IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

UNITED STATES OF AMERICA and STATE OF MICHIGAN ex rel. JAMES LAFORTUNE and JAMES LAFORTUNE, individually,

Plaintiff,

v.

MEMORANDUM AND ORDER
06-C-278-S

BEACON AMBULANCE SERVICE, INC.,

Defendant.

Relator James LaFortune commenced this qui tam action on behalf of the United States and the State of Michigan alleging that the defendant Beacon Ambulance Service made false claims for Medicaid payments in violation of the False Claims Act, 31 U.S.C. § 3729(a)(1) and (2) and the Michigan Medicaid False Claims Act, MCL § 400.601. 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

Relator was employed by defendant as an Emergency Medical Technician("EMT")-basic from February 2002 to November 2005. Emergency medical technicians are categorized in three levels of increasing training and expertise: EMT-basis, EMT-intermediate and

EMT-paramedic. Defendant is in the business of emergency medical transportation in Iron County Wisconsin and Gogebic and Ontonagon Counties, Michigan. Defendant transports patients from their residences or from accident scenes to area hospitals. If the patient is a Medicaid or Medicare recipient, defendant submits reimbursement claims through Medicare, and through Michigan and Wisconsin Medicaid programs.

Contrary to Wisconsin regulatory requirements, defendant frequently transported patients that required an EMT-paramedic level of care with one EMT-paramedic and one EMT-basic. This practice was contrary to Wisconsin law requiring two EMT-paramedics. After the service was provided defendant fraudulently added the name of an additional EMT-paramedic to the report to certify compliance with Wisconsin requirements. Such claims were then submitted for Medicare reimbursement. Relator was personally asked to add names of non-participating EMT-paramedics to a report.

Relator routinely provided care to patients in the back of the ambulance while an EMT-paramedic drove during transportation of patients. Notwithstanding that relator provided the care, defendant billed Medicare and Medicaid for the higher cost EMT-paramedic service, falsely representing that care had been provided by the EMT-paramedic. This is evidenced by treatment reports in relator's handwriting. As a result of this practice defendant knowingly presented false claims for service greater than it actually provided to Medicare and Medicaid.

MEMORANDUM

Defendants move to dismiss the complaint for failure to state a claim pursuant to Rule 12(b) based on the failure to satisfy the heightened pleading requirements of Rule 9(b).

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).

The complaint sufficiently sets forth claims that defendant engaged in improper billing practices that systematically inflated charges to Medicare and Medicaid for medical services delivered during ambulance transportation. The obvious inference from the

allegations is that claims for payment were knowingly false. Because the complaint describes in detail the process by which defendant allegedly falsely billed the government 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. Although the allegations of the complaint are necessarily limited to relator's personal knowledge given his role in the alleged fraudulent billing process, they are sufficiently detailed as to who participated in the conduct and when, where and how the fraud was accomplished to permit an effective investigation and response to the allegations.

Defendant's reliance on the United States ex rel. Crews v. NCS Healthcare of Illinois, Inc., 460 F.3d 853, 856 (7th Cir. 2006) is misplaced and misleading since Crews was resolved on a motion for summary judgment, not on a motion to dismiss.

ORDER

IT IS ORDERED that defendant's motion to dismiss the complaint pursuant to Rules 12(b)(6) and 9(b) is DENIED.

Entered this 21st day of February, 2007.

BY THE COURT:
S/

JOHN C. SHABAZ
District Judge