view the second prong
7 of the reverse false claims provision—which is intended to expand the meaning of
8 a "false claim" under the FCA, an anti-fraud statute that tracks the common law
9 elements of fraud—as omitting the materiality element of common law fraud.
10

11
12 A contrary ruling would have adverse consequences. For example, it would
13 permit the government to generate reverse-FCA claims for the purpose of
14 avoiding a materiality requirement by asserting that a defendant violated its
15 statutory obligation to report and return Medicare overpayments, rather than
16 asserting that the defendant fraudulently overcharged the government and then
17 failed to repay the overpayment. *See, e.g., United States v. Kinetic Concepts, Inc.*,
18 2017 WL 2713730, at *13 (C.D. Cal. Mar. 6, 2017) (concluding that the
19 government's reverse-FCA claim, which asserted that the defendant fraudulently
20 overcharged the government and then failed to repay the overpayment, was
21 redundant of a false presentment claim for payment).
22

23 In addition, in the instant case, failing to require the government to show
24 that United's chart review practices were material would enable the government to
25 pursue an FCA claim based on United's *known* practices for submitting diagnostic
26 codes for reimbursement. As previously discussed, CMS undeniably knew for
27 years about United's practices and was aware when it made the challenged
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1 payments that United's coders never sought to independently confirm the validity
2 of the diagnostic codes identified by the doctors. *See, e.g.*, Dkt. 623, Ex. D-21 at
3 671. After holding a conference with United in 2014 about the claims review
4 process, receiving emails from United about their chart review practices, and bid
5 forms that confirmed the practices, CMS chose not to require changes to United's
6 chart review procedures (Dkt. 616-1 at D117, D136), and continued to pay
7 United's claims.
8

9
10 Although not dispositive, this type of behavior by the government has been
11 recognized as a factor undermining a "false claim" or materiality contention,
12 because if, as the record indicates, United was open with the government about
13 United's chart review procedures, and the government knew of those procedures
14 and nevertheless paid the claims for years without changing its position (as CMS
15 contemplated doing in 2014), the government's conduct would be hard to
16 reconcile with the concept that the government believed United to be making a
17 material false claim for payment by failing to independently verify diagnostic
18 codes identified by doctors. *See Escobar*, 579 U.S. at 195 (noting that "if the
19 Government pays a particular claim in full despite its actual knowledge that
20 certain requirements were violated," and "has signaled no change in position,"
21 that is "very strong evidence that those requirements are not material").
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23
24 Courts in this circuit have upheld the requirement that fraud must be part of
25 a reverse false claim, before and after the 2009 amendments to the FCA. *See e.g.*
26 Cafasso, 637 F.3d at 1056 ("Section 3729(a)(7) of the FCA—the reverse false
27 claims provision—does not say otherwise. It makes actionable the knowing use of
28 a false record or statement to conceal, avoid, or decrease an obligation ... to
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transmit money or property to the Government . . . This provision attempts to provide that *fraudulently* reducing the amount owed to the government constitutes a false claim.”) (internal quotations omitted and emphasis added); *See also Kelly*, 846 F.3d at 336 (quoting *Cafasso* for the same proposition with respect to the current reverse false claim provision (3729(a)(1)(G))); *Scott v. Arizona Center for Hematology and Oncology PLC*, 2018 WL 1210903, at *7 (D. Ariz. March 8, 2018) (requiring fraudulent conduct for a reverse false claim). Fraud requires materiality. Thus, the Special Master recommends the Court deny the government's motion for summary adjudication on the issue of materiality.

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IV. RECOMMENDATION

Based on the foregoing, it is respectfully recommended that United's pending Motion for Summary Judgment be GRANTED and the government's Motion for Partial Summary Judgment be DENIED. Pursuant to the District Judge's Order Appointing Special Master and Federal Rule of Civil Procedure 53, the parties may file a motion to modify, adopt or objections to this Report and Recommendation within 14 days of the date of this Report.

IT IS SO RECOMMENDED.

DATED: 3/3/2025

DocuSigned by:

Hon. Suzanne Segal (Ret.)

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Honorable Suzanne H. Segal (Ret.)
Special Master