IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF GEORGIA ROME DIVISION

UNITED STATES OF AMERICA,	*	
	*	
Plaintiff,	*	
	*	
v.	*	4:18-CV-00191-ELR
	*	
CHARLES C. ADAMS, M.D., et al.,	*	
	*	
Defendants.	*	
	*	

O R D E R

Presently before the Court is Defendants Charles C. Adams, M.D., and Charles C. Adams, M.D., P.C., d/b/a Full Circle Medical Center, d/b/a Personal Integrative Medicine PLLC's "Motion for Summary Judgment." [Doc. 115]. The Court's reasoning and conclusion are set forth below.

I. Background[1]

This case involves allegedly false claims Defendants made to Medicare for payment for chelation therapy Dr. Adams provided. Medicare is a federal health benefit program that provides insurance coverage for people 65 years of age or older and for people with disabilities. See Defendants' Statement of Undisputed Facts

[1] Unless otherwise noted, the facts reported herein are undisputed.

("Defs.' SOMF") ¶ 20 [Doc. 116]. Medicare is administered by the Centers for Medicare and Medicaid Services ("CMS"). See id. ¶ 21. CMS contracts with Medicare Administrative Contractors ("MACs") to administer the Medicare program and process claims for reimbursement submitted by providers. See id. ¶¶ 40–41. The MAC responsible for processing claims in Dr. Adams' region during the relevant time period was Cahaba GBA ("Cahaba"). See id. ¶ 42. However, Cahaba's contract with CMS terminated in 2018 and was replaced by Palmetto GBA. See id. ¶¶ 43–44.

When medical providers submit claims to Medicare for payment, certain information is required, including details regarding the services and/or items billed. See id. ¶¶ 22–23. Specifically, providers use codes that describe a patient's diagnosis, illness, or condition, and codes that describe the services or items furnished. See id. ¶ 24. These codes can be found in the International Classification of Diseases, Ninth Revision ("ICD-9") and the Healthcare Common Procedure Coding System ("HCPCS") manual. See id. ¶ 25; see also United States' Response to Defendants' Statement of Undisputed Facts and Statement of Additional Facts ("Pl.'s SOMF") ¶¶ 123–124 [Doc. 136]. Additionally, when submitting a claim to Medicare, a provider represents that the claim complies with Medicare's coverage rules and certifies that the items or services for which it seeks payment are

"reasonable and necessary for the diagnosis or treatment of the illness or injury. See Pl.'s SOMF ¶¶ 83, 122.

Dr. Adams operates his medical practice, Personal Integrative Medicine PLLC, in Ringgold, Georgia. See Defs.' SOMF ¶ 6. As part of his practice, Dr. Adams administers chelation therapy, whereby a patient is provided with a "chelator" or "chelating agent" which binds to metals within the body, so that the metals may then be excreted from the body in urine. See id. ¶¶ 8–9. Dr. Adams states that in 2008 he became aware that other physicians were successfully submitting claims to Medicare for chelation therapy and that these physicians employed Cheryl Sweeney and her billing company, CLS Billing Services ("CLS"), to handle their billing. See id. ¶¶ 13–14; see also Pl.'s SOMF ¶ 13. Thereafter, Dr. Adams hired Ms. Sweeney and CLS and began to submit claims to Medicare for chelation therapy in which he used ethylenediamine-tetra-acetic-acid ("EDTA") as the chelating agent to treat a condition Dr. Adams refers to as "excess body burden of heavy metals[.]" See Defs.'s SOMF ¶¶ 10–11, 15; see also Pl.'s SOMF ¶ 105. According to Dr. Adams, symptoms of excess body burden of heavy metals can include: high blood pressure, inability to sleep, headaches, nervousness, anxiety, and gastrointestinal issues. See Defs.'s SOMF ¶ 10. The Parties dispute what advice Ms. Sweeny and CLS provided to Dr. Adams regarding Medicare's payment of

claims for EDTA chelation to treat excess body burden of heavy metals. See Defs.' SOMF ¶ 15; Pl.'s SOMF ¶¶ 106–108.

