

Relator Failed to Sufficiently Plead its FCA Action by Relying on Big Data Alone, Resulting In Big Dismissal

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by Andrew Brantingham

In early August, the U.S. District Court for the Western District of Texas granted a hospital system's motion to dismiss a False Claims Act case that illustrates the increasing intersections in FCA litigation between data analytics and health care providers' efforts to increase revenue through aggressive management of coding and billing practices. *United States ex rel. Integra Med Analytics, LLC v. Scott et al.*, No. 5:17-CV-886-DAE, 2019 U.S. Dist. LEXIS 136547 (W.D. Tex. Aug. 5, 2019).

Plaintiff Integra Med Analytics bills itself as a data analytics and litigation support firm, but it also files FCA cases as a relator. Integra alleged the defendants, including Baylor University Medical Center-Dallas and related entities, engaged in a scheme to submit fraudulent Medicare claims by systematically upcoding claims with "Complication or Comorbidity" ("CC") or "Major Complication or Comorbidity" ("MCC") codes, which add \$1,000 to \$25,000 to the value of reimbursement claims. Integra's allegations focused on the defendants' training programs that allegedly encouraged doctors to apply MCC and CC codes, and encouraged use of terminology in medical records that would justify application of these codes. Integra pressed for an inference of fraud based on its statistical analysis, which purportedly showed the defendants' use of certain MCC and CC codes was above average as compared to other hospitals.

The defendants moved to dismiss, attacking the case as a classic "parasitic" FCA claim brought by a serial relator and argued the FCA's public disclosure bar foreclosed the suit because Integra's analytics brought no new information to the government beyond what was already inherent in the underlying CMS data. They also contended Integra's allegations of fraud were mere conclusions and opinions, unsupported by specific factual allegations, and thus Integra had failed to state a plausible claim for relief under Rule 8(a) or plead the alleged fraud with particularity under Rule 9(b) of the Federal Rules of Civil Procedure.

The Court agreed that Integra failed to plead sufficient facts to make out a plausible claim for relief. Citing CMS guidance "encourag[ing] hospitals to engage in complete and

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accurate coding,” and to “focus their documentation and coding efforts to maximize reimbursement,” the Court concluded that the “mere fact that Defendants took targeted steps to increase their coding of CCs and MCCs to increase hospital[] revenues is neither fraudulent, nor improper per se.” Ultimately, the Court found Integra’s allegations were “‘not only compatible with’ but arguably ‘more likely explained by’ lawful conduct.” That is, at least as plausible as an inference of fraud was the inference that the defendants’ targeted coding programs and above-average utilization of certain codes were explained by their simply being “better than their peers in their efforts to ensure their medical documentation and coding maximized the opportunities for legitimate reimbursement from CMS.” Integra failed to plead any specific facts suggesting the defendants applied any of the codes with fraudulent intent, and in the absence of such facts, the mere fact that the defendants’ training and coding practices were effective in increasing revenue did not mean they were fraudulent.

The case stands as a reminder to healthcare providers that programs designed to maximize reimbursement opportunities can give rise to litigation exposure, particularly in the era of big data. Of course, such programs can be entirely legitimate and legal—as the Court emphasized in this case—but providers would be wise to ensure that any program focused on driving revenue through coding practices places equal emphasis on compliance, integrity, and honesty.