No. 19-50818

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

UNITED STATES OF AMERICA EX REL.
INTEGRA MED ANALYTICS L.L.C.,

Plaintiff – Appellant

v.

BAYLOR SCOTT & WHITE HEALTH,
BAYLOR UNIVERSITY MEDICAL CENTER-DALLAS,
HILLCREST BAPTIST MEDICAL CENTER,
SCOTT & WHITE HOSPITAL-ROUND ROCK,
SCOTT & WHITE MEMORIAL HOSPITAL-TEMPLE

Defendants – Appellees

On Appeal from the United States District Court, Western District of Texas
San Antonio Division, No. 5:17-cv-00886, Honorable David Alan Ezra, Presiding

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BRIEF FOR APPELLANT

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record for Appellant Integra Med Analytics LLC certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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STATEMENT REGARDING ORAL ARGUMENT

Appellant, Integra Med Analytics LLC, respectfully requests oral argument. In addition to potentially touching on emerging legal issues related to the False Claims Act, this appeal will also require the Court to consider complicated factual allegations and sophisticated statistical and econometric analyses. Oral argument may assist the Court in understanding and resolving these issues.

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JURISDICTIONAL STATEMENT

Relator Integra Med Analytics LLC ("Integra" or "Appellant") appeals from (1) the August 5, 2019 order (the "Order") granting Defendants' motion to dismiss Integra's Second Amended Complaint (the "Complaint"), and (2) the resulting Clerk's Judgment in a Civil Action entered on August 6, 2019 (the "Judgment"). The final Order and Judgment were entered by the Honorable David Alan Ezra in the United States District Court for the Western District of Texas, San Antonio Division, and dismissed Integra's claims in their entirety, with prejudice, against all Defendants, including Baylor Scott & White Health, Baylor University Medical Center–Dallas, Hillcrest Baptist Medical Center, Scott & White Hospital–Round Rock, and Scott & White Memorial Hospital–Temple (collectively, "Baylor," "Defendants," or "Appellees"). Integra timely filed a Notice of Appeal, dated September 4, 2019.

This court has jurisdiction over the appeal under 28 U.S.C. § 1291.

STATEMENT OF ISSUES PRESENTED FOR REVIEW

1. Did the District Court err in holding that Integra was required to plead that Defendants "knew that using a particular code was incorrect" in order to state an FCA claim, when the minimum scienter required under the FCA is "reckless disregard" of the truth or falsity of the alleged false claims?

2. Did the District Court err by drawing all inferences about Integra's statistical and econometric analyses in favor of Defendants in deciding Defendants' motion to dismiss the Complaint?

3. Did the District Court improperly weigh the evidence and apply a probability standard at the pleadings stage instead of the plausibility standard required under Rule 8(a)?

STATEMENT OF THE CASE

Through its investigation—which included interviewing former employees, reviewing training materials, and extensive econometric analyses—Integra uncovered that Defendants deliberately and routinely applied unwarranted Complication or Comorbidity ("CC") or Major Complication and Comorbidity ("MCC") secondary codes in order to falsely inflate their Medicare claims. Integra's allegations are pleaded in extensive detail and confirmed with exhaustive quantitative, statistical, and econometric analyses. Integra brought this action to recover the more than $61.8 million paid by the United States as a result of Defendants' upcoding scheme.

I. Overview of Medicare reimbursement and upcoding.

The Defendants' hospital group was created from the combination of two Texas healthcare systems, Baylor Health Care System and Scott & White Healthcare. (ROA.182.) Together, this organization operated approximately 20 short-term acute care hospitals with inpatient Medicare claims throughout central and north Texas. (*Id.*) Defendants operated their hospital group through a number of wholly-owned and controlled entities, including the defendant facilities. (*Id.*) Medicare reimbursements accounted for approximately half of Defendants' gross revenue. (*Id.*)

Medicare makes payments to Defendants and other short-term acute care hospitals on a per-discharge basis—*i.e.*, one payment for each inpatient hospital stay. (ROA.185.) The payment is designed to cover the average cost of resources needed to treat each patient's needs. (*Id.*) To make this determination, hospitals must first accurately code the services provided to each patient. Medicare then assigns the patient's claim to a diagnosis related group ("DRG"), which groups claims that are expected to require similar amounts of resources. (*Id*.) The DRG is the most impactful factor in determining the average payment for each Medicare claim. (*Id.*)

The DRG is primarily determined by the provider-assigned principal diagnosis codes, surgical procedure codes, and secondary diagnosis codes. (ROA.186.) The Centers for Medicare and Medicaid Services ("CMS") publishes a list of secondary codes each year that, when added to a claim, result in that claim being considered a CC or an MCC. (*Id.*) Adding a CC secondary code can increase the value of a claim by $1,000–$10,000; Adding an MCC secondary code increases the value by $1,000–$25,000. (*Id.*)

II. Defendants engaged in a scheme to drive noncompliant Medicare coding through the application of unwarranted CCs and MCCs.

Like most hospital groups, Defendants have a system-wide clinical documentation improvement ("CDI") program. (ROA.187.) These programs are usually designed to promote accurate documentation and coding of patients'

diagnoses. (*Id.*) Under the leadership of Vice President Anthony Matejicka, however, Defendants' CDI program was singularly focused on inflating Defendants' Medicare revenue through upcoding claims with unwarranted CCs and MCCs. (*Id.*) These efforts pervaded every level of Defendants' CDI program, beginning with training doctors and staff to focus on documenting diagnoses that allow MCCs. (ROA.188-90.) When doctors failed to diagnose an MCC, Defendants' CDI specialists pressured doctors to change their original diagnoses to document MCCs. (ROA.191-97.) Defendants even routinely offered unnecessary medical services to allow for the coding of profitable MCCs. (ROA.187-99.)

