No. 21-

IN THE

Supreme Court of the United States

THOMAS E. PARKER, JR., QUI TAM PLAINTIFF FOR AND ON BEHALF OF THE UNITED STATES OF AMERICA AND THE STATE OF WASHINGTON,

Petitioner,

v.

SEA-MAR COMMUNITY HEALTH CENTER, A WASHINGTON PUBLIC BENEFIT CORPORATION,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Does a plaintiff state a claim under the False Claims Act by alleging a purposeful scheme to fraudulently double rates charged to Medicaid for pediatric dental patients by requiring patients to attend two separate appointments for their yearly six-month checkup, when only one is necessary and appropriate under the prevailing standard of care?

STATEMENT OF RELATED CASES

- Parker for & on behalf of United States v. Sea-Mar Cmty. Health Ctr., No. 3:18-cv-05395-RBL, U. S. District Court for the Western District of Washington. Judgment entered Aug. 13, 2020.

- Parker v. Sea-Mar Cmty. Health Ctr., No. 20-35825, U. S. Court of Appeals for the Ninth Circuit. Judgment entered Jul. 13, 2021. Motion for Rehearing En Banc denied Aug. 18, 2021.

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PETITION FOR WRIT OF CERTIORARI

Petitioner Thomas E. Parker, Jr., Qui Tam Plaintiff for and on behalf of the United States of America and the State of Washington, respectfully petitions this Court for a Writ of Certiorari to review the decision of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

The panel opinion of the Ninth Circuit is unpublished and included as Petitioners' Appendix ("app.") 1a-4a. The Ninth Circuit's order denying *en banc* review is available at app. 14a-15a. The unpublished decision of the district court is available at 2020 WL 4698813 and is included at app. 5a-13a.

JURISDICTION

The district court had jurisdiction under federal question jurisdiction authorized under 28 U.S.C. § 1331 for petitioner, Thomas E. Parker's, claims as a qui tam plaintiff against Sea-Mar Community Health Center ("Sea-Mar"), under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, and 31 U.S.C. § 3730, *et seq.* The district court had supplemental jurisdiction of Parker's state law claims under 28 U.S.C. § 1367, which Parker brought under Washington's Medicare Fraud False Claims Act, Wash. Rev. Code § 74.66.020, et seq. Parker filed a timely appeal to the Ninth Circuit Court of Appeals. On July 13, 2021, a panel of the Ninth Circuit issued a memorandum opinion affirming the district court's dismissal of Parker's case, and the panel denied Parker's petition for rehearing *en banc* on August 18, 2021.

This Court has jurisdiction under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS AT ISSUE

This case involves the False Claims Act, 31 U.S.C. § 3729, *et seq.*, and 31 U.S.C. § 3730, *et seq.* ("FCA"), the relevant portions of which are provided at app. 16a-32a.

INTRODUCTION

A child's routine, six-month dental exam includes a tooth cleaning that does not require a second appointment. Any parent or person who received pediatric dental care in the past several decades knows that a routine dental exam requires one visit; that is the standard of care in Washington State and everywhere else in this country, as appellant, Thomas E. Parker, alleged in his complaint, supported by expert testimony. Requiring a second appointment for routine tooth cleanings is a well-recognized scheme to defraud Medicaid, as recognized by states like New York and the federal government through the Department of Justice who have successfully secured settlements against Medicaid providers to end such this exact fraudulent billing practice.

In an outlier opinion, that conflicts with precedent from this Court, the other Circuits of the Court of Appeals, and state and federal enforcement actions across the country, the Ninth Circuit wrongfully found that Parker did not plead a case under the FCA. Parker stated a claim under an implied false certification theory blessed by this Court in *Universal Health Servs., Inc. v. United States (Escobar)*, 579 U.S. 176, 136 S. Ct. 1989, 195

L. Ed. 2d 348 (2016) ("*Escobar*"), because he alleged that Sea-Mar Community Health Center Sea-Mar knowingly, and systematically submitted claims for payment that did not meet Washington's required billing regulations. The Ninth Circuit's decision conflicts with this, and other, precedent, warranting *certiorari*.

STATEMENT OF THE CASE[1]

(1) Sea-Mar Provides Medical and Dental Care to Thousands of Patients and Receives Reimbursement for Services from the Federal Government

Sea-Mar is a FQHC authorized under federal law. 3-ER-567. FQHCs provide Medicaid beneficiaries a managed care option instead of a traditional fee for service method which pays Medicaid providers a set fee for individual identified medical/dental services. 3-ER-568–69. FQHCs in Washington State must be primarily engaged in providing outpatient health services. 3-ER-569. FQHCs in general are "safety net" medical providers, and Sea-Mar mostly serves Medicaid beneficiaries. *Id.*

Sea-Mar and other FQHCs provide medical care, dental services, and behavioral health services, together with some other health care services, as well as housing.

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1. In this appeal from a Fed. R. Civ. P. 12(b)(6) dismissal, a court must accept all allegations in the complaint as true and construe them in the light most favorable to the plaintiff. *E.g.*, *O'Hare Truck Serv., Inc. v. City of Northlake*, 518 U.S. 712, 715, 116 S. Ct. 2353, 2355, 135 L. Ed. 2d 874 (1996); *Mayall on Behalf of H.C. v. USA Water Polo, Inc.*, 909 F.3d 1055, 1060 (9th Cir. 2018). Thus, the facts are largely taken directly from Parker's final amended complaint. 3-ER-566–87.

3-ER-567–68. Sea-Mar's network of health care service providers consists of more than 90 medical, dental, and behavioral health clinics in 12 Washington counties. 3-ER-570. Sea-Mar serves tens of thousands of Medicaid beneficiaries each year, including thousands of pediatric dental patients. 3-ER-567. Most of these patients are children and young adults; many are from disadvantaged financial and social circumstances. 3-ER-573.

Sea-Mar's Medicaid related claims are paid by the State of Washington after submission to Washington's Health Care Authority ("HCA"). *Id.* Washington State promulgates regulations and billing manuals that regulate Sea-Mar's billing practices. *See* Wash. Admin. Code ch. 182-502.

FQHCs are, for most dental services, subject to a prospective payment system which categorizes most dental and health care visits to a FQHC as an "encounter" subject to a single payment of a set "encounter" fee for most health care services provided to a client on a single day. 3-ER-569–70. The encounter rate is intended to provide for a method for the delivery of health care services which combines several routine health care services at a single health care appointment on a single day and resulting in a single billing to Medicaid. *Id.* Combining several routine health care services at a single health care appointment allows for increased access to health care by under-served communities by reducing the number of necessary health care visits by a patient, leading to reduced patient transportation time, less inconvenience, less pain and suffering, and resulting in less lost time for work and school obligations to attend medical/dental appointments by Medicaid beneficiaries and their parents.

3-ER-579–82. Providing several services during a single visit is common and reduces the strain on limited health care resources. 3-ER-578, 579–82.

The applicable billing manual defines "encounter" as "a face-to-face visit between a client and an FQHC provider of healthcare services who exercises independent judgment when providing healthcare services to the individual client." 3-ER-499. The manual states that services and supplies that are "incidental" to the primary encounter, here the dental exam, "are factored into the encounter rate and will not be paid separately." 3-ER-500–01. Specifically, with regard to dental encounters, the manual states that only one dental encounter fee may be provided in a single day. 3-ER-507. But it lists an exception: "When a dental service requires multiple visits (*e.g.*, root canals, crowns, dentures), an encounter code must be billed with the number of visits, when the dental services are complete." 3-ER-507.

The encounter fee reimbursement rate leads to a reimbursement amount which is typically much greater in amount than a traditional "fee for service" payment system which pays a set fee for a single specific dental or health care treatment. *E.g.*, 3-ER-577. For each single treatment for a "fee for service" payment system, a separate fee is earned for each service provided. *Id.* Encounter fees typically pay much more than a single "fee for service" payment for each of the sometimes several health care services provided in a single day because of the intended combining or "bundling" of several health care treatments into one visit on one date. 3-ER-500–01.

