UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
AT CHATTANOOGA

UNITED STATES OF AMERICA, *ex rel.* GLENDA MARTIN, Plaintiffs, v. LIFE CARE CENTERS OF AMERICA, INC. Defendant.	)	Civil Action No. 1:08-CV-251 MATTICE/CARTER
UNITED STATES OF AMERICA, *ex rel.* TAMMIE TAYLOR, Plaintiffs, v. LIFE CARE CENTERS OF AMERICA, INC., Defendant.	)	Civil Action No. 1:12-CV-64 MATTICE/CARTER

UNITED STATES' MEMORANDUM IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS

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INTRODUCTION

The United States' Complaint in Intervention ("Complaint")[1] alleges, in significant detail and replete with examples, how Defendant Life Care Centers of America, Inc. ("Life Care") demanded, threatened, and pressured its therapists to provide patients with as many therapy minutes as possible in order to bill Medicare and TRICARE at the highest rate possible, frequently without regard for patient need or medical necessity. The Complaint details how Life Care management pushed its therapists to provide the "Ultra High" level of therapy to their patients; instructed its therapists on specific techniques to achieve those minutes even when those techniques were not skilled services covered by Medicare or TRICARE; rewarded therapists and managers who increased revenue by meeting its Ultra High goals; and retaliated against those who would not or could not do so. The Complaint demonstrates how far-reaching and deeply entrenched Life Care's conduct was by describing not only the corporate conduct, but how that conduct affected management and therapists across Life Care's regions and facilities. Ultimately, Life Care's scheme was effective, and the Complaint details the scheme's detrimental impact on specific patients and on the public fisc by providing examples of specific false or fraudulent claims for payment.

Life Care's Memorandum in Support of its Motion to Dismiss ("Memorandum"), (Doc. No. 81), essentially advances four arguments, none of which provides a plausible basis for dismissal: (1) claims for payment for skilled rehabilitative therapy can never be "false" under the False Claims Act if the therapy was ordered by independent physicians and carried out by

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[1] The United States filed nearly identical complaints in both the *Martin* and *Taylor* actions. *Martin*, Case No. 1:08-cv-251 (Doc. 62); *Taylor*, Case No. 1:12-cv-64 (Doc. 16). This Court consolidated the cases and designated the *Martin* case as the lead action. (*Martin*, Doc. 67 (Nov. 15, 2012)). Following this order, the United States filed its consolidated Complaint in Intervention. (Doc. No. 69). This Memorandum cites to the Consolidated Complaint.

therapists exercising subjective clinical judgment; (2) the recent settlement in *Jimmo v. Sebelius*, Case No. 5:11-cv-17-CR (D. Vt.), precludes all False Claims Act cases based on fraudulent rehab therapy; (3) the Complaint does not meet the pleading requirements under Federal Rule of Civil Procedure 9(b); and (4) the Complaint should be dismissed because the Government failed to comply with the procedural requirements of the False Claims Act. Life Care is not only wrong on the law, but its Memorandum mischaracterizes and ignores the factual allegations in the Complaint to support its arguments. When taken in the light most favorable to the Government—as required in a motion to dismiss—the Complaint alleges a plausible legal theory under the False Claims Act; it sets forth specific facts regarding individual false claims that more than sufficiently meets the pleading requirements of Rule 9(b). This Memorandum addresses each of Life Care's arguments below.

I. Legal standard on a motion to dismiss.

When ruling on a motion to dismiss for failure to state a claim, the court "must construe the allegations of the complaint in the light most favorable to plaintiffs, accept all well-pled factual allegations as true, and decide whether the complaint contains sufficient facts to state a claim for relief that is plausible on its face." *U.S. Citizens Ass'n v. Sebelius*, Case No. 11-3327, 2013 U.S. App. Lexis 2245, at *14-15 (6th Cir. Feb. 1, 2013). While legal conclusions and a "formulaic recitation of the elements of a cause of action will not do," the court must consider only whether the allegations are "plausible," which stops well short of a "probability" standard. *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (*quoting Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555-57 (2007)).

The False Claims Act ("FCA") is "intended to reach all types of fraud, without qualification, that might result in financial loss to the Government." *United States v. Neifert-*

White Co., 390 U.S. 228, 232 (1968). The Complaint asserts two counts under the FCA. Compl. ¶¶ 184-189. Count I asserts a violation of 31 U.S.C. § 3729(a)(1)(A). Section 3729(a)(1) "imposes liability when (1) a person presents, or causes to be presented, a claim for payment or approval; (2) the claim is false or fraudulent; and (3) the person's acts are undertaken 'knowingly,' i.e. with actual knowledge of the information, or with deliberate ignorance or reckless disregard for the truth or falsity of the claim." *United States ex rel. Bledsoe v. Cmty. Health Sys., Inc.* 342 F.3d 634, 640 (6th Cir. 2003) (*Bledsoe I*). Under Count II, the United States alleges that Life Care (1) made, used, or caused to be made or used (2) false records or statements, that are (3) material to false or fraudulent claims, and that (4) Life Care did so knowingly. 31 U.S.C. § 3729(a)(1)(B). Counts III, IV, and V allege common-law claims arising from the same set of facts as Counts I and II, and they are addressed in Section V of this Memorandum.

II. The Complaint sufficiently alleges that the claims submitted by Life Care were "false" under the FCA.

As a threshold matter, Life Care limits its arguments for dismissal of the FCA counts to the "falsity" element. Life Care does not dispute that with respect to Count I, the Complaint alleges that Life Care caused the presentment of claims for payment to Medicare and TRICARE, or that the Complaint sufficiently alleges that the claims were submitted "knowingly."[2] Similarly, regarding Count II, Life Care does not contend that the Complaint fails to allege that records containing medically unnecessary or unskilled therapy minutes—the Minimum Data Set, or MDS, forms—were made, used, or caused to be made or used, or that the Complaint does not

[2] Even had Life Care opted to do so, the Complaint provides significant factual support for its contention that the claims were submitted knowingly. *See* Compl. ¶¶ 161-183 (providing numerous examples of complaints received from staff regarding the lack of medical necessity of therapy). In any event, even under Rule 9(b), knowledge need only be pled generally.

adequately plead knowledge or the materiality of the MDS forms to payment of Life Care's claims. Thus, at its core, Life Care's only argument is that the Complaint does not adequately allege that the claims or MDS forms are false, or that Life Care caused them to be false. Given the numerous details set forth in the Complaint regarding Life Care's business practices, and the specific examples of patients and claims for payment alleged to be false, the Government has more than met its burden of pleading facts that constitute "plausible" false claims under the FCA. *Iqbal*, 556 U.S. at 678.

The legal theory underlying the Government's allegations—that Life Care submitted claims to Medicare and TRICARE for medically unreasonable and unnecessary services in violation of 42 U.S.C. § 1395y(a)(1)(A)—falls squarely within well-established case law holding that such claims are actionable as "false" under the FCA. *See United States ex rel. Riley v. St. Luke's Episcopal Hosp.*, 355 F.3d 370, 376 (5th Cir. 2004) ("[C]laims for medically unnecessary treatment are actionable under the FCA."); *United States ex rel. Mikes v. Straus*, 274 F.3d 687, 700-701 (2d Cir. 2001) (claims for medically unnecessary services are "false" under the FCA); *see also Chesbrough v. VPA, P.C.*, 655 F.3d 461, 468 (6th Cir. 2011) (adopting reasoning in *Mikes*); *United States ex rel. Augustine v. Century Health Servs.*, 289 F.3d 409, 415 (6th Cir. 2002) (claims for payment submitted in violation of Medicare regulations on which payment is conditioned are "false" claims under the FCA).[3]

Life Care advances three overly broad and sweeping arguments for why the claims for payment cannot be "false" under the FCA as a matter of law. Specifically, Life Care argues that

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[3] Likewise, the requirement that the services be "skilled," 42 C.F.R. § 409.32, is also a condition of payment and material to the payment of claims. *See* 42 C.F.R. § 409.30 ("Posthospital SNF care . . . is covered . . . only for days when [a resident] needs and receives care of the level described in § 409.31." (describing, *inter alia*, care that requires the skills of a therapist)).

the claims cannot be "false" because (1) physicians certified patients' overall need for skilled therapy; (2) therapists exercised subjective clinical judgments; and (3) the therapy regulations are "confusing," citing, in particular, the *Jimmo* settlement. Yet, courts have routinely rejected all of these arguments as a basis for dismissal of an FCA complaint. At best, the arguments primarily raise questions of fact which should be adjudicated following discovery and not on a motion to dismiss.

A. The Complaint alleges that Life Care's therapists—and not independent physicians—set patients at the Ultra High RUG level.

Life Care first seeks dismissal on the basis that the therapy was provided pursuant to the orders of independent physicians, and therefore the company is immune from FCA liability. Mem. at 1, 11, 14. Life Care's arguments fail because they misstate the allegations in the Complaint and, even if they did not, would still fail as a matter of law. First, Life Care implies that physicians prescribed the number of therapy minutes for each patient, Mem. at 11-12, 14, 19, but the Complaint alleges that those determinations were made by Life Care, and *not* the patient's physicians. *E.g.*, Compl. ¶¶ 3, 52, 74-75, 77, 112. Merely because physicians certified the overall *need* for skilled therapy did not categorically entitle Life Care to provide each patient with the maximum amount of therapy possible to hit the Ultra High billing target. The Complaint alleges that Life Care management—and not independent physicians—set the number of minutes of therapy for patients, and that the amount of therapy set by Life Care was not medically reasonable or necessary. *E.g.*, Compl. ¶¶ 65, 77, 112. Although Life Care may argue otherwise, that is a factual matter that is not appropriately raised at this stage of the proceeding.

To the extent physicians were involved in authorizing the patient's overall need for and duration of skilled therapy, the Complaint alleges that physicians generally relied on the information and recommendations of Life Care. Under similar circumstances, courts have

consistently held that a defendant is not absolved from FCA liability where a physician relies upon the defendant when prescribing treatment. In *United States ex rel. Landis v. Hospice Care of Kansas, LLC*, Case No. 06-2455, 2010 U.S. Dist. Lexis 129484 (D. Kan. Dec. 7, 2010), for example, the court rejected arguments that physician judgment automatically precludes FCA liability. The United States had alleged that the defendant submitted false claims to Medicare for patients that were not medically qualified for hospice care, notwithstanding that the patients' physician certified the need for hospice. *Id.* at *5. The court held that the claims were actionable because the United States did "not allege that the physicians made false certifications independently, but that the physicians could not legitimately exercise their medical judgment because defendants provided false information on which the physicians relied." *Id.* at *14. Other courts have reached similar conclusions. *See, e.g., Strom ex rel. United States v. Scios, Inc.*, 676 F. Supp. 2d 884, 891 n.2 (N.D. Cal. 2009) (rejecting argument that the complaint amounted to "second guessing doctors' considered medical judgments" because the complaint "alleges that doctors prescribed [a certain drug] only because they were induced to do so by Defendants' misrepresentations" to doctors.); *United States ex el. Westmoreland v. Amgen, Inc.*, 738 F. Supp. 2d 267, 277-78 (D. Mass. 2010) (rejecting argument that drug company could not be liable for false claims where drug prescribed by independent physicians); *United States ex rel. Franklin v. Parke-Davis*, 147 F. Supp. 2d 39, 52 (D. Mass. 2001) (same).

The Complaint alleges that physicians signed therapy orders relying on the recommendations of therapists, without being informed that those recommendations were dictated by Life Care's corporate Ultra High goals. Specifically, the Complaint alleges that the physicians "relied heavily on therapists to propose a frequency and duration of therapy . . . , not knowing that Life Care had actually set those amounts to meet corporate target RUG levels."

Compl. ¶ 130. The Complaint further alleges that "physicians commonly signed certifications days or a week after the patient was admitted," and that physicians generally would approve therapy over the phone after speaking with a Life Care therapist and "without ever having met the patient or performed an independent evaluation." Compl. ¶ 129. The Complaint describes a specific instance of a physician who signed conflicting therapy orders, Compl. ¶ 131, demonstrating that physicians would "sometimes sign stacks of certifications" without paying close attention. Compl. ¶ 130. Accordingly, the Complaint alleges that while physicians relied upon Life Care's therapists and staff regarding a patient's general need for skilled therapy, Life Care's therapists set the duration and frequency of therapy actually provided and did so based upon corporate Ultra High goals rather than individual patient need. Again, to the extent Life Care contests the accuracy or truthfulness of these allegations, that is a question of fact to be developed during discovery and is not ripe for adjudication at this time.

B. Claims based on medical judgments can be "false" under the FCA.

Life Care also argues that, as a matter of law, no claims for skilled rehabilitative therapy services can ever be "false" under the FCA because the provision of such services involves "subjective, clinical determinations," Mem. at 19, that cannot be objectively verified. In the same vein, Life Care contends that what constitutes "skilled therapy" is so inherently subjective that as a matter of law it could not possibly have submitted false claims for unskilled therapy, regardless of what activities the therapists were engaged in. *Id.*

Notably, Life Care starts from the faulty premise that the Complaint challenges the independent clinical judgments of its therapists. Rather, the United States brought this action precisely because Life Care frequently *prevented* therapists from exercising their medical judgment and instead used corporate targets to dictate the amount of therapy provided to

Medicare and TRICARE patients. *E.g.*, Compl. ¶ 65 (Ultra High targets set regardless of patient need); ¶ 77 (instructing therapists to provide each patient with specified amount of therapy regardless of patient need); ¶ 87 (rehab committee mandated that facilities provided Ultra High therapy regardless of patient need); ¶ 90 (program billed Medicare for unskilled care that artificially inflated length of a patient's stay); ¶ 112 (Life Care managers instructed therapists to assign patients to Ultra High category regardless of patient need).