The United States provides that the medical consensus is that chelation therapy using EDTA is warranted only when a patient is showing symptoms of lead poisoning and has extremely elevated blood lead levels. See Pl.'s SOMF ¶¶ 72–74. However, Dr. Adams admits that he "does not treat patients for lead poisoning," which he contends is different from excess body burden of heavy metals. See Defs.' SOMF ¶ 12. Thus, the United States argues that Defendants presented false claims to Medicare by submitting claims for chelation therapy of ailments other than lead poisoning using diagnostic codes that indicate lead or other heavy metal poisoning. See generally Compl.; see also Pl.'s SOMF ¶¶ 95–96, 129–131. Additionally, the United States contends that Defendants' claims for chelation therapy included false certifications that the chelation therapy was both reasonable and necessary to treat the patient's illness or injury and that the claims adhered to Medicare's coverage rules, including two (2) National Coverage Determinations ("NCD").[2] See Compl.; see also Pl.'s ¶¶ 95–96, 134–136, 139, 141–142. Defendants dispute that their Medicare claims for chelation therapy violated any Medicare coverage rules and

[2] NCDs are policies promulgated by CMS describing what services Medicare will or will not cover. See Defs.' SOMF ¶ 34.

additionally provide that chelation therapy was reasonable and necessary when administered to Dr. Adams' patients. See Defs.' SOMF ¶¶ 30, 33, 39, 53–63.

On August 27, 2018, the United States filed this action on behalf of the United States Department of Health and Human Services ("HHS") and CMS. See Compl. The United States asserts four (4) claims: Count I, a claim for violations of the False Claims Act ("FCA"), 31 U.S.C. § 3729(a)(1)(A), based on the submission of false claims for payment; Count II, a claim for violations of the FCA, 31 U.S.C. § 3729(a)(1)(B), based on the making of false records and statements used to submit false claims for payment to Medicare; Count III, a claim for payment by mistake of fact; and Count IV, a claim for unjust enrichment. See generally id.

After the Court denied Defendants' motion to dismiss, the Parties conducted extensive fact and expert discovery, which concluded on May 18, 2021. [Docs. 25, 32, 46, 65, 78, 96, 99]. Defendants filed their instant motion for summary judgment on July 19, 2021, which the United States opposes.[3] [Docs. 115, 137]. Having been fully briefed, the motion is now ripe for the Court's determination. The Court begins by setting out the relevant legal standard before addressing the Parties' arguments.

[3] The Court notes that it granted the Parties' various requests to extend the summary judgment briefing deadlines and permitted the Parties to file briefs in excess of the page limits set by this district's Local Rules. [See Docs. 108, 112, 113, 114, 127, 128, 138, 140].

II. Legal Standard

The Court may grant summary judgment only if the record shows "that there is no genuine dispute as to any material fact and that the movant is entitled to judgment as a matter of law." See FED. R. CIV. P. 56(a). A factual dispute is genuine if there is sufficient evidence for a reasonable jury to return a verdict in favor of the non-moving party. See Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986). A factual dispute is material if resolving the factual issue might change the suit's outcome under the governing law. See id.

When ruling on the motion, the Court must view all the evidence in the record in the light most favorable to the non-moving party and resolve all factual disputes in the non-moving party's favor. See Reeves v. Sanderson Plumbing Prods., Inc., 530 U.S. 133, 150 (2000). The moving party need not positively disprove the opponent's case; rather, the moving party must establish the lack of evidentiary support for the non-moving party's position. See Celotex Corp. v. Catrett, 477 U.S. 317, 325 (1986).

If the moving party meets this initial burden, in order to survive summary judgment, the non-moving party must then present competent evidence beyond the pleadings to show that there is a genuine issue for trial. See id. at 324–26. The essential question is "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail

as a matter of law." See Anderson, 477 U.S. at 251–52. "The mere existence of a scintilla of evidence" supporting the non-movant's case is insufficient to defeat a motion for summary judgment. See id. at 252. There must be evidence on which a jury could reasonably find for the non-moving party. See id.

III. Discussion

By their instant motion, Defendants contend that they are entitled to judgment as a matter of law on the United States' FCA claims.[4] [See Doc. 115]. Notably, the FCA "serves as a mechanism by which the [United States] may police noncompliance with Medicare reimbursement standards after payment has been made." United States v. AseraCare, Inc., 938 F.3d 1278, 1284 (11th Cir. 2019). The FCA imposes civil liability against any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment" to the federal government or who "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." See id. (quoting 31 U.S.C. § 3729(a)(1)(A)–(B)). To prevail on an FCA claim, the United States must demonstrate four (4) essential elements: that the defendant (1) made a false statement, (2) with scienter, (3) that was material, (4) causing the Government to

[4] The Court notes that the instant motion is one for partial (not total) summary judgment, as Defendants only seek summary judgment on two (2) of the United States' four (4) claims. [Doc. 115]. Specifically, Defendants seek summary judgment on the United States' Counts I and II (brought pursuant to the FCA) but not Count III (Payment by Mistake of Fact) or Count IV (Unjust Enrichment). [See id.]; see also Compl. ¶¶ 201–207; [Doc. 25 at 68, 71] (denying Defendants' motion to dismiss the United States' Counts III and IV).

make a payment. See Urquilla-Diaz v. Kaplan Univ., 780 F.3d 1039, 1045 (11th Cir. 2015).