In Washington, the "fee for service" reimbursement rate for Medicaid beneficiaries for routine dental

prophylaxis cleaning is $36.25 for individuals over 13 years old and $22.98 for individuals under 13 years old. Sea-Mar's current encounter rate is over $190.00 for dental services, showing an obvious incentive to charge two encounter rates, even though a single six-month preventative tooth exam and cleaning requires just one. 3-ER-577.

(2) Parker, a former Sea-Mar Employee, Stated a Claim Under the FCA and its State Equivalent

Parker worked for Sea-Mar as a dental assistant from 2001 until 2013. Parker became deeply knowledgeable of the workings of Sea-Mar during his employment and his complaint stems from his personal knowledge of Sea-Mar's operations. 3-ER-570. When he filed his complaint, Parker and his family continued to receive healthcare, including dental health services, from Sea-Mar. Parker remained in contact with former employees of Sea-Mar, including two who provided information in his complaint and identified in it as confidential informants. 3-ER-570.

Parker also engaged a well-qualified expert in dental practices, a dentist Dr. Michael Davis, to review Sea-Mar's practices. 3-ER-579–81. Parker included Dr. Davis's conclusions in his complaint. *Id.*

(a) Sea-Mar Engages in Systematic Patient Churning and Unbundling to Defraud Medicaid

The standard of dental care in Washington requires that routine dental examinations, radiographic imaging, related services, and prophylaxis (*i.e.*, routine, preventive) cleaning should ordinarily be provided on one day during

a single dental care visit. 3-ER-579–82. This standard of care applies to around 95 percent of pediatric patients who do not require a more thorough deep-clean or other treatment that may take place at a second dental visit. 3-ER-578, 579–82. Again, Parker alleged that a separate visit for dental cleaning is rare; less than five percent of a pediatric patients require more extensive cleanings that require a separate dental appointment. *Id.* This is confirmed by the billing manual which gives examples of services that might require a second visit, listing intensive procedure like root canals, crowns, or dentures that are nothing like a routine dental cleaning. 3-ER-507.

Despite this standard of care, Sea-Mar adopted a policy that requires a dental examination by a dentist and radiographic imaging by a dental assistant on one day and the administration of prophylaxis dental cleaning on another day performed by a dental hygienist. 3-ER-578. This allows Sea-Mar to bill two separate encounter fees at $190.00 each, when only one is required. *Id.* Parker alleged that this policy has existed since at least 2013. 3-ER-573.

This practice by Sea-Mar is a well-known fraud perpetrated on state Medicaid payment agencies by FQHCs around the United States. 4-ER-627–33 (Dr. Michael W. Davis, DDS, *FQHCs Churn Patients in a Big Scam*, Today's Dental News October 16, 2019). The practice is often known as "patient churning." *Id.* Patient churning is the institutional practice of inflating revenues by maximizing visits/encounters when payment is determined by the number of encounters and not by the procedures accomplished. 4-ER-627–33. This method of fraud has been described and labeled as Medicaid fraud by both Washington and the National Commentators,

including the American Dental Association and the former editor of the WSDA news, the publication of the Washington State Dental Association. 3-ER-580.

The type of fraud perpetrated by Sea-Mar for dental services is widely recognized and publicized as fraudulent within the FQHC industry. 2-ER-71. Other states, including New York, have successfully settled FCA claims against FQHCs that use this scheme. 4-ER-639–44 (*e.g.*, Press Release, New York State Attorney General, A.G. Schneiderman Announces $325,000 Medicaid Fraud Settlement with Erie County Dental Clinic (January 9, 2012) ("The audit-investigation determined that in addition to performing unnecessary procedures, the clinic performed procedures that should have been done in one visit [including 'cleanings, X-rays, and dental exams'] over multiple visits, resulting in additional fraudulent reimbursements").

Indeed, the Department of Justice also prosecutes such fraudulent practices, as shown by a very recent example from its Connecticut office. Press Release, *Health Center Pays $350K to Settle Improper Billing Allegations Related to Medicaid Dental Services*, United States Department of Justice, United States Attorney's Office, District of Connecticut (August 11, 2021), https://www.justice.gov/usao-ct/pr/health-center-pays-350k-settle-improper-billing-allegations-related-medicaid-dental. As stated in that release:

> ...CORNELL SCOTT HILL HEALTH CORPORATION ("CSH") has entered into a civil settlement agreement with the federal and state governments and has paid $350,000 to

> resolve allegations that CSH improperly billed the Connecticut Medicaid program for certain dental services.
>
> CSH is a Federally Qualified Health Center ("FQHC") that provides a variety of health care services, including dental services, to Connecticut Medicaid beneficiaries and other individuals.
>
> …
>
> The allegations against CSH arise out of improper billing for certain dental services, specifically prophylactic cleanings and dental exams. The government alleges that CSH implemented a policy that required Medicaid patients to receive prophylactic cleanings and dental exams on separate days, resulting in CSH getting paid two encounter rates instead of just one rate.
>
> To resolve their liability, CSH paid $350,000 to the federal and state governments for conduct occurring between January 1, 2017 through December 31, 2019. In addition, CSH has agreed to change its policy and offer all Medicaid beneficiaries the option of scheduling a prophylactic cleaning and dental examination on the same day.

Parker's allegations were no different; he alleged a policy "require[ing] Medicaid patients to receive prophylactic cleanings and dental exams on separate days." *Id.*

Parker argued that these kinds of investigations supported his claim and showed, among other things, Sea-Mar's knowledge and scienter; Sea-Mar cannot deny that they knew of, or should have known of, this common scheme by FQHCs to defraud Medicaid.[2] 2-ER-71, 79.

(b) Parker Alleged that Providing Only Necessary Services According to the Standard of Care and Is a Condition of Payment Under Applicable Billing Rules and Regulations

As a condition of payment by Washington State's Medicaid processor for dental treatment provided to Medicaid beneficiaries, Sea-Mar must only provide services that are "medically necessary" and must meet "accepted dental or medical practice standards" in the delivery of that dental care. Wash. Admin. Code §§ 182-535-1079(1)(c) and (f). Parker argued that by "patient churning," and "unbundling," (*i.e.*, separating dental care that is normally performed in one visit into a second medically unnecessary visit to maximize encounter fees) Sea-Mar violates conditions of payment set forth in Wash. Admin. Code §§ 182-535-1079(1)(c) and (f). *E.g.*, 2-ER-75; 3-ER-579 (arguing that Sea-Mar subjected patients to unnecessary appointments). Parker alleged that the HCA will not pay for dental care that does not meet the prevailing standard of care. 3-ER-579; Wash. Admin. Code § 182-502-0100(1)(c) (billing "according to agency rules and billing instructions" is a "condition[] of payment").

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2. "Knowing" or "Knowingly," as defined by 31 U.S.C. § 3729(b)(1)(A) and Wash. Rev. Code § 74.66.010(7)(a)(b), includes "deliberate ignorance" or "reckless disregard" of the truth or falsity of the information and does not require proof of any specific intent to defraud.

Parker also alleged that by providing dental services below the standard of care, Sea-Mar abuses their Medicaid dental patients by subjecting them to the added pain and suffering that results from unnecessary dental appointments.[3] 3-ER-582.

As discussed above, Parker obtained review by a consulting expert, Dr. Davis, regarding Sea-Mar's splitting of dental appointments and included the expert's conclusions in his Third Amended Complaint. 3-ER-579–81. Dr. Davis stated that Sea-Mar's policy of unbundling prophylaxis tooth cleaning from routine dental exams violates the standard of care in Washington State for dentistry and is a well-known method FQHCs use to defraud Medicaid in the dental industry. *Id.* This practice systematically violates the standard of care, subjects approximately 95 percent of Sea-Mar patients to unnecessary dental appointments, and allows Sea-Mar to overbill Medicaid by charging two encounter fees for dental care that should only require one. *Id.*

Indeed, Sea-Mar has been investigated for such practices in the past. Washington's Attorney General, though its "false claims unit," recently investigated Sea-

3. Parker alleged that Sea-Mar undermines the philosophic basis for the FQHC encounter fee: that health care services are delivered more efficiently and more comprehensively to underserved communities when multiple health care services are provided on a single day at one health care visit. Sea-Mar unnecessarily imposes multiple medical appointments on patients, which may be considered a form of medical abuse, and, in the process, violates the standard of care by scheduling routine dental care treatments on separate days that should occur together on one day. 3-ER-582.