Moreover, even if Life Care personnel were permitted to exercise any medical judgment, several circuit courts have held that a knowing false opinion or judgment may be actionable under the FCA. *See United States ex rel. Loughren v. Unum Group*, 613 F.3d 300, 310-312 (1st Cir. 2010) (holding that statements made by applicants for Social Security benefits could be actionable under the FCA "even if they were just an expression of the applicants' opinions, so long as the applicants knew of facts which would reasonably preclude such an opinion."); *Riley*, 355 F.3d at 376 (reversing dismissal of FCA case, finding allegation that defendant "ordered the [medical] services knowing they were unnecessary[,]" could subject defendant to FCA liability."); *Mikes*, 274 F.3d at 700-701. As the Fourth Circuit explained in *United States ex rel. Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 792 (4th Cir. 1999), "an opinion or estimate carries with it 'an implied assertion, not only that the speaker knows no facts which would preclude such an opinion, but that he does know facts which justify it." Furthermore, courts have long held that false estimates may subject a defendant to criminal liability under the False Statements Statute, 18 U.S.C. § 1001, and the Criminal False Claims Act. *See United States v. White*, 765 F.2d 1649 (11th Cir. 1985); *see also United States v. Shah*, 44 F.3d 285, 289-92 (5th Cir. 1995); *United States v. Hartness*, 845 F.2d 158, 160-61 (8th Cir. 1988). Thus, if

Life Care knew, or recklessly disregarded, whether there was a basis for its clinical judgments, then it may still be liable under the FCA.

Even assuming *arguendo* that only objectively verifiable facts were actionable under the FCA, the case law is clear that medical reasonableness and necessity can be established through objectively verifiable facts. Notably, the defendant in *Hospice Care*, discussed earlier, made the very same argument as Life Care does here, contending that a doctor's determination as to whether a patient had a qualifying terminal illness is a "subjective medical opinion that cannot be false." 2010 U.S. Dist. Lexis 129484 at *13. The court rejected the argument, explaining that while "FCA liability must be based on an objectively verifiable fact[,] facts that rely upon clinical medical judgments are not automatically excluded from liability under the FCA." *Id.* at *13-14. Other courts have reached similar conclusions. *United States ex rel. Morton v. A Plus Benefits, Inc.*, 139 F. Appx. 980, 983 (10th Cir. 2005) (court "not prepared to conclude that in all instances, merely because the verification of a fact relies upon clinical medical judgments . . . the fact cannot form the basis of an FCA claim."); *Riley*, 355 F.3d at 376; *Mikes*, 274 F.3d at 700-701.

In this case, Life Care has proffered no credible reason for why skilled rehabilitation therapy services should be carved out from the myriad of medical services that are subject to the Medicare prohibition against payments for services that are not medically reasonable and necessary. *See United Seniors Ass'n v. Shalala*, 182 F.3d 965, 967 (D.C. Cir. 1999) ("If a service is deemed not to have been reasonable and necessary, Medicare will not make payment and the doctor generally is prohibited from charging the patient."); *Mount Sinai Hosp., Inc. v. Weinberger*, 517 F.2d 329, 334 (5th Cir. 1975) (explaining that 42 U.S.C. § 1395y controls whether particular services are covered by Medicare). Indeed, Life Care's only concrete

distinction between skilled therapy services and other Medicare covered services is the *Jimmo* settlement; however, as discussed below, *infra* at 11, not even the plaintiffs in that action contended that the Medicare regulations were confusing or unclear.

Life Care's additional argument—that it was incapable of distinguishing between skilled and unskilled services—ignores Medicare regulations and guidance setting forth clear standards for what constitutes skilled therapy. *See, e.g.*, Compl. ¶¶ 21-22 (*quoting* regulations and Manual provisions containing the criteria for skilled therapy). The applicable regulations define skilled services and identify the criteria for skilled therapy. 42 C.F.R. § 409.31(a) defines skilled services as services which, *inter alia*, "[r]equire the skills of technical or professional personnel such as" physical, speech, and occupational therapists. The regulations at 41 C.F.R. § 409.33 explain which types of exercises that would and would not constitute skilled therapy (*e.g.*, exercises that are routine in nature do not constitute skilled therapy under ordinary circumstances). The Medicare Benefit Policy Manual provides further detailed information regarding skilled services, and includes guidance on therapy topics such as assessment, therapeutic exercises, gait training, range of motion, ultrasound, hot-packs and other modalities, and a listing of types of services considered unskilled. Medicare Benefit Policy Manual, ch. 8, Sec. 30.4.1.2; 30.5.[4] Taken together, the Medicare regulations and Manual provide sufficient guidance for distinguishing between skilled and unskilled therapy. While Life Care argues that its therapists were "confused" by the regulations, Mem. at 18, whether and how Life Care employees were in fact "confused" by the Medicare regulations, and whether their purported confusion actually affected their provision of rehabilitation therapy, is a matter for the finder of fact.

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[4] The Manual can be found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c08.pdf.

Finally, Life Care appears to repeatedly advance the curious argument that Medicare regulations actually *require* skilled nursing facilities to maximize the amount of therapy provided to each patient to the highest possible RUG level. Mem. at 4, 10, 14, 15 n.6, 41 (*citing* 42 C.F.R. § 483.25). The regulation Life Care cites, however, merely requires nursing facilities to "provide the *necessary* care and services to attain or maintain the highest *practicable* physical, mental, and psychological well-being" of each patient. *Id.* (emphasis added). Thus, the regulation does nothing more than mirror the Medicare statute's requirements that services be "necessary." 42 U.S.C. § 1395y(a)(1)(A) (services must be "reasonably and necessary for . . . treatment"). The Complaint alleges that Life Care foisted therapy on patients who did not need that level of therapy. To the extent Life Care is arguing that its therapists were in fact confused by this regulation, that is again a factual matter that cannot be raised on a motion to dismiss.

C. The *Jimmo* settlement has no effect on this action and is unrelated to the allegations in the Complaint.

Life Care also seeks dismissal of this action based on the settlement in *Jimmo v. Sebelius*, Case No. 5:11-cv-17-CR (D. Vt.)—allegations that the Government denied and settled without any admission of liability. *See Jimmo* Answer, Doc. 58; Settlement Agreement, Doc. 82-1, at 29. *Jimmo* was a class-action involving plaintiffs who alleged that Medicare contractors improperly applied an "improvement standard" to claims for skilled rehab therapy. *See Jimmo* Am. Compl. (Doc. 13).

Taking a cue from the *Jimmo* plaintiffs, Life Care argues that the Complaint here applies the same alleged "improvement standard" to measure falsity. Mem. at 10, 17. Contrary to Life Care's assertions, the Complaint does not apply an "improvement standard," but rather seeks damages for claims submitted in violation of the same regulations that the *Jimmo* plaintiffs acknowledged were both clear and appropriate as written.

Although Life Care's Memorandum includes an extensive (but factually incorrect) discussion of *Jimmo*, Life Care cites only a single example from the Complaint that it contends is inconsistent with the *Jimmo* settlement. Mem. at 10. Specifically, Life Care takes issue with paragraph 135, wherein the Complaint asserts: "Life Care therapists provided and billed Medicare for therapy that was excessive in frequency, duration, or intensity for beneficiaries who could not be reasonably expected to ***benefit*** from ***skilled*** therapy." (emphasis added). (Life Care also cites two patients the Complaint includes as representative of patients that could not benefit from skilled therapy. Mem. at 10-11 (*citing* Compl. ¶ ¶ 136, 140)). The paragraph simply does not allege, as Life Care would have the Court believe, that the United States is applying an improvement standard that was supposedly eliminated by the settlement in *Jimmo*. First, in this context, "benefit" is not the same as "improvement"; under Medicare regulations, a patient could benefit from skilled therapy that prevents or slows a deterioration in the patient's current condition. The Complaint asserts that Life Care knowingly provided and billed for therapy that did not even benefit patients, because its therapy goals were based on corporate standards designed to meet billing targets and not based on a patient's actual needs. Second, the Complaint's allegations relate to *skilled* therapy, and not all therapeutic exercises intended to maintain a patient's current condition are billable as skilled therapy. As Life Care's own Memorandum explains, with a few exceptions, "the actual carrying out of maintenance programs (*e.g.*, general supervision of exercise and repetitive exercises), are generally considered unskilled . . . ." Mem. at 17 (paraphrasing 42 C.F.R. § 409.33(d)(13)). Thus, while repetitive exercises may in fact benefit a patient, general supervision of those exercises is not considered a skilled service and is not billable as skilled therapy.

The Memorandum further attempts to shoehorn *Jimmo*'s unproven allegations regarding how certain Medicare contractors applied skilled nursing facility regulations into claims that the regulations were so confusing that Life Care could not, under any circumstances, knowingly violate them. The allegations in *Jimmo* were about how Medicare's *contractors*, including lower-level adjudicators, did not follow *clear* regulations, and the *Jimmo* complaint never alleged that therapists or healthcare providers were "confused" by those regulations. To the contrary, the *Jimmo* plaintiffs expressly stated, "[t]he relevant [SNF regulation] makes it clear that the Improvement Standard does not determine coverage[,]" *Jimmo* Am. Compl. ¶ 31, that "the problem is not with the regulations[,]" *Jimmo* Pl. Opp. to Mtn. to Dismiss, Doc. 32, at 1, that the plaintiffs "are not asking for changes in the Medicare program," *id.* at 16, and that the SNF regulations "are good regulations." *Id.* at 27. The *Jimmo* Complaint also avers that "[m]any of CMS' manual provisions support and reinforce the regulatory prohibition against an Improvement Standard as a condition of coverage." Am. Compl. ¶ 34. Indeed, the *Jimmo* settlement nowhere admits or acknowledges that the regulations or other guidance were confusing, nor does the court's ruling in *Jimmo* on the motion to dismiss constitute a judgment regarding the truthfulness of the allegations.

In fact, Life Care does not argue that its therapists were actually confused. Even had there been "confusion," Life Care does not explain what the effect of such purported confusion would be. For example, if Life Care therapists thought that they were required to discharge patients who were not improving, then presumably they would have provided *less* therapy—exactly the opposite of the allegations in the Complaint. Regardless, any actual confusion would raise factual questions appropriate for trial but not for a motion to dismiss.

D. The Complaint sufficiently alleges that Life Care caused the making and use of false statements material to false and fraudulent claims.

The Complaint sufficiently alleges that Life Care caused the making or use of false statements material to the false claims for skilled therapy services, in violation of 31 U.S.C. § 3729(a)(1)(B). The Complaint alleges that Life Care submitted Minimum Data Set (MDS) forms that included minutes for medically excessive, unnecessary, and unreasonable therapy. Compl. ¶¶ 63-64, 160, Exh. 2. The MDS is material to the falsity of the claims: the therapy minutes on the MDS form determine the RUG level for a patient, and, therefore, the amount of money requested by Life Care when submitting its electronic claim for payment. Compl. ¶¶ 35-41. Medicare regulations specifically provide that completion of the MDS is a prerequisite to Medicare payment. Compl. ¶ 40 (*citing* 63 Fed. Reg. at 26,265). Further, providers submitting the MDS must certify that the information "was collected in accordance with applicable Medicare and Medicaid requirements." *Id.* By knowingly submitting MDS forms that included non-billable minutes, Life Care made, used, or caused to be made or used false statements material to false or fraudulent claims.

Life Care responds to these allegations by focusing on the word "collected" in the certification, arguing that the Complaint does not allege that the minutes were "collected" improperly. Mem. at 22. Life Care's argument is misguided for two reasons. First, because the therapy minutes on the MDS determine the amount of payment, the MDS is "material" to the falsity of the claim regardless of the provider certification. Second, with respect to the certification, Life Care appears to argue that it is entitled to knowingly include as many non-billable, artificially inflated therapy minutes as it likes, so long as they "collected" those inflated minutes appropriately. This argument is not only facially absurd, but contradicted by the certification statement itself, which makes clear that such minutes are used as a basis for billing

and therefore must, in fact, be properly billable: "I understand that this information is used . . . as a basis for payment from federal funds." Compl. ¶ 40 (*quoting* MDS certification). Life Care's contrary argument—that providers are allowed to include false and fraudulent minutes on the MDS—must therefore be rejected.

III. The Complaint meets the standards of Rules 8(a)(2) and 9(b).

The purpose of Rule 9(b) "is not to reintroduce formalities to pleading, but is instead to provide defendants with a more specific form of notice as to the particulars of their alleged misconduct." *United States ex rel. Bledsoe v. Cmty. Health Sys.*, 501 F.3d 493, 503 (6th Cir. 2007) (*Bledsoe II*). Thus, Rule 9(b) must be interpreted in harmony with Rule 8, which requires that a complaint provide "a short and plain statement of the claim" made by "simple, concise, and direct allegations." *Id.* (*quoting* Fed. R. Civ. P. 8(a)). "Rule 9(b) must not be read to abrogate Rule 8 [] and a court considering a motion to dismiss for failure to plead fraud with particularity should always be careful to harmonize the directives of rule 9(b) with the broader policy of notice pleading." *Friedlander v. Nims*, 755 F.2d 813 n.3 (11th Cir. 1985) (citations omitted). *See also Michaels Bldg. Co. v. Ameritrust Co., N.A.*, 848 F.2d 674, 679 (6th Cir. 1988) ("[T]he two must be read in harmony."). Under Rule 8, a complaint need not allege an exhaustive roadmap of a plaintiff's claims, but must be sufficient to "give the defendant fair notice of what the . . . claim is and the grounds upon which it rests." *Erickson v. Pardus*, 551 U.S. 89, 93 (2007) (*quoting Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555-56 (2007)). For purposes of Rule 8(a)(2), a claim has "facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S at 678. In other words, while Rule 9(b) adds particularity requirements for allegations of fraud or mistake, it should not be read to defeat the general policy

of "simplicity and flexibility" in pleadings contemplated by the Federal Civil Rules. *Michaels Bldg. Co. v. Ameritrust Co., N.A.*, 848 F.2d 674, 679 (6th Cir. 1988) (internal quotations and citations omitted).