A. Defendants trained doctors and CDI staff to aggressively document MCCs.

Matejicka spearheaded Defendants' efforts to focus doctors and CDI staff on coding for MCCs. Two of Defendants' former employees confirmed to Integra that Matejicka personally trained employees on key words to increase Medicare reimbursements, noting that doctors and staff received a list of MCCs on which to focus, rather than focusing on accurately documenting diagnoses regardless of the impact on revenue. (ROA.188.) Defendants made clear to their doctors how important coding MCCs was to the Defendants' bottom line and quality metrics. (ROA.189.)

In an internal August 2012 presentation to doctors titled "Fundamentals of Hospital Medicine: What No One Taught Us!"—which Integra uncovered in its

investigation—Matejicka encouraged doctors to use what he referred to as "magic words" that "provide triggers for reimbursement." (*Id.*) The "magic words" described in the presentation included "encephalopathy" and "acute respiratory failure," two MCCs that Integra identified as being misapplied by Defendants. (*Id.*) Matejicka encouraged doctors to use these words notwithstanding their clinical propriety, arguing that "Coding Language Trumps Clinical Terminology." (*Id.*)

Matejicka also emphasized that his coding guidelines would increase doctors' salaries, stating "Your hospital data will determine your income!" (ROA.190.) He then closed his presentation by asking, "Do you want to 'see one more patient' or take one minute to improve your documentation ???," suggesting that using his "magic words" would generate more revenue than seeing an additional patient. (*Id.*) The presentation even described an example where adding an MCC would both increase hospital reimbursement by $8,444.94 as well as improve so-called "pay for performance" metrics for doctors, resulting in "SO MUCH WIN." (*Id.*)

Matejicka's program openly steered doctors away from non-MCC diagnoses toward specific, higher-paying MCCs. Defendants provided doctors with tip sheets called "Teal Quickies" that pushed doctors to clinically document patient services in a way that maximized Medicare revenue. (*Id.*) For instance, in training doctors how to document altered mental status ("AMS"), Defendants encouraged the

diagnosis of encephalopathy (an MCC) or acute delirium (a CC), explaining that these secondary codes increased the patient's "severity of illness" and thus Medicare reimbursement. Defendants blithely added that "there are other causes of AMS, too ☺." (*Id*.) The implication was clear: staff should favor diagnoses that lead to valuable secondary codes.

After Matejicka left in 2014, Defendants' rate of MCCs declined slightly. (ROA.188.) But Defendants' Health Information Management Department ("HIM") soon picked up where Matejicka left off, pressing staff to continue coding unethically. According to a former medical coder interviewed by Integra, Defendants' HIM Department directly instructed her coding supervisor to apply unnecessary coding to increase revenue. (*Id.*) The medical coder eventually quit because she "was continually getting directives to compromise her integrity." (*Id.*)

B. Defendants pressured doctors to change their diagnoses.

Hospitals are not allowed to apply a CC or MCC unless it is sufficiently documented in the patient's medical files. Where medical files are unclear, hospitals may send doctors "queries" designed to improve the accuracy of coding.[1] The American Health Information Management Association ("AHIMA")—which alongside CMS is one of four "Cooperating Parties" that approve CMS coding

[1] ICD-10-CM Official Guidelines for Coding and Reporting at 18, *available at* https://goo.gl/nE2qmY.

guidelines[2]—explicitly prohibits CDIs from issuing a leading query that directs doctors to code in a specific way, but rather requires that queries be neutrally issued so that "the provider of record [may] unbiasedly respond with a specific diagnosis or procedure."[3] Defendants ignored this guidance, instead sending queries that would request doctors to document specific, revenue-increasing CCs and MCCs. (ROA.191.)

Through its investigation, Integra obtained "documentation clarification sheets" used by Defendants' CDI staff to query physicians for additional documentation. (ROA.192.) These sheets reveal a clear intent to influence doctors to code CCs and MCCs. For instance, in the AMS query sheet, Defendants ask their doctors to document the underlying cause, but only provide options yielding a CC or MCC. (*Id.*) There are, of course, many other common causes for AMS that do not yield an CC or MCC. (ROA.192-93.) Defendants' clarification sheets for "Diseases of the Respiratory System" and the tip sheet for comorbidities are similarly biased. (ROA.193-94.) The query specifically defines acute respiratory failure, an MCC, but not any other respiratory disease. Even the name Defendants gave to this document, "#35 Respiratory Failure" indicates that CDIs used this

[2] AHIMA, "Who We Are," *available at* https://goo.gl/Ec593n.

[3] AHIMA, Guidelines for Achieving a Complaint Query, *available at* http://bok.ahima.org/doc?oid=302673#.XbyphZpKiUk.

sheet in order to get doctors to document respiratory failure as opposed to other non-CC or non-MCC respiratory diseases. (ROA.194.) Not surprisingly, each option listed in the query except for "Hypoxemia" are CCs or MCCs, and even Hypoxemia is simply a symptom that may indicate the patient has one of the other respiratory diagnoses listed. (ROA.193.)

Defendants also prompted doctors to document CCs and MCCs with post-surgery progress notes that encouraged particularly uncommon pairings. (ROA.195.) For instance, in progress notes for plastic surgery patients, Defendants gave doctors a multiple-choice option to include severe protein calorie malnutrition. (*Id.*) Integra's analysis shows that the Defendants' rate of severe protein malnutrition in plastic surgery claims dwarfs the national rate. A staggering 6.56% of the plastic surgery patients treated by three Defendant hospitals were assigned severe protein-calorie malnutrition—over 8 times the national average. (ROA.195-96.)