Mar for very similar deceptive practices to that described in Parker's complaint – unbundling dental services and charging encounter fees for services that do not require multiple visits. 3-ER-570–72. The State discovered that Sea-Mar systematically administered routine fluoride treatments at a separate appointment from a patient's routine dental exam, charging a separate encounter fee. Sea-Mar agreed to pay $3.65 million as a result of the investigation. *Id.* The Seattle Times reported the details of the case and settlement based nearly identical allegations to those that Parker alleged:

> Sea Mar Community Health Centers, which provides health services to mostly poor and many minority residents in 10 counties, has agreed to pay $3.65 million to settle an investigation by the state Attorney General's Office into improper Medicaid billings.
>
> Attorney General Bob Ferguson said the 2½-year investigation revealed the healthcare provider overbilled Medicaid for thousands of dental appointments, according to a news release.
>
> Ferguson said his office's false-claims unit raised concerns over the billings, which occurred between 2010 and 2014, and involved routine anti-cavity fluoride treatments.
>
> The AG's office alleged that the fluoride treatments, which could have been performed by dental assistants as part of a patient's regular six-month checkups, were instead billed

> at a higher rate as stand-alone appointments with a dentist or hygienist.

4-ER-608–10 (Mike Carter, *Sea Mar to pay $3.65M to settle probe into Medicaid billings*, Seattle Times, January 16, 2015). Parker alleged essentially the same facts, that Sea-Mar routinely unbundled dental services, prophylaxis cleaning, to churn patients and artificially increase unnecessary encounter fees. *See generally*, 3-ER-566-87 (complaint).

Again, Parker alleged that this recent investigation and settlement provided other evidence for the elements of a FCA claim – that Sea-Mar acted with scienter and that its unbundling practices are material to Washington State's decision to make payments for dental services provided to Medicaid patients. 3-ER-586.

(c) Parker Alleged that Sea-Mar Created False Records to Further its Patient Churning/ Unbundling Scheme

Parker also alleged that Sea-Mar filed false claims for reimbursement and created false documents pertaining to dental services in support of claims for payment submitted to HCA for services provided to Medicaid beneficiaries. 3-ER-586. Parker alleged that his occurred for years, but this policy was formally announced to Sea-Mar employees by Sea-Mar's directors. 3-ER-575, 4-ER-615–17.

Pursuant to Sea-Mar policy, all patient prophylaxis cleanings which are exclusively provided by dental hygienists are falsely billed to HCA under a dentist's NPI number and taxonomy code. 3-ER-572–75. When

submitting claims for dental services performed by dental hygienists for the unbundled services, Sea-Mar always falsely represents to HCA that these services were provided or "rendered" by named dentists under their NPI numbers and a dentist's taxonomy code. *Id.* Parker alleged that Sea-Mar creates false documents in support of their false claims because the dentists so identified did not render the billed for services. *Id.* He alleged that this practice violates the False Claims Act and HCA billing guidelines as Sea-Mar knows. *Id*., 3-ER-586.

By failing to properly identify the health care provider who provided the care by using the provider's true NPI and taxonomy code, Sea-Mar violated billing guidelines, creating false documents and filing false claims with Medicaid in express violation of applicable Medicaid billing policies, rules, and regulations. 3-ER-585–86. Sea-Mar, in submitting these bills using false taxonomy codes and thereby concealing the true provider who "rendered" the billed for services, made false claims for Medicaid reimbursement. *Id.*

By failing to bill using the correct health care provider and taxonomy codes, Parker alleged that Sea-Mar furthered its unbundling and patient churning scheme by concealing its practice to separate routine dental services to obtain duplicate encounter fees. *Id.* Parker alleged that by billing Medicaid under an NPI number and taxonomy code assigned to a dentist who did not provide any treatment to a Medicaid beneficiary, Sea-Mar violated 31 U.S.C. § 3729(a)(1)(A), 31 U.S.C. § 3729(a)(1)(G) and Wash. Rev. Code §§ 74.66.020(1)(a) and (g). *Id.*

Parker alleged that the State of Washington is unaware that Sea-Mar is separating services to receive unearned duplicate encounter fees, in part, because of this deception. 2-ER-75. Again, Parker argued that had Washington known of Sea-Mar's concealment, the claims would not have been paid. *Id.*

(3) Procedural History

Sea-Mar never answered Parker's complaint; it moved to dismiss for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6). 6-ER-1283–89. No discovery occurred in the district court. 2-ER-67.

Parker amended his complaint twice, before the district court, the Honorable Judge Leighton, dismissed his third amended complaint with prejudice, incorrectly concluding that Parker failed to state a claim under the FCA or its state equivalent. 1-ER-3–9.

Parker timely appealed. 6-ER-1289. The Court of Appeals for the Ninth Circuit issued a memorandum opinion affirming dismissal on July 13, 2021. Parker timely field a motion for rehearing *en banc*, which was denied on August 18, 2021. This timely petition follows.

REASONS FOR GRANTING THE PETITION

I. The Ninth Circuit's Decision Conflicts with Supreme Court Precedent on an Issue of National Importance

Review is warranted to resolve conflicts on an issue of national importance. Parker's complaint alleged a FCA

claim based on the implied false certification theory, a theory this Court blessed in *Escobar*.[4] There, this Court overruled conflicting case law among the circuits, holding that a valid FCA claim does not require an affirmative false statement. Rather, liability under the FCA "encompasses claims that make fraudulent misrepresentations, which include certain misleading omissions." 136 S.Ct. at 1999. "When, as here, a defendant makes representations in submitting a claim but omits its violations of statutory, regulatory, or contractual requirements, those omissions

4. The elements of an FCA *qui tam* action are well established. A defendant is liable under the FCA if it knowingly presents a false or fraudulent claim for approval, 31 U.S.C. § 3729(a)(1)(A), or if it makes or uses a false record or material statement to the Government calculated to avoid or decrease an obligation to pay money to the Government. 31 U.S.C. § 3729(a)(1)(G). Under the Act, a plaintiff must allege: "(1) a false statement or fraudulent course of conduct, (2) made with the scienter, (3) that was material, causing, (4) the government to pay out money or forfeit moneys due." *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 899 (9th Cir. 2017), *cert. denied*, 139 S. Ct. 783 (2019). The statute is unique in that private citizens are permitted to bring FCA claims as relators on behalf of the United States – but this speaks to its board and liberally interpreted purpose to reach all types of fraud discussed below.

Washington State's Medicare Fraud False Claims Act, Wash. Rev. Code § 74.66.020, *et seq.*, mirrors its federal counterpart. Given a lack of authority to the contrary, neither party argued that an analysis under state law is any different than the FCA. This makes sense given that Washington interprets state statutes in line with existing federal analogs. *State v. Black*, 676 P.2d 963 (Wash. 1984) (construing the Washington Consumer Protection Act by looking to the federal counterpart); *McClellan v. Sundholm*, 574 P.2d.371 (Wash. 1978) (construing the State's Securities Act by looking to the federal counterpart).

can be a basis for liability if they render the defendant's representations misleading with respect to the goods or services provided." *Id.*[5]

Here, applicable billing regulations state that Sea-Mar must only bill for services that are "medically necessary," and those services must meet "accepted dental or medical practice standards" (*i.e.*, the standard of care). Wash. Admin. Code §§ 182-535-1079(1)(c) and (f). Parker alleged that these are necessary conditions of payment.

