PUBLICATION

Plausibility Requirement for Pleading in FCA Cases Remains a Viable Defensive Tool

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September 25, 2019

The recent federal court opinion issued in *United States ex rel. Integra Med Analytics, LLC v. Baylor Scott & White Health*, et al, illustrates the continued importance of examining the plausibility of allegations made in qui tam lawsuits by relators seeking enormous bounties under the federal False Claims Act (which is codified as amended at 31 U.S.C. § 3729, et seq). On behalf of the United States (which chose not to intervene), Integra Med Analytics, LLC sued a prominent Texas hospital system (Baylor Scott & White Health, Baylor University Medical Center-Dallas, Hillcrest Baptist Medical Center, Scott & White Hospital-Round Rock, and Scott & White Hospital-Temple) that operates a network of inpatient short-term acute care hospitals and four affiliates.

Integra Med Analytics's qui tam suit claimed that the defendants systematically upcoded secondary diagnosis codes (which are used in determining the severity level of Diagnoses Related Groups) in order to increase their revenue from Medicare by about $62 million over seven years. They allegedly did so by applying *Complication or Comorbidity* (CC) and *Major Complication or Comorbidity* (MCC) codes to their reimbursement claims for higher payment levels. Integra Med Analytics further alleged that the underlying medical diagnoses did not justify upcoding the claims. It relied upon its proprietary statistical analysis of CMS's inpatient claims data for short-term acute care hospitals from 2011 through 2017 that, it contended, showed how the defendants had coded the MCCs at significantly higher-than-average rates. Integra Med Analytics argued this scheme resulted in the defendants fraudulently receiving $61.8 million from false claims that had been submitted.

The defendants moved to dismiss the complaint based on (1) the False Claims Act's Public Disclosure Bar, (2) failure to plead fraud with the particularity required by Rule 9(b) of the Federal Rules of Civil Procedure, and (3) failure to state a plausible claim for relief as required by Rule 8(a) of the Federal Rules of Civil Procedure. The court did not reach the public disclosure bar argument, reasoning that dismissal with prejudice was appropriate under Rule 8(a)'s plausibility requirement in conjunction with Rule 9(b)'s requirement that fraud claims be pleaded with specificity. While Integra Med Analytics argued that a strong inference should be made that the claims actually were submitted to further the scheme, the court instead found that Integra Med Analytics had not *plausibly alleged* that the scheme was to submit false claims. The court cited to case law holding where a complaint pleads facts that are merely consistent with a defendant's liability, it stops short of the line between possibility and plausibility of entitlement to relief, and observed "[t]hat Defendants provided a certain treatment at rates higher than average, even significantly higher than average, is not by itself indicative of fraud or unnecessary treatment." In particular, the court explained, Integra Med Analytics's allegation that the defendants made a concerted effort to induce physicians to use the MCC codes to increase revenue was not enough to overcome the motion to dismiss since doing just that was not, in itself, illegal. Rather, an equally plausible reason for the conduct was that the defendants wanted "to improve hospital revenue through accurate coding of patient diagnoses in a way that will be appropriately recognized and reimbursed by CMS commensurate with the type and amount of services rendered." In support, the court cited to, among other things, CMS's comments in its August 2007 final rule, Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates, noting that "CMS is well aware of the existence of hospital 'methods for improving clinical documentation in order to increase reimbursement' and that hospitals 'utiliz[e] clinical documentation specialists that work on the hospital treatment floors to encourage

improvements in clinical documentation' to 'improve coding and increase payment.'" The court concluded that the fact that the defendants took targeted steps to increase their coding of CCs and MCCs to increase hospital revenues was neither fraudulent, nor improper per se.

Analysis and Application

The current trend in government enforcement is use of analytics to identify potential targets of an investigation or attempt to corroborate witness and whistleblower information. When confronted with statistics and figures from government agents suggesting a client is significantly outside the norm for a particular type of service or one of the most frequent users of a particular code, health care providers and facilities have to recognize that data can act like a blinking red beacon on their billing numbers. However, *Integra Med Analytics* supports the simple notion that data is not enough to make a False Claims Act case. Providers and facilities need to be conscious of the fact that efforts to improve revenue through more accurate and efficient coding can be perceived, by disgruntled employees and the government, as something more nefarious. Documentation regarding efforts, clarifying intent in writing, verification audits, and consistent training on ethics and proper billing are key components of being prepared for an eventual inquiry. Furthermore, when confronted with statistics, facilities and providers need to be willing to ask tough questions about whether the statistics are valid, if they account for relevant variables, and if they ignore obvious explanations. For instance, a common analytics issue is the relationship between a certain provider and a service like a pharmacy or DME company. There are a myriad of reasonable explanations for a nearly exclusive relationship, including obvious factors such as the lack of available options. Lastly, *Integra Med Analytics* suggests that providers and facilities do not need to essentially feel guilty for wanting to be profitable, or for maximizing the value of lawful billing. In truth, payors, like the government, will not hesitate to deny claims for payment that they believe they can lawfully deny, and those decisions are often appealed and overturned. Parties in a financial transaction are expected to act in their own self-interest, and, as long as the positions taken are reasonable interpretations of existing law, regulations and guidance, the actions are unlikely to violate the False Claims Act.

The Outlook for Providers

Although the False Claims Act has become the federal government's primary enforcement tool in the health care industry, the statute provides several meaningful provisions that experienced counsel can use to challenge allegations seeking to impose ruinous financial penalties against legitimate providers. It is important for providers to work closely with experienced counsel whenever the first hint of a possible whistleblower suit emerges, oftentimes with the receipt of a government agency subpoena to produce records, so that a successful strategy can be developed and deployed. Such document requests too often are viewed as routine audits, when they instead are just the tip of the iceberg of litigation risks. Fortunately, as the *Integra Med Analytics* case demonstrates, courts can be convinced to grant relief when presented with well-supported and well-reasoned arguments.