As one former coder described, Defendants' CDI staff were effectively "trained in sales" in order to convince doctors to change their clinical documentation in inappropriate ways. (ROA.196.) According to another former coder, Defendants' CDI staff pressured doctors to record MCCs in an effort to increase revenue. For example, CDIs influenced doctors to record "acute respiratory failure" (an MCC identified by Integra for excessive use) instead of

COPD exacerbation because that is what "[CDIs] want to hear . . . doctors have been told and told and told so they do." (ROA.197.) The staff member added, "CDIs should be questioning acute respiratory failure instead of insisting [on it]." (*Id.*)

C. Defendants provided unnecessary treatment that would enable them to code MCCs.

Integra also uncovered that Defendants excessively and unnecessarily kept post-operative patients on ventilator support, which is one of the clinical indicators for "acute respiratory failure." (ROA.198.) Integra found that Defendants' patients undergoing major heart surgery were placed on mechanical ventilation over twice the national average. (*Id.*) Correspondingly, for post-operative heart surgery patients, Defendants coded acute respiratory failure (not present on admission) at 36.9% which is 2.75 times higher than the national average of 13.4%. (*Id.*)

Defendants' high rate of post-operative respiratory failure stands in stark contrast to CDI experts who state that post-operative respiratory failure is extremely rare and should not be routinely coded. (ROA.199.) As such, one CDI expert notes that "patients being purposely maintained on the ventilator after heart surgery or any surgery because of weakness, chronic lung disease, massive trauma are NOT in acute respiratory failure." (*Id.*) However, diagnosing post-operative acute respiratory failure can lead to large increases in reimbursement. According to another CDI expert, "'Postop' respiratory failure is classified as one of the most

severe, life-threatening reportable surgical complications a patient can have. The diagnosis of respiratory failure following surgery often results in a huge payment increase to the hospital—sometimes $20,000 to $30,000 or even more." (*Id.*)

Despite the high bar for accurately coding acute respiratory failure, Integra's analysis shows that Defendants were liberal in its application, consistent with the training and instructions disseminated by their CDI staff. In Defendants' documentation clarification sheet for "Diseases for the Respiratory System," Defendants' doctors were told that "the use of artificial ventilation such as BiPAP would also qualify" for diagnosing acute respiratory failure. (ROA.199.) In other words, Defendants trained their staff to code acute respiratory failure based on the use of a ventilator, even if clinical indicators suggested otherwise. (*Id.*)

III. Integra's quantitative, statistical, and econometric analyses reliably indicate that Defendants successfully carried out their upcoding scheme.

Integra developed unique algorithms and statistical processes to analyze inpatient CMS claims for short-term acute care hospitals from 2011 to 2017. These methods—which included studying CMS claims data, together with numerous other data sources—allowed Integra to identify the specific false claims stemming from Defendants' pervasive upcoding. (ROA.200-31.)

A. Integra's "bin-based" analysis of CMS data.

Integra first formed groupings corresponding to 184 specific principal diagnosis codes. To control for the patient's principal diagnosis, Integra used these

groupings as comparative "bins." (ROA.200.) Within each bin, Integra compared the usage rate of specific MCCs at hospitals in the Defendants' system to usage rates in other acute care inpatient hospitals. (*Id.*) Integra built in several conservative limits on its bin analysis to ensure that only truly fraudulent claims were analyzed. For instance, Integra excluded any claims for which adding an MCC did not increase the value of the relevant Medicare claim. (*Id.*) Similarly, Integra excluded claims involving patients who died in the course of their treatment, as these claims tend to involve patients that are sicker and have higher MCC rates. (*Id.*)

Given that some natural variation in MCC rates among hospitals is expected, Integra used two additional filters to ensure that it identified truly abnormal usage. First, only instances where MCCs were used more than twice the national rate or were used at a rate three percentage points higher than in other hospitals were considered false claims. (ROA.200-01.) Integra also validated the results of its analysis by determining each pattern's statistical significance. Integra used claim groupings only if there was less than a 1 in 1,000 possibility of Integra's findings being due to chance. (*Id.*) Indeed, Integra found that most groupings it identified had less than 1 in 1,000,000 possibility of being due to chance. (ROA.241.)

For example, among Defendants' more than 838 claims involving a principal diagnosis of Nonrheumatic Aortic Valve Disorder, 59 (or 7.04%) had an

accompanying secondary MCC of encephalopathy. Non-defendant hospitals around the country, by contrast, had more than 200,000 Nonrheumatic Aortic Valve Disorders claims, but only 2.67 percent of those claims reported encephalopathy as an MCC. In other words, Defendants coded encephalopathy on these claims at a rate that is 2.64 times higher than comparable hospitals—and profited nearly $13,000 each time it did so. (ROA.201.) The Complaint sets out in great detail the same analysis for 209 combinations of principal diagnoses and misstated MCCs for which the Defendants excessively coded three MCCs, including encephalopathy at a rate more than 1.54 times that of other hospitals (ROA.204-14), respiratory failure at a rate more than 1.73 times that of other hospitals (ROA.214-25), and severe malnutrition at a rate of more than 3.14 times that of other hospitals (ROA.225-36).

B. Integra's analyses eliminated alternate explanations for Defendants' excessive coding.

To validate the results of its bin-based analysis, Integra ran a fixed-effect linear regression model to control for innocent explanations. (ROA.236-64.) Integra sought out data from numerous sources, which it used to control for an array of patient characteristics such as age, gender, and race, as well as county demographic factors such as unemployment rate, median income, urban-rural differences, length of stay, and discharge status. Integra also used county-level demographic data, such as unemployment rate, percent of population without a

high school diploma, median income, and the rural-urban continuum codes from the Department of Agriculture as control variables, which provide a useful proxy for income and education levels of each patient. This regression analysis considered millions of claims and thousands of possible fraudulent patterns. (ROA.237-47.)

