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 for the Western District of Texas, San Antonio Division, No. 5:17-cv-00886

Motion for Leave to File Brief of *Amici Curiae* Chamber of Commerce of the United States of America and American Hospital Association in Support of Appellees and Affirmance

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DARYL JOSEFFER
TARA S. MORRISSEY
U.S. CHAMBER
LITIGATION CENTER
1615 H Street NW
Washington, D.C. 20062
TMorrissey@USChamber.com
Counsel for Chamber of Commerce of the United States of America

JEFFREY S. BUCHOLTZ
JEREMY M. BYLUND
GABRIEL KRIMM
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com
(202) 626-2907
Counsel for Movants

December 23, 2019

Additional Counsel:

MELINDA REID HATTON
MAUREEN D. MUDRON
AMERICAN HOSPITAL
ASSOCIATION
800 Tenth Street, N.W.
Two City Center
Suite 400
Washington, D.C. 20001
(202) 638-1100
Counsel for American
Hospital Association

Pursuant to Rules 27 and 29 of the Federal Rules of Appellate Procedure, the Chamber of Commerce of the United States of America and the American Hospital Association (AHA) respectfully move for leave to file the attached brief of *amici curiae* in support of Appellees and affirmance. Counsel for Appellees consents to this motion. Counsel for relator Integra Med Analytics L.L.C. stated that relator does not consent. Counsel for Integra did not respond to undersigned counsel's question about whether Integra plans to file an opposition.

This Court should allow the Chamber and the AHA to participate as *amici* in this appeal. Under the governing rules, motions for leave to file *amicus* briefs must state "the movant's interest" and "the reason why an *amicus* brief is desirable and why the matters asserted are relevant to the disposition of the case." Fed. R. App. P. 29(a)(3). The Court should grant this motion because the Chamber and the AHA each have a keen interest in False Claims Act *qui tam* cases like this one and because the proposed *amicus* brief would assist the Court in its consideration of the important issues raised by this appeal.

I. The Chamber and the AHA Have an Interest in this Case.

The Chamber of Commerce of the United States of America is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than three million businesses and professional organizations of every size, in every industry, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts.

The American Hospital Association (AHA) represents nearly 5,000 hospitals, healthcare systems, and other healthcare organizations. AHA members are committed to improving the health of the communities they serve and to helping ensure that care is available to and affordable for all Americans. The AHA educates its members on healthcare issues and advocates on their behalf so that their perspectives are considered in formulating health policy.

One way the Chamber and the AHA promote the interests of their members is by participating in cases with important implications for their members—including cases arising under the False Claims Act (FCA) and its *qui tam* provisions.

This appeal is important to AHA and Chamber members because meritless *qui tam* lawsuits pose potentially devastating risks to hospitals and other businesses, forcing them to divert scarce resources from their core missions. Members of both the Chamber and the AHA are frequent targets in lawsuits brought by putative whistleblowers under the FCA, as many are heavily regulated and operate complex organizations that contract with the government or receive reimbursement for providing care under government healthcare programs. These issues are particularly salient in the healthcare industry because approximately *two-thirds* of the FCA cases filed in a recent two-year period involved healthcare defendants. *See* U.S. Dep't of Justice, Fraud Statistics—Overview: Oct. 1, 1986-Sept. 30, 2018, at 1, 3 (2018), https://www.justice.gov/civil/page/file/1080696/download. It is thus critically important to the members of the Chamber and the AHA that courts correctly enforce federal pleading requirements and dismiss *qui tam* actions that do not satisfy those requirements.

II. This *Amicus* Brief is Desirable and Relevant.

"Even when a party is very well represented, an amicus may provide important assistance to the court." *Neonatology Associates, P.A.*

v. C.I.R., 293 F.3d 128, 132 (3d Cir. 2002) (Alito, J.). "Some friends of the court are entities with particular expertise not possessed by any party to the case. Others argue points deemed too far-reaching for emphasis by a party intent on winning a particular case." *Id.* (quotation marks and citation omitted). In this case, the Movants' proposed *amicus* brief fulfills both functions.

