No. __-____

IN THE

Supreme Court of the United States

UNITED STATES OF AMERICA, ex rel.,
INTEGRA MED ANALYTICS, L.L.C.,

Petitioner,

v.

BAYLOR SCOTT & WHITE HEALTH;
BAYLOR UNIVERSITY MEDICAL CENTER–DALLAS;
HILLCREST BAPTIST MEDICAL CENTER;
SCOTT & WHITE HOSPITAL–ROUND ROCK;
SCOTT & WHITE MEMORIAL HOSPITAL TEMPLE,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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October 26, 2020

QUESTIONS PRESENTED

Numerous circuits have held that a relator may state a claim under the False Claims Act, 31 U.S.C. §§ 3729-32 (the "FCA"), by alleging "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009). In *U.S. ex rel. Customs Fraud Investigations, LLC v. Victaulic Co.*, the Third Circuit found that a relator may plausibly allege reliable indicia of the submission of false claims through the use of statistical analyses. 839 F.3d 242, 256-58 (3d Cir. 2016).

1. In using statistical analyses to meet federal pleading standards, to what extent must a relator exclude possible alternative explanations for alleged misconduct?

2. Did the Fifth Circuit err when it failed to credit Petitioner's statistical analyses because of what it perceived to be an "obvious alternative explanation," even though the relator pleaded facts tending to exclude the court's explanation?

PARTIES TO THE PROCEEDING

Petitioner Integra Med Analytics, L.L.C., is a Texas limited liability company with its principal place of business in the State of Texas.

Respondent Baylor Scott & White Health is a corporation with its principal place of business in the State of Texas.

Respondent Baylor University Medical Center – Dallas is a corporation with its principal place of business in the State of Texas.

Respondent Hillcrest Baptist Medical Center is a corporation with its principal place of business in the State of Texas.

Respondent Scott & White Hospital – Round Rock is a corporation with its principal place of business in the State of Texas.

Respondent Scott & White Memorial Hospital – Temple is a corporation with its principal place of business in the State of Texas.

CORPORATE DISCLOSURE STATEMENT

Petitioner Integra Med Analytics L.L.C. has no parent corporation, and no publicly held corporation owns 10% or more of its stock.

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INTRODUCTION

The FCA is a remedial statute intended to "protect the Treasury against the hungry and unscrupulous host that encompasses it on every side." S. Rep. No. 99-345, at 11 (1986) (quoting *United States v. Griswold*, 24 F. 361, 366 (D. Or. 1885)). Congress passed the FCA's *qui tam* provisions to "encourage[] and expand[] citizen involvement" in the FCA to people with unique experience and expertise, and to "deputize more 'private attorneys general' in the war on fraud." Statement of Hon. Charles E. Grassley, False Claims Act Implementation, Subcomm. On Admin. Law and Govt'l Relations of the Jud. Comm., 101st Cong. 1-2 (1990). Recognizing that relators typically do not have access to evidence proving all elements of an FCA claim, numerous circuits have held that a relator may meet its pleading obligations under Federal Rules of Civil Procedure 8 and 9(b) by alleging "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009).[1]

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[1] The First, Third, Ninth, Tenth, and District of Columbia Circuits have since expressly adopted this relaxed pleading standard first set out in *Kanneganti*. *U.S. ex rel. Duxbury v. Ortho Biotech Prod., L.P.*, 579 F.3d 13, 29 (1st Cir. 2009); *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153, 156-57 (3d Cir. 2014); *Ebeid ex rel. United States v. Lungwitz*, 616 F.3d 993, 998-99 (9th Cir. 2010); *U.S. ex rel. Lemmon v. Envirocare of Utah, Inc.*, 614 F.3d 1163, 1172 (10th Cir.

With large amounts of data becoming increasingly accessible in a wide array of industries, FCA relators like Integra Med Analytics L.L.C. ("Integra") have looked to data analytics as an important tool in establishing such indicia. Integra filed this action based on exhaustive econometric analyses of Medicare claims data coupled with a factual investigation indicating that Respondent Baylor Scott & White Health and its affiliated hospitals (together, "BSW") engaged in a scheme to "upcode" Medicare claims. This scheme included training doctors to diagnose patients in a particular way to allow for favorable coding, and issuing leading queries that pressured doctors to change previous diagnoses if they ignored their training. Integra's allegations are confirmed by quantitative analyses that not only demonstrate the scope of BSW's fraud, but also mathematically exclude innocent explanations.