Next, Integra controlled for the potential impact that specific doctors had on MCC rates, and specifically whether Defendants' doctors were more disposed to identifying encephalopathy, respiratory failure, and severe malnutrition than other doctors. This analysis demonstrated that individual doctors who treated patients at both the Defendants' hospitals and other hospitals were nearly twice as likely to code one of the misstated MCCs when treating at the Defendants' hospitals. (ROA.247-58.)[4]

Integra also analyzed the subset of patients that attended both a Defendant hospital and at least one other hospital between 2011 and 2017, and then compared the rate of the MCC codes used when those patients were treated at each. Yet again, Integra discovered that these patients were nearly twice as likely to be

[4] Integra also re-ran its regression analysis for the subset of claims that have at least 10 claims by a doctor at the Defendants' hospital and a non-Defendant hospital. Defendants' rate of any MCC, after these controls, was 155.93 percent of the rate at other hospitals, with Defendants' severe malnutrition rate at 231.14 percent of the rate at other hospitals. (ROA.256-57.)

diagnosed with an MCC while being treated at a Defendant hospital. (ROA.258-62.) Notably, patients were nearly three times as likely to be diagnosed with severe malnutrition. (ROA.261.)

Finally, Integra considered whether Defendants' excessive coding of MCCs could be explained by the region in which Defendants' hospitals are located, notwithstanding that Integra had already controlled for a variety of county demographic factors described above. To that end, Integra compared Defendants' MCC rate to other hospitals within the Defendants' relevant metropolitan statistical area. Defendants had a higher rate of each MCC in every MSA. (ROA.263-64.)

The results of Integra's analyses—as well as Integra's documentary evidence and information learned from interviews—all point to the same conclusion: Defendants carried out the scheme to inflate their Medicare revenue to great effect. Integra has calculated that, as a result of this scheme, Defendants received an unwarranted $61.8 million in false claims across all principal diagnosis categories. (ROA.266.)

C. Procedural history.

Integra commenced this action on September 12, 2017, alleging that, through their system-wide scheme to pressure coders and doctors to apply unwarranted MCCs, Defendants (i) knowingly presented, or caused to be presented, false claims to Medicare for payment or approval (31 U.S.C. §

3729(a)(1)(A)); (ii) knowingly made, used, or caused to be made or used, a false record or statement material to false claims to Medicare (31 U.S.C. § 3729(a)(1)(B)); and (iii) knowingly avoided an obligation to re-pay Medicare for overpayments (31 U.S.C. § 3729(a)(1)(G)). (ROA.270.)

Integra filed its First Amended Complaint on April 19, 2018. The United States declined to either intervene or move to dismiss Integra's claims, and filed its Notice of Election to Decline Intervention on June 18, 2018. (ROA.3) Before serving Defendants, Integra wished to amend its pleading with additional information uncovered in its investigation. Integra filed its Second Amended Complaint on August 8, 2018. (ROA. 180.)

On October 23, 2018, Defendants filed their Motion to Dismiss the Second Amended Complaint, arguing that (i) Integra's claims were barred by the FCA's public disclosure bar; (ii) Integra did not plead its claims with sufficient particularity under Fed. R. Civ. P. 9(b); and (iii) Integra did not plead a plausible claim for relief under Fed. R. Civ. P. 8(a). Integra filed its opposition on December 3, and briefing was completed on December 21, 2018.

On August 5, 2019, the District Court issued the Order, which found that "dismissal is appropriate under Rule 8(a) working in conjunction with rule 9(b)."

(ROA.445.)[5] The District Court issued its Judgment the next day. Integra now appeals the Order and Judgment on the ground that the extensive facts outlined above state a plausible claim for relief under Federal Rule of Civil Procedure 8(a) and 9(b).

SUMMARY OF THE ARGUMENT

Integra uncovered specific facts establishing that Defendants systematically inflated reimbursement claims submitted to Medicare through a practice known as "upcoding." These allegations are pleaded in extensive detail and confirmed with exhaustive quantitative, statistical, and econometric analyses. This is sufficient to state an FCA claim under Rules 8(a) and 9(b) of the Federal Rules of Civil Procedure, which both require the Court to view all alleged facts as true and draw all inferences in favor of Integra. The District Court turned this standard on its head, brushing aside Integra's extensive factual allegations, drawing improbable statistical inferences in favor of Defendants, and weighing the probability of Integra's allegations.

Throughout the Order, the District Court repeatedly justified dismissal by speculating about "lawful conduct" that it believed was "equally consistent" with Integra's allegations. That is simply not the law. With its influential *Iqbal* and

[5] The Court did not reach Defendants' argument related to the FCA's public disclosure bar.

Twombly decisions, the Supreme Court made clear that Integra need only "nudge [its] claims across the line from conceivable to plausible" in order to meet its burden. This signaled a departure from the previous standard for dismissal under Rule 8(a), which required a defendant moving to dismiss a complaint to show "beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Conley v. Gibson*, 355 U.S. 41, 45–46 (1957). Through its Order, the District Court implicitly revived the specter of *Conley* but in the inverse—requiring Integra to disprove all potential sets of facts that the District Court believes may exonerate the Defendants. In doing so, the District Court demands far more than is required under Rules 8(a) and 9(b).

The District Court's attempt to shoehorn its factual theories into Integra's allegations resulted in three distinct, reversible errors. First, the District Court heightened the FCA's scienter standard to require that Integra demonstrate that Defendants "knew that using a particular code was incorrect" in order to state a claim. (ROA.448.) But under the FCA, "knowingly" includes reckless disregard for the truth or falsity of an alleged false claim. The Complaint easily clears this low threshold with specific allegations regarding Defendants' scienter, which need only be alleged generally under Rule 9(b).

Second, the District Court plucked data from Integra's analyses out of context to support its counter hypothesis. But under Rules 8(a) and 9(b), the

District Court was required to draw all inferences in favor of Integra, not in favor of its own theory. In any event, Integra's allegations refute the District Court's improperly drawn inferences, demonstrating with mathematic precision that the upcoding identified in the Complaint was not attributable to chance, but to Defendants' misconduct.