In the case at bar, Defendants argue that the United States has failed to present evidence of two (2) elements: falsity and materiality. [See Doc. 117 at 10]. The Court addresses each element in turn.

A. Falsity

Defendants make two (2) arguments in support of their contention that the United States cannot satisfy the falsity element of its FCA claims. [See id. at 11]. Defendants first argue that the claims submitted to Medicare for chelation therapy cannot be false because "there is no CMS rule, regulation or guidance that prohibits the claims at issue." [See id.] Next, Defendants contend that the conflicting expert testimony submitted by the Parties regarding the standard of care for chelation therapy does not show falsity, but instead, amounts to a "mere difference of opinion between physicians." [See id. at 11, 16]. The Court begins with Defendants' "difference in medical opinion" argument.

The Medicare Act imposes requirements for federal reimbursement of medical expenses. One such requirement is that "no payment may be made . . . for any expenses incurred for items or services" that "are *not reasonable and necessary* for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." See 42 U.S.C. § 1395y(a)(1)(A) (emphasis added).

Physicians and medical providers who seek reimbursement from Medicare must "certify the necessity of the services and, in some instances, recertify the continued need for those services." See 42 C.F.R. 424.10(a) (2013). Accordingly, a claim for reimbursement can be false if it seeks "reimbursement for services or costs that either are not reimbursable or were not rendered as claimed." See Graves v. Plaza Med. Centers, Corp., 276 F. Supp. 3d 1335, 1340 (S.D. Fla. 2017).

In the instant case, one of the theories the United States advances is that Defendants' claims are false because the use of chelation therapy was not reasonable and necessary for the diagnosis or treatment of the patients' illnesses or injuries. [See Docs. 117 at 16; 137 at 2, 22]. Defendants appear to concede that the Parties' evidence reveals genuine disputes as to the standard of care for chelation therapy and whether Dr. Adams' use of chelation therapy was reasonable and necessary. [See Doc. 117 at 16, 18–21]; [see also Doc. 141 at 7] ("It is undisputed that the government's expert – Dr. Travis Olives – and Dr. Adams and his expert – Dr. Eric Born — disagree on the standard of care for chelation therapy."). Moreover, Defendants highlight the points of contention between the Parties' respective experts. [See id. at 18–21]. For example:

> Dr. Olives and Dr. Born disagree on the standard of care for the administration of EDTA chelation therapy and whether Dr. Adams' treatment of his patients using chelation therapy was medically necessary. Dr. Olives contends that Dr. Adams did not conduct a thorough enough medical history to justify diagnosing his patients with lead toxicity; the use of provoked urine testing is not the standard of

> care for determining whether to administer EDTA chelation, and the blood lead levels of Dr. Adam's patients were not sufficiently high enough to justify using EDTA chelation. Dr. Born, on the other hand, believes that Dr. Adams did, in fact, have enough information to justify his diagnoses and the use of EDTA chelation in his patients was warranted based on available blood lead levels and provoked urine testing.

[See Doc. 117 at 21]. However, Defendants argue that the experts' disputes amount to nothing more than "mere difference[s] in medical opinion between physicians[,]" which are not material to a finding of falsity. [See id. at 16]. In support, Defendants rely heavily upon the district court's opinion in U.S. v. AseraCare, 176 F. Supp. 3d 1282, 1283 (N.D. Ala. 2016) ("AseraCare II"), and the Eleventh Circuit's opinion reviewing the district court decision, United States v. AseraCare, Inc., 938 F.3d 1278, 1297 (11th Cir. 2019) ("AseraCare III"). In AseraCare II, the district court, in a case involving Medicare claims for hospice benefits, granted summary judgment in favor of the defendant *sua sponte* and held that "contradiction based on clinical judgment or opinion alone cannot constitute falsity under the FCA as a matter of law." See 176 F. Supp. 3d at 1283. On appeal, the Eleventh Circuit vacated the district court's grant of summary judgment and remanded the case for reconsideration, but agreed with the district court's conclusion that "to show objective falsity as to a claim for hospice benefits, the Government must show something more than the mere difference of reasonable opinion[.]" See AseraCare III, 938 F.3d at 1297.