The seminal case on meeting the *Kanneganti* standard through statistical analyses coupled with factual allegations—which also involved a non-insider relator like Integra—found an FCA claim to be well pleaded based on far less factual detail supported by far less robust statistical analyses than those offered by Integra. *U.S. ex rel. Customs Fraud Investigations, LLC v. Victaulic Co.*, 839 F.3d 242, 256-58 (3d Cir. 2016). In that case, the Third Circuit rejected calls from the dissent to essentially conduct a non-evidentiary *Daubert*

2010); *U.S. ex rel. Heath v. AT & T, Inc.*, 791 F.3d 112, 126 (D.C. Cir. 2015).

review of the reliability of the relator's analysis. That is precisely what the Fifth Circuit panel did below in dismissing Integra's claims. The court seized on a contested "obvious alternative explanation" of complex data based on its own interpretation of 3 graphs among the 28 graphs in Integra's complaint.

This signals an impossible standard for FCA relators relying in part on statistical analyses, as they would need to anticipate and rule out every possible alternative explanation that a judge may deem "obvious" without any discovery, hearing, or trial. Worse still, the panel below either completely discounted or simply ignored factual allegations and other statistical indications that refuted the court's theory. Integra drew these allegations from an exhaustive, multifaceted investigation involving interviews of former employees, internal training documents and presentations, as well as an analysis of millions of Medicare records. This dwarfs the small sample of 221 records that formed the basis of the claims brought by the relator in *Victaulic*.

Certiorari is thus necessary to ensure that a relator in part relying on statistical analyses to demonstrate reliable indicia of the submission of false claims does not face a far higher pleading standard in the Fifth Circuit than a similarly situated relator in the Third Circuit. Certiorari is also necessary to correct the Fifth Circuit's error in assessing Integra's statistical analyses in a vacuum, without considering whether Integra's additional factual

allegations tend to exclude the panel's proposed "obvious alternative explanation."

DECISIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit affirming the United States District Court for the Western District of Texas's judgment is reported in the Federal Appendix at 816 F. App'x 892. *See also* App. 1a–36a. The District Court's order granting BSW's motion to dismiss is unreported, but it may be found at No. 5:17-CV-886-DAE, 2019 WL 3713756. *See also* App. 37a–53a.

STATEMENT OF JURISDICTION

On May 28, 2020, the Fifth Circuit issued an opinion affirming the District Court's decision to grant BSW's motion to dismiss. On March 19, 2020, this Court issued Order 589, which extended the deadline to file any petition for a writ of certiorari to 150 days from the date of the lower court judgment. The Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

RULES INVOLVED

Federal Rule of Civil Procedure 8(a) states:

Rule 8. General Rules of Pleading

(a) CLAIM FOR RELIEF. A pleading that states a claim for relief must contain: (1) a short and plain

statement of the grounds for the court's jurisdiction, unless the court already has jurisdiction and the claim needs no new jurisdictional support; (2) a short and plain statement of the claim showing that the pleader is entitled to relief; and (3) a demand for the relief sought, which may include relief in the alternative or different types of relief.

Federal Rule of Civil Procedure 9(b) states:

Rule 9. Pleading Special Matters

(b) FRAUD OR MISTAKE; CONDITIONS OF MIND. In alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally.

STATEMENT OF THE CASE

A. Factual Background

Medicare makes payments for each inpatient hospital stay in an amount designed to cover the average cost of resources needed to treat each patient's needs. App. 63a, ¶ 17. Providers code each claim, and Medicare then assigns the claim to a diagnosis related group ("DRG") comprising claims of similar conditions that are expected to require similar resources. *Id.* The Centers for Medicare and Medicaid Services ("CMS") publishes a list of secondary codes each year that can be added to a DRG as a Complication or Comorbidity ("CC") or Major Complication or Comorbidity ("MCC"). App.

64a, ¶ 19. Adding a CC or MCC to a claim increases the severity level of its DRG and thus increases the amount Medicare pays on the claim. App. 64-65a, ¶ 19. Integra's investigation uncovered how BSW systematically applied unwarranted CCs and MCCs to falsely inflate their Medicare revenue. App. 58a, ¶ 1. Integra confirmed these findings with exhaustive quantitative, statistical, and econometric analyses. App. 80-139a, ¶¶ 40-109.