Third, the District Court repeatedly weighed the evidence Integra sets out in the Complaint, discounting or wholly ignoring the allegations of the scheme described in the context of training, tip sheets, and interview assessments, and determining that the quantitative analysis was, in the Court's view, "equally consistent" with "lawful conduct." This is an exercise for the fact finder at trial, not for the District Court on a motion to dismiss. Integra obviously believes its allegations and analyses lead only to the conclusion that Defendants engaged in a scheme to submit false claims. But to the extent Integra's allegations could support multiple conclusions, the District Court was bound at this stage to view such allegations in favor of Integra.

PLEADING STANDARD AND STANDARD OF REVIEW

A dismissal for failure to plead an FCA claim in accordance with Rules 8(a) and 9(b) is treated as a dismissal for failure to state a claim under Rule 12(b)(6). *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 185 (5th Cir. 2009) (citing *U.S. ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 125 F.3d 899, 901 (5th Cir.

1997)). The Court "review[s] *de novo* a district court's grant of a Rule 12(b)(6) motion, 'accepting all well-pleaded facts as true and viewing those in the light most favorable to the plaintiff.'" *Greene v. Greenwood Pub. Sch. Dist.*, 890 F.3d 240, 242 (5th Cir. 2018) (quoting *SGK Props., LLC v. U.S. Bank Nat'l Ass'n*, 881 F.3d 933, 943 (5th Cir. 2018)). Rule 12(b)(6) motions "are viewed with disfavor and are rarely granted." *Lormand v. U.S. Unwired, Inc.*, 565 F.3d 228, 232 (5th Cir. 2009).

Rule 9(b) requires FCA claimants to "state with particularity the circumstances constituting" the fraud; however, "[m]alice, intent, knowledge, and other conditions of a person's mind may be alleged generally." Fed. R. Civ. P. 9(b). "Rule 9(b)'s ultimate meaning is context-specific" and "depend[s] on the claim at hand." *Kanneganti*, 565 F.3d at 188. Typically, the plaintiff must plead the "time, place and contents" of the false representation—or the "who, what, where, and when"—but this Court has found that Rule 9(b) applies differently to FCA claims: "if [the relator] cannot allege the details of an actually submitted false claim, [the relator] may nevertheless survive by alleging particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *Id.* at 190. Courts have found that this application of Rule 9(b) strikes a balance between preventing "fishing expeditions" and allowing for discovery in situations where records of the alleged

fraud are largely in possession of the Defendants. As the Court explained, "details of a scheme to present fraudulent bills to the Government and allegations making it likely bills were actually submitted limits any 'fishing' to a small pond that is either stocked or dead." *Id.* at 191.

In addition to Rule 9(b), an FCA claim must also meet the plausibility threshold of Rule 8(a), which requires only "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a). This rule is designed simply "to give the defendant fair notice of what the . . . claim is and the grounds upon which it rests." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 545 (2007) (citations omitted). It requires no more than "enough facts to state a claim to relief that is plausible on its face." *Id.* at 570. The Supreme Court has cautioned that "plausibility standard is not akin to a 'probability requirement.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). In other words, Rule 8(a) "does not require [plaintiff] to present its best case or even a particularly *good* case, only to state a plausible case." *U.S. v. Bollinger Shipyards, Inc.*, 775 F.3d 255, 263 (5th Cir. 2014) (emphasis in original).

ARGUMENT

The Order misconstrues the FCA's scienter requirement and fails to draw all inferences in favor of Integra as required on a motion to dismiss. The Order also erroneously applies a probability standard instead of the correct plausibility

standard, leading the District Court to improperly dismiss Integra's FCA claim because it believed an alternative explanation is "arguably more likely" than the fraud alleged. (ROA. 451.) Applying the proper standard under Rules 8(a) and 9(b), as modified in *Kanneganti*, the Court should reverse the Order and find that Integra has adequately pleaded both a scheme to submit false claims and reliable indicia that the scheme was carried out.

I. The District Court erred by applying the wrong scienter requirement to an FCA claim.

The Complaint alleges that, led by their head of Physician Documentation and Coding, Anthony Matejicka, Defendants engaged in a three-pronged scheme to code unwarranted MCCs. (ROA.187.) First, Defendants trained doctors and CDI staff to use "magic words" to "provide triggers for reimbursement," leading to higher paying MCCs. (ROA.188-91.) Training materials uncovered by Integra show that Matejicka openly steered doctors away from non-MCC diagnoses toward specific, higher-paying MCCs. (ROA.190-91.) Second, if Defendants' doctors ignored their training, Defendants either pressured doctors to code MCCs or sent doctors leading "queries" that encouraged diagnoses warranting profitable MCCs. (ROA.191-97.) Third, Defendants provided patients with unnecessary services to justify adding MCCs to their file. (ROA.198-200.)

The Complaint further specifies the three MCCs that Defendants' scheme promoted—encephalopathy, respiratory failure, and severe malnutrition. Notably,

many of Defendants' internal documents cited by Integra pushed these particular MCCs. (See ROA.189 (training presentation encouraging doctors to diagnose encephalopathy and respiratory failure); ROA.190 (tip sheet encouraging doctors to diagnose encephalopathy); ROA.193 (query leading doctors to change diagnosis to various MCCs, including respiratory failure); ROA.195 (surgical progress note for plastic surgery patients recommending a diagnosis of severe protein calorie malnutrition).)

Such schemes regularly survive dismissal under the FCA. *See, e.g.*, *U.S. ex rel. Texas v. Planned Parenthood Gulf Coast*, 9-09-CV-124, 2012 WL 13036270, at *6 (E.D. Tex. Aug. 10, 2012) (declining to dismiss FCA claim where relator alleged a scheme to "bill federal and state government programs based on a predetermined list of services regardless of whether the patient's chart indicated the services were actually provided[.]"); *U.S. ex rel. Ramsey-Ledesma v. Censeo Health, LLC*, 3:14-CV-00118-M, 2016 WL 5661644, at *6 (N.D. Tex. Sept. 30, 2016) (declining to dismiss FCA claim where relator alleged a scheme to promote "specific conditions that were allegedly diagnosed and coded in the absence of necessary testing," along with identifying a "key executive who acted in furtherance of the scheme.").