However, upon review, the Court finds that Defendants' reliance on these cases is misplaced. As an initial matter, the Court agrees with the United States that the Eleventh Circuit's finding regarding falsity in AseraCare III was specific to Medicare's reimbursement for the hospice services at issue in that case. See 938 F.3d at 1297. The Eleventh Circuit even noted that the "reasonable and necessary" standard (at issue in this case) is different from the hospice-benefit provision in AseraCare III, which instead "looks to whether a physician has based a recommendation for hospice treatment on a genuinely-held clinical opinion as to a patient's likely longevity." See id. at 1300 n.15; see also Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc., 953 F.3d 1108, 1119 (9th Cir. 2020) (noting that the Eleventh Circuit in AseraCare III distinguished its holding regarding a hospice-benefit provision from the medical necessity requirement); United States v. Cross Garden Care Ctr., LLC, No. 8:16-CV-961-T-27AEP, 2019 WL 6493972, at *5 n.5 (M.D. Fla. Dec. 3, 2019) ("the language in AseraCare limited its application to the context of Medicare reimbursement for hospice services").

Nevertheless, even if the holding in AseraCare III clearly applied to this case, the Eleventh Circuit noted therein that a clinical judgment *can* reflect an objective falsehood and trigger FCA liability if the medical opinion "on which the claim is based contains a flaw that can be demonstrated through verifiable facts." See 938 F.3d at 1297. The Eleventh Circuit further explained that such an objective

falsehood could be shown where "a certifying physician fails to review a patient's medical records or otherwise familiarize himself with the patient's condition" or "when expert evidence proves that no reasonable physician could have concluded that a patient was terminally ill given the relevant medical records." See id. Finally, the Eleventh Circuit concluded that an FCA claim fails as a matter of law only when there are *no* "facts and circumstances surrounding the patient's certification [as terminally ill] that are inconsistent with the proper exercise of a physician's clinical judgment[.]" See id.; see also Winter, 953 F.3d at 1119 (explaining that the Eleventh Circuit in AseraCare III "clearly did not consider all subjective statements—including medical opinions—to be incapable of falsity, and identified circumstances in which a medical opinion would be false").

In AseraCare III, the Eleventh Circuit found that there were no facts or circumstances suggesting that the physician's exercise of judgment was improper because "the Government's expert declined to conclude that AseraCare's physicians had lied about their clinical judgment or even that their judgments were unreasonable and wrong—as opposed to just different from what the Government's expert opined." See 938 F.3d at 1297. The matter at bar is distinguishable because the United States' expert, Dr. Olives, does not merely *disagree* with Drs. Adams' and Born's opinions, but rather, identifies specific facts and circumstances surrounding Dr. Adams' diagnoses and treatment that are allegedly inconsistent with the proper

exercise of care.[5] [See Docs. 117 at 21; 137 at 25–26]. Dr. Olives opines that Dr. Adams diagnosed patients without obtaining an adequate medical history or conducting a thorough physical exam; improperly chelated patients with blood lead levels below the level at which lead poisoning is clinically indicated; chelated patients before testing their blood lead levels or receiving the blood lead level results; and inappropriately used provoked urine testing conducted after chelation to indicate a patient's lead levels. See Defs.' SOMF ¶¶ 95–100; see generally Olives Report [Doc. 117-1]; see also Dr. Travis D. Olives Deposition at 140:2–141:3 ("Olives Dep.") [Doc. 118] (explaining why the checklist form Dr. Adams used is inadequate to obtain a medical history); id. at 145:9–17 (describing how a physician would attribute a patient's symptoms to lead); id. at 147:7–8 ("You would never ever, ever, ever chelate somebody until you had verified it was venous blood."); id. at 129:20–130:5 (stating that there is no clinical utility for provoked urine testing). Therefore, contrary to Defendants' argument, the Court finds there is evidence that the disagreements between the Parties' experts rise above mere "differences in opinion" and present disputes of material fact as to whether Dr. Adams' conduct was consistent with the underlying standard of care. See AseraCare III, 938 F.3d at 1297.