Parker pleaded an FCA claim by alleging that Sea-Mar submits claims for payment while falsely certifying that unbundling routine cleanings to double encounter fees is necessary and meets the standard of care in Washington. By submitting for payment two encounter fees for every routine six-month dental appointment for its pediatric

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5. This broad reading only makes sense, given that the purpose of the FCA is "to reach all types of fraud, without qualification, that might result in financial loss to the Government." *United States v. Niefert White Co.,* 390 U.S. 228, 232, 88 S. Ct. 959, 19 L. Ed. 2d 1061 (1968). The Act itself dates back to the Civil War when Congress learned that "the United States had been billed for nonexistent or worthless goods, charged exorbitant prices for goods delivered, and generally robbed in purchasing the necessities of war." *Escobar*, 136 S. Ct. at 1996. Congress allowed private citizens to file *qui tam* suits on the government's behalf, evidence that curbing waste and fraudulent charges to the government are important federal objectives that are often inadequately addressed by bureaucratically stagnated and politically motivated enforcement agencies. *See, e.g.*, *Cook Cty., Ill. v. U.S. ex rel. Chandler*, 538 U.S. 119, 133, 123 S. Ct. 1239, 155 L. Ed. 2d 247 (2003) (discussing legislative history of FCA and the *qui tam* provision for which Congress has "enhanced the incentives for relators to bring suit").

patients, Sea-Mar certified that those two fee-generating encounters were necessary, among the "accepted dental or medical practice standards." But expert testimony, commonsense, and identical enforcement actions from Medicaid regulators across the country confirmed that they were not. Therefore, Parker stated a claim under Escobar.

Parker did more than enough to support his allegations for purposes of the pleading stage. He submitted evidence from a dental expert, the Washington and American Dental Associations, false claims settlements from other states, as well as publications from the United States National Library of Medicine,[6] showing that the accepted dental practice standard is for several services to be provided during and incidental to a single biannual exam, including prophylaxis (preventative) tooth cleanings. Sea-Mar knowingly violates this accepted dental standard to artificially inflate Medicaid payments, and the core function of the FCA is to curtail such fraudulent behavior leading to governmental overpayment and waste. The district court and Court of Appeals should have construed this evidence in Parker's favor and allowed him to conduct discovery and attempt to prove the merits of his case in court.

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6. *See Dental Exam*, MedlinePlus, https://medlineplus.gov/lab-tests/dental-exam/ (last accessed November 9, 2021) ("A typical dental exam will include a cleaning by a hygienist, x-rays on certain visits, *and* a checkup of your mouth by the dentist."); *see also Dental exam for children*, Mayo Clinic, https://www.mayoclinic.org/tests-procedures/dental-exam-for-children/about/pac-20393745 (last accessed November 9, 2021) ("During a dental exam, the dentist or hygienist will clean your child's teeth *and* evaluate your child's risk of tooth decay.") (emphasis added).

But even if that evidence were not enough, the billing manual and regulations also state that services and supplies that are "incidental" to the primary encounter, here the dental exam, "are factored into the encounter rate and will not be paid separately." 3-ER-500–01; Wash. Admin. Code § 182-548-1450(2). The Ninth Circuit made *no mention* of this aspect of Parker's argument. Parker alleged that a routine tooth cleaning, commonly administered on the same day as a dental exam by a dental hygienist, is more like an incidental service than it does a separate encounter. 3-ER-578. Sea-Mar unbundled this service and systematically churned its patients in knowing violation of the policies and regulations on dental billing to double its encounter fees. *Id.* Again, these fraudulent practices have been grounds for enforcement actions by the Department of Justice and various states including Washington and New York, as shown by the press releases and serious fines imposed above. *At the very least*, a jury could find that Sea-Mar wrongfully double-billed encounter fees for routine checkups, and Parker should have a chance to conduct discovery and pursue his claims.

Here, the Ninth Circuit disregarded the applicable billing regulations. In doing so, it seemingly inserted a requirement that billing regulations or manual must *expressly forbid* the *exact fraudulent practice* alleged to state an actionable claim. App. at 3a ("Nothing in the statute, regulations or guidance prohibits scheduling dental exams and cleanings in separate visits and billing each as an encounter."). That is not the standard this Court set in *Escobar*, or by the various Circuits of the Court of Appeals since this Court decided *Escobar*.[7] *See,*

7. Even if it were the standard, Parker met this burden by alleging that Sea-Mar violated regulations and manuals that were

e.g., *Bishop v. Wells Fargo & Co.*, 870 F.3d 104, 107 (2d Cir. 2017) (there is no "particularity requirement" for "the underlying statute or regulation upon which the plaintiff relies" to "*expressly* state[] the provider must comply in order to be paid.") (emphasis in original); *United States ex rel. Polukoff v. St. Mark's Hosp.*, 895 F.3d 730, 743 (10th Cir. 2018) (medical procedures must be "reasonable and necessary" to be reimbursed under Medicare, meaning they are "[f]urnished in accordance with accepted standards of medical practice" and "[a]ppropriate including the duration and frequency that is considered appropriate for the item or service" as can be established by testimony from the medical community) (particular heart procedure not prohibited for payment, but testimony from doctors showed it was being provided unnecessarily and to an inappropriate number of patients).[8]

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conditions of payment – by systematically violating prevailing dental standards in order to charge a separate encounter fee for incidental services – thereby stating an FCA claim under an implied false certification theory. The Ninth Circuit created further conflicts by refusing to accept as true the allegations in Parker's complaint for purposes of a 12(b)(6) motion. *E.g.*, *O'Hare*, 518 U.S. at 715 (a "complaint's factual allegations are taken as true").

8. The Ninth Circuit's opinion conflicts even with its own precedent. There is no requirement that a particular medical practice be *expressly forbidden* if it is generally impermissible to submit unnecessary or inappropriate procedures to increase fees on a systematic scale. *See, e.g.*, *United States ex rel. Rose v. Stephens Inst.*, 909 F.3d 1012, 1017 (9th Cir. 2018), *cert. denied*, 139 S. Ct. 1464 (2019) (theory applies "when an entity has previously undertaken to expressly comply with a law, rule or regulation [but does not], and that obligation is implicated by submitting a claim for payment"); *Winter ex rel. United States v. Gardens Regional Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1116 (9th Cir. 2020), *cert.*

The FCA does not impose such a strict bar as the Ninth Circuit imposed. Quite the opposite; as this Court has explained, the purpose of the FCA is "to reach all types of fraud, without qualification, that might result in financial loss to the Government." *Niefert,* 390 U.S. at 232. Thus, the FCA must be liberally interpreted achieve its goals of curbing government waste. The Ninth Circuit's opinion is an outlier post-*Escobar* and should be corrected to ensure uniform application of the FCA.

The Ninth Circuit also created conflicts when it stated that Parker had a duty to "rebut" the evidence that because Washington paid Sea-Mar's claims in the past, Sea-Mar's misleading claims were not material to its decision to pay. App. at 4a. Parker has no such duty on a 12(b)(6) motion. Even the Ninth Circuit has held that "[m]ere [government] approval [of claims submitted for payment] cannot preclude False Claims Act liability." *Campie*, 862 F.3d at 905. Rather, payment by the government is merely evidence against materiality if the government had "actual knowledge that certain requirements were violated." *Escobar*, 136 S.Ct. at 2003–04. To the extent there is any doubt, such matters are "matters of proof, not legal grounds to dismiss relators' complaint." *Id.* at 907.

Parker plainly alleged that the payor would not pay Sea-Mar's claims if it had actual knowledge that they violate applicable billing regulations. Actual knowledge is a question of fact, as even the Ninth Circuit recognized

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denied, 2021 WL 666435 (2021) (hospital submitted false Medicare claims by certifying that patients' inpatient hospitalizations were necessary, a condition of payment under federal regulations and billing guides).

in *Campie*. 862 F.3d at 907 (what the government knew is a question of "evidence"); *see also*, *State v. Lowery*, 475 P.3d 505, 511 (Wash. Ct. App. 2020) (analogous state FCA claim) (actual knowledge is a question of fact). The Ninth Circuit's conflicting analysis necessitates correction.

Certiorari review and reversal is warranted in this case.

II. The Court Should Grant Review of this Important Federal Question to Ensure Uniform Application of Federal Law

The Court should grant review to settle this issue and ensure uniform application of federal law. With the lower courts' decisions in place, there exists a divide over whether courts permit an FCA claim to go forward based on testimony that a medical or dental procedure is unnecessary and violates the standard of care.