The District Court in part agreed, finding that Integra's Complaint "alleges a scheme, spearheaded by Anthony Matejicka, to increase the number of claims

submitted that include CCs and MCCs and contains reliable indicia leading to a strong inference that claims were actually submitted based on that scheme." (ROA.446.) But the District Court concluded that Integra failed to adequately plead that, through their scheme, Defendant intended to submit *false* claims. (*Id.*) The District Court emphasized that, "to state a claim for relief, there must be an allegation that a defendant knew that using a particular code was incorrect." (ROA.448.) This holding fundamentally misstates the FCA's express scienter requirement. While it is true that FCA liability is based on "knowingly" submitting false claims, the FCA defines "knowingly" to include "deliberate ignorance," and "reckless disregard." 31 U.S.C. § 3729(b)(1). Thus, Integra need not show that Defendants "knew that using a particular code was incorrect." (ROA.448.) Instead, Integra need only plead facts upon which, viewed in the light most favorable to Integra, "one may reasonably infer that [Defendants] acted 'in reckless disregard of the truth or falsity'" of the alleged false claims. *Bollinger*, 775 F.3d at 263 (citations omitted). And because Rule 9(b) provides that knowledge and intent may be alleged generally, Integra's allegations need only meet Rule 8(a)'s threshold of plausibility (not Rule 9(b)'s particularity requirement). *See Bollinger*, 775 F.3d at 260–61.

Integra's allegations of knowledge easily meet Rule 8(a)'s plausibility threshold. For instance, the Complaint quotes a coder that formerly worked for

Defendants who said management gave her "directives" to code in specific ways, and she eventually quit because such directives forced her to compromise her integrity. (*Id*.) The coder also stated that CDIs were "trained in sales" to generate revenue by convincing doctors to change their clinical documentation in inappropriate ways. (ROA.196.) Another former coding and compliance staff member states that CDI personnel would inappropriately pressure doctors to document acute respiratory failure, noting, "CDIs should be questioning acute respiratory failure instead of insisting." (ROA.197.) Further, Integra sets out in great detail how Defendants trained their doctors and coders to favor diagnoses that lead to profitable MCCs regardless of clinical accuracy. For instance, Defendants provided doctors with tip sheets called "Teal Quickies" that pushed doctors to diagnose AMS patients with encephalopathy (an MCC) or acute delirium (a CC), explaining that these secondary codes increased the patient's "severity of illness" and thus Medicare reimbursement. Clearly recognizing the implicit bias toward such profitable codes, Defendants added that "there are other causes of AMS, too ☺." (ROA.191.)

The Complaint is littered with similar examples, and it is certainly *reasonable* to infer from these allegations that Defendants acted with at least reckless disregard as to the accuracy of their coding. *Rodriguez v. Rutter*, 310 Fed. App'x 623, 626 (5th Cir. 2009) ("The complaint must be liberally construed, with

all reasonable inferences drawn in the light most favorable to the plaintiff."). Thus, the Complaint alleges far more than what Rule 8(a) requires to "nudge [its allegations of scienter] across the line from conceivable to plausible." *Twombly*, 550 U.S. at 570.

Indeed, another FCA claim with analogous facts recently survived dismissal. *U.S. ex rel. Emerson Park v. Legacy Heart Care, LLC*, No. 3:16-CV-0803-S, 2019 WL 4450371, at *5–9 (N.D. Tex. Sept. 17, 2019). There, the relator alleged that the head of the defendant's central billing department "stressed" to the relator that use of a certain classification for a medical condition was the lowest classification that defendant could use to "get paid . . . by Medicare." *Id.* at *8. The same individual later "reprimanded" the relator for not using that classification, even though the patient's medical records did not support its use. *Id.* "Viewing the Complaint in the light most favorable to Relator," the Court held "these allegations sufficient to show that [the defendant] may have acted in reckless disregard as to whether the claims it submitted actually complied with Medicare laws and regulations." *Id.*

Just as in *Legacy Heart Care*, Integra has also pleaded facts to show that Defendants have at least acted in reckless disregard as to whether their claims warranted reimbursement from Medicare. And taking Integra's specific allegations as true—as the Court must—Integra has thus pleaded Defendant's fraudulent

scheme with sufficient specificity to comply with Rule 8(a) and 9(b)'s objectives of "ensuring the complaint 'provides defendants with fair notice of the plaintiffs' claims," while preventing "the filing of baseless claims as a pretext to gain access to a 'fishing expedition.'" *Kanneganti*, 565 F.3d at 191 (quotations omitted).

II. The District Court impermissibly drew inferences from Integra's statistical and econometric analyses in favor of Defendants.

Integra has not only pleaded the particulars of Defendants' fraudulent scheme, but has also set out sophisticated statistical and econometric analyses providing "reliable indicia that lead to a strong inference that claims were actually submitted." *Kanneganti*, 565 F.3d at 190. But in dismissing the Complaint, the District Court improperly drew all inferences from Integra's analyses in favor of Defendants. This error requires reversal. *See Bollinger*, 775 F.3d at 262–63 (reversing dismissal of FCA claim where "the district court erred . . . by focusing on facts the [plaintiff] did not plead rather than the inferences that the pleaded facts supported, and by viewing the facts in the light most favorable to [defendant].").

It is beyond dispute that, together with details of a fraudulent scheme, a relator may satisfy Rule 9(b) by providing "statistical evidence to strengthen the inference of fraud beyond mere possibility, without necessarily providing details as to each false claim." *U.S. ex rel. Duxbury v. Ortho Biotech Prod., L.P.*, 579 F.3d 13, 29 (1st Cir. 2009) (same). Here, Integra employed robust analyses to strengthen

the inference—which must be drawn in Integra's favor—that Defendants committed Medicare fraud beyond mere possibility.