1. Integra alleges that BSW's clinical documentation improvement ("CDI") program—which is supposed to promote accurate documentation and coding—in fact sought to inflate BSW's Medicare revenue through upcoding claims with unwarranted CCs and MCCs. App. 65a, ¶ 20. These efforts began with training doctors and staff to focus on documenting diagnoses that allow MCCs. App. 67-70a, ¶¶ 23-26. When doctors failed to diagnose an MCC, BSW's CDI specialists pressured doctors to change their original diagnoses to document MCCs. App. 70-77a, ¶¶ 27-36. BSW even routinely offered unnecessary medical services to allow for the coding of profitable MCCs. App. 78-79a, ¶¶ 37-39.

BSW's CDI program focused doctors on infusing diagnoses with key words that allowed for coding MCCs rather than focusing on accuracy. App. 67a, ¶ 23. These so-called "magic words" included "encephalopathy" and "acute respiratory failure"—two MCCs that Integra identified as being misapplied by BSW. App. 68a, ¶ 24. Management emphasized that complying with these efforts would increase doctors' salaries, stating "Your hospital

data will determine your income!" App. 69a, ¶25. They asked doctors, "Do you want to 'see one more patient' or take one minute to improve your documentation ???," suggesting that using management's "magic words" would generate more revenue than seeing an additional patient. *Id.* BSW also provided doctors with tip sheets called "Teal Quickies" that pushed doctors to clinically document patient services in a way that maximized Medicare revenue. App. 69-70a, ¶26. For instance, in training doctors how to document altered mental status ("AMS"), BSW encouraged the diagnosis of encephalopathy (an MCC) or acute delirium (a CC), explaining that these secondary codes increased the patient's "severity of illness" and thus Medicare reimbursement. *Id.* As a clear indication of fraudulent intent, the Teal Quickie included "☺" next to the instruction to use the MCC codes when noting that non-MCC items could very well be the actual cause of the noted condition. *Id.* With this reference, BSW explicitly encouraged its doctors to use MCCs even when they were not warranted and to laugh about it. BSW's training was thus a one-way ratchet to promote the use of revenue-increasing MCCs—after all, if BSW was truly concerned with accuracy, it would have also encouraged doctors to use non-MCC and non-CC codes where warranted.

When doctors ignored this training, CDI staff worked to change the resulting diagnoses. App. 70-77a, ¶¶27-36. Hospitals are not allowed to apply a CC or MCC unless it is sufficiently documented in the patient's medical files. Where medical files are

unclear, hospitals may send doctors "queries" for clarification. The American Health Information Management Association ("AHIMA")—which approves CMS coding guidelines[2]—prohibits CDIs from issuing leading queries directing doctors to code in a specific way to allow "the provider of record [to] unbiasedly respond with a specific diagnosis or procedure."[3] BSW ignored these guidelines, issuing "documentation clarification sheets" that reveal a clear intent to influence doctors to code the same CCs and MCCs identified by Integra to have been used excessively by BSW. App. 71-74a, ¶¶ 28-31. BSW similarly prompted doctors to document CCs and MCCs with post-surgery progress notes that encouraged particularly uncommon pairings. App. 74a, ¶ 32. For instance, in progress notes for plastic surgery patients, BSW gave doctors a multiple-choice option to include severe protein calorie malnutrition. *Id.* Integra's analysis shows that the BSW's rate of severe protein malnutrition in plastic surgery claims dwarfs the national rate. App. 75a, ¶ 33. A staggering 6.56% of the plastic surgery patients treated by three BSW hospitals were assigned severe protein-calorie malnutrition—over 8 times the national average. *Id.*

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[2] CMS, ICD-10-CM Official Guidelines at 1, *available at* https://go.cms.gov/31J2BoZ (listing AHIMA as a Cooperating Partner).

[3] AHIMA, *Guidelines for Achieving a Compliant Query Practice* (2019), *available at* https://bit.ly/3kkqiuP.