Here, the district court entered its flawed dismissal based on outdated caselaw. It stated:

> [C]ourts have repeatedly held that "billing for medical services that do not meet the standard of care does not give rise to a [sic] FCA violation' because the FCA 'is an inappropriate vehicle for policing quality of care, which is better left to local regulation and enforcement."

1-ER-6 (citing *United States ex rel. Lockyer v. Hawaii Pac. Health*, 490 F. Supp. 2d 1062, 1076 (D. Haw. 2007) and *United States ex rel. Dooley v. Metic Transplantation Lab, Inc.*, No. CV 13-07039 SJO (JEMx), 2017 WL 4323142 at *26 (C.D. Cal. June 27, 2017)) (quotation omitted).

Those cases, both from district courts and one unpublished, hinged on overturned case law. *Lockyer* cited an outdated case from the Second Circuit to support its decision. 490 F. Supp. 2d at 1076 ("The Court agrees with the reasoning in *Mikes v. Straus*, 274 F.3d 687, (2d Cir. 2001), which held that billing for medical services that do not meet the standard of care does not give rise to a FCA violation."). But this Court unanimously abrogated *Mikes* in *Escobar*, 136 S. Ct. at 1999, finding that its holding was too narrow. Again, this Court clarified that "[w]hen, as here, a defendant makes representations in submitting a claim but omits its violations of statutory, regulatory, or contractual requirements, those omissions can be a basis for liability if they render the defendant's representations misleading with respect to the goods or services provided." *Id.*

It is no wonder that more recent decisions have come the opposite conclusion than the outdated cases like those on which the district court relied. *See Winter, supra*, (allegations that treatment was not medically necessary supported an FCA claim); *Polukoff*, 895 F.3d 730, *supra*, and *United States ex rel. Gerald Polukoff, M.D. v. St. Mark's Hosp.*, 2020 WL 2927865 at *4 (D. Utah June 3, 2020) (declarations from doctors about the standard of care for performing certain medical procedures were admissible and relevant to prove FCA case against doctors who allegedly overbilled for medical services that were unnecessary); *United States ex rel. Jackson v. DePaul Health Sys.*, 454 F. Supp. 3d 481, 494 (E.D. Pa. 2020) (standard of care is relevant because a claim is "factually false [and actionable under the FCA] due to the provision of worthless services where a defendant sought federal reimbursement for a procedure with no medical value.") (quotation omitted); *United States ex rel. Schultz v. Naples*

Heart Rhythm Specialists, P.A., 2020 WL 1852432 at *3 (M.D. Fla. Apr. 13, 2020) (standard of care is relevant to show medical necessity of treatment billed to Medicare).

Contrary to the Ninth Circuit's outlier opinion, this can include unbundling and patient churning where such practices are not necessary but meant to artificially inflate federally paid fees. *United States ex rel. Salters v. Am. Family Care, Inc.*, 262 F. Supp. 3d 1266, 1285 (N.D. Ala. 2017) (finding that allegations of unbundling supports a claim under the FCA where the applicable billing manual "provides that 'routinely bundled' claims are not paid for separately."); *U.S. ex rel. Doe v. DeGregorio*, 510 F. Supp. 2d 877, 885 (M.D. Fla. 2007) (allegations of unbundling medical services to inflate claims for federal reimbursement supports a valid claim under the FCA). Parker's complaint is no different.

The lack of uniformity is astonishing given that as recently as several weeks before this petition was filed, the Department of Justice came to a $350,000 settlement to end another FQHC's identical practice of "implement[ing] a policy that required Medicaid patients to receive prophylactic cleanings and dental exams on separate days, resulting in CSH getting paid two encounter rates instead of just one rate." In addition to the monetary penalty, the FQHC agreed to "agreed to change its policy and offer all Medicaid beneficiaries the option of scheduling a prophylactic cleaning and dental examination on the same day." Parker alleged identical fraudulent behavior.

Granting *certiorari* and reviewing this case would further the goals of the FCA, properly algin the lower courts on their various interpretations of the FCA, and call attention to particular fraudulent practice on a

national scale. This would potentially save the American taxpayer millions, not to mention the state and federal enforcement agencies who have to pursue FQHC's one by one, in jurisdiction after jurisdiction, to prevent this fraud. Supreme Court review is appropriate and necessary to resolve the important federal questions raised by this case.

CONCLUSION

Parker respectfully requests that the petition for a writ of *certiorari* should be granted. This Court should step in to ensure uniform application of the FCA, an important federal tool that can save the American taxpayer millions if property enforced, which the Ninth Circuit failed to do.

Respectfully submitted,

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APPENDIX

APPENDIX A — MEMORANDUM OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT, FILED JULY 13, 2021

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 20-35825

THOMAS E. PARKER, JR., QUI TAM PLAINTIFF FOR AND ON BEHALF OF THE UNITED STATES OF AMERICA AND THE STATE OF WASHINGTON,

Plaintiff-Appellant,

and

UNITED STATES OF AMERICA, *ex rel*; STATE OF WASHINGTON, *ex rel*,

Plaintiffs,

v.

SEA-MAR COMMUNITY HEALTH CENTER, A WASHINGTON PUBLIC BENEFIT CORPORATION,

Defendant-Appellee.

Appeal from the United States District Court
for the Western District of Washington.
D.C. No. 3:18-cv-05395-RBL.
Ronald B. Leighton, District Judge, Presiding.

Appendix A

July 6, 2021, Argued and Submitted,
Seattle, Washington;
July 13, 2021, Filed

MEMORANDUM[*]

Parker appeals from the dismissal of his False Claims Act lawsuit. We have jurisdiction under 28 U.S.C. § 1291 and affirm the district court.

Parker claims that Sea Mar Community Health Center, a federal qualified health center, is defrauding Medicaid through how it schedules and bills for oral prophylaxis cleanings. Sea Mar moved to dismiss Parker's lawsuit. Dismissal under Rule 12(b)(6) may be based on either: (1) lack of a cognizable legal theory, or (2) insufficient facts under a cognizable legal theory. *Godecke ex rel. United States v. Kinetic Concepts, Inc.*, 937 F.3d 1201, 1208 (9th Cir. 2019) (quoting *Balistreri v. Pacifica Police Dep't*, 901 F.2d 696, 699 (9th Cir. 1988)). As False Claims Act lawsuits sound in fraud, the complaint must satisfy Federal Rule of Civil Procedure 9(b). *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1116 (9th Cir. 2020). Parker is required to plead "with particularity the circumstances constituting fraud," Fed. R. Civ. P. 9(b), and to plead "'the who, what, when, where, and how of the misconduct charged,' including what is false or misleading about a statement, and why it is false," *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1180 (9th Cir. 2016) (quoting *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998 (9th Cir.

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* This disposition is not appropriate for publication and is not precedent except as provided by Ninth Circuit Rule 36-3.

2010)). We review the district court's dismissal of a case de novo. *Winter*, 953 F.3d at 1116.

Parker fails to state a legally cognizable theory that "unbundling" routine dental cleanings from dental exams and billing the cleanings under the supervising dentist's National Provider Identifier ("NPI") rather than the NPI of the dental hygienist who performed the cleaning constitutes "a false statement or fraudulent course of conduct." *United States ex rel. Hendow v. Univ. of Phoenix*, 461 F.3d 1166, 1174 (9th Cir. 2006). Nothing in the statute, regulations or guidance prohibits scheduling dental exams and cleanings in separate visits and billing each as an encounter. *Contra* Wash. Admin. Code § 182-548-1450(3) (2017) (requiring fluoride treatments and sealants be provided on the same day as an encounter-eligible service). There is also nothing prohibiting billing under the supervising dentist's NPI. To the contrary, a dentist must supervise a dental hygienist performing in-clinic cleanings, Wash. Admin. Code § 246-817-550(9), and the billing guidelines note that "a dental hygienists may bill an encounter only when s/he provides a service independently — not jointly with a dentist." Parker fails to plead a legally cognizable theory that the alleged billing and scheduling of cleanings by Sea Mar are fraud against Medicaid as Sea Mar's billing procedures comport with Washington law.