First, the Chamber and the AHA have "particular expertise" relevant to this case concerning the importance of the pleading requirements at issue and the coding practices challenged by Integra. *Id.* In view of their broad and diverse memberships, both organizations have the uncommon ability to assess whether a judicial decision will have a significant effect on cases and business practices not directly before the Court. They likewise have distinct insight into what legal questions are important in FCA *qui tam* litigation, especially when such litigation concerns allegations of "upcoding." In their brief, the Chamber and the AHA have provided background and color that will aid the Court's consideration of Integra's *qui tam* pleadings.

Second, the Chamber and the AHA argue "points deemed too far-reaching for emphasis by a party intent on winning a particular case."

Id. Although the parties rightly focus on the facts of this case, the Movants' *amicus* brief makes more general points about the coding regime at issue, the interplay between that regime and the practice of medicine, and the effect all of this has on billing conventions and hospital administration. The brief likewise explains the broader, and increasingly more common, phenomenon of professional-relator suits and shows the inherent difficulty of satisfying federal pleading standards through use of the professional-relator business model.

All other preconditions are satisfied. Under Federal Rule of Appellate Procedure 29(a)(4)(E), the proposed *amici* certify that no party or party's counsel authored the attached brief in whole or in part; no party or party's counsel contributed money intended to fund the brief's preparation or submission; and no person other than the Chamber and the AHA, their counsel, and their members contributed money intended to fund the brief's preparation or submission. The brief is also timely because it is filed within seven days of the filing of Appellees' brief. *See* Fed. R. App. P. 29(a)(6). Finally, the brief complies with Federal Rule of Appellate Procedure 29(a)(5), because it is no more than half the maximum length of Appellees' brief.

CONCLUSION

This Court should grant the motion for leave to file the proposed *amicus* brief.

Respectfully submitted,

/s/ *Jeffrey S. Bucholtz*

DARYL JOSEFFER
TARA S. MORRISSEY
U.S. CHAMBER
LITIGATION CENTER
1615 H Street NW
Washington, D.C. 20062
TMorrissey@USChamber.com

JEFFREY S. BUCHOLTZ
JEREMY M. BYLUND
GABRIEL KRIMM
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com

MELINDA REID HATTON
MAUREEN D. MUDRON
AMERICAN HOSPITAL
ASSOCIATION
800 Tenth Street, N.W.
Two City Center
Suite 400
Washington, D.C. 20001
(202) 638-1100

December 23, 2019

Counsel for Movants and Proposed Amici Curiae

CERTIFICATE OF COMPLIANCE

The undersigned counsel for Movants certifies that:

1. No privacy redactions were required in this motion.

2. Any required hard copies of this motion are exact copies of the ECF filing dated December 23, 2019.

3. The ECF submission was scanned for viruses with the most recent version of McAfee Endpoint Security, and, according to the program, is free of viruses.

4. This motion complies with the word limits of Fed. R. App. P. 27(d)(2) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f), it contains 972 words.

5. This motion complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type-style requirements of Fed. R. App. P. 32(a)(6), because it has been prepared in a proportionally spaced typeface using Microsoft Word in 14-point Century Schoolbook font.

Dated: December 23, 2019

/s/ *Jeffrey S. Bucholtz*

JEFFREY S. BUCHOLTZ
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com

CERTIFICATE OF SERVICE

I hereby certify that on December 23, 2019, I electronically filed the foregoing motion using the Court's CM/ECF system, which will send notification of such filing to all counsel of record.