A plaintiff satisfies the elements of Rule 9(b) in an FCA case by alleging "the time, place, and content of the alleged misrepresentation on which he or she relied; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud." *Bledsoe I*, 342 F.3d 634, 643 (6th Cir. 2003) (internal quotations and citations omitted).[5] *See also United States ex rel. Lane v. Murfreesboro Dermatology Clinic*, Case No. 4:07-cv-4, 2010 WL 1926131, at *5 (E.D. Tenn. May 12, 2010). "When Rule 9(b) applies to a complaint, a plaintiff is not expected to actually prove his allegations, and we defer to the properly pleaded allegations of the

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[5] *Bledsoe I* held that pleading these elements with particularity would satisfy Rule 9(b), but did not specifically hold that pleading all of these elements was required in an FCA case. *Bledsoe I*, 342 F.3d at 643. *Bledsoe I*'s recitation of these elements quotes a common law fraud case. *Id.* As numerous other courts have noted, however, the FCA is different from common law fraud in significant respects. First, it only requires that the defendant act "knowingly," which means, with respect to certain information, the defendant acts with actual knowledge of the information, in deliberate ignorance of the information's truth or falsity, or in reckless disregard of the information, and "no proof of specific intent to defraud is required." 31 U.S.C. § 3729(b)(1). Second, the FCA subjects defendants to liability for presenting, or causing to be presented, false claims, without the additional element of reliance. *United States ex rel. Grubbs v. Ravikumar Kanneganti*, 565 F.3d 180, 189 (5th Cir. 2009) ("The False Claims Act, in contrast [to common law fraud], lacks the elements of reliance and damages."); *San Francisco Bay Area Rapid Transit Dist. v. Spencer*, Case No. 04-04632, 2006 U.S. Dist. Lexis 88022, at *49-50 (N.D. Cal. Dec. 5, 2006) ("[U]nlike a RICO or fraud claim, a false claims action does not require a showing of actual reliance, but only that the falsity 'has a natural tendency' to influence action."). Lastly, because the FCA imposes a civil penalty for the submission of a false claim, *id.* § 3729(a)(1), it "exposes [defendants to liability for] even unsuccessful false claims . . . ." *Grubbs*, 565 F.3d at 189. *See also Hutchins v. Wilentz, Goldman & Spitzer*, 253 F.3d 176, 183 (3d Cir. 2001) ("[R]ecovery under the [FCA] is not dependent upon the government's sustaining monetary damages") (internal quotation and citation omitted); *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 785 n.7 (4th Cir. 1999) ("[T]here is no requirement that the government have suffered damage as a result of the fraud"); *United States v. Killough*, 848 F.2d 1523, 1533 (11th Cir. 1988) (defendant can be liable for FCA's civil penalties "[e]ven [when] the government cannot prove actual damages");*United States ex rel. Taylor v. Gabelli*, 345 F. Supp. 2d 313, 327-28 (S.D.N.Y. 2004) ("[T]he weight of authority suggests that there is no damages element" under the FCA).

complaint." *United States ex rel. Clausen v. Lab. Corp. of Am.*, 290 F.3d 1301, 1313 (11th Cir. 2002). *See also United States ex rel. Grubbs v. Ravikumar Kanneganti*, 565 F.3d 180, 189 (5th Cir. 2009) ("[S]urely [Rule 9(b)] ought not to be read to insist that a plaintiff plead the level of detail required to prevail at trial."). The purpose of Rule 9(b) is to "prevent spurious charges and provide notice to defendants of their alleged misconduct, not to require plaintiffs to meet a summary judgment standard before proceeding to discovery." *United States ex rel. Longest v. Dyncorp Int'l, LLC*, Case No. 6:03-cv-816, 2006 U.S. Dist. Lexis 1838, at *14 (M.D. Fla. Jan. 9, 2006). *See also Sanderson v. HCA-The Healthcare Co.*, 447 F.3d 873, 877 (6th Cir. 2006) (purpose of Rule 9(b) is to protect defendants against "spurious charges") (*quoting Clausen*, 290 F.3d at 1310). Moreover, "where the fraud allegedly was complex and occurred over a period of time, the requirements of Rule 9(b) are less stringently applied." *Bledsoe II*, 501 F.3d at 510 (internal quotations and citations omitted).

As discussed below, the Complaint asserts plausible allegations that lay out in detail the time, place, and content of the alleged misrepresentations, the fraudulent scheme, the fraudulent intent of the defendant, and the injury to the United States, *Bledsoe I*, 343 F.3d at 643, providing the Defendant adequate notice of its alleged misconduct and "allow[ing] the court to draw the reasonable inference that the defendant is liable[,]" *Iqbal*, 556 U.S. at 678, under the FCA. As such, the Complaint satisfies Rules 8(a)(2) and 9(b). Indeed, the numerous details set forth in the Complaint are more than "enough to raise a right to relief above the speculative level on the assumption that all the allegations in the complaint are true." *Ass'n of Cleveland Fire Fighters v. City of Cleveland, Ohio*, 502 F.3d 545, 548 (6th Cir. 2007) (*citing Twombly*, 550 U.S. at 555). As Life Care has not challenged the sufficiency of the Government's allegations with respect to

fraudulent intent or injury (even if required in an FCA case), these elements will not be addressed in this Opposition.[6]

A. The Complaint alleges the false content of the claims with particularity.

The Complaint adequately sets forth the false content of the claims. The Complaint alleges that Life Care engaged in a nationwide scheme to pressure therapists into submitting claims for rehab therapy that included medically unnecessary and unskilled minutes. *E.g.* Compl. at ¶ 3 (Life Care "engaged in a systematic scheme" and set "Ultra High-related targets that were completely unrelated to its beneficiaries' actual conditions, diagnoses, or needs."); ¶ 4 ("Life Care therapists routinely provided generic . . . services that did not (and could not) benefit" patients). Life Care instructed therapists to provide therapy based upon billing targets rather than patients' medical needs. *E.g.* Compl. ¶ 76 ("All [Life Care Center] residents to receive 2+ hrs of therapy per day."); ¶ 93 ("Advised [manager] to continue to focus energies towards setting minutes to achieve RU . . . ."); ¶ 114 (memorandum instructed therapy staff: "do not change (decrease) the minutes . . . . The minutes have been planned to meet a certain RUG category by a certain date."). The Complaint also explains how therapists provided non-beneficial or unskilled therapy to meet these artificial billing targets. *E.g.* Compl. ¶ 74 (encouraging therapists to tack on 15 minutes each day); ¶¶ 117-118 (continuously approaching patients for more therapy); ¶¶ 144-147 (using modalities to increase therapy minutes); ¶¶ 150-151 (group therapy); ¶¶ 155-158 (unskilled services). Accordingly, because the claims for

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[6] Although the Defendant does not challenge these elements, the Complaint sufficiently pleads the fraudulent intent and injury. The Complaint contains extensive allegations detailing the numerous complaints made to Life Care regarding medically unnecessary therapy. Compl. ¶¶ 161-183. The Complaint also adequately pleads the injury to the Government, by alleging that the unnecessary therapy caused Medicare and TRICARE to pay more for the claims than they would have paid for nonfraudulent claims. *E.g.* Compl. ¶¶ 5, 33 (explaining increase in Ultra High claims and the amount of payment associated with those claims).

payment and MDS forms included therapy minutes that were not medically necessary or were not skilled, they were "false" under the FCA. *See Mikes* , 274 F.3d at 700-701 (claims for medically unnecessary health care services are "false claims" within the FCA).

The Complaint also describes 21 specific false claims for ten different patients. Compl. Exh. 1. The Complaint includes the claim number, the date of the claim, the Life Care facility, and the RUG level. *Id.* For each of these patients, the Complaint also lists the false information on the MDS form, specifically the number of therapy minutes listed on the MDS. Exh. 2. The Complaint explains *why* the minutes included on the claims and MDS forms are false. Compl. ¶¶ 135-140, 142-143, 147, 149, 151, 157 (setting forth the factual basis for the allegations of medically unnecessary and/or unskilled therapy provided to the sample patients). For example, the Complaint describes how Medicare was billed for a patient's "repetitive arm exercises and transfers that were not tailored to Patient B's conditions or needs and did not require the unique skills of a therapist." Compl. ¶ 137. The Complaint lists how Life Care billed for therapy for another patient on a day when that patient, according to the therapist's notes, was "unable to participate successfully in treatment." Compl. ¶ 138. The Complaint also describes how Life Care billed Medicare for skilled therapy for a patient who performed the same routine exercises every day, including when nursing staff—rather than therapy staff—assisted the patient with those same types of exercises. Compl. ¶ 157.

Accordingly, Life Care's argument—that the Complaint's allegations regarding the content of the false claims are "conclusory"—is spurious. Mem. at 24. Life Care essentially argues, without any supporting case law, that the United States is required to include the equivalent of an expert report as part of its complaint. *E.g.* Mem. at 24-25 (suggesting that complaints must include the "medical qualifications" of the individuals the plaintiff uses in

formulating its complaint in order to pass muster under Rule 9(b)). Yet, all that is necessary at this stage is enough information to "allow the court to draw the reasonable inference that the defendant is liable" under the FCA. *Iqbal*, 556 U.S. at 678. These detailed allegations are more than sufficient to meet the notice requirements of Rule 8(a)(2) and 9(b). Requiring more at this early stage of the case would transform pleading requirements into a requirement that the plaintiff prove the allegations in the complaint. *Clausen*, 290 F.3d at 1313 ("When Rule 9(b) applies to a complaint, a plaintiff is not expected to actually prove his allegations, and we defer to the properly pleaded allegations of the complaint.").

B. The Complaint sets forth the fraudulent scheme with particularity.

The Complaint pleads in great detail numerous Life Care business practices that caused the submission of false claims, and provides specific examples of those practices. Accordingly, the Complaint meets the particularity standards as set forth by this Court and the Sixth Circuit. As this Court has explained, because "pleading every instance of fraud would be extremely ungainly, if not impossible . . . where [the plaintiff] pleads a complex and far reaching fraudulent scheme with particularity, the [plaintiff] will survive a motion to dismiss where he or she provides examples of specific false claims submitted to the government pursuant to that scheme, [and therefore] a [plaintiff] may proceed to discovery on the entire fraudulent scheme." *United States ex rel. Lane v. Murfreesboro Dermatology Clinic, PLC*, Case No. 4:07-cv-4, Doc. 157 at 4 (E.D. Tenn. Mar. 20, 2012)[7] (*quoting Bledsoe II*, 501 F.3d at 509, 510) (internal quotations and citations omitted).

Courts confronted with similar cases have found that a complaint meets the requirements of Rule 9(b) where it provides examples of business practices that could lead to pressure on staff

[7] The opinion is not available through Westlaw or Lexis, but can be accessed by the Court and all parties through PACER.

to provide medically unnecessary care. In *Hospice Care*, 2010 U.S. Dist. Lexis 129484 (D. Kan. Dec. 7, 2010), discussed previously, the court held that the government's complaint met the requirements of Rule 9(b) where it alleged "business practices that allegedly caused the false submissions." *Id.* at *19. As with the case here, the *Hospice Care* court explained that the complaint adequately pled allegations that the defendant "pressured employees to [provide hospice care to unqualified patients,] and disregarded concerns from consultants and employees that their practices created a risk of approving patients who were ineligible for hospice care." *Id.* at *16.

In *Hospice Care*, the court found that the complaint sufficiently set forth the fraudulent scheme where the complaint "clearly sets out the scheme plaintiffs allege defendants used to submit hospice claims for ineligible plaintiffs," by providing "detailed information regarding how defendants used their business practices to allegedly violate the FCA." *Id.* at *19; *see also Strom ex rel. United States v. Scios, Inc.*, 676 F. Supp. 2d 884, 891 (N.D. Cal. 2009) (finding sufficient particularity where complaint alleged how defendant's "marketing activities" caused the submission of false claims).

The Complaint identifies Life Care business practices that caused its facilities to submit claims for medically unnecessary therapy, and provides specific examples and instances of these practices. The Complaint alleges Life Care accomplished the scheme by:

- Setting targets for Ultra High therapy and length of stay. Compl. ¶¶ 65-83.
    - The Complaint lists specific presentations with goals of 50% Ultra High, *id.* ¶ 67, and 70% Ultra High, *id.* ¶ 68, and that such goals were reinforced through correspondence and other means. *Id.* ¶¶ 73-88.

- The Complaint includes how specific individuals, such as Antoinette Meulke, instructed the rehab managers to increase their Ultra High billings by providing additional therapy for the sole purpose of increasing the Ultra High claims. *Id.* ¶¶ 73-74.