The complaint also fails to plead scienter as to the alleged fraudulent nature of the unbundling and using the dentist's NPI to bill cleanings performed by a dental hygienist. As these practices are not prohibited by statute, regulations, or guidelines, Sea Mar could not have submitted the claims with the "knowledge of the falsity and with intent to deceive." *See Hendow*, 461 F.3d at 1175.

Finally, Parker does not adequately plead the materiality of the alleged wrongdoing by Sea Mar. It would be clear on the face of the Medicaid claims if Sea Mar were scheduling cleanings separate from dental exams as the claim form requires the procedure code for all services provided. As the Washington Health Care Authority paid the claims without objection, there "is strong evidence" that the alleged unbundling, even if below the standard of care, is not material. *See Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2004, 195 L. Ed. 2d 348 (2016). It is also clear on the face of the claim forms that a dentist's NPI was being used to bill services typically performed by dental hygienists, such as dental cleanings. Again, the Washington Health Care Authority knowingly paid these claims. Plaintiff failed to adequately rebut the strong evidence that any alleged false statements or fraudulent course of action was material to the government payor.

AFFIRMED.

APPENDIX B — ORDER OF THE UNITED STATES DISTRICT COURT FOR THE WESTERN DISTRICT OF WASHINGTON, FILED AUGUST 13, 2020

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

CASE NO. C18-5395RBL

THOMAS E. PARKER, JR., QUUI TAM PLAINTIFF FOR AND ON BEHALF OF THE UNITED STATES OF AMERICA AND THE STATE OF WASHINGTON,

Plaintiff,

v.

SEA-MAR COMMUNITY HEALTH CENTER, A WASHINGTON PUBLIC HEALTH CORPORATION,

Defendant.

August 13, 2020, Decided
August 13, 2020, Filed

ORDER

THIS MATTER is before the Court on Defendant's Motion to Dismiss Third Amended Complaint [Dkt. #55]. The Court has reviewed the materials filed for and against the motion. Oral argument is not necessary. The

Court wrote a comprehensive Order explaining why the Plaintiff's Second Amended Complaint was Dismissed [Dkt. #51]. The Court finds nothing new in the Third Amended Complaint which can save the Third Amended Complaint from the same fate. For the reasons stated below, the Motion to Dismiss Third Amended Complaint [Dkt. #55] is **GRANTED** and the claims are **DISMISSED WITH PREJUDICE**.

A. Relator's Unbundling Claim Fails to Satisfy Rule 8, and the Relator Offers No New Arguments This Court Has Not Already Considered and Rejected.

1. Nothing in the statutes, regulations or Billing Guides requires a prophylaxis cleaning to occur during the same visit as a dental examination, and there are no plausible allegations of any false representation.

Relator's Response reiterates—almost word for word—his prior argument in response to Sea Mar's Motion to Dismiss his second amended complaint (SAC), that a dental hygienist's services are "incidental" to a dentist's examination. However, this Court has already held that this argument is "both contrary to the definition of a dental encounter, and misplaced" and determined that "nothing in the statutes or regulations or Billing Guides generally requires the treatment or prevention of a dental problem (such as a cleaning) occur during the same visit as the administration of radiographs and a dentist's examination." April 28 Order at 13:13-15, 14:4-7. [Dkt. #41]. Indeed, "the FQHC Billing Guide makes

clear which services must be billed together and when; similarly, it provides clearly when a service should be billed separately as fee-for-service." *Id.* at 14:8-10. Once again, it is telling that Relator has not alleged Sea Mar violated these guidelines.

It is also undisputed that Sea Mar must bill the procedure codes for each service rendered. Sea Mar asserted this argument in its prior dismissal motion as well, and Relator still does not argue to the contrary. Indeed, because HCA calculates the reimbursement amount by taking the difference between the encounter rate and the fee-for-service payment for the particular procedure code submitted, it ***needs*** the procedure codes in order to reimburse Sea Mar. Relator's conclusory assertion that Sea Mar has attempted to "conceal" the unbundling is thus nonsensical. There is no false representation as to what services were provided on what day.

2. Relator's materiality and scienter assertions are conclusory and nonsensical.

Relator has merely recycled his prior materiality and scienter arguments by cutting and pasting—with a few changed words—from Relator's response to Sea Mar's prior motion to dismiss. These arguments thus suffer the same flaws as before.

Significantly, Relator does not dispute that the bills clearly show which services were provided on which day nor does Relator allege that the government refused to pay any claims. As it did before, the Relator cannot

adequately allege that the "unbundling" was material to the government's decision to pay. Relator previously tried to clear this hurdle by arguing the government's "knowledge of a fraud is...not a defense to an FCA claim" but now concedes "except to the extent it is pertinent to the issue of materiality." Under *Escobar*, "if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is *very strong evidence that those requirements are not material." Universal Health Servs., Inc. v. United States ex rel. Escobar*, 136 S. Ct. 1989, 2003, 195 L. Ed. 2d 348 (2016).

Relator, however, continues to speculate that HCA "is apparently unaware that Sea Mar is separating services" (Response at 7:2-3) and that "[h]ad the State of Washington known of Sea Mar's concealment, the claims would not have been paid" (Response at 7:3-4). But as explained above ***and*** in Sea Mar's motions to dismiss, ***and*** as reflected in the Court's April 28 Order, this speculation is implausible because the procedure codes for each service rendered are provided to and are apparent to HCA. *See* April 28 Order at 15:5-10. [Dkt. #51].

Relator's scienter argument is similarly conclusory and unpersuasive. It is recycled from Realtor's prior response brief to Sea Mar's motion to dismiss the SAC. The Court is confused by how the use of a dentist versus hygienist NPI code would make the dates of service of the prophylaxis cleanings and dental examinations any more or less apparent to HCA. Nor, does the dentist versus hygienist NPI code make any difference as to the encounter payment to Sea Mar.

B. Relator's Standard of Care Claims Should Be Dismissed for Failure to Satisfy Rule 8.

1. FCA is an inappropriate vehicle for alleged standard of care violations.

As an initial matter, as reflected in this Court's April 28 Order, courts have repeatedly held that "'billing for medical services that do not meet the standard of care does not give rise to a [sic] FCA violation' because the FCA 'is an inappropriate vehicle for policing quality of care, which is better left to local regulation and enforcement.'" *See* April 28 Order at 16:12-15 [Dkt. #51] (citing *United States ex rel. Lockyer v. Hawaii Pac. Health*, 490 F. Supp. 2d 1062, 1076 (D. Haw. 2007) and *United States ex rel. Dooley v. Metic Transplantation Lab, Inc.*, No. CV 13-07039 SJO (JEMx), 2017 U.S. Dist. LEXIS 99506, 2017 WL 4323142, at *26 (C.D. Cal. June 27, 2017)).

Relator attempts to distinguish *Lockyer* by arguing that it does not support Sea Mar's position. Relator offers no real explanation, except to claim that Washington has two specific administrative rules which require that a Medicaid provider meet the standard of care, making *Lockyer* distinguishable from this case. The regulations upon which Relator relies do not impose a standard of care for scheduling prophylaxis cleaning, as Relator claims. Accordingly, *Lockyer* controls, because Relator "does not point to a provision . . . that requires" scheduling of services be completed in accordance with any standard of care "in order to bill [Medicaid]." *See Lockyer*, 490 F. Supp. 2d at 1076.

Relator also argues that *Lockyer* has been implicitly overruled by *Escobar*. But nothing in *Escobar* is contrary to *Lockyer's* holding that a breach of standard of care allegation "by itself does not give rise to a[n] FCA claim." *Id. Cf., Escobar*, 136 S. Ct. at 2001. Indeed, *Escobar* supports that the FCA is not an appropriate vehicle for policing quality of care. *See id.*, 136 S. Ct. at 2004 ("We emphasize . . . that the False Claims Act is not a means of imposing treble damages and other penalties for insignificant regulatory . . . violations. This case centers on allegations of fraud, not medical malpractice.").