Dated: December 23, 2019

/s/ *Jeffrey S. Bucholtz*

JEFFREY S. BUCHOLTZ
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com

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DARYL JOSEFFER
TARA S. MORRISSEY
U.S. CHAMBER
LITIGATION CENTER
1615 H Street NW
Washington, D.C. 20062
TMorrissey@USChamber.com
Counsel for Chamber of Commerce of the United States of America

JEFFREY S. BUCHOLTZ
JEREMY M. BYLUND
GABRIEL KRIMM
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com
(202) 626-2907
Counsel for Amici Curiae

December 23, 2019

Additional Counsel:

MELINDA REID HATTON
MAUREEN D. MUDRON
AMERICAN HOSPITAL
ASSOCIATION
800 Tenth Street, N.W.
Two City Center
Suite 400
Washington, D.C. 20001
(202) 638-1100
Counsel for American
Hospital Association

CORPORATE DISCLOSURE STATEMENT AND CERTIFICATE OF INTERESTED PERSONS

Under Federal Rule of Appellate Procedure 26.1 and Circuit Rule 28.2.1, the undersigned counsel of record certifies that *amici* Chamber of Commerce of the United States of America and American Hospital Association state that each has no parent corporations and no publicly held company owns 10% or more of its stock.

The undersigned counsel of record also 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 so that the judges of this Court may evaluate possible disqualification or recusal.

Plaintiff-Appellant:

Integra Med Analytics, L.L.C. (a/k/a Integra Med Analytics LLC)

Affiliates of Plaintiff-Appellant:

Integra FEC LLC; Integra REC LLC; Integra Research Group LLC; John M. Griffin

Counsel for Plaintiff-Appellant:

P. Jason Collins, Jeremy H. Wells, and Morgan Menchaca of Reid Collins & Tsai LLP

Defendants-Appellees:

Baylor Scott & White Health Baylor Scott & White Holdings; Baylor University Medical Center - Dallas; Baylor University Medical Center Baylor Health Care System; Hillcrest Baptist Medical Center Hillcrest Health System, Inc.; Scott & White Memorial Hospital; Scott & White Healthcare; Scott & White Hospital - Round Rock, and Scott & White Healthcare

Counsel for Defendants-Appellees:

R. Jeffrey Layne, Benjamin Koplin, James F. Segroves, Megan A. Hudgeons, and Ryan M. Pate of Reed Smith LLP

Real Party in Interest:

United States of America

Counsel for Real Party in Interest:

Thomas A. Parnham Jr. of the United States Attorney's Office for the Western District of Texas

***Amici Curiae*:**

The Chamber of Commerce of the United States of America and the American Hospital Association

Counsel for *Amici Curiae*:

Jeffrey S. Bucholtz, Jeremy M. Bylund, and Gabriel Krimm of King & Spalding LLP

Daryl Joseffer and Tara Morrissey of the U.S. Chamber Litigation Center

Melinda Reid Hatton and Maureen D. Mudron of the American Hospital Association

/s/ *Jeffrey S. Bucholtz*

JEFFREY S. BUCHOLTZ
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com

Counsel for Amici Curiae

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INTEREST OF *AMICI CURIAE*

The Chamber of Commerce of the United States of America is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than three million businesses and professional organizations of every size, in every industry, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts.

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One way *amici* promote the interests of their members is by participating in cases with important implications for their members—including cases arising under the False Claims Act and its *qui tam* provisions.

This appeal is important to *amici*'s members because meritless *qui tam* lawsuits pose potentially devastating risks to their businesses, forcing them to divert scarce resources from their core missions. *Amici*'s members are frequent targets in lawsuits brought by putative whistleblowers under the FCA, as many are heavily regulated and operate complex organizations that contract with the government or receive reimbursement for providing care from government healthcare programs. These issues are particularly salient in the healthcare industry because approximately *two-thirds* of the FCA cases filed in a recent two-year period involved healthcare defendants. *See* U.S. Dep't of Justice, Fraud Statistics—Overview: Oct. 1, 1986-Sept. 30, 2018, at 1, 3 (2018), https://www.justice.gov/civil/page/file/1080696/download. It is thus critically important to *amici*'s members that courts correctly enforce federal pleading requirements and dismiss *qui tam* actions that do not satisfy those requirements.