- Instructing and encouraging therapists to provide the Ultra High level of care to each patient, regardless of the patient's individual needs. *E.g. id.* ¶¶ 65-83.
  - The Complaint discusses presentations given in the Bluegrass region in March 2007, for example, and elsewhere demanding that therapists provide each patient with "2+ [hours] of therapy per day." *Id.* ¶¶ 76-77.
  - The Complaint references specific instances, including how the rehab manager at Life Care's Inverrary facility instructed her staff not to "change (decrease) the minutes that are planned . . . . The minutes have been planned to meet a certain RUG category by a certain date." *Id.* ¶ 114.
- Establishing a central, corporate committee to increase Ultra High billing at Life Care facilities.
  - The Complaint details Life Care's Rehab Opportunity Committee, sets forth the names of the individuals on the committee, and explains how the committee's "function was to identify those facilities that failed to meet Life Care's financial targets and to help them to increase their Ultra High billings." *Id.* ¶¶ 84-88.

- Requiring regional managers to visit facilities to demand increases in Ultra High therapy levels.
    - The Complaint discusses how Regional Rehab Directors visited facilities with the goal of increasing their Ultra High billings. *Id.* ¶¶ 92-97.
    - The Complaint cites specific facility visit reports, including ones where rehab directors "advised [rehab services manager] to continue to focus energies towards setting minutes to achieve RU level . . . ." *Id.* ¶ 93.
- Promoting programs intended primarily to increase therapy use to achieve pre-set Ultra High goals.
    - The Complaint sets forth specific divisional initiatives to increase therapy and lists the names of individuals involved in those efforts. For example, the Complaint discusses how in the Heartland Division, vice president Dick Odenthal established a "$400 club" to encourage high billing. *Id.* ¶ 100.
    - One former regional vice president complained that the club, according to his exit interview, "placed enormous stress on the [executive directors] to do whatever was necessary (but not always legal or ethical) to be members of this club." *Id.* ¶ 104. Life Care's senior vice president for rebab, Michael Reams, encouraged executive directors to join the club. *Id.* ¶ 101.
- Rewarding facilities that met Ultra High goals.
    - The Complaint lists examples of how Life Care rewarded facilities and divisions that met corporate targets, *id.* ¶¶ 121-127, including, for example, the Southeast Division in 2006, *id.* ¶ 122, and specific regions in 2007. *Id.* ¶ 123.

- Evaluating employees based upon their Ultra High billing.
    - The Complaint explains how Life Care evaluated its employees' job performance by their ability to increase Ultra High therapy levels, and cites to specific job performance evaluations. *Id.* ¶¶ 105-109.
    - The Complaint lists the specific job titles of employees evaluated in this manner: division rehab directors, regional rehab directors, facility rehab directors, and even the therapists themselves. *Id.* ¶¶ 106-109.

Life Care's primary argument with respect to this Rule 9(b) element is that the Complaint does not specifically link each practice to specific false claims. Mem. at 26-27. The Government, however, has no obligation to link an individual action, such as an email or presentation, to a specific claim. Rather, the United States is only required to prove that Life Care's conduct was a "substantial factor" that led to the submission of false Ultra High claims. *See, e.g., United States ex rel. Schmidt v. Zimmer, Inc.*, 386 F.3d 235, 244 (3d Cir. 2004) ("[A]ssuming that a jury were to conclude that [defendant's] marketing scheme was a substantial factor in bringing about . . . [false statements] and the [false claims] were a normal consequence of the situation created by that scheme," the defendant could be found liable under the FCA); *Franklin*, 147 F. Supp. 2d at 52 (applying substantial factor test); *United States ex rel. Freedman v. Suarez-Hoyos*, Case No. 8:04-cv-933, 2012 U.S. Dist. Lexis 135230, at *22-25 (M.D. Fla. Sep. 21, 2012) (discussing the use of the "substantial factor" test in FCA cases); *Hospice Care*, 2010 U.S. Dist. Lexis 129484 (holding that complaint met 9(b) where business practices caused false claims, even though specific claims were not linked to specific practices). The Complaint's detailed allegations concerning the pressure placed upon therapists is more than enough to

demonstrate that such conduct was a substantial factor in the submission of the false therapy claims.

Life Care's reliance on *United States v. Kernan Hosp.*, 880 F. Supp. 2d 676 (D. Md. 2012) is misplaced. Mem. at 26-27. Life Care selectively quotes the case to make the argument that a complaint must link specific instances of conduct with specific claims. The full quote, however, makes clear that the material defect in the *Kernan* complaint was that it failed to identify *any* false claims. As the *Kernan Hosp.* court explained:

> The Complaint alleges a complicated scheme . . . , but utterly fails to link this scheme with any claims actually submitted. At the July 12 hearing, after being asked what specific false claims were at issue, counsel for the Government proffered that the false claims were the cost reports submitted by Kernan to the HSCRC. However, ***the Complaint does not identify a single cost report submitted to the HSCRC***, nor does it even explain the circumstances under which such reports are submitted.

Id. 686-87 (emphasis added).

Unlike in *Kernan Hosp.*, the United States' Complaint alleges actual false claims and actual false statements. It explains in detail why those claims are false, how the inflated therapy minutes affect payment, and how the claims and statements are submitted or used in the billing process. *Kernan Hosp.* is therefore distinguishable.

Similarly, Life Care attempts to classify the *methods* by which Life Care encouraged therapists to bill for unnecessary therapy into separate "schemes," and then argues that the Complaint lacks sufficient particularity as to each "scheme." Mem. at 31-33. The argument misinterprets the Complaint, which alleges an overall scheme in which Life Care pressured its therapists to provide each patient with the Ultra High level of therapy, regardless of patient need.

The Complaint contains examples of *how* Life Care accomplished that scheme,[8] along with representative false claims and statements, which together is sufficient to provide notice to the Defendant of the allegations against it. *See United States ex rel. Schuhardt v. Wash. Univ.*, 228 F. Supp. 2d 1018, 1034 (E.D. Mo. 2002) ([P]laintiffs have identified specific amounts billed for specific patients as representative samples of the alleged fraudulent billing. The Court does not believe . . . that plaintiffs should be required to provide a specific allegation to substantiate each and every general allegation within the complaint."). Each method of accomplishing this scheme is not, therefore, a separate and discrete "scheme," as Life Care contends.

C. The Complaint specifies the *who* with reasonable particularity.

Although an FCA complaint must name the people or entity that committed the violations, where a complaint names a corporate defendant, it meets the requirements of Rule 9(b) by alleging that the corporate defendant committed the acts upon which FCA liability is predicated. "Where . . . the [plaintiff] has alleged that the corporation has committed the fraudulent acts, it is the identity of the corporation, not the identity of the natural person, that the [plaintiff] must necessarily plead with particularity." *Bledsoe II*, at 506 (refusing "defendant's invitation to engraft a new and formulistic pleading requirement onto the FCA."). While the identity of natural persons within the corporation may be "relevant to the inquiry of whether the relator has pled the circumstances constituting fraud with particularity[,]" it is not required. *Id.* Moreover, even in cases that have looked to whether the complaint listed natural persons within a corporation, the title of such persons is generally sufficient. *See Hospice Care*, 2010 U.S. Dist. Lexis 129484 at *18 (complaint met Rule 9(b) where it identifies the title of employees); *United*

[8] *E.g.*, Compl. ¶ 74 (encouraging therapists to tack on 15 minutes each day); *id.* ¶¶ 93, 114 (setting therapy minutes based on achieving pre-set billing level); *id.* ¶¶ 117-118 (continuously approaching patients for more therapy); *id.* ¶¶ 144-147 (using modalities to increase treatment); *id.* ¶¶ 150-151 (group therapy); *id.* ¶¶ 155-158 (unskilled services).

States ex rel. Drennen v. Fresenius Med. Care Holdings, Inc., Case No. 09-10179, 2012 U.S. Dist. Lexis 29136, at *5-6 (D. Mass. Mar. 6, 2012) (holding that complaint met Rule 9(b) even though it did not list the names of the employees who actually submitted the claims).

The Complaint meets the "who" requirement of Rule 9(b). It specifies that it is the Defendant, Life Care, that caused the submission of false claims to Medicare. *E.g.* Compl. ¶¶ 3-4. Moreover, as demonstrated from the summary of allegations, above, the Complaint goes further than *Bledsoe II* requires, by including allegations involving specific individuals, by both name and title. The Complaint includes allegations against Life Care corporate officers Cathy Murray, Michael Reams, and Antoinette Meulke, and identifies others by title, including divisional rehab directors, divisional vice presidents, and rehab service managers, among others. Life Care's argument, therefore, that the United States did not "identify anybody" involved in the conduct, Mem. at 30, is clearly false.

D. The Complaint sets forth *when* the conduct occurred with particularity.

To meet Rule 9(b)'s timeframe requirement, the complaint need only allege the "rough" time period of the conduct. *United States ex rel. Duxbury v. Ortho Biotech Prods.*, 579 F.3d 13, 30 (1st Cir. 2009). "When an underlying fraudulent activity is alleged to have occurred systematically and continuously over a period of time it is sufficient to allege a general time frame of the fraud in question." *United States v. NHC Healthcare Corp.*, 115 F. Supp. 2d 1149, 1151 (W.D. Mo. 2000). *See also United States ex rel. Tillson v. Lockheed Martin*, Case No. 5-cv-39, 2004 U.S. Dist. Lexis 22246, at *42 (W.D. Ky. Sep. 29, 2004) (complaint meets 9(b) where it includes "approximate dates" of conduct). As the court in *Hospice Care* explained, a complaint is sufficiently particular as to time where it "allege[s] the date, or series of dates, when specific business practices were in use; when communications took place; when claims were

submitted; and when the alleged violations occurred." *Hospice Care*, 2010 U.S. Dist. Lexis 129484 at *19.

The Complaint sets forth the time period of the conduct with particularity. The Complaint alleges generally that the conduct in question occurred during the time period of 2006 through the present. Compl. ¶ 3. The Complaint also includes numerous examples of presentations, facility visit reports, emails, awards, performance evaluations, and of other specific business practices, and includes the date or time period of these actions. *E.g.* ¶ 67 (2008 Rehab Opportunities presentation); ¶68 (2008 Division Goals presentation); ¶ 72 (July 2006 Rehab Key Indicators report); ¶ 73 (June 8, 2006 email from Antoinette Meulke); ¶ 76 (March 2007 Bluegrass Regional meeting); ¶ 77 (2008 presentation); ¶ 83 (May 2006 email); ¶ 85 (Rehab Opportunity Committee established in 2005); ¶ 89 (July 2006 action plan); ¶ 93 (June 2007 facility visit summary); ¶ 95 (December 13, 2006 visit summary); ¶ 97 (May 27, 2005 visit summary); ¶ 101 (March 23, 2006 email); ¶ 114 (April 2007 memorandum). Finally, the Complaint lists the dates for ten representative claims, Exh. 1, and the assessment reference date on the MDS forms associated with each such claim. Exh. 2. Thus, the Complaint sets forth the time period with particularity.

E. The Complaint identifies the *locations* with particularity.

The Complaint sufficiently identifies the locations where the conduct occurred. Although it does not list every location, "allegations of specific claims in one state or region satisfy Rule 9(b) requirements by establishing a nationwide inference of fraud." *United States ex rel. Spay v. CVS Caremark*, Case No. 09-4672, 2012 U.S. Dist. Lexis 180602, at *134 (E.D. Pa. Dec. 20, 2012) (denying motion to dismiss on Rule 9(b) grounds where complaint "outline[s] numerous precise examples of Defendants' alleged fraud . . . . [and] then goes on to assert that these

allegedly improper practices . . . have been performed on a nationwide basis." *Id.* at *138). *See also Fresenius*, 2012 U.S. Dist. Lexis 29136, at *5-6 (where plaintiff identified the locations of the claims submission, and alleged that "by reason of [defendant's] national billing practices, this billing likely occurred at [defendant's] other facilities throughout the country[,]" the plaintiff met Rule 9(b)); *Duxbury*, 579 F.3d at 31 (where plaintiff "has alleged facts that false claims were in fact filed by the medical providers [plaintiff] identified, [these allegations] further support[] a strong inference that such claims were also filed nationwide."); *Hospice Care*, 2010 U.S. Dist. Lexis 129484 at *19 (holding complaint meets Rule 9(b) because, "although the specific branch is not always identified, defendants can determine the location by identifying the employee or patient involved in the specific events laid out in the Complaint.").

The Complaint meets Rule 9(b)'s location requirement by providing specific examples of locations where the conduct occurred and the facilities for which false claims were presented and false statements were made, and by providing significant factual support for the nationwide allegations. The Complaint alleges that the pressure to bill at Ultra High levels emanated from Life Care's headquarters in Cleveland, Tennessee, Compl. ¶ 12, and discusses the participation in the scheme of Life Care employees who worked there. *E.g.* Compl. ¶¶ 73, 86, 101. The Complaint also establishes that Life Care engaged in this conduct on a nationwide basis. *E.g.* Compl. ¶¶ 3, 65-70 (Ultra High targets), ¶¶ 73-75 (direction from corporate officer to increase therapy minutes), ¶¶ 84-91 (corporate Rehab Opportunity Committee); *see also* summary of fraudulent scheme, at 21-24, *supra*. As Life Care's own Memorandum concedes, at 30, the Complaint also references a number of facilities where FCA violations occurred, *e.g.*, Compl. ¶ 83 (Kansas), ¶ 89 (Denver, Colorado); ¶ 93 (Las Vegas, Nevada); ¶ 94 (Twin Falls, Idaho),

¶ 95 (Lauderhill, Florida); ¶ 97 (Elyria, Ohio); ¶ 116 (Collegedale, Tennessee), as well as specific divisions. *E.g. id.* ¶ 68 (Southeast Division); ¶ 76 (Bluegrass Region); ¶ 99 (Heartland Division). Finally, the Complaint also includes the name of the facility for representative false claims and false statements, Compl. Exhs. 1-2, as well as the location where Life Care submitted its claims for payment. *Id.* ¶ 44 (Tennessee). Accordingly, the Complaint adequately alleges a nationwide scheme, supported by particular business practices, and specific examples of locations where the conduct occurred and where false claims were submitted.