In addition to using written queries leading doctors to document CCs and MCCs, BSW also exerted verbal pressure to influence doctors. App. 75-76a, ¶¶ 34-35. For example, Integra found that CDI staff repeatedly sought to pressure doctors to record "acute respiratory failure" (an MCC identified by Integra for excessive use) instead of COPD exacerbation. App. 76a, ¶ 35. According to a former BSW employee, doctors often acquiesced to CDI pressure and coded "acute respiratory failure" because that is what "[CDIs] want to hear . . . doctors have been told and told and told so they do." *Id.* The staff member added, "CDIs should be questioning acute respiratory failure instead of insisting." *Id.*

Integra also uncovered that BSW excessively and unnecessarily kept post-operative patients on ventilator support, which is one of the clinical indicators for "acute respiratory failure." App. 78a, ¶ 37. Integra found that BSW patients undergoing major heart surgery were placed on mechanical ventilation over twice the national average. *Id.* And even though post-operative respiratory failure is extremely rare, BSW coded acute respiratory failure for 36.9% of post-operative heart surgery patients, which is 2.75 times higher than the national average. *Id.* And in such claims, BSW received up to $30,000 in additional reimbursement from Medicare. App. 79a, ¶ 38. These findings are consistent with the training and instructions disseminated by BSW CDI staff. In BSW's training materials for "Diseases for the Respiratory System," BSW doctors were told that "the use of

artificial ventilation such as BiPAP would also qualify" for diagnosing acute respiratory failure. App. 79a, ¶ 39. In other words, BSW trained their staff to code acute respiratory failure based on the use of a ventilator, even if clinical indicators suggested otherwise.

2. To confirm and measure BSW's pervasive upcoding, Integra developed unique algorithms and statistical processes to analyze inpatient CMS claims for short-term acute care hospitals from 2011 to 2017. App. 80-83a, ¶¶ 40-45. Integra first formed groupings corresponding to 184 specific principal diagnosis codes. App. 80a, ¶ 41. To control for the patient's principal diagnosis, Integra used these groupings as comparative "bins." *Id.* Within each bin, Integra compared the usage rate of specific MCCs at hospitals in the BSW system to usage rates in other acute care inpatient hospitals. *Id.* Integra found statistically significant, excessive usage of "encephalopathy," "acute respiratory failure," and "severe malnutrition." App. 83a, ¶ 46.

For example, Integra found that among BSW's more than 838 claims involving a Nonrheumatic Aortic Valve Disorders, 59 had had an accompanying secondary MCC of encephalopathy, representing 7.04 percent of their Nonrheumatic Aortic Valve Disorders claims. App. 81a, ¶ 43. The other non-BSW hospitals, used by Integra for benchmarking, had more than 200,000 Nonrheumatic Aortic Valve Disorders claims, but only 2.67 percent of those claims reported encephalopathy as an MCC. *Id.* In other words, BSW coded encephalopa-

thy on these claims at a rate that is 2.64 times higher than comparable hospitals—and profited nearly $13,000 each time it did so. App. 82a, ¶43.

Integra validated the results of its bin-based analysis by analyzing competing alternative explanations. App. 106-35a, ¶69-102. To rule out that patient characteristics drove the higher rates of MCCs at BSW, Integra ran a fixed-effect linear regression model. App. 107a, ¶70. Integra sought out data from numerous sources, which it used to control for an array of patient characteristics such as age, gender, and race, as well as patient claim characteristics such as length of stay and discharge status. *Id*. Integra also used county-level demographic data, such as unemployment rate, percent of population without a high school diploma, median income, and the rural-urban continuum codes from the Department of Agriculture as control variables, which provide a useful proxy for income and education levels of each patient. *Id*. This regression analysis considered millions of claims and found that even after controlling for a host of patient characteristics, BSW excessively added MCCs to its claims such that it was ranked the seventh highest out of 737 hospital systems for the MCC patterns analyzed by Integra. App. 108a, ¶70; App. 115a, ¶80.

Next, Integra examined the extent to which doctors contributed to BSW's excessive MCC rates. App. 117-28a, ¶82-93. Integra demonstrated that individual doctors who treated patients at both BSW hospitals and other hospitals were nearly

twice as likely to code one of the three misstated MCCs when treating at BSW hospitals. App. 117-18a, ¶ 83. Integra similarly analyzed the subset of patients who were admitted to both a BSW hospital and at least one other non-BSW hospital between 2011 and 2017, and then compared the rate of the MCC codes used when those patients were treated at each. App. 129-33a, ¶¶ 94-99. Again, Integra discovered that these patients were nearly twice as likely to be diagnosed with an MCC while being treated at a BSW hospital. App. 129-30a, ¶ 95.

Finally, Integra considered whether BSW's excessive coding of MCCs