[5] To the extent Defendants argue that Dr. Olives is not a qualified to serve as an expert, the Court notes that Defendants have not moved this Court to exclude his testimony. [See Doc. 117 at 18].

And, as the Eleventh Circuit explained in AseraCare III, conduct inconsistent with the underlying standard of care may demonstrate "objective falsehood." See id.

Thus, viewing the evidence in the light most favorable to the United States as the non-moving party, the Court finds that a reasonable jury could conclude that Dr. Adams' diagnoses and treatments were not reasonable and necessary, and, therefore, that his Medicare claims contained a false certification. See id. Because the Court finds that there are genuine disputes of material fact regarding whether Dr. Adams' diagnoses and related treatments were reasonable and necessary, Defendants are not entitled to summary judgment on the element of falsity.[6] See Anderson, 477 U.S. at 248.

B. Materiality

Next, Defendants argue that they are entitled to summary judgment on the FCA claims because the United States cannot prove the element of materiality. [See Doc. 117 at 22]. For a false statement in a claim to violate the FCA, it must be material. See Urquilla-Diaz, 780 F.3d at 1045. The FCA defines "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4). In Universal Health Servs., Inc. v. United States ex rel. Escobar, 579 U.S. 176 (2016), the Supreme Court

[6] The Court need not address Defendants' alternative falsity argument because the Court finds that Defendants are not entitled to summary judgment on this element.

clarified the materiality requirement. There, the Court explained that the materiality requirement is "demanding," such that minor or insubstantial compliance with the particular statutory, regulatory, or contractual requirement at issue does not make a statement material—nor does it suffice to merely show that the Government "would have had the option to decline to pay if it knew of the defendant's noncompliance." See id. at 194. "The *sine qua non* of materiality is some quotient of potential influence on the decisionmaker—in this case, CMS." See United States ex rel. Janssen v. Lawrence Mem'l Hosp., 949 F.3d 533, 540 (10th Cir. 2020), cert. denied, 141 S. Ct. 376 (2020).

Relevant factors to determining materiality include but are not limited to:

> (1) whether the Government consistently refuses to pay similar claims based on noncompliance with the provision at issue, or whether the Government continues to pay claims despite knowledge of the noncompliance; (2) whether the noncompliance goes to the 'very essence of the bargain' or is only 'minor or insubstantial;' and (3) whether the Government has expressly identified a provision as a condition of payment.

See id. (citing Escobar, 579 U.S. at 195 n.5). None of these factors are independently dispositive. See United States v. Brookdale Senior Living Cmtys., Inc., 892 F.3d 822, 831 (6th Cir. 2018).

Here, Defendants make three (3) arguments that the alleged falsities in Dr. Adams' Medicare claims were not material: (1) Dr. Garrett's expert testimony is insufficient to prove materiality; (2) the United States had actual knowledge of Dr.

Adams' billing methodology and continued to pay his Medicare claims; and (3) similarly, despite this actual knowledge, the United States never audited Dr. Adams' billing practices for chelation therapy. [See Doc. 117 at 22–26]. The Court addresses these arguments in turn.

First, Defendants claim that the United States has produced no evidence as to materiality because its expert witness (Dr. Garett) was not employed by the region's MAC (Cahaba) during the period when Dr. Adams' claims were submitted. [See id. at 24–25]. Essentially, Defendants appear to contend that, to succeed on its claims, the United States must provide evidence of Cahaba's *actual* payment decisions at the time and that Cahaba specifically would not have reimbursed Dr. Adams' claims for chelation therapy had it known that Dr. Adams was using the treatment for conditions other than lead poisoning. [See id.] However, Defendants provide no authority showing any such requirement. [See generally id.] Indeed, in Escobar, the Supreme Court explained that evidence of an actual payment decision is just one way a plaintiff can prove materiality because materiality "look[s] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation." See 579 U.S. at 195; see also Janssen, 949 F.3d at 541 ("rather than directing courts to focus exclusively on a reasonable person—as they would under a purely objective analysis—or exclusively on the mindset of the misrepresenter—as they would under a purely subjective analysis—Escobar focuses

the materiality inquiry on the *likely* reaction of the recipient") (emphasis added); United States ex rel. Morsell v. NortonLifeLock, Inc., 560 F. Supp. 3d 32 (D.D.C. 2021) (rejecting a similar argument by a defendant based on Escobar because proving materiality does not require evidence of the government's *actual* contracting or payment decisions and stating that "if materiality looks to the effect on the 'likely' behavior of the recipient, it cannot always require evidence of actual effect"). Thus, the Court rejects Defendants' argument that the United States provided no evidence of materiality simply because Dr. Garett did not work for Cahaba at the time the alleged false claims were submitted. [See Doc. 117 at 24].