C. Relator's Unbundling and Standard of Care Claims Also Fail To Satisfy Rule 9(b)

Beyond the single example involving L.C., Relator still has not alleged any other specific examples of unbundling, nor has he alleged any policy regarding unbundling. Relator's Unbundling and Standard of Care claims must be dismissed again for failure to satisfy Rule 9(b).

1. The September 2016 "policy" is not an unbundling policy

Relator asserts in his Response that "Sea Mar has formally adopted a policy that requires a dental examination by a dentist ... on one day and the administration of prophylaxis dental cleaning on another day performed by a dental hygienist." Response at 7:21-8:5. Relator's Response claims that this formal policy was announced in the September 1, 2016 email, and refers to his allegations at Third Amended Complaint (TAC) §§ XVI and XIX.

No matter how many times one reads the September 1, 2016 "Plan of Action" email, one will never find any reference to scheduling requirements for dental examinations or prophylaxis cleanings, much less any mention of unbundling the two procedures. *See* TAC Ex. 6. Indeed, the TAC describes the September 2016 "Plan of Action" as a policy for "billing for services provided solely by a dental hygienist under a dentist's NPI" (TAC § XIX) and "list[ing] a dentist as the provider of the service even when the service is performed by a dental hygienist" (TAC § XVI).

The Court is not persuaded by the argument. Relator's Unbundling Claim (and related Standard of Care Claim) are based entirely on one example, L.C.'s May 20, 2017 visit.

2. Relator alleges only one example of a separate prophylaxis cleaning appointment for one patient—not 95% of Sea Mar's patients

With no unbundling "policy" and no other specific examples of unbundling, Relator's argument that "every" patient's dental exam and prophylaxis cleaning are split (Response at 1:24-25), or that this has damaged "over 95% of Sea Mar patients" (Response at 6:10-11) are without basis. As Sea Mar pointed out in its Motion, Relator's 95% figure appears to be based solely on the allegation that Dr. Davis (of Albuquerque, New Mexico) believes a separate prophylaxis appointment would only be medically necessary for 5% of all patients. Relator's Response does not contradict this. There are thus absolutely no factual

allegations in the TAC that support a conclusion that 95% of Sea Mar's patients have separately scheduled prophylaxis cleanings.

3. Relator has not satisfied Rule 9(b) with respect to the Unbundling and Standard of Care Claims

Relator attempts to argue that he has sufficiently alleged the "who" "what" "where" "when" and "how" of the unbundling, but makes little effort to satisfy the standard set forth in this Court's April 28, Order. Response at 24:14-23. To the contrary, Relator's effort to describe how he has satisfied Rule 9(b) only draws attention to his failure to meet this standard.

For example, Relator argues he has sufficiently identified the "where" by generally alleging "Sea Mar's ninety healthcare clinics in Washington State." But this general allegation, unsupported by specific allegations, is directly contrary to the standard set forth in the case cited in the Court's April 28 Order, *United States ex rel. Jorgenson v. Alan Ritchey, Inc.* No. C01-588Z, 2007 U.S. Dist. LEXIS 31542, 2007 WL 1287932, at *3 (W.D. Wash. Apr. 27, 2007) in which the court had dismissed the fraud allegations related to defendant's other locations as they were unsupported by specific allegations of fraud, explaining "alleged fraudulent activity at one [location] does not constitute an allegation for a different [location]." Similarly, although this Court expressly noted Relator's failure to "provide any dates, times...the relevant treatments were provided," (April 28 Order at 16) Relator

argues conclusorily that "when" is sufficiently identified by the general period "from 2013" on. Response at 24:19-20. Relator argues he has sufficiently alleged the "who" by identifying "Sea Mar and their employees," including Dr. Narvaez, and Valerie Hubbard. But nothing in the TAC alleges that Dr. Narvaez or Valerie Hubbard were involved in any unbundled treatment on any particular date—rather they are referenced only in connection with the September 2016 "Plan of Action" discussing NPI numbers—and "Sea Mar and their employees" is hardly specific enough to "identify the dental hygienists or billing staff that were involved." Once again, the argument is unavailing.

Relator's Unbundling and Standard of Care claims should therefore also be dismissed for failure to satisfy Rule 9(b).

CONCLUSION

The Motion to Dismiss is **GRANTED**. Because Relator has now had four attempts to state a plausible claim, and cannot do so, his claims are **DISMISSED WITH PREJUDICE**.

Dated this 13th day of August, 2020.

/s/ Ronald B. Leighton
Ronald B. Leighton
United States District Judge

APPENDIX C — DENIAL OF REHEARING OF THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT, DATED AUGUST 18, 2021

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 20-35825

D.C. No. 3:18-cv-05395-RBL
Western District of Washington, Tacoma

THOMAS E. PARKER, JR., QUI TAM
PLAINTIFF FOR AND ON BEHALF OF THE
UNITED STATES OF AMERICA AND
THE STATE OF WASHINGTON,

Plaintiff-Appellant,

- and -

UNITED STATES OF AMERICA,
ex rel; STATE OF WASHINGTON, *ex rel*,

Plaintiffs,

v.

SEA-MAR COMMUNITY HEALTH CENTER, A
WASHINGTON PUBLIC BENEFIT CORPORATION,

Defendant-Appellee.

Appendix C

ORDER

Before: HAWKINS, CLIFTON, and IKUTA, Circuit Judges.

Judge Ikuta votes to deny the petition for rehearing en banc, and Judge Hawkins and Judge Clifton so recommend.

The full court has been advised of the petition for rehearing en banc and no judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for rehearing en banc (Docket Entry No. 38) is DENIED.

APPENDIX D — RELEVANT STATUTORY PROVISIONS

31 U.S.C. § 3729

(a) Liability for Certain Acts.—

(1) In general.—Subject to paragraph (2), any person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);

(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;

(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;

(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government,

is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 [1]), plus 3 times the amount of damages which the Government sustains because of the act of that person.

(2) Reduced damages.—If the court finds that—

(A) the person committing the violation of this subsection furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the defendant first obtained the information;

(B) such person fully cooperated with any Government investigation of such violation; and

(C) at the time such person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under this title with respect to such violation, and the person did not have actual knowledge of the existence of an investigation into such violation,

the court may assess not less than 2 times the amount of damages which the Government sustains because of the act of that person.

(3) Costs of civil actions.—

A person violating this subsection shall also be liable to the United States Government for the costs of a civil action brought to recover any such penalty or damages.

(b) Definitions.—For purposes of this section—

(1) the terms "knowing" and "knowingly"—

(A) mean that a person, with respect to information—

(i) has actual knowledge of the information;

(ii) acts in deliberate ignorance of the truth or falsity of the information; or

(iii) acts in reckless disregard of the truth or falsity of the information; and

(B) require no proof of specific intent to defraud;

(2) the term "claim"—

(A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—

(i) is presented to an officer, employee, or agent of the United States; or

(ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—

(I) provides or has provided any portion of the money or property requested or demanded; or

(II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; and

(B) does not include requests or demands for money or property that the Government has paid to an individual as compensation for Federal employment or as an income subsidy with no restrictions on that individual's use of the money or property;

(3) the term "obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment; and

(4) the term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

Appendix D

31 U.S.C. § 3730

(b) Actions by Private Persons.—

(1) A person may bring a civil action for a violation of section 3729 for the person and for the United States Government. The action shall be brought in the name of the Government. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

Appendix D

Wash. Admin. Code § 182-502-0100

General conditions of payment.

(1) The medicaid agency reimburses for medical services furnished to an eligible client when all the following apply:

(a) The service is within the scope of care of the client's Washington apple health program;

(b) The service is medically or dentally necessary;

(c) The service is properly authorized;

(d) The provider bills within the time frame set in WAC 182-502-0150;

(e) The provider bills according to agency rules and billing instructions; and

(f) The provider follows third-party payment procedures.

(2) The agency is the payer of last resort, unless the other payer is:

(a) An Indian health service;

(b) A crime victims program through the department of labor and industries; or

(c) A school district for health services provided under the Individuals with Disabilities Education Act.

