IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

UNITED STATES ex rel. JEAN LIVERMORE
and WANDA J. OLSON,

Plaintiffs,

v.

MEMORANDUM AND ORDER
05-C-636-S

HUDSON HOSPITAL, HUDSON PHYSICIANS,
GROUP HEALTH PLAN, INC. and
REGIONS HOSPITAL,

Defendants.

Relators Jean Livermore and Wanda Olson commenced this qui tam action on behalf of the United States alleging that the defendants Hudson Hospital, Hudson Physicians, Group Health Plan, Inc. and Regions Hospital knowingly made and conspired to make false claims for Medicare and Medicaid payments from the United States in violation of 31 U.S.C. § 3729(a)(1) and (2). The United States has declined to intervene in the action. Jurisdiction is based on 28 U.S.C. §§ 1345 and 1367. The matter is presently before the Court on defendants' motion to dismiss pursuant to Rules 12(b)(6) and 9(b), Fed. R. Civ. P. The following is a summary of the allegations of the complaint.

FACTS

Defendant Hudson Hospital provides emergency services, and outpatient and inpatient care. Defendants Group Health, Inc., Hudson Physicians and Regions Hospital employ physicians who perform medical services at defendant Hudson Hospital. Between September 2003 and November 2004 relators were employed as coders in the records department of Hudson Hospital. Relators' jobs included reviewing patient treatment documents and other documents and applying standardized codes to the services provided at Hudson Hospital. The coded services were then billed to Medicare, Medicaid and commercial third party insurers.

During their employment relators observed the following eight record keeping and billing practices at Hudson Hospital:

(1) Emergency room physicians completed preprinted blue charge tickets for services performed in the Hudson Hospital emergency room. These tickets included preprinted options to enter the level of evaluation and management (level 1 through level 5, or critical care) and particular procedures performed. Two of the individual procedures related to "prolonged services." Hudson Hospital charged Medicare for prolonged services preformed in the emergency room.

(2) Physicians frequently indicated that they had provided critical care to patients on the blue ticket but failed to document the time spent administering critical care. Nurses also completed

pink tickets indicating facility costs incurred in providing emergency room care without providing the time spent administering critical care. Notwithstanding the lack of time documentation for critical care, Hudson Hospital billed medicare for these services.

(3) Physicians providing care for fractures failed to document whether they had specifically set the break and applied a splint or whether they referred the patient to an orthopaedic surgeon. Hudson Hospital regularly charged Medicare for the application of a splint when there was no specific documentation of its performance. Additionally, Medicare was billed separately for physician services in the fracture case and a facility charge for supplies and nurses services associated with the fracture care. It was often impossible for coders to determine whether a doctor, nurse or patient applied a splint. As a result Medicare was sometimes billed multiple times for the same fracture care.

(4) Hudson Hospital routinely billed for Dermabond (on the pink facilities ticket), a topical skin adhesive used in lieu of sutures to repair lacerations, in nearly every instance of a laceration, even though the physician's blue ticket indicated that sutures were applied.

(5) When the blue card indicated a level of care and a separate individual service, Hudson Hospital sometimes increased the level of care number instead of billing for the proper level of

care plus the service, resulting in medicare paying more than it would have had the charge been separate.

(6) Hudson Hospital billed payors for infusions using the Medicare code whether or not Medicare was the primary insurer.

(7) Hudson Hospital billed Medicare separately for supplies used during minor emergency room procedures even though payment for these items was already included in the charge for the service, thereby double billing for the supplies.

(8) Hudson Hospital split its emergency room and inpatient charges for patients transferred from emergency to inpatient care regardless of whether it was billing Medicare or private insurance.

MEMORANDUM

Defendants move to dismiss the complaint in its entirety for failing to satisfy the heightened pleading requirements of Rule 9(b). Alternatively, they argue that allegations 4, 6, 8 and part of 3 set forth above fail to state claims as a matter of law. Relators oppose all aspects of the motion.

A complaint should be dismissed for failure to state a claim only if it appears beyond a reasonable doubt that the plaintiffs can prove no set of facts in support of the claim which would entitle the plaintiffs to relief. Conley v. Gibson, 355 U.S. 41, 45-46 (1957). In order to survive a challenge under Rule 12(b)(6) a complaint "must contain either direct or inferential allegations

respecting all the material elements necessary to sustain recovery under some viable legal theory." Car Carriers, Inc. v. Ford Motor Co., 745 F. 2d 1101, 1106 (7th Cir. 1984). The heightened pleading requirement of Rule 9(b) requires the claimant to set forth "the who, what, when and where of the alleged fraud" so that the accused party is given adequate notice "of the specific activity that plaintiff claims constituted the fraud" so that it may file an "effective responsive pleading." Lachmund v. ADM Investor Services, Inc., 191 F.3d 777, 782-83 (7th Cir. 1999).

In order to properly assess the sufficiency of the complaint, each claim must be considered in light of the allegations against each defendant. The allegations concerning Defendant Hudson Hospital are most detailed and developed. Hudson Hospital employed the relators. Hudson Hospital's billing practices are at the heart of the claims and relators have personal knowledge of these practices. In general, allegations about these practices are ample to survive a rule 9(b) challenge because they give detailed accounts of systematic billing practices established by Hudson Hospital resulting in overcharges to Medicare. While such allegations may not lend themselves to the identification of particular instances of overcharges, they certainly are sufficient to permit effective responsive pleading. Hudson Hospital can readily respond to allegations that its billing practices

systematically overcharged Medicare during the limited period of relator's employment.