Life Care relies on *Corsello v. Lincare, Inc.*, 428 F.3d 1008, 1013 (11th Cir. 2005) for its argument that a complaint cannot allege a nationwide scheme and also meet Rule 9(b). Mem. at 31. The complaint at issue in *Corsello*, however, contained none of the elements required to meet Rule 9(b), and failed to identify any false claims. *Corsello*, 428 F.3d at 1013. Corsello's complaint did not include any "indicia of reliability," and his allegations were mostly made "'on information and belief' . . . and failed to provide an underlying basis for [his] assertions." *Id.* at 1013-14. *Corsello*, therefore, is distinguishable.

F. The Complaint provides representative examples of specific patients, specific false claims, and specific false statements.

While a complaint must allege at least some actual false claims, the Sixth Circuit has expressly rejected the argument that the plaintiff in a FCA case must list every false claim at issue. *Bledsoe II*, 501 F.3d at 510. As this Court has explained, ""pleading every instance of fraud would be extremely ungainly, if not impossible . . . where [the plaintiff] pleads a complex and far reaching fraudulent scheme with particularity, the [plaintiff] will survive a motion to dismiss where he or she provides examples of specific false claims submitted to the government pursuant to that scheme, [and therefore] a [plaintiff] may proceed to discovery on the entire fraudulent scheme." *United States ex rel. Lane v. Murfreesboro Dermatology Clinic, PLC*, Case

No. 4:07-cv-4, Doc. 157 at 4 (E.D. Tenn. Mar. 20, 2012) (*quoting Bledsoe II*, 501 F.3d at 509, 510) (internal quotations and citations omitted).

Accordingly, a plaintiff need only provide "representative samples of the broader class of claims" at issue in the complaint. *Bledsoe II*, 501 F.3d at 510. In doing so, however, the complaint need not set forth specific claims for every facility or region, for "allegations of specific claims in one state or region satisfy Rule 9(b) requirements by establishing a nationwide inference of fraud." *CVS Caremark*, 2012 U.S. Dist. Lexis 180602 at *134; *see also United States ex rel. Schuhardt v. Wash. Univ.*, 228 F. Supp. 2d at 1034 ([P]laintiffs have identified specific amounts billed for specific patients as representative samples of the alleged fraudulent billing. The Court does not believe . . . that plaintiffs should be required to provide a specific allegation to substantiate each and every general allegation within the complaint."). The standard for pleading representative samples is not high, and courts have found that alleging even one claim with particularity satisfies Rule 9(b). *See, e.g., United States ex rel. Daugherty v. Bostwick Labs.*, Case No. 1:08-cv-354, 2012 U.S. Dist. Lexis 178641 (S.D. Ohio Dec. 18, 2012) (complaint alleging one example of fraudulent scheme sufficient); *United States v. Villaspring Health Care Ctr.*, Case No. 3:11-cv-43, 2011 U.S. Dist. Lexis 145534, at *12 (E.D. Ky. Dec. 19, 2011) (five examples); *United States ex rel. Sharp v. E. Okla Orthopedic Ctr.*, Case No. 05-cv-572, 2009 U.S. Dist. Lexis 15988, at *53 (N.D. Okla. Feb. 27, 2009) (14 examples).

The Complaint satisfies these requirements. The Complaint lists 21 false claims, for ten specific patients, from ten different facilities. Compl. ¶ 159; Exh. 1. The Complaint also includes the claim number and the date of the claim. For each of these patients, the Complaint lists the false information on the MDS form, the date of the MDS, and the number of therapy minutes listed on the MDS. Compl. ¶ 160; Exh. 2. Each of these claims are within the time

period covered by the Complaint, and include allegations that the patients were provided unnecessary therapy and/or therapy that was not skilled, which is the basis for the alleged fraudulent scheme. The Complaint also explains the factual basis underlying the allegations regarding the sample claims. Compl. ¶¶ 135-157. Accordingly, the samples are representative, thereby satisfying the final element of Rule 9(b).

IV. The Government did not violate the FCA's procedures and dismissal is not warranted.

The Sixth Circuit has noted that the dismissal of a complaint is "a particularly severe sanction and is usually justified only in circumstances of bad faith or other like action." *Arch. Ins. Co. v. Broan-Nutone, LLC*, Case No. 11-6221, 2012 U.S. App. Lexis 26464, at *10 (6th Cir. Dec. 21, 2012) (internal quotations and citations omitted); *cf. Schafer v. City of Defiance Police Dep't*, 529 F.3d 731, 736-37 (6th Cir. 2008) (noting that the sanction of "dismissal of a claim for failure to prosecute is a harsh sanction which the court should order only in extreme situations showing a clear record of contumacious conduct by the plaintiff.") (internal quotations omitted). Here, Life Care seeks the dismissal of this case based on the length of time in which the *Taylor* and *Martin* cases remained under seal. Neither the facts nor the law support the imposition of such a "severe sanction" in this case.

As a factual matter, the United States adhered to the procedural requirements set forth in the FCA. In March 2012, *United States ex rel. Taylor v. Life Care Centers of America, et al.*, Case No. 1:12-cv-64 (*"Taylor"*), was transferred from the U.S. District Court for the Southern District of Florida to this Court, and the cases were later consolidated. (Doc. 67.) Before the case was transferred, the Florida court granted extensions of the seal deadline upon a finding of good cause. (*Taylor*, Docs. 1-1 at 15-16, 41-42, 54, 73.) On August 23, 2010, more than four

months before the expiration of the seal deadline, the Florida court *sua sponte* "administratively closed" the case "pending the Government's decision to intervene." (*Id.* at 11.)

Similarly, this Court granted several extension requests of the seal deadline in *United States ex rel. Martin v. Life Care Centers of America*, Case No. 1:08-cv-251 ("*Martin*") prior to its consolidation with *Taylor*. (Docs. 6, 11, 27, 32.) In granting one such extension on August 30, 2010, the Court ordered the Government to submit status reports every six months until the Government had made its intervention decision. (Doc. 27.) In addition, on January 13, 2011, the Court ordered the seal deadline extended indefinitely, administratively closed the case "for statistical purposes," and required the Government to continue providing status reports every six months. (Doc. 32.) The Government consistently complied with the Court's orders. (*See* Docs. 28, 36, 46.)

Life Care now urges dismissal of this action apparently because the Government did not seek additional extensions of the seal deadline in *Taylor* after the Florida court *sua sponte* administratively closed the case "pending the Government's decision to intervene," (*Taylor*, Doc. 1-1 at 11), or in *Martin* after the Court extended the seal deadline indefinitely and administratively closed the case. (Doc. 32). As the procedural history described above shows, however, the Government consistently followed the FCA's procedures and the orders of this Court and the Southern District of Florida. The Government sought and received extensions of the seal deadline as contemplated by the FCA. In each extension request or status update, the Government candidly described its investigation and the reasons it believed "good cause" existed for extending the seal and intervention deadlines. Given the administrative closing of the *Taylor* and *Martin* cases, the government was not required to continue seeking seal extensions and therefore no FCA procedures were breached. Yet, even after the Court administratively closed

the *Martin* case, the United States continued to provide the Court with status updates every six months. Docs. 28, 36, 46.

Nor do the cases cited by Life Care support the dismissal of the United States' Complaint. In *United States ex rel. Summers v. LHC Group, Inc.*, 623 F.3d 287, 292-93 (6th Cir. 2010), the case principally relied on by Life Care in favor of dismissal, the relator did not comply with the FCA's requirement that a *qui tam* complaint be filed under seal. *Id.* at 289. The court, recognizing that the primary purpose of the seal requirement "is to permit the Government sufficient time in which it may ascertain the status quo and come to a decision as to whether it will intervene in the case," held that the violation of the FCA's seal requirement by the relator was cause for dismissal because it was a precondition to a relator's "right to bring suit in the name of the Government." *Id.* at 292, 298.[9]

Summers and the other cases cited by Life Care are distinguishable from this case. First, for the reasons stated above, the Government did not violate the seal provisions of the FCA. While this Court has criticized the Government for, among other things, keeping this matter under seal for as long as it did, the Government nonetheless followed the FCA's procedural requirements and followed all court orders throughout its investigation. Second, while the United States certainly must follow the FCA's seal procedures, the cases cited by Life Care do not mandate the dismissal of (or arbitrary limitation of) an FCA lawsuit even assuming *arguendo*

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[9] The other cases cited by Life Care also involved a relator's breach of the FCA's seal requirement, and in those cases the courts determined that the relator's failure to adhere to the seal requirements prevented the Government from conducting its investigation, and therefore so frustrated the purposes of the FCA that dismissal of the relator's complaint was appropriate. *United States ex rel. Pilon v. Martin Marietta Corp.*, 60 F.3d 995, 996, 1000 (2d Cir. 1995); *United States ex rel. Le Blanc v. ITT Indus., Inc.*, 492 F. Supp. 2d 303, 304 (S.D.N.Y. 2007); *United States ex rel. Erickson v. Am. Inst. of Biologic Sci.*, 716 F. Supp. 908, 910-12 (E.D. Va. 1989) (finding also that the FCA's seal requirement was a precondition to a *qui tam* relator bringing suit on behalf of the Government).

there were an alleged breach of the seal procedures by the Government. Given that the primary purpose of the seal is to permit the Government to investigate *qui tam* allegations, *Summers*, 623 F.3d at 292, dismissal would be a particularly "harsh sanction" in a case like this one where the Government investigated the *qui tam* allegations, intervened in the *qui tam* action, and filed suit.

V. The Complaint adequately pleads the Government's common law claims of unjust enrichment, payment by mistake, and conversion.

A. Unjust Enrichment

Life Care first argues that unjust enrichment is not a stand-alone claim for relief. Mem. at 41. The case cited by Life Care to support this proposition indicates only that the issue of whether a stand-alone claim for unjust enrichment is recognized under federal common law is "subject to debate." *United States v. Houston*, Case No. 2:09-91, 2011 U.S. Dist. Lexis 118962, at *16 n.3 (M.D. Tenn. Oct. 14, 2011). The U.S. Court of Appeals for the Sixth Circuit, however, has expressly recognized claims for unjust enrichment. *See United States v. Goforth*, 465 F.3d 730, 733 (6th Cir. 2006) (identifying the elements of a claim for unjust enrichment under Tennessee law); *United States ex rel. Banton v. UT Med. Group, Inc.*, Case No. 2:03-cv-2740, at 27-28 n.9 (W.D. Tenn. Jan. 27, 2010) (Exh. 1) (using Tennessee law to identify the federal common law elements for an unjust enrichment claim). Accordingly, this argument does not warrant dismissal of the Government's claim for unjust enrichment.

The elements of a claim for unjust enrichment are: "(1) a benefit conferred upon the defendant by the plaintiff; (2) appreciation by the defendant of such benefit; and (3) acceptance by the defendant of such benefit under such circumstances that it would be inequitable for [the defendant] to retain the benefit without payment of the value thereof." *Goforth*, 465 F.3d at 733-34 (citation omitted). Life Care appears to challenge only the third element by regurgitating its arguments in favor of dismissal of the Government's FCA claims. For the reasons stated in

section II above, Life Care misconstrues the Government's allegations and none of these arguments support dismissal of the claim for unjust enrichment. Instead, it would be inequitable for Life Care to retain money it received for unreasonable, unnecessary, and unskilled services, and the Complaint sufficiently pleads a claim for unjust enrichment.

B. Payment by Mistake

Life Care argues that the Government's claim for payment by mistake should be dismissed because the Complaint does not allege that the Government was mistaken about any fact. *See Banton*, Case No. 2:03-2740, Exh. 1 at 28 (identifying elements of payment by mistake as "(1) a payment made (2) through a mistake of fact"). Again, Life Care erroneously argues that determinations of medical necessity and skilled therapy services are entirely subjective and thus do not constitute "facts." Mem. at 42. For the reasons stated in section II above, the Complaint adequately pleads a claim for payment by mistake by alleging that Life Care misrepresented that it was billing government health care programs only for services that were medically reasonable, necessary, and skilled.

C. Conversion

Life Care also argues for dismissal of the Government's claim for conversion because the Complaint does not allege who exercises control over the money paid by the Government for the unreasonable, unnecessary, and unskilled services billed by Life Care. Mem. at 42 (*citing Houston*, 2011 U.S. Dist. Lexis 118962, at *18 ("Conversion involves an act of control or dominion over the property that seriously interferes with the owner's rights.") (quotation omitted)). However, paragraph twelve of the Complaint expressly indicates that the Government paid funds to Life Care and its facilities. Compl. ¶ 12. Whether those funds were later diverted to other entities that Life Care does not control will be determined during discovery. For

purposes of the present motion, however, the Complaint's allegations adequately state a claim for conversion.