Integra first grouped inpatient claims data for all short-term acute care hospitals by 184 different principal diagnosis codes. Integra then used these groupings to compare usage rate of MCCs at hospitals in the Defendants' hospital system to usage rates in other acute care inpatient hospitals. Integra conservatively limited its findings to the 209 combinations of principal diagnosis codes and misstated MCCs that Defendants used more than twice the national rate or at a rate three percentage points higher than other hospitals. Integra further limited its findings to groupings in which there was a less than 1 in 1,000 chance the findings were due to chance. (*See* ROA.200-02.) Moreover, Integra used linear regressions to control its findings for an array of conceivable characteristics that might innocently affect a hospital's MCC rates, including race, age, gender, principal diagnosis, length of stay, discharge stats, and treating doctor. (ROA.237-65.) Integra's analyses go beyond "strengthening the inference" of fraud. It demonstrates Defendants' fraud with mathematical precision.

Courts agree that this is more than enough to provide sufficiently reliable indicia that Defendants submitted false claims. *See, e.g., U.S. ex rel. Customs Fraud Investigations, LLC v. Victaulic Co.*, 839 F.3d 242, 258 (3d Cir. 2016). In *Victaulic*, a relator brought an FCA claim against a pipe-fitting company for not

marking the country of origin on its fittings to avoid import duties. *Id.* at 257. The relator's complaint provided a list of public shipments of the importing company, together with a statistical analysis of the markings on the company's goods available on eBay showing that less fittings were marked than would be expected. *Id.* Notably, compared to the relator in *Victaulic*, Integra has alleged far more details about Defendants' scheme, has offered far more compelling quantitative, statistical, and econometric analyses, and has based its analyses on profoundly more reliable data than eBay listings. *See also U.S. ex rel. Integra Med Analytics LLC v. Providence Health & Servs.*, CV 17-1694 PSG (SSX), 2019 WL 3282619, at *19 (C.D. Cal. July 16, 2019) (adopting *Victaulic* in connection with similar analyses demonstrating a similar scheme).

Courts have also regularly found that plaintiffs may use statistical analyses to strengthen inferences of fraudulent conduct outside the context of the FCA. For instance, in suits related to wrongful manipulation of stock options, courts have found that shareholder plaintiffs may meet their pleading burden simply by analyzing the return on investment realized by the party exercising the suspect stock options compared to the return that a public investor would have realized from a similar investment in company stock over the same period. *See, e.g.*, *Ryan v. Gifford*, 918 A.2d 341, 354–55 (Del. Ch. 2007). Much like the Defendants here, the *Ryan* defendants argued that such analyses offered "nothing more than

statistical abstractions," but the court found that it was "required to draw reasonable inferences"—in favor of the plaintiff—"and need not be blind to probability." *Id.* n.34. This reasoning has since been adopted in the Ninth Circuit and in federal courts around the country. *See Lynch v. Rawls*, 429 F. App'x 641, 644 (9th Cir. 2011) (reversing 12(b)(6) dismissal); *Plymouth Cnty. Retirement Assn. v. Schroeder*, 576 F. Supp. 2d 360, 370–71 (E.D.N.Y. 2008).[6]

Unlike the *Ryan* court, the District Court here opted to turn a blind eye to probability, rejected Integra's reasonable inferences from its statistical and econometric analyses, and went out of its way to draw inferences in Defendants' favor. The Complaint sets out in detail the statistical significance of Defendants' anomalous coding. Indeed, Integra has demonstrated that there is only between 1/1,000 and 1/100,000,000 possibility (depending on the diagnosis group) that the Defendants' excessive use of MCCs could be attributed to chance. (ROA.237-65.) The District Court rationalizes these findings in favor of Defendants by citing a few graphs from the Complaint, claiming that the trend line in the graphs indicate that Integra's findings are "arguably more likely explained by" Defendants "simply

[6] Courts have also found that plaintiffs may meet their pleading burden using statistical analyses in numerous other contexts. *See, e.g.*, *Boykin v. Georgia-Pac. Corp.*, 706 F.2d 1384, 1390 (5th Cir. 1983) (holding plaintiff made prima facie case of racial discrimination using statistical evidence); *Hinds Cty., Miss. v. Wachovia Bank N.A.*, 708 F. Supp. 2d 348, 360 (S.D.N.Y. 2010) (finding statistical evidence alone to be enough to raise a plausible inference of conspiracy).

[being] better than their peers in their efforts to ensure their medical documentation and coding maximized the opportunities for legitimate reimbursement from CMS." (ROA.473.) It is hard to imagine a clearer example of failing to draw inferences in favor of the plaintiff upon a motion to dismiss. *Bollinger*, 775 F.3d at 260 (holding that the court improperly drew inferences in favor of defendant).

To be sure, the District Court is correct that there is nothing wrong with hospitals "taking full advantage of coding opportunities to maximize Medicare payment *that is supported by documentation in the medical record*." (ROA.469 (quoting 72 FR at 47181).) But Integra alleges that Defendants' scheme *corrupted the medical record itself* through extraordinary pressure in the form of aggressive training and leading queries, with specific allegations of the particular training and tip sheets. This pattern of aggressive documentation and coding is also what is attested to by Defendants' former employees who were referenced throughout the complaint. Contrary to the Order, neither CMS nor the Department of Justice endorse such conduct. For instance, when a leading query is found by a CMS contractor, CMS requires the contractor to subject the claims to heightened

scrutiny.[7] And when the government detects a pattern of leading queries, it will step in.[8]

In any event, Integra's analyses directly refute the improper inference drawn by the District Court. If Defendants were simply "taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record" (72 FR at 47181), then MCC rates could be above average but would be within the range of coding observed across the country at other facilities for each medical condition. In contrast, a focus on coding beyond the medical conditions observed would lead to extremely unusual coding outside of the distributional norms commonly observed across a range of medical conditions. In most cases, Integra observed coding so rare that only one in a million chance that it would be consistent with normal practices. Yet, the court ruled that the findings were "*equally consistent* with a scheme to improve hospital revenue . . . in a way that will be appropriately recognized and reimbursed." (ROA.468 (emphasis added).) This is simply an incorrect inference based on the statistical evidence. The

[7] *See, e.g.*, CMS Manual Sys., Pub. 100-10 Medicare Quality Improvement Organization, Oct. 10, 2014, *available at* https://goo.gl/RBNCau.