STATEMENT OF COMPLIANCE WITH RULE 29(a)

Amici seek to file this brief by leave of court pursuant to Federal Rule of Appellate Procedure 29(a). No party or counsel for a party authored this brief in whole or in part. No party, counsel for a party, or person other than *amici*, their members, or counsel made any monetary contribution intended to fund the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

Despite all the apparent resources at its disposal, Integra Med Analytics L.L.C. can only speculate that the Baylor Scott & White Hospitals claimed reimbursement for treating conditions that their Medicare patients did not have or for care the Hospitals did not provide. Integra's complaint fails to allege sufficient facts to support the most basic element of False Claims Act liability: that claims submitted for reimbursement were *false*.

By relying almost exclusively on claims data to allege fraudulent billing, Integra's complaint omits the critical factual allegations of falsity necessary to clear the plausibility and particularity hurdles of Rule 8(a) and Rule 9(b). And those shortcomings should come as no surprise given Integra's business model. As a professional relator, Integra has no inside information about patient records, clinicians' medical judgments, or coding practices at the Hospitals. Integra obtained data from CMS showing what the Hospitals billed to Medicare. And Integra can analyze that data—as the Government already does. But it takes more than analytics to plead a viable fraud claim. Without something more—such as facts showing that a doctor diagnosed a patient with a condition she

knew the patient did not have or that a hospital employee knowingly used a code that did not correspond to the doctor's diagnosis, so that the code contained in a Medicare claim was false—Integra cannot "nudge" its statistics-based theory that the Hospitals' Medicare claims contained false codes "across the line from conceivable to plausible." *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 570 (2007).

BACKGROUND

Integra Med Analytics L.L.C. is not a whistleblower. It has never worked for or provided services to the Hospitals. It has no firsthand knowledge of the Hospitals' operations. What it does have is a "team of data scientists and forensic analysts … with strong quantitative backgrounds and analytical experience." Integra Med Analytics, http://integramedanalytics.com/ (last visited Dec. 8, 2019). And by mining data obtained from CMS, that team found that the Hospitals used certain Medicare secondary diagnosis codes more often than other hospitals.

According to its complaint, Integra followed up that statistical analysis with a limited investigation of the Hospitals' coding practices. With reference to documents and interviews of former employees, Integra

alleges that the Hospitals, "[l]ike most hospital groups," operated a "clinical documentation improvement" program—a program "typically designed to promote the accurate documentation of a patient's diagnoses and treatment such that they can be properly coded for reimbursement." ROA.187. The Government affirmatively encourages hospitals to pay attention to their coding in order to pursue full reimbursement, but according to Integra, the Hospitals' program stood out for its coaching of doctors' documentation practices and its emphasis on the importance of coding language for full reimbursement. *See* ROA.197.

The complaint provides precious little factual detail, however, about the alleged inaccuracy of the codes in question—in other words, whether the Hospitals' claims were false. Amid vague claims that some coding personnel felt uncomfortable about certain unspecified practices, Integra fails to identify any concrete instances of codes being applied contrary to or in the absence of a legitimate medical diagnosis. And despite asserting that staff pressured doctors to fully document codable conditions, Integra conspicuously stops short of making any meaningful factual allegation that doctors were told to pursue revenue enhancement contrary to their medical judgment. *See Ashcroft v. Iqbal*, 556 U.S. 662,

678 (2009) (holding that only well-pleaded factual allegations—rather than "labels and conclusions" or "naked assertion[s]"—are entitled to be credited at the motion-to-dismiss stage).

Picking up on this gap in Integra's pleading, the district court correctly dismissed Integra's complaint for failure to state a claim. *See* ROA.437–53. The court concluded that Integra had sufficiently alleged that the Hospitals submitted *claims* pursuant to the alleged policy of maximizing revenue by, for example, "training staff to be on the lookout for opportunities to code for CCs and MCCs" and "encourag[ing] [doctors] to diagnose in ways that could permit coding for CCs and MCCs." ROA.446. But Integra failed to plead facts—let alone particularized facts as required by Rule 9(b)—showing that any such claims were *false*.