Having concluded that the allegations are generally sufficient to satisfy Rule 9(b) specificity requirement as to defendant Hudson Hospital, the Court now addresses Hudson Hospital's specific Rule 12(b)(6) challenges to the individual claims against it. First, defendants contend that the allegation of separate billing for casting services and supplies is neither fraudulent nor improper. Relators make no substantive argument in response, noting only that their factual allegations must be taken as true. However, as defendants properly point out, the issue properly raised on a motion to dismiss is whether the alleged facts, if true, support a claim -- in this case, whether separately billing for casting services and supplies is somehow fraudulent. Plaintiff suggests no basis to conclude that the separate billing is contrary to Medicare regulations, much less that it is fraud on the government to bill separately for the items. Accordingly, the claim must be dismissed. Luckey v. Baxter Healthcare Corp., 183 F.3d 730, 732 (7th Cir. 1999).

The second claim challenged by defendants is the allegation that defendant improperly used a medicare code number for infusions even when the private payor was the primary insurer. The complaint specifically alleges: "when the bills were generated, payors were billed with this Q0081 Medicare Code – whether or not Medicare was

the primary insurer." While this allegation is somewhat ambiguous, one possible interpretation is that Medicare was improperly billed for all infusions even though another insurer was primarily liable. Assuming that is true, the allegation may state a viable claim.

The third challenged claim is that Hudson Hospital split its emergency room and inpatient charges for patients transferred from emergency to inpatient care. Relators concede that this procedure was permitted under applicable Medicare Regulations, but argue that it was improper to bill non-Medicare insurers in this manner and that this error in billing other insurers "may have affected Medicare patient co-pays, co-insurance and deductibles." Plaintiff does not allege (or explain in its opposition brief) how double billing a private insurer could be fraud on the United States. The allegation supports a suggestion that private insurers or their individual insureds might have been overcharged by this billing practice but does not support a claim of fraud on the government. Accordingly, that claim must be dismissed as to all defendants.

Based on the stipulation of the parties, defendant Group Health is an agent of the individual doctors who performed services at the Hudson Hospital for which Medicare was billed using the allegedly improper billing practices. Similarly, the allegations of the complaint are that defendants Regions Hospital and Hudson Physicians also contracted to provide physicians services to the hospital and were acting as agents of the physicians in submitting

bills prepared by Hudson Hospital to Medicare. Accordingly, the claims against these three defendants are based on claims made to Medicare for physician services performed at and billed by Hudson Hospital. The relevant allegations are that the individual doctors prepared and submitted documents for billing purposes and that defendant Hudson Hospital acted as the agent of the physician-employing defendants in preparing and submitting improperly inflated bills for reimbursement, and that these defendant's knew the bills were improperly inflated. While these allegations are not particularly clear, they are sufficient to put the defendants on notice of the claims against them. Namely, that they and the physicians they represent knowingly benefitted from the fraudulent billing schemes employed by Hudson Hospital on its own and their behalf.

Hudson Physicians argues (in a position joined by the other defendants') that the complaint does not sufficiently allege that its physicians were employed at Hudson Hospital. This argument is not a matter for resolution on a Rule 12(b)(6) motion. The complaint alleges that defendants Regions, Hudson Physicians and Group Health provided physicians to Hudson Hospital during the period of relator's employment and that Hudson Hospital improperly inflated bills for their services. If physicians from any of the three groups did not provide services at Hudson Hospital during the relevant period, it can be readily established on summary judgment.

However, at this stage in the proceeding the Court is bound to accept the allegations as true. Certainly the allegations are sufficient to permit the defendants to effectively respond to the pleadings. Similarly, relators can be put to their proof on the issue of knowledge of the billing practices on summary judgment.

Claim number 4, however, relating to the universal billing for Dermabond in laceration cases, does not state a claim against these defendants. According to the complaint, physicians correctly reported that lacerations were repaired with sutures, but Hudson Hospital billed Medicare for Dermabond "on the facilities side" in instances where it was not actually applied. The only possible interpretation of this allegation is that physician services were properly billed to Medicare but that the Dermabond charge on behalf of Hudson Hospital ("the facilities side") was improper. Accordingly, there is no basis for a claim against the physicians or their agents based on excessive billing for Dermabond.

CONCLUSION

The complaint sufficiently sets forth claims that defendant Hudson Hospital on its own behalf and on behalf of the physicians practicing at the hospital, engaged in improper billing practices that systematically inflated charges to Medicare both for physician services and hospital charges. Because the complaint describes in detail a process applied for the improper benefit of all defendants

it is sufficient to permit effective responsive pleading even though it lacks the type of claim by claim specificity which would be present in the more typical case of larger individual fraudulent claims. However, several of the alleged billing improprieties fail as a matter of law to state claims and therefore must be dismissed.

ORDER

IT IS ORDERED that the motion of all defendants to dismiss claims concerning separate billing for casting services and supplies and splitting emergency room and inpatient charges is GRANTED.

IT IS FURTHER ORDERED that the motion of defendants Hudson Physicians, Group Health Plan, Inc. and Regions Hospital to dismiss the claim based on alleged improper Dermabond charges is GRANTED.

IT IS FURTHER ORDERED that defendants' motions to dismiss are in all other respects DENIED.

Entered this 12th day of May, 2006.

BY THE COURT:

S/

JOHN C. SHABAZ
District Judge