Finally, Life Care again argues that the Complaint does not allege that the Government is entitled to any funds in Life Care's possession because the Complaint does not adequately allege that Life Care provided unreasonable, unnecessary, and unskilled therapy. For the reasons stated above in section II, Life Care's argument is meritless, and the Complaint sufficiently pleads a claim for conversion against Life Care.

CONCLUSION

For the foregoing reasons, the Defendant's Motion to Dismiss should be denied.

Dated: March 22, 2013

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 22, 2013 I caused a true and correct copy of the foregoing United States' Memorandum in Opposition to Defendant's Motion to Dismiss to be filed with the Court's CM/ECF system, which will send an electronic notice of filing to all counsel of record.

s/ Jonathan H. Gold
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EXHIBIT 1

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

UNITED STATES OF AMERICA, ex rel. GENE BANTON, Plaintiffs, v. UT MEDICAL GROUP, INC., DR. TIMOTHY FABIAN, DR. MARTIN CROCE, DR. KENNETH KUDSK, DR. HENRY G. HERROD, DR. TIFFANY BEE, WILLIAM R. RICE, JOHN AND JANE DOE I-XV, Defendants.	)	No. 03-cv-2740-JPM-dkv

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS HERROD AND RICE'S MOTION TO DISMISS THE UNITED STATES' AMENDED COMPLAINT

Before the Court is Defendants Dr. Henry G. Herrod and William R. Rice's ("Defendants") Motion to Dismiss the United States' Amended Complaint (Docket Entry ("D.E.") 85), filed August 27, 2009. Plaintiff the United States of America ("United States") responded to the motion on September 28, 2009. (D.E. 97.) A telephonic hearing was held on this motion on November 19, 2009. Present for Defendants were Kemper B. Durand, Esq. and William H. Haltom, Jr., Esq.; present for the United States were Kevin P. Whitmore, Esq. and William W. Siler, Esq.

I. Background

The United States asserts six causes of action against Defendants pursuant to the False Claims Act ("FCA"), 31 U.S.C. §§ 3729 et seq. and common law fraud.[1] The United States' amended complaint-in-intervention ("amended complaint") alleges that Defendants, along with UT Medical Group, Inc. ("UTMG") and other named Defendant doctors, engaged in a complex medical billing fraud scheme from 1998 to 2008. The Relator, Gene Banton, filed a qui tam complaint under seal on October 2, 2003, notifying the Attorney General and the United States Attorney's Office for the Western District of Tennessee of the alleged fraudulent acts. (D.E. 1.)

After seeking multiple 120-day extensions and conducting a five-year investigation, the Government filed a Notice of Intervention on November 20, 2008. (D.E. 20.) At this time, the qui tam complaint and related documents were unsealed and released to the Defendants. (Id. 1.) On February 6, 2009, the Government filed a complaint-in-intervention (D.E. 23), which was amended on June 9, 2009 (D.E. 53). The amended complaint asserts that Defendants, acting with Drs. Timothy Fabian, Martin Croce, Kenneth Kudsk, Tiffany Bee, and John and Jane Doe I-XV (collectively "Defendant Doctors"), utilized their dual roles as

[1] The Government has combined two separate causes of action under § 3729(a)(1) and § 3729(a)(2) into one claim for relief. As a result, the Court will assume that the Government intended to assert these causes of action separately.

UTMG members and University of Tennessee employees to orchestrate a clinical study billing scheme to defraud the United States.[2] (Am. Compl. ¶¶ 8-15.)

In its most basic form, the amended complaint alleges that Defendant Doctors would recruit Medicare and Medicaid patients at the Regional Medical Center ("the MED") to participate in clinical studies, which were paid for by pharmaceutical companies. (Id. ¶¶ 46-47.) Although pharmaceutical companies paid the University of Tennessee for the clinical study procedures ("protocol procedures") ordered and performed at the MED, the Government asserts that the University of Tennessee refused to use this money to reimburse the MED, causing the MED to submit false reimbursement claims to Medicare and Medicaid. (Id. ¶¶ 33-36.) Dr. Herrod, the former Dean of the College of

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[2] Because the amended complaint asserts that the alleged fraudulent scheme would not have been possible without the individual defendants' dual roles as UTMG members and University of Tennessee employees, it is important to outline the position of each Defendant.

- **Dr. Fabian** - is the Chair of the Department of Surgery at the College of Medicine and Chair of Surgery at UTMG. He also serves on UTMG's Board of Directors. (Am. Compl. ¶ 11.)
- **Dr. Croce** - is a Professor of Surgery and Chief of Trauma and Critical Care Division of the College of Medicine. He is also a UTMG member. (Id. ¶ 12.)
- **Dr. Bee** - is an Assistant Professor of Surgery at the College of Medicine and a UTMG member. (Id. ¶ 13.)
- **Dr. Kudsk** - was a former Professor of General Surgery at the College of Medicine and a former UTMG member. (Id. ¶ 14.)
- **John and Jane Doe I-XV** - are current and former medical doctors in the College of Medicine and UTMG members. (Id. ¶ 15.)

Medicine and former Chairman of the UTMG Board of Directors, and Mr. Rice, the former Chancellor of the University of Tennessee and a former UTMG Board of Director, allegedly allowed the unused pharmaceutical funds to be transferred to university accounts for the use and benefit of Defendant Doctors. (Id. ¶ 63.)

In greater detail, the amended complaint states that pharmaceutical companies routinely solicit university faculty members nationwide to conduct clinical studies. (Id. ¶ 40.) In this case, the Defendant Doctors, being leading faculty members at the College of Medicine, were recruited by pharmaceutical companies to administer, manage, and perform clinical studies. (Id. ¶¶ 45-46.) Once a clinical study had been approved by the University of Tennessee, its costs and administration details were formalized in a contract between the sponsoring pharmaceutical company and the University of Tennessee. (Id. ¶ 47.) Sponsoring pharmaceutical companies would pay the University of Tennessee an agreed-upon amount for each clinical study in exchange for the Defendant Doctors administering, managing, and performing the protocol procedures. (Id. ¶¶ 46, 71, 91.)

The Government asserts that the Defendant Doctors would turn to the MED to recruit Medicare and Medicaid patients to participate in these clinical studies. (Id. ¶ 58.) The

Defendant Doctors' ability to work at the MED, according to the amended complaint, was based solely on their membership in UTMG, the private practice arm of the University of Tennessee Health Science Center. (Id. ¶ 55.) The United States asserts that absent the Defendant Doctors' membership in UTMG and UTMG's "professional services" contract with the MED, the Defendant Doctors would have been unable to recruit Medicare and Medicaid patients to participate in pharmaceutical-sponsored clinical studies or perform protocol procedures. (Id. ¶¶ 55-58.)

After executing the contracts with pharmaceutical companies and securing clinical study patients from the MED, the Government asserts that the University of Tennessee would contract with the MED to purchase the necessary protocol procedures such as diagnostic tests and pharmacy services. (Id. ¶ 50.) The "sole purpose of this contract was to ensure that the protocol procedures were paid for by the University [of Tennessee] from monies provided by the pharmaceutical companies instead of being billed to [Medicare and Medicaid]." (Id.) Pursuant to Medicare and Medicaid secondary payer rules, these two government programs cannot be billed directly for claims where a third-party, in this case a pharmaceutical company, is responsible for paying the medical tests and services. (Id. ¶¶ 19, 24.) The University of Tennessee allegedly refused to pay for its protocol procedures, causing the MED to submit

fraudulent reimbursement claims to Medicare and Medicaid. (Id. ¶ 39.) Defendants Herrod and Rice allegedly allowed the unused pharmaceutical funds to be transferred to University of Tennessee accounts in the names of Defendant Doctors for their use and benefit. (Id. ¶¶ 34-35, 63.)

In their Federal Rule of Civil Procedure 12(b)(6) Motion, Defendants assert that (1) the United States' amended complaint should be dismissed for failure to comply with False Claims Act (FCA) guidelines and this Court's previous orders; (2) the allegations asserted are time barred; and (3) even if the allegations are not time barred, the FCA claims and the common law claims fail to meet Rule 9(b)'s heightened pleading standard. Each argument is addressed in turn by the Court.

II. Analysis

a. Timely Assertion of a Rule 12(b)(6) Motion

The United States contends that Defendants waived their right to assert a Rule 12(b)(6) claim because it was raised after Defendants filed a responsive pleading on July 23, 2009. (U.S. Resp. to Defs.' Mot. to Dismiss ("U.S. Resp.") 3.) The Court finds that Defendants are permitted to assert a Rule 12(b)(6) motion despite previously filing a responsive pleading. Rule 12(b) requires that "a motion making any [12(b)] defenses shall be made before pleading." Fed. R. Civ. P. 12(b). However, as a "matter of motions practice, a [12(b)] motion

[filed after a responsive pleading] may be properly considered as one for judgment on the pleadings under Federal Rule of Civil Procedure 12(c), and evaluated, nonetheless, under the standards for dismissal under Rule 12(b)(6)." Scheid v. Fanny Farmer Candy Shops, Inc., 859 F.2d 434, 436 (6th Cir. 1988).

Furthermore, on December 18, 2009 the Court GRANTED Defendants' Unopposed Motion for Leave to Amend Answer to United States of America's Amended Complaint. (D.E. 126.) Pursuant to Defendants' amended answer, a Rule 12(b)(6) defense is properly asserted and before this Court.

b. Dismissal for Failure to Comply with Statutory Guidelines and Court-ordered Deadlines

For the reasons stated in the Court's Order Granting in Part and Denying in Part UT Medical Group, Inc.'s Motion to Dismiss the United States' Amended Complaint ("January 27, 2010 Order," D.E. 130), the Court DENIES Defendants' Motion to Dismiss the United States' amended complaint for failing to timely comply with FCA guidelines and court-ordered deadlines.

c. FCA Statute of Limitations

As a threshold matter, Defendants contend that the allegations asserted in the amended complaint dating back as far as 1998 are barred by the FCA's statute of limitations provided in 31 U.S.C. § 3731(b).

Pursuant to 31 U.S.C. § 3731(c) and for the reasons stated in the Court's January 27, 2010 Order, (D.E. 130 at pp. 10-18), the Court finds that the FCA claims asserted against Defendants are not barred by the statute of limitations.

d. Rule 9(b) Analysis for FCA Claims

Finding that the United States' claims are not barred by the FCA statute of limitations, the Court must analyze whether the United States' amended complaint satisfies Rule 9(b)'s heightened pleading requirements as it relates to the allegations against Defendants Herrod and Rice.

i. Exception to Rule 9(b)

For the reasons stated in the January 27, 2010 Order, (D.E. 130 at pp. 19-21), the Court declines to relax Rule 9(b)'s heightened pleading requirements.

ii. Rule 9(b) Requirements

In reviewing a dismissal pursuant to Rule 9(b) for failure to plead fraud with particularity, the Court "must construe the complaint in the light most favorable to the plaintiff, accept all factual allegations as true, and determine whether the complaint contains 'enough facts to state a claim to relief that is plausible on its face.'" Bledsoe II, 501 F.3d at 502 (quoting Bell Atl. Corp. v. Twombly, 550 U.S. 544, 570 (2007)).

To satisfy Rule 9(b), an FCA complaint "at a minimum, must 'allege the time, place, and content of the alleged

misrepresentation . . .; the fraudulent scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud.'" United States ex rel. Marlar v. BWXT Y-12, L.L.C., 525 F.3d 439, 444 (6th Cir. 2008) (quoting United States ex rel. Bledsoe v. Cmty. Health Sys. Inc. (Bledsoe I), 342 F.3d 634, 643 (6th Cir. 2003)). To satisfy Rule 9(b), a complaint must provide specific allegations as to each defendant's role in the fraud. See United States ex rel. Bledsoe v. Cmty. Health Sys., Inc., No. 2:00-0083, 2001 WL 1804546, at *6 (M.D. Tenn. Sept. 18, 2001).

Where the complaint alleges "a complex and far-reaching fraudulent scheme," Bledsoe II, 501 F.3d at 510, the scheme must be pled with particularity. Id. Pleading an "actual false claim with particularity is an indispensable element of a complaint that alleges a FCA violation in compliance with Rule 9(b)." Id. at 504. "[E]xamples [of fraud] will support more generalized allegations . . . only to the extent that the examples are *representative samples*" of the entire fraudulent scheme. Id.

Finally, the concept of a false or fraudulent scheme "should be construed as narrowly as is necessary to protect the policies promoted by Rule 9(b)." Id. at 510. Although the "overarching" purpose of Rule 9(b) is to ensure that a defendant "possesses sufficient information to respond to an allegation of

fraud," the Rule also serves to discourage discovery "fishing expeditions" and protect a defendant from unwarranted damage to its reputation caused by "spurious charges of immoral and fraudulent behavior." See United States ex rel. Snapp, Inc. v. Ford Motor Co., 532 F.3d 496, 504 (6th Cir. 2008) (quotations omitted).

In its amended complaint the United States alleges three causes of action pursuant to the FCA 31 U.S.C. §§ 3729 et seq. The applicable provisions impose liability, inter alia, on any person who:

> (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;
>
> (2) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; [or]
>
> (3) conspires to defraud the Government by getting a false or fraudulent claim allowed or paid[.]

31 U.S.C. § 3729(a)(1994).

1. FCA §§ 3729(a)(1)-(a)(2)

Under 31 U.S.C. § 3729(a)(1), liability is imposed when "(1) a person presents, or causes to be presented, a claim for payment or approval; (2) the claim is false or fraudulent; (3) the person's acts are undertaken 'knowingly', i.e., with actual knowledge of the information, or with deliberate ignorance or

reckless disregard for the truth or falsity of the claim." Bledsoe II, 501 F.3d at 503. The only difference between §§ 3729(a)(1) and (a)(2) is that under (a)(2), the "defendant must have . . . caus[ed] to be made . . . a false record or statement. . ." See Snapp, 532 F.3d at 504-505. The Sixth Circuit has held that "proof of 'presentment' [of the false claim to the government] is not required for actions under subsections (a)(2) and (a)(3)," referencing conspiracy. Marlar, 525 F.3d at 447 (quotations omitted).

A. Pleading Allegations with Particularity

With respect to the United States' claims pursuant to §§ 3729(a)(1)-(a)(2), the Court finds that the amended complaint satisfies Rule 9(b)'s heightened pleading requirements, ensuring that Defendants Herrod and Rice may prepare a responsive pleading and that concerns about unwarranted discovery are deterred.

The United States' amended complaint describes the alleged fraudulent scheme in great detail identifying the dates and parties involved. In particular, the amended complaint asserts that between 1998 and 2008, Defendant Doctors, acting in their capacity as agents, employees, and/or members of UTMG, along with Defendants Herrod and Rice, both former UTMG Board of Directors, orchestrated a complex clinical study reimbursement scheme. (Am. Compl. ¶¶ 6-15, 25, 31-40.) These Defendants

allegedly utilized their dual roles as University of Tennessee employees and UTMG members to negotiate clinical study contracts, recruit clinical study patients, perform clinical study procedures, and direct pharmaceutical funding into accounts for the use and benefit of Defendant Doctors. (Id. ¶¶ 33-63.) In particular, the amended complaint asserts that Defendants Herrod and Rice allowed unused pharmaceutical money to be transferred to university accounts for the discretionary benefit of Defendant Doctors - an essential step for the success of the alleged fraudulent scheme. (Id. ¶¶ 63.)

The Relator, a former employee of the University of Tennessee and former director of research at the MED (id. ¶ 36), was in a first-hand position to observe the alleged clinical study billing practices. In this position, the Relator asserts specific allegations of fraud representative of the broader scheme. In particular, the Relator claims that he was given access to a completed clinical trial sponsored by Glaxo-Wellcome Pharmaceutical Company called "IMIA 1001." (Id. ¶ 69.) A review of this file indicated that on February 1, 1999, Glaxo-Wellcome paid the University $79,049.51 for conducting the IMIA 1001 clinical trial, of which $13,174.93 was disbursed to the University for facility fees, leaving $65,874.58 for the direct costs of the study. (Id. ¶ 71.)

According to the amended complaint, on or about February 23, 1999, the University's administration authorized the transfer of $65,874.58 to the doctor administering the study's individual account. (Id.) The amended complaint lists other examples of similar residual accounts set up for the use of Defendant Doctors after the completion of clinical studies. (Id. ¶ 91.) These examples include the residual account number, the pharmaceutical sponsor, the total amount received from the pharmaceutical company, the amount invoiced to the University, and the potential residual funds to Defendant Doctors. (Id.) The specificity of these representative examples of the alleged scheme permits Defendants to prepare a responsive pleading.

Most importantly, the United States pleads with particularity specific examples of false claims that are representative of the entire alleged fraudulent scheme. The amended complaint lists a series of clinical studies that have been performed by Defendant Doctors involving Medicare and Medicaid patients receiving treatment at the MED. (Id. 24-28.) Each study includes a clinical study identification number, the pharmaceutical sponsor, and the name of the doctor administering the study. (Id.)

From this list, the United States selected a random sample of clinical studies to examine for possible false claims. (Id. ¶ 89.) Docket Entry 100 lists specific protocol procedures that

were ordered by the University of Tennessee from the MED but never paid for, causing the MED to make false records or submit false reimbursement claims to Medicare or Medicaid.[3] This list includes the clinical study identification number, the patient name, the date of service, and the type of service performed. (D.E. 100.) The selected studies were managed, administered, and performed by Drs. Fabian, Kudsk, Croce, and Bee. (Am. Compl. 24-28.) Over 560 protocol procedures are pled with particularity and representative of the entire alleged fraudulent scheme. (See D.E. 100.) The United States asserts that the MED submitted fraudulent reimbursement claims to the Government for payment because these protocol procedures were allegedly never paid for by the University of Tennessee.

Although the United States does not present actual invoices demonstrating that the MED submitted and received reimbursements from Medicare or Medicaid, this is not fatal to its complaint. Defendants contends that the United States' amended complaint fails to meet Rule 9(b)'s pleading requirements because Docket

[3] The United States originally submitted this list as Docket Entry 24. On October 9, 2009, the United States filed a Notice of Correction, stating that upon further review of the MED's billing records, certain procedures listed in Docket Entry 24 were never submitted to Medicare or Medicaid for payment. Of the 758 protocol procedures originally listed, 196 were redacted for lack of government reimbursement.

The methodology for compiling this list is based on the MED's own records. According to the United States' Response, a clinical test was considered a protocol procedure if it was ordered by a UTMG doctor's research nurse or coordinator since only they had privileges to order these procedures. (U.S. Resp. at 16.)

Entry 100 is missing crucial information regarding the actual submission of false claims such as the date the claim was submitted to the Government for reimbursement, the amount the Government paid for the claim, and the date the claim was paid. (See Defs.' Mot. to Dismiss 9.) In support of its contention, Defendants cite four cases, two of which are of primary importance - United States ex rel. Clausen v. Laboratory Corporation of America, Inc., 290 F.3d 1301 (11th Cir. 2002),[4] and United States ex rel. Marlar v. BWXT Y-12, L.L.C., 525 F.3d 439 (6th Cir. 2008).[5]

In Clausen and Marlar, the courts dismissed the Relators' qui tam complaints for failing to allege with particularity if or when actual false claims were submitted to the Government for payment - "the *sine qua non* of a FCA violation." See Marlar,

[4] After the Government declined to intervene, the Relator in Clausen was forced to pursue its qui tam complaint against a competitor laboratory on its own. 290 F.3d at 1304. The Relator alleged that the defendant laboratory conducted unnecessary tests on its patients, and improperly billed the Government for reimbursement. Id. The qui tam complaint included details about conversations with defendant employees, specific patient medical records, and descriptions of allegedly improper laboratory tests. Id. The Relator, however, failed to allege any facts that these false claims were submitted to the Government for payment. Id. at 1312. The Relator merely relied on a conclusory statements that defendant laboratory submitted the false claims. Id.

[5] In Marlar, the Relator filed a qui tam complaint alleging that her former employer, a nuclear power facility, systematically underreported work-related injuries to receive greater government compensation for a safe work environment. See Marlar, 525 F.3d at 442. The Relator was a nurse practitioner who worked in the facility's health department. Id. In her qui tam complaint, the Relator provided general examples that the medical records of unidentified employees did not include reports of work-related injuries or prescription drug treatment. Id. In addition to only pleading general examples of the fraudulent scheme, the Relator did not "identify any specific claims that were submitted to the United States," or state a basis for her belief that claims were submitted. Id. at 446.

525 F.3d at 446; Clausen, 290 F.3d at 1311-12. The court in Marlar found that the Relator relied solely on "information and belief" that actual false claims were submitted, without identifying specific claims that may have been submitted or stating any reason for the belief that claims were submitted, likely submitted, or should have been submitted to the Government. Marlar, 525 F.3d at 446. Similarly, in Clausen, the court emphasized that the Relator's complaint merely raised questions about the defendant's billing practice, but offered nothing more than "conclusory statements" that defendant actually submitted false claims. Clausen, 290 F.3d at 1312. Clausen found that the complaint must provide "some indicia of reliability" to support the allegation of "*an actual false claim* for payment being made to the Government." Id. at 1311.

The circumstances in Marlar and Clausen are both distinguishable from this case. In this case, the United States has pled sufficient facts from which the Court can infer a reliable link between the alleged clinical billing scheme and the submission of false claims to the Government. The amended complaint asserts that all procedures listed in Docket Entry 24 (now Docket Entry 100 following the Notice of Correction) were submitted by the MED for payment from Medicare and Medicaid. (Am. Comp. ¶ 90; Notice of Correction, D.E. 99.) During the October 27, 2009 telephonic hearing, the United States

reasserted that the MED, the entity directly responsible for submitting the reimbursement claims to Medicare and Medicaid, confirms that the alleged fraudulent protocol procedures listed in Docket Entry 100 were submitted and received payment from the Government. Construing these facts in the light most favorable to the United States, the Court finds that the MED's statements establish a reliable link between the fraudulent scheme and the actual submission of claims for payment. As the party directly responsible for submitting the alleged false claims, the MED's statements are more than "conclusory statements" made by indirect parties relying solely upon "information and belief."[6]

Finally, the information included in Docket Entry 100 provides sufficient information for Defendants to prepare a responsive pleading. Docket Entry 100, as noted above, lists the clinical study number, the patient name, date of service, and type of service for each alleged fraudulent protocol procedure. Furthermore, the clinical study number permits Defendants to identify the doctor responsible for managing and administering the study and the pharmaceutical company sponsor. These details provide examples of actual false claims that are

[6] Clausen and Marlar both involved qui tam actions where the United States declined to intervene. In Clausen, the Relator identified himself as a "current competitor" of the defendant laboratory. Clausen, 290 F.3d at 1302. When the Government, the actual party harmed by the alleged fraud is not involved in the litigation, there may be heightened concerns that a Relator's allegations are brought for improper motives.

representative of the entire scheme and permit Defendants to respond to the United States' amended complaint.

Since the United States' amended complaint sets forth the time, the place, the details of the fraudulent scheme, the parties involved, specific examples of false claims that are representative of the entire scheme, and provides sufficient facts for the Court to reliably infer these false claims were submitted and paid by the Government, the Court finds that claims under §§ 3729(a)(1)-(a)(2) are pled with sufficient particularity to satisfy Rule 9(b).

B. Causation Under §§ 3729(a)(1)-(2)

Finally, a well-pled claim under §§ 3729(a)(1) or (a)(2) must establish a causal connection between Defendants Herrod's and Rice's actions and the alleged presentment of false claims for payment or making of false records. Because the United States is not asserting that Defendants directly submitted false claims, it must be able to assert that Defendants caused false claims to be presented for payment or caused false records to be created. In general, causation liability under the FCA requires more than mere knowledge of submission of false claims. See United States v. Murphy, 937 F.2d 1032, 1039 (6th Cir. 1991) (finding that the allegation that defendant knew or was aware of the fraud does not eliminate the need for some action by the

defendant whereby the claim is presented or caused to be presented).

Where causation has been determined, the defendant has both knowledge of the false claim and has taken "some sort of affirmative action" that causes or assists the presentment of a false claim for payment. See United States ex rel. Sikkenga v. Regence BlueCross BlueShield of Utah, 472 F.3d 702, 714-15 (10th Cir. 2006). Courts analyzing the issue have borrowed traditional tort principles to determine if there is a sufficient nexus between the conduct of one party and the ultimate presentation of false claims.[7] Under this analysis, the causation requirement under Rule 9(b) will only be met if a defendant's actions played a substantial role in the presentment of false claims for payment, and it was foreseeable that a defendant's actions would lead to the submission of false claims

[7] Sikkenga, 472 F.3d at 715 (finding that the Relator alleged sufficient facts that an insurer caused false claims to be submitted by a laboratory to Medicare by "agreeing [with the laboratory] to circumvent" contractual and statutory requirements, and "assuring" [the laboratory] that the insurer would continue to accept the improperly coded reimbursement claims); United States ex rel. Drescher v. Highmark, Inc., 305 F. Supp. 2d 451, 458 (E.D. Pa. 2004) (finding relator alleged sufficient facts that a private insurer caused false claims to be submitted by incorrectly denying reimbursement claims when it should have been paying them. As a result of the denial, the claims were returned to the original parties who resubmitted them improperly to Medicare for payment. Even though insurer did not directly present the claims, the Government's theory of causation was plausible, and therefore permitted to proceed past the summary judgment stage.); United States ex rel. Franklin v. Parke-Davis, Div. of Warner-Lambert Co., No. 96-11651PBS, 2003 WL 22048255, at *4-7 (D. Mass. Aug. 22, 2003) (applying a two-part test using traditional tort principles to assess causation liability under the FCA. Assessing whether defendant's conduct was a substantial factor in causing the presentation of false claims to Medicaid, and whether it was foreseeable that defendant's actions would cause false claims to be presented. Court found that by promoting its drug for uses not approved by the FDA, defendant drug company caused prescribing physicians to submit false claims to Medicaid.)

for payment. See United States ex rel. Franklin v. Parke-Davis, Div. of Warner-Lambert Co., No. 96-11651PBS, 2003 WL 22048255 *4-7 (D. Mass. Aug. 22, 2003).

The amended complaint alleges specific facts that Defendants Herrod and Rice were both placed on notice of the fraudulent billing practices on multiple occasions through an advisory opinion and meetings. Paragraphs 37 and 38 of the amended complaint assert that an advisory opinion, explaining the fraudulent nature of the clinical billing practices, was presented and discussed with Dr. Herrod and Mr. Rice. (Id. ¶¶ 37-38.) The amended complaint further asserts that Defendant Rice met with the Relator on several other occasions, including June 22, 2001, to discuss the clinical study billing problems concerning Defendant Doctors. (Id. ¶¶ 80-81.) In response, Defendant Rice allegedly took no action to stop the problem, explaining that the drug companies did not care how the money was spent. (Id. ¶ 81.) The Relator also allegedly met with Defendant Herrod on April 29, 2003 and June 12, 2003 to discuss the fraudulent clinical study billing practices. (Id. ¶¶ 86-87.) Defendant Herrod did not take any action to stop the alleged acts. (Id. ¶ 87.)

Additionally, the United States has alleged sufficient facts to assert that Defendants Herrod and Rice took affirmative action which caused the MED to present false claims for payment

or make false records. According to the alleged scheme, the MED would not have submitted false claims to Medicare or Medicaid had it been able to receive proper reimbursement from the University of Tennessee for the protocol procedures. (See id. ¶ 50.) Instead, Defendants, through their administrative roles at the University of Tennessee, allowed the unused pharmaceutical money to be transferred to university "residual accounts" for the discretionary benefit of Defendant Doctors. (Id. ¶ 63.) According to the United States, without the use of the residual accounts, Defendant Doctors would have been unable to access the unused pharmaceutical funds - an essential step in the fraudulent scheme. (See id. ¶¶ 63-71.)

Construing these allegations in the light most favorable to Plaintiff, it would be foreseeable that allowing residual accounts to be established on behalf of Defendant Doctors and permitting Defendant Doctors to continue clinical studies would cause the MED to submit false reimbursement claims or make false records to get claims approved. Therefore, under the causation analysis, the United States has asserted sufficient facts alleging that Defendants had knowledge of the fraudulent billing scheme, took affirmative action to guarantee the success of this scheme, and it was foreseeable that this action would lead to the submission of false claims or the making of false records.

As a result, the Court DENIES Defendants' Motion to Dismiss the United States' claims pursuant to §§ 3729(a)(1)-(a)(2).

2. FCA § 3729(a)(3)

To prevail on a conspiracy claim under 31 U.S.C. § 3729(a)(3) the United States must prove that "(1) the defendant knowingly conspired with one or more persons to get a false or fraudulent claim allowed or paid by the United States, and (2) that one or more of the conspirators performed any act to effect the object of the conspiracy." United States ex rel. Augustine v. Century Health Serv., 136 F. Supp. 2d 876, 888 (M.D. Tenn. 2000). A civil conspiracy does not require an express agreement among all the conspirators, and each conspirator does not have to know all the details of the illegal plan or all of the participants involved. United States v. Murphy, 937 F.2d 1032, 1039 (6th Cir. 1991). It must be shown, however, that there was a single plan and that the alleged co-conspirator shared in the general conspiratorial objective. See id.

In this case, the amended complaint asserts that Defendants' responsibilities at the University of Tennessee were essential to the execution of the alleged fraudulent scheme. The specific allegations contend that Defendants Herrod and Rice allowed the Research Administration Office at the University of Tennessee to establish accounts to retain "residual" money leftover as a result of not paying the MED for protocol

procedures and causing it to improperly bill Medicare or Medicaid. (Am. Compl. ¶¶ 34, 63, 79-87.) Defendants Herrod and Rice allowed Defendant Doctors to use the money in these residual accounts for their own discretionary expenses. (Id. ¶ 35.) Defendants Herrod and Rice had knowledge that the clinical study billing practices and the establishment of residual accounts were fraudulent based on the review of a legal opinion and discussions with the Relator. (Id. ¶¶ 37-28, 80-81, 86-87.) Without the alleged assistance of Defendants Herrod and Rice, Defendant Doctors would have been unable to establish financial accounts on their behalf and complete the objective of the alleged conspiracy.

Based on these reasons, the Court DENIES Defendants' Motion to Dismiss the United States' claims pursuant to § 3729(a)(3).

e. Rule 9(b) Analysis for Common Law Fraud Claims

i. Common Law Fraud Claims in Dispute

Defendants contend that the United States' claim for "disgorgement of profits" should be dismissed because it is a remedy, not a cause of action. (UTMG's Mot. to Dismiss (D.E. 70) 29.) The United States does not contest this argument.

The Court GRANTS Defendants' Motion to Dismiss as it relates to the United States' claim for disgorgement of profits. The Court finds that although "disgorgement is pled as a separate cause of action, [it] is actually an equitable remedy

designed to deprive a wrongdoer of his unjust enrichment." Performance HR, Ltd., Inc. v. Archway Ins. Servs. L.L.C., No. 08-3432, 2008 WL 4739381, at *5 (E.D. Pa. Oct. 23, 2008); see also Restatement (Third) of Restitution & Unjust Enrichment § 51 Cmt. a Tentative Draft 2007) (Enrichment of Wrongdoers: Disgorgement; Accounting) ("[Disgorgement] is not in itself a source of substantive liability. Rather it addresses the amount of recovery once liability has been established under [unjust enrichment].")

ii. Statute of Limitations for Unjust Enrichment and Payment Under Mistake of Fact Claims

Defendants contend that the United States' claims for unjust enrichment and payment under mistake of fact are barred by Tennessee's three year statue of limitations for actions involving injury to real or personal property. (UTMG's Mot. to Dismiss (D.E. 70) 24.[8]) In response, the United States asserts that the applicable statue of limitations period for its unjust enrichment and payment by mistake claims is six years pursuant to 28 U.S.C. § 2415(a). (U.S. Resp. 18-19.)

The Court finds that the United States' claims for unjust enrichment and payment under mistake of fact are governed by the six-year statute of limitations period set forth in 28 U.S.C. § 2415(a). In relevant part, § 2415 provides:

[8] For arguments based on common law claims, Defendants Herrod and Rice refer the Court to Defendant UTMG's Motion to Dismiss (D.E. 70) for the supporting legal analysis.

> **§ 2415. Time for commencing actions brought by the United States.** (a) Subject to the provisions of section 2416 of this title, and except as otherwise provided by Congress, *every action for money damages brought by the United States or an officer or agency thereof which is founded upon any contract express or implied in law or fact, shall be barred unless the complaint is filed within six years after the right of action accrues* or within one year after final decisions have been rendered in applicable administrative proceedings required by contract or by law, whichever is later . . . .

28 U.S.C. § 2415(a) (emphasis added). It is well established that common law claims for unjust enrichment and payment under mistake of fact brought in the context of FCA claims are subject to the six-year statute of limitations period provided in § 2415(a). See, e.g., FDIC v. Bank One, 881 F.2d 390, 392-93 (7th Cir. 1989; United States v. Carell, No. 09-445, 2009 WL 3335031, at *8-9 (M.D. Tenn. Oct. 13, 2009); United States ex rel. Monahan v. Robert Wood Johnson Univ. Hosp., Nos. 02-5702 08-1265, 2009 WL 1288962, at *11 (D.N.J. May 7, 2009); United States v. Intrados/Int'l Mgmt. Group, 265 F. Supp. 2d 1, 12-13 (D.D.C. 2002).

As amended by FERA § 4(b), 31 U.S.C. § 3731(c) provides that all of the United States' claims, including its common law claims, relate back to the date of the relator's qui tam complaint, so long as they arise out of the same conduct, transaction, or occurrence. See 31 U.S.C. § 3731(c). In

particular, § 3731(c) states that the United States may, in its complaint-in-intervention, include:

> "*any additional claims* with respect to which the Government contends it is entitled to relief. For statute of limitation purposes, any such Government pleading shall relate back to the filing date of the [qui tam complaint], to the extent that the claim of the Government arises out of the [same] conduct, transactions, or occurrences set forth . . . in the [qui tam complaint]."

31 U.S.C. § 3731(c) (emphasis added).

Pursuant to 28 U.S.C. § 2514(a) and 31 U.S.C. § 3731(c), the United States' claims against Defendants for unjust enrichment and payment under mistake of fact are not time barred because they have been asserted within six years of the October 2, 2003 qui tam complaint.

iii. Unjust Enrichment and Payment by Mistake

As a threshold matter, Defendants assert that the United States' claim for unjust enrichment should be dismissed as a matter of law because there are express contracts governing the rights and obligations of the parties with respect to the clinical trials in dispute. (See UTMG's Mot. to Dismiss (D.E. 70) 27.)

The Court rejects Defendants' assertion because the United States has never asserted that there were contracts between any of the named Defendants. The contracts referred to in the United States' amended complaint are between the University of

Tennessee and pharmaceutical companies, and the University of Tennessee and the MED. (Am. Compl. ¶¶ 48, 50.) These contracts would only limit the remedies available to the contracting parties - the pharmaceutical companies and the MED, not the United States. See Cloverdale Equip. Co. v. Simon Aerials, Inc., 869 F.2d 934, 939 (6th Cir. 1989) (finding unjust enrichment, a quasi-contractual theory of recovery, is only appropriate in the absence of an express contract between parties).

Next, the Court finds that the United States' claims for unjust enrichment and payment under mistake of fact are sufficiently pled to satisfy Rule 9(b).[9] Under Tennessee law,

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[9] The United States asserts that federal law governs its common law claims for unjust enrichment and payment under mistake of fact. (U.S. Resp. 19-21.) To determine the applicable law, the Court must first determine if federal or state law governs the United States' common law claims; and second, if federal law applies, whether the Court should adopt state law or apply a uniform federal rule. See United States v. Kimbell Foods, Inc., 440 U.S. 715, 718 (1979) (determining that federal law governed the controversy, but adopting state law as the appropriate federal rule). Kimbell held that "federal law governs questions involving the rights of the United States arising under nationwide federal programs." Id. at 726 (citing Clearfield Trust Co. v. United States, 318 U.S. 363, 366-67 (1943)). Because this case involves the rights of the United States arising under Medicare and Medicaid, nationwide federal programs, the Court finds that federal law governs the United States' unjust enrichment and payment under mistake of fact claims.

The more difficult question is whether these claims, although governed by federal law, require the Court to impose uniform federal rules or adopt state law. The factors to consider when making this determination "depend[] upon a variety of considerations . . . relevant to the nature of the specific governmental interests and to the effects upon them of applying state law." Kimbell Foods, 440 U.S. at 728. In particular, courts should consider: (1) the need for a nationally uniform body of law; (2) whether the application of state law is in conflict with federal law; and (3) whether the application of state law would frustrate the specific objectives of the federal programs. See id. In this case, the Court does not find a strong need for a nationally uniform body of law for unjust enrichment or payment under mistake of fact. Furthermore, the application of Tennessee state law does not conflict with

"the elements of an unjust enrichment claim are: (1) a benefit conferred upon the defendant by the plaintiff; (2) appreciation by the defendant of such benefit; and (3) acceptance of such benefit under such circumstances that it would be inequitable for him to retain the benefit without payment of the value thereof." Freeman Indus. v. Eastman Chem. Co., 172 S.W.3d 512, 525 (Tenn. 2005) (quotations omitted). To prevail on a payment under mistake of fact claim under Tennessee law, a plaintiff must show that there had been (1) a payment made (2) through a mistake of fact. W.E. Richmond & Co. v. Security Nat'l Bank, 64 S.W.2d 863, 874 (Tenn. Ct. App. 1933).

The amended complaint, as noted above in the Court's analysis of the FCA claims, describes the alleged fraudulent scheme in great detail. According to the amended complaint, Defendants received a benefit each time the MED submitted false reimbursement claims to Medicare and Medicaid for clinical study procedures, rather than receiving payment from the University of Tennessee. Defendants Herrod and Rice were allegedly able to enlarge the University of Tennessee's research budgets which they administered by allowing the transfer of unused pharmaceutical funds to accounts on behalf of Defendant Doctors.

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general unjust enrichment or payment under mistake of fact principles and will not frustrate the specific objectives of Medicare or Medicaid. As a result, the Court will adopt Tennessee state law to determine the rights of the United States against Defendants for unjust enrichment and payment under mistake of fact.

(U.S. Resp. 24.) Being able to retain this alleged benefit without payment would be unjust. Furthermore, the Government would not have made payments for clinical study procedures had it known that pharmaceutical companies were the primary payers. (Am. Compl. ¶¶ 5, 24.)

Finally, Defendants contend that the United States must establish that it conferred a direct benefit, rather than an indirect or incidental benefit, upon Defendants. (See UTMG's Mot. to Dismiss, D.E. 70, 28.) The Tennessee Supreme Court, however, has refuted this argument expressly holding that a "plaintiff may recover for unjust enrichment against a defendant who receives *any* unjust benefit from the defendant - direct or indirect." See Freeman Indus., 172 S.W.3d at 125. The Supreme Court went on to define a benefit "as any form of advantage that has a measurable value including the advantage of being saved from an expense or loss." Id. (citing Lawrence Warehouse Co. v. Twohig, 224 F.2d 493, 498 (8th Cir. 1955)).

In this case, the amended complaint describes the details of an alleged clinical study billing scheme that allowed unused pharmaceutical money to be transferred into Defendant Doctors accounts, rather than being paid to the MED. Although residual accounts were not established directly on behalf of Defendants Herrod and Rice, the United States asserts that Defendants benefited from the alleged scheme by enlarging the University of

Tennessee's research budgets which they administered. (U.S. Resp. 24.) Because the Defendants allegedly participated and benefited from the clinical study billing scheme, the United States is entitled to assert common law theories for unjust enrichment and payment by mistake.

Based on these reasons, the Court DENIES Defendants' Motion to Dismiss the United States' unjust enrichment and payment under mistake of fact claims.

III. Conclusion

For the foregoing reasons, Defendants' Motion to Dismiss the United States' Amended Complaint is GRANTED in part and DENIED in part.

SO ORDERED this 27th day of January, 2010.

/s/ JON PHIPPS McCALLA
CHIEF UNITED STATES DISTRICT JUDGE