[8] *See* Press Release, U.S. Dept. of Justice, Good Samaritan Hospital Agrees to Pay $793,548 to Settle FCA Allegations (Mar. 28, 2012) ("employees used leading questions so that the physician would answer that the patient was malnourished, which was the result [defendant] wanted to achieve"), *available at* https://goo.gl/5tshx2.

odds that the District Court's theory that the coding practices are inside of observable norms is rejected by the data as highly improbable with a one-in-a-million probability. As can be seen in Figure 12 of the complaint, Defendants are not just an outlier, but an extreme outlier. (ROA.246.) Out of 737 systems with at least 10,000 claims, only six in the entire country use MCC rates more aggressively than Defendants.

Moreover, in seeking to eliminate every conceivable innocent explanation for Defendants' excessive MCC coding, Integra looked at claims stemming from doctors that treated patients at both the Defendant hospitals and other hospitals. (ROA.247-58.) If the District Court's hypothesis were true, one would expect those doctors to take the extraordinary training given by Defendants and apply it to their efforts in diagnosing patients at other facilities. But instead, Integra found those doctors' patients were far more likely to be coded with an MCC at a Defendant facility than anywhere else. (*Id*.)

In sum, Integra's consistent and profound statistical evidence in support of its specific allegations of a scheme through training, tip sheets, and interviews, "permit the court to infer more than the mere possibility of misconduct." *Ashcroft*, 556 U.S. at 679. Integra has thus stated a claim under Rules 8(a) and 9(b).

III. The District Court erred in applying a probability standard to Integra's claims instead of Rule 8(a)'s plausibility standard.

The District Court found that dismissal was appropriate because Integra's allegations, while consistent with the fraudulent scheme alleged, are "*equally consistent* with a scheme to improve hospital revenue . . . in a way that will be appropriately recognized and reimbursed." (ROA.468-69 (emphasis added); *see also* ROA.471 ("Plaintiff's allegations are *equally consistent* with the conclusion that Defendants were taking steps to improve the accuracy and consistency of their medical documentation and coding so as to align it with terminology that CMS would recognize and reimburse appropriately." (emphasis added).); ROA.473 (reasoning that Integra's findings are "*arguably more likely explained by*" Defendants "simply [being] better than their peers in their efforts to ensure their medical documentation and coding maximized the opportunities for legitimate reimbursement from CMS") (emphasis added).)

Circuit courts interpreting *Iqbal* and *Twombly* uniformly agree that Rule 8(a) does not allow courts to weigh competing inferences in this manner on a motion to dismiss. *Bollinger*, 775 F.3d at 263 ("[T]he district court erred by improperly weighting the evidence, by focusing on facts the United States did not plead rather than the inferences that the pleading facts supported, and by viewing the facts in the light most favorable to [defendant]."); *SD3, LLC v. Black & Decker (U.S.) Inc.*, 801 F.3d 412, 425 (4th Cir. 2015) ("[I]t is not our task at the motion-to-dismiss

stage to determine 'whether a lawful alternative explanation appear[s] more likely' from the facts of the complaint.") ; *Swanson v. Citibank, N.A.*, 614 F.3d 400, 404 (7th Cir. 2010) ("'Plausibility' in this context does not imply that the district court should decide whose version to believe, or which version is more likely than not."); *Braden v. Wal-Mart Stores, Inc.*, 588 F.3d 585, 597 (8th Cir. 2009) ("Just as a plaintiff cannot proceed if his allegations are 'merely consistent with' a defendant's liability' . . . so a defendant is not entitled to dismissal if the facts are merely consistent with lawful conduct."). Indeed, the Supreme Court has expressly held that the Rule 8(a) "plausibility standard is not akin to a 'probability requirement.'" *Iqbal*, 556 U.S. at 678 (quoting *Twombly*, 555 U.S. at 557).

The District Court's application of a probability requirement is thus a clear misapplication of the pleading standard under Rule 8(a), as interpreted by *Twombly* and *Iqbal*, which require Integra to allege only more than a "mere possibility" of Medicare Fraud, which it has done through extensive allegations of both the scheme and the dramatic extent to which the scheme was carried out. As demonstrated above, Integra has actually shown how Medicare fraud is occurring from the training materials, interviews, and statistical evidence.

CONCLUSION

For the foregoing reasons, Integra respectfully requests that this Court reverse the District Court's Order and Judgment, find that Integra has adequately pleaded its FCA claims, and remand for further proceedings.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 5th day of November, 2019, an electronic copy of the foregoing brief was filed with the Clerk of Court for the United States Court of Appeals for the Fifth Circuit using the appellate CM/ECF system, and that service on Appellees' counsel will be accomplished by the CM/ECF system.

/s/ *P. Jason Collins*
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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 7,617 words, as determined by the word-count function of Microsoft Word, excluding the parts of the brief exempted by Federal Rule of Appellate Procedure 32(f) and Fifth Circuit Rule 32.2.

2. This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Times New Roman font.

/s/ *P. Jason Collins*
P. Jason Collins

CERTIFICATE OF ELECTRONIC COMPLIANCE

I hereby certify that, in the foregoing brief filed using the Fifth Circuit CM/ECF document filing system, (1) the privacy redactions required by Fifth Circuit Rule 25.2.13 have been made, (2) the electronic submission is an exact copy of the paper document, and (3) the document has been scanned for viruses with the most recent version of a commercial virus scanning program and is free of viruses.

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