Defendants' second and third arguments are intertwined, and both are predicated on the United States' knowledge of Dr. Adams' alleged misconduct. [See id. at 25–26]. Defendants contend that the alleged falsities were immaterial because the United States had actual, direct knowledge of Dr. Adams' billing methodology, yet continued to approve his claims and never audited his billing practices for chelation therapy. [See id.] As relevant here, the Supreme Court has explained that:

> proof of materiality can include, but is not necessarily limited to, evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement. Conversely, if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material. Or, if the Government regularly pays a particular type of claim in full despite actual knowledge that certain requirements were violated, and has

> signaled no change in position, that is strong evidence that the requirements are not material.

See Escobar, 579 U.S. at 194–95. Here, Defendants proffer that the United States had actual knowledge of the alleged falsities in Dr. Adams' chelation claims. Specifically, Defendants claim that a former employee (Kim Foushee) of CLS, the billing consultant company used by Dr. Adams, reported that CLS and its owner, Ms. Sweeney, were "improperly instructing physicians on how to bill [Medicare] for chelation therapy." [See Doc. 117 at 25–26]. In support, Defendants rely on Ms. Foushee's testimony that she alerted the Office of Inspector General of HHS of these practices in 2006, but the agency did "absolutely nothing" to follow up or further investigate. [See id. at 25] (citing Kim Foushee Deposition at 18:23–19:2 ("Foushee Dep.") [Doc. 121]). According to Defendants, if United States had investigated CLS or issued guidance on the billing of chelation therapy as a result of Ms. Foushee's report, Dr. Adams "never would have submitted [the disputed] claims to Medicare." [See id. at 25–26]. Thus, Defendants posit that the United States' failure to take such action combined with its continued payment of Dr. Adams' claims "demonstrates that any purported falsity in Dr. Adams' claims was immaterial to" the payment decision. [See id.]

As noted above, in Escobar, the Supreme Court found that there is "strong" evidence of immateriality if the United States actually knows that false claims are being submitted but continues to pay the claims. See 579 U.S. at 195. Upon review,

the Court finds there is a dispute of material fact as to whether Medicare had actual knowledge of the alleged falsities contained in Dr. Adams' claims. In its response to the present motion, the United States relies on different portions of Ms. Foushee's deposition to argue that her report did not provide Medicare with sufficient knowledge of Dr. Adams' alleged misconduct. [See Doc. 137 at 29–30]. For example, the United States emphasizes that Ms. Foushee's report of CLS' and Ms. Sweeney's conduct was two (2) years before Dr. Adams filed his first claim to Medicare for chelation therapy and, thus, her report was not about him. [See id.] (citing Foushee Dep. at 42:21–43:11). Additionally, the United States contends that Ms. Foushee's report was not specific to chelation therapy, but focused on improper Medicare billing codes used for cancer treatment. [See id.] (citing Foushee Dep. at 14:21–15:9, 32:20–34:22).

Viewing the evidence in the light more favorable to the United States as the non-moving party, the Court finds that a reasonable jury could find that Medicare did not have actual knowledge that Dr. Adams was submitting allegedly false claims, and, thus, its continued payment of his claims would not constitute evidence of immateriality. Cf. Janssen, 949 F.3d at 542 (granting summary judgment to defendant on materiality where CMS continued to pay the defendant's claims for years despite the ongoing lawsuit and knowledge of an investigation into a specific claim made against the defendant regarding the central allegations in the case).

Accordingly, the Court finds that Defendants are not entitled to summary judgment on the element of materiality. See Anderson, 477 U.S. at 248.

In sum, because there are genuine disputes of material fact as to both the falsity and materiality elements of the United States' FCA claims, the Court denies Defendants' motion for summary judgment. [Doc. 115].

IV. Conclusion

Accordingly, the Court **DENIES** Defendants' "Motion for Summary Judgment" [Doc. 115] and **DIRECTS** the Parties to confer and file a consolidated pretrial order pursuant to Local Rule 16.4 within thirty (30) days of the entry of this order. See LR 16.4, NDGa.

SO ORDERED, this 16th day of May, 2022.

Eleanor L. Ross

Eleanor L. Ross
United States District Judge
Northern District of Georgia