First, that a claim contained a code added as a result of the alleged policy is insufficient, because an effort to increase reimbursement through use of secondary diagnosis codes "is not in and of itself [a scheme] to submit false claims"—*i.e.*, a scheme to use *false* codes. ROA.446. Moreover, even if a claim contained a code that some doctors or coding personnel would disagree with, that is likewise insufficient, as differing medical judgments are not the stuff of fraud claims. *See* ROA.452. In

simple terms, therefore, Integra would have had to "alleg[e] that a defendant knew that using a particular code was incorrect," and Integra did not and could not make such an allegation. ROA.448.

ARGUMENT

The district court correctly held that Integra's complaint failed to state a valid FCA claim. Statistics concerning the prevalence of certain codes do not plead that any particular use of a code was incorrect. Every statistical distribution has a top, so being at the top cannot mean one is committing fraud. Nor do allegations of efforts to increase reimbursement through coding show a scheme to use false codes. The Government *wants* hospitals to pay attention to coding in order to obtain all appropriate reimbursement. *See* HHS, *Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates*, 72 Fed. Reg. 47,130, 47,175–82 (Aug. 22, 2007). Integra thus was required to plead with particularity that the Hospitals used false codes.

That Integra failed to do so is hardly surprising given Integra's business model: Integra is a data-analysis company that has no inside knowledge about why the Hospitals used any particular code for any

given patient and no basis to allege that the Hospitals ever used a code that was contrary to the doctor's medical judgment. "Professional relators" like Integra, that prospect for a relator's bounty based on data from CMS, do not advance the Government's interest in safeguarding public funds. The Government has access to the same data and more, as well as sophisticated tools to mine the data and identify situations potentially calling for investigation. Baseless *qui tam* actions like this one clog the courts and raise healthcare costs for everyone.

I. Integra Failed To Plead Particularized Facts Showing That The Hospitals Used False Diagnosis Codes.

A complaint in federal court is supposed to seek redress for a wrong, not to go prospecting in an effort to find one. Rule 8(a) requires every plaintiff to plead meaningful, non-conclusory factual allegations that, if true, make liability "plausible" and not merely possible. *Iqbal*, 556 U.S. at 680; *Twombly*, 550 U.S. at 570. False Claims Act plaintiffs face the additional requirement to plead their claims with particularity via "'simple, concise, and direct' allegations of the 'circumstances constituting fraud[.]'" *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180,

186 (5th Cir. 2009) (quoting *Williams v. WMX Techs., Inc.*, 112 F.3d 175, 178 (5th Cir. 1997)).

These rules have particular bite in a case like this alleging FCA violations relating to diagnosis codes. The FCA requires "a false statement or fraudulent course of conduct." *United States v. Hodge*, 933 F.3d 468, 473 (5th Cir. 2019) (quoting *U.S. ex rel. Harman v. Trinity Indus. Inc.*, 872 F.3d 645, 653–54 (5th Cir. 2017)). But diagnosis codes reflect medical judgment, so there is often room for disagreement about which code or codes to use—and medical judgment is not fraud, even if other doctors disagree with a given judgment. *See, e.g., U.S. ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004).

For example, Integra focused on the Hospitals' use of the secondary diagnosis code for the "Major Complication or Comorbidity" of "severe malnutrition." *See* ROA.441. But there is no established consensus on how to pinpoint the existence or severity of malnutrition, so a diagnosis of severe malnutrition inevitably reflects a clinician's judgment call. *See* Carol Rees Parrish, M.S., R.D., *Coding for Malnutrition in Adult Patient: What the Physician Needs to Know*, Practical Gastroenterology, Sept. 2014, at 56–64. A claim containing that code can be "false or fraudulent"

under the FCA only if no reasonable doctor could have given that patient such a diagnosis. *See also United States v. AseraCare, Inc.*, 938 F.3d 1278, 1297 (11th Cir. 2019) ("A properly formed and sincerely held clinical judgment is not untrue even if a different physician later contends that the judgment is wrong.").