(3) The agency does not reimburse providers for medical services identified by the agency as client financial obligations, and deducts from the payment the costs of those services identified as client financial obligations. Client financial obligations include, but are not limited to, the following:

(a) Copayments (copays) (unless the criteria in chapter 182-517 WAC or WAC 182-501-0200 are met);

(b) Deductibles (unless the criteria in chapter 182-517 WAC or WAC 182-501-0200 are met); and

(c) Spenddown (see WAC 182-519-0110).

(4) The provider must accept medicare assignment for claims involving clients eligible for both medicare and Washington apple health before the agency makes any payment.

(5) The provider is responsible for verifying whether a client has Washington apple health coverage for the dates of service.

(6) The agency may reimburse a provider for services provided to a person if it is later determined that the person was ineligible for the service when it was provided if:

(a) The agency considered the person eligible at the time of service;

(b) The service was not otherwise paid for; and

(c) The provider submits a request for payment to the agency.

(7) The agency does not pay on a fee-for-service basis for a service for a client who is enrolled in a managed care plan when the service is included in the plan's contract with the agency.

(8) Information about medical care for jail inmates is found in RCW 70.48.130.

(9) The agency pays for medically necessary services on the basis of usual and customary charges or the maximum allowable fee established by the agency, whichever is lower.

Appendix D

Wash. Admin. Code § 182-535-1079

Dental-related services—General.

(1) Clients described in WAC 182-535-1060 are eligible to receive the dental-related services described in this chapter, subject to coverage limitations, restrictions, and client age requirements identified for a specific service. The medicaid agency pays for dental-related services and procedures provided to eligible clients when the services and procedures:

(a) Are part of the client's dental benefit package;

(b) Are within the scope of an eligible client's Washington apple health program;

(c) Are medically necessary;

(d) Meet the agency's authorization requirements, if any;

(e) Are documented in the client's dental record in accordance with chapter 182-502 WAC and meet the department of health's requirements in WAC 246-817-305 and 246-817-310;

(f) Are within accepted dental or medical practice standards;

(g) Are consistent with a diagnosis of a dental disease or dental condition;

(h) Are reasonable in amount and duration of care, treatment, or service; and

(i) Are listed as covered in the agency's rules and published billing instructions and fee schedules.

(2) For orthodontic services, see chapter 182-535A WAC.

(3) The agency requires site-of-service prior authorization, in addition to prior authorization of the procedure, if applicable, for nonemergency dental-related services performed in a hospital or an ambulatory surgery center when:

(a) A client is not a client of the developmental disabilities administration of the department of social and health services (DSHS) according to WAC 182-535-1099;

(b) A client is age nine or older;

(c) The service is not listed as exempt from the site-of-service authorization requirement in the agency's current published dental-related services fee schedule or billing instructions; and

(d) The service is not listed as exempt from the prior authorization requirement for deep sedation or general anesthesia (see WAC 182-535-1098 (1)(c)(v)).

(4) To be eligible for payment, dental-related services performed in a hospital or an ambulatory surgery center must be listed in the agency's current published outpatient

fee schedule or ambulatory surgery center fee schedule. The claim must be billed with the correct procedure code for the site-of-service.

(5) Under the early and periodic screening, diagnostic, and treatment (EPSDT) program, clients age twenty and younger may be eligible for dental-related services listed as noncovered. The standard for coverage for EPSDT is found in chapter 182-534 WAC.

(6) The agency evaluates a request for dental-related services that are:

(a) In excess of the dental program's limitations or restrictions, according to WAC 182-501-0169; and

(b) Listed as noncovered, according to WAC 182-501-0160.

Appendix D

Wash. Rev. Code § 74.66.010

Unless the context clearly requires otherwise, the definitions in this section apply throughout this chapter:

(1)(a) "Claim" means any request or demand made for a medicaid payment under chapter 74.09 RCW or other applicable law, whether under a contract or otherwise, for money or property and whether or not a government entity has title to the money or property, that:

(i) Is presented to an officer, employee, or agent of a government entity; or

(ii) Is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the government entity's behalf or to advance a government entity program or interest, and the government entity:

(A) Provides or has provided any portion of the money or property requested or demanded; or

(B) Will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(b) A "claim" does not include requests or demands for money or property that the government entity has paid to an individual as compensation for employment or as an income subsidy with no restrictions on that individual's use of the money or property.

(2) "Custodian" means the custodian, or any deputy custodian, designated by the attorney general.

(3) "Documentary material" includes the original or any copy of any book, record, report, memorandum, paper, communication, tabulation, chart, or other document, or data compilations stored in or accessible through computer or other information retrieval systems, together with instructions and all other materials necessary to use or interpret the data compilations, and any product of discovery.

(4) "False claims act investigation" means any inquiry conducted by any false claims act investigator for the purpose of ascertaining whether any person is or has been engaged in any violation of this chapter.

(5) "False claims act investigator" means any attorney or investigator employed by the state attorney general who is charged with the duty of enforcing or carrying into effect any provision of this chapter, or any officer or employee of the state of Washington acting under the direction and supervision of the attorney or investigator in connection with an investigation pursuant to this chapter.

(6) "Government entity" means all Washington state agencies that administer medicaid-funded programs under this title.

(7)(a) "Knowing" and "knowingly" mean that a person, with respect to information:

(i) Has actual knowledge of the information;

(ii) Acts in deliberate ignorance of the truth or falsity of the information; or

(iii) Acts in reckless disregard of the truth or falsity of the information.

(b) "Knowing" and "knowingly" do not require proof of specific intent to defraud.

(8) "Material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.

(9) "Obligation" means an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or rule, or from the retention of any overpayment.

(10) "Official use" means any use that is consistent with the law, and the rules and policies of the attorney general, including use in connection with: Internal attorney general memoranda and reports; communications between the attorney general and a federal, state, or local government agency, or a contractor of a federal, state, or local government agency, undertaken in furtherance of an investigation or prosecution of a case; interviews of any qui tam relator or other witness; oral examinations; depositions; preparation for and response to civil discovery requests; introduction into the record of

a case or proceeding; applications, motions, memoranda, and briefs submitted to a court or other tribunal; and communications with attorney general investigators, auditors, consultants and experts, the counsel of other parties, and arbitrators or mediators, concerning an investigation, case, or proceeding.

(11) "Person" means any natural person, partnership, corporation, association, or other legal entity, including any local or political subdivision of a state.

(12) "Product of discovery" includes:

(a) The original or duplicate of any deposition, interrogatory, document, thing, result of the inspection of land or other property, examination, or admission, which is obtained by any method of discovery in any judicial or administrative proceeding of an adversarial nature;

(b) Any digest, analysis, selection, compilation, or derivation of any item listed in (a) of this subsection; and

(c) Any index or other manner of access to any item listed in (a) of this subsection.

(13) "Qui tam action" is an action brought by a person under RCW 74.66.050.

(14) "Qui tam relator" or "relator" is a person who brings an action under RCW 74.66.050.

Appendix D

Wash. Rev. Code § 74.66.020

(1) Subject to subsections (2) and (4) of this section, a person is liable to the government entity for a civil penalty of not less than the greater of ten thousand nine hundred fifty-seven dollars or the minimum inflation adjusted penalty amount imposed as provided by 31 U.S.C. Sec. 3729(a) and not more than the greater of twenty-one thousand nine hundred sixteen dollars or the maximum inflation adjusted penalty amount imposed as provided by 31 U.S.C. Sec. 3729(a), plus three times the amount of damages which the government entity sustains because of the act of that person, if the person:

(a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(b) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;

(c) Conspires to commit one or more of the violations in this subsection (1);

(d) Has possession, custody, or control of property or money used, or to be used, by the government entity and knowingly delivers, or causes to be delivered, less than all of that money or property;

(e) Is authorized to make or deliver a document certifying receipt of property used, or to be used, by the government entity and, intending to defraud the government entity,

makes or delivers the receipt without completely knowing that the information on the receipt is true;

(f) Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the government entity who lawfully may not sell or pledge property; or

(g) Knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the government entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity.