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INSURANCE LAW BLOG

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Fourth Circuit Finds False Claims Seeking Medicaid Reimbursement "Arise Out Of" Medical Incident Triggering E&O Coverage

BY:

In *Affinity Living Grp., LLC v. StarStone Specialty Ins. Co.,* 959 F.3d 634 (4th Cir. 2020), the United States Court of Appeals for the Fourth Circuit addressed whether a False Claims Act ("FCA") suit against an insured for allegedly submitting false Medicaid reimbursement claims fell within an errors and omissions policy's coverage grant for "damages resulting from a claim arising out of a medical incident." The insured, an operator of adult care homes, allegedly submitted reimbursement claims for resident services that were never provided in violation of the federal False Claims Act and the North Carolina False Claims Act. A private party brought a *qui tam* action, and the insured sought insurance coverage for the suit.

The insurer's policy covered "damages resulting from a claim arising out of a medical incident. The policy defined "[m]edical incident" as an "act, error or omission in [the insured's] rendering or failure to render medical professional services," i.e., health care services or the treatment of a patient. While the parties agreed that rendering, or failing to render, personal-care services qualifies as a "medical incident," the insurer argued, and the court agreed that billing Medicaid for reimbursement is not itself a "medical incident." Nevertheless, even though merely seeking Medicaid reimbursement is not itself a "medical incident," the Fourth Circuit agreed with the insured that the Medicaid claims "*arise out of*" a "medical incident."

To get there, the Court noted that the policy did not define the phrase, "arising out of," and thus North Carolina law applied in interpreting the meaning of "arising out of" in the policy. For insurance policy provisions, North Carolina courts interpret the phrase "arising out of" broadly to include only a causal connection when used in a provision extending coverage, but interpret the phrase more narrowly to require proximate causation when used in a provision excluding coverage. As used in the policy at issue, the Court found the term "arising out of" falls within a provision extending coverage and so must be interpreted broadly requiring only some minimal "causal connection" between the conduct defined in the policy and the injury for which coverage is sought. The Court observed that there is no connection if the injury "was directly caused by some independent act or intervening cause wholly dissociated from, independent of, and remote from" the conduct defined in the policy."

In *Affinity*, however, the Fourth Circuit reasoned that the allegedly false billing does not arise in a vacuum. Rather, the complaint alleged that the personal-care-services billing is false, and thus gives rise to a claim for damages, because the insured failed to provide the personal-care services to its residents. In other words, the Court concluded that the insured's allegedly false billing was not "wholly disassociated from" the personal-care services themselves because "but for the failure to provide the services, no claim for damages exists." *Id*. at 642. Thus, even if the alleged false billing was not a "medical incident" itself, the failure to render medical professional services met the minimal causal relationship to the billing required under North Carolina law. The Fourth Circuit vacated the district court's decision granting judgment on the pleadings in the insurer's favor, and remanded the matter for further proceedings.

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