Indeed, nearly every step leading to the submission of a Medicare claim carries the potential for lawful variation. Doctors will vary in their exercise of professional judgment and diagnosis of codable conditions. *See* Neil Issar, *More Data Mining for Medical Misrepresentation? Admissibility of Statistical Proof Derived from Predictive Methods of Detecting Medical Reimbursement Fraud*, 42 N. Ky. L. Rev. 341, 362–63 (2015); Isaac D. Buck, *Caring Too Much: Misapplying the False Claims Act to Target Overtreatment*, 74 Ohio St. L.J. 463, 467 (2013). Among physicians who reach the same codable diagnosis, claims will continue to differ based on documentation practices. For example, doctors will vary in how thoroughly they document clinical judgments. Coding analysts will likewise vary in how they communicate with doctors, interpret medical records, and convert those records into claims. *See* Issar, *supra*, at 350. It was on these issues that the Hospitals' documentation-

improvement program focused, ROA.187; *see also id.* (noting that "most hospital groups" have these programs)—and rightly so, as the Government "encourage[s] hospitals to engage in complete and accurate coding" and has "reaffirm[ed its] view that hospitals focus their documentation and coding efforts to maximize reimbursement." 72 Fed. Reg. at 47,181.

That a hospital is an "outlier" in the use of certain diagnosis codes thus does not show that its claims are false. To be sure, such data might in some cases be consistent with the existence of an FCA violation. Perhaps such data could lead the Government to conduct additional inquiry to learn whether there is a basis to bring an FCA claim. But such data cannot by themselves *be* an adequate basis to bring an FCA claim. Even putting Rule 9(b) aside, a complaint must plead facts that make a violation "plausible," and it is insufficient for a complaint's well-pleaded factual allegations to be merely "consistent with" the existence of liability. *Twombly*, 550 U.S. at 570.

Although the Court is well acquainted with *Twombly*, that decision is instructive enough in this case to be worth recalling. *Twombly* concerned an antitrust claim of a conspiracy to set prices. Such a

conspiracy is, of course, illegal. But the plaintiffs had alleged a conspiracy only in conclusory, formulaic terms. 550 U.S. at 550-51. Their meaningful factual allegations—non-conclusory and thus entitled to be taken as true—showed only "parallel" behavior by the defendants. *Id*. at 564. And parallel behavior by competitors is, by itself, lawful and often natural. While the defendants' parallel behavior was undeniably "consistent with" the existence of the claimed conspiracy, the complaint required the Court to leap from the lawful behavior actually pleaded to infer unlawful behavior that was not itself pleaded with adequate factual allegations. *See id*. The Court refused to make that leap and directed courts to be more vigilant in enforcing Rule 8(a), announcing the now-familiar "plausibility" standard. *See id*. at 565–70.

Twombly's analysis is a perfect fit for a case based on statistical patterns in Medicare billing. It is "only natural," *id*. at 566, for a hospital to apply diagnosis codes to the fullest extent permitted by law. Indeed, the Government encourages hospitals to do so. *See* 72 Fed. Reg. at 47,175–82. So a complaint alleging only that a hospital applied certain codes to a high number of Medicare claims cannot cross the line between

"conceivable" and "plausible" liability under the FCA. *Twombly*, 550 U.S. at 570.

Nor can vague assertions of malfeasance suffice to fill in the gaps. Courts must disregard legal conclusions masquerading as factual allegations and focus instead on tangible actions. *See Iqbal*, 556 U.S. at 681. So nebulous and conclusory accusations of "upcoding" accomplish nothing; only well-pleaded allegations of the use of false codes are entitled to the assumption of truth. *See id.*

Integra, moreover, had to plead its fraud claim with particularity under Rule 9(b). *See, e.g., Grubbs*, 565 F.3d at 186. That required, at a minimum, detailed factual allegations of situations where the Hospitals' personnel used a code that contradicted the doctor's diagnosis or where the doctor rendered a diagnosis that was not merely debatable or incorrect but false—*i.e.*, that the doctor did not believe or no reasonable doctor could have believed—in order to permit the use of an inapplicable code. Integra came nowhere near meeting this requirement.

Indeed, while *Grubbs* adopted a less demanding approach to Rule 9(b) than some circuits have followed, *see id.* at 186–88, *Grubbs* itself makes clear that Integra's complaint was inadequate. In *Grubbs*, the

relator pleaded that he was personally approached by doctors and nurses who asked him to participate in billing for face-to-face visits for every patient even though the doctors did not have face-to-face visits with many patients (and instead did so only "as needed"). *Id.* at 184. He pleaded specific instances, complete with names and dates, where doctors had recorded face-to-face care when they had not provided any. *Id.* Although the relator was unable to plead the specifics of *claims* later submitted for those nonexistent face-to-face visits, there was no question that he pleaded particularized facts showing that any such claims would be *false*. *Id.* at 191–92.

This case is the flip side of the coin. Integra pleaded information about claims—the information this Court held in *Grubbs* was *not* necessary—but failed to plead facts, let alone particularized facts, showing that any claims were false. Integra's billing data cannot stand in for adequate factual allegations of falsity, because billing data says nothing about falsity. The Court in *Grubbs* recognized this, explaining that "[s]tanding alone, raw bills—even with numbers, dates, and amounts—are not fraud without an underlying scheme to submit the bills for unperformed or unnecessary work." *Id.* at 190.

II. Integra's Deficient Complaint Exemplifies the Problems with "Professional Relators."

It is no accident that Integra's complaint failed to meet basic pleading standards: Integra is a "professional relator" that lacked the kind of inside information that defines the genuine whistleblowers whom Congress sought to incentivize in the FCA's *qui tam* provisions. *See Graham Cty. Soil & Water Conservation Dist. v. U.S. ex rel. Wilson*, 559 U.S. 280, 294 (2010) (describing the 1986 FCA amendments as "[s]eeking the golden mean between adequate incentives for whistle-blowing insiders with genuinely valuable information and discouragement of opportunistic plaintiffs who have no significant information to contribute of their own" (quoting *U.S. ex rel. Springfield Terminal R. Co. v. Quinn*, 14 F.3d 645, 649 (D.C. Cir. 1994)).

As explained above, it is difficult to see how data mining on its own could enable a non-insider to plead a viable fraud claim. Statistical analysis may be capable of rendering an inference of fraud "conceivable," but only people with firsthand knowledge of a company's operations and its patient records can provide the details necessary to plead fraud with particularity. Professional relators like Integra therefore must attempt

to supplement their data mining with real-world information from insiders.

Integra seemingly recognized as much, as it claimed to have conducted "[a] multi-faceted investigation of Baylor and its leadership." ROA.182. But Integra's "investigation" was much less than advertised. According to Integra, it learned that the Hospitals implemented a documentation-improvement program and sought to "improve revenue" by "guid[ing]" and "persuad[ing]" doctors to make codable diagnoses, ROA.188, and "steer[ing] doctors away from [non-codable] diagnoses," ROA.190. But there is nothing fraudulent about that unless the Hospitals told doctors to make codable diagnoses even when not supported by their medical judgment. Integra conspicuously failed to allege any such instruction and failed to point to any contradictions between what was actually billed and what was in the patient records.

Instead, Integra relied on vague innuendo. It contended that medical coders "received pressure … to code unethically," *id.*, but did not identify any coders who allegedly received such pressure; identify anyone who allegedly applied such pressure; identify any instance where coders billed for services unsupported by a patient's medical record; or explain

what it means by this vague reference to "pressure." Similarly, it contended—again in the telltale passive voice—that codes were "inappropriately applied," *id.* at 196, without identifying who applied them, for which patients, which codes were allegedly inappropriate, or why they were inappropriate.

Despite their increasing prevalence, companies like Integra do nothing to aid the Government's anti-fraud efforts. The Government already has access to the raw claims data on which professional relators rely (and more). And the Government already conducts its own statistical analyses of that data to identify patterns that may warrant further inquiry. Buck, *supra*, at 467–68, 481–82, 485–86. A professional relator's "proprietary analysis," ROA.182, thus tells the Government little if anything it does not already know.

Professional relators' bounty-hunting efforts can also be troubling. To obtain the inside knowledge they need to go beyond mere statistical analysis, professional relators must enlist insiders. But an insider who has genuine firsthand knowledge of fraud can go to the Government and has no apparent incentive to provide information to a professional relator—enabling the professional relator to seek the bounty that the

insider might be able to claim herself. According to the Government, some professional relators appear to have solved this problem by resorting to false pretenses to elicit information from insiders. *See* U.S. Mot. Dismiss Relator's Second Am. Compl. 5, ECF No. 116, *U.S. ex rel. Health Choice Group, LLC v. Bayer Corp.*, No. 5:17-cv-126-RWS-CMC (E.D. Tex.) (describing one professional relator's surreptitious efforts to gather information from hospital insiders under the guise of a "research study"); *see also Health Choice Alliance LLC ex rel. United States v. Eli Lilly & Co., Inc.*, 2019 WL 4727422, at *8 (E.D. Tex. Sept. 27, 2019) (dismissing the professional relator suit at the Government's request).

Even when they offer no benefit to the Government, professional relators impose significant costs on the healthcare community and the broader public. By attacking hospitals on the basis of data alone, they have the potential to raise costs and influence practices for the worse. *Cf.* Buck, *supra*, at 495–501 (describing the downside of any data-focused fraud enforcement regime). Because of the extraordinarily draconian nature of FCA liability—treble damages plus per-claim penalties—defendants often cannot afford to litigate and are forced to settle even meritless lawsuits. *See id.* at 496; David A. Hyman, *Health Care Fraud*

and Abuse: Market Changes, Social Norms, and the Trust "Reposed in the Workmen," 30 J. Legal Stud. 531, 552 (2001). In addition to burdening hospitals financially, *see* Keith D. Barber et al., *Prolific Plaintiffs or Rabid Relators? Recent Developments in False Claims Act Litigation*, 1 Ind. Health L. Rev. 135, 172 (2004), this process may signal to doctors that the law mandates convention without regard to clinical appropriateness or legitimate medical judgment—a message that prevents the necessary evolution of care. *See* Buck, *supra*, at 495, 499–501.

For all these reasons, it is critical that the Court enforce Rule 8(a) and Rule 9(b) in suits like this. If a professional relator could get past a motion to dismiss armed only with statistics and vague innuendo, FCA litigation will explode even more than it already has.

CONCLUSION

This Court should affirm the district court's judgment.

Respectfully submitted,

/s/ *Jeffrey S. Bucholtz*

DARYL JOSEFFER
TARA S. MORRISSEY
U.S. CHAMBER
LITIGATION CENTER
1615 H Street NW
Washington, D.C. 20062
TMorrissey@USChamber.com

JEFFREY S. BUCHOLTZ
JEREMY M. BYLUND
GABRIEL KRIMM
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com

MELINDA REID HATTON
MAUREEN D. MUDRON
AMERICAN HOSPITAL
ASSOCIATION
800 Tenth Street, N.W.
Two City Center
Suite 400
Washington, D.C. 20001
(202) 638-1100

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Counsel for *Amici Curiae*

CERTIFICATE OF COMPLIANCE

The undersigned counsel for *amici* certifies that:

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Dated: December 23, 2019

/s/ *Jeffrey S. Bucholtz*

JEFFREY S. BUCHOLTZ
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com

CERTIFICATE OF SERVICE

I hereby certify that on December 23, 2019, I electronically filed the foregoing brief using the Court's CM/ECF system, which will send notification of such filing to all counsel of record.

Dated: December 23, 2019

/s/ *Jeffrey S. Bucholtz*

JEFFREY S. BUCHOLTZ
KING & SPALDING LLP
1700 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
JBucholtz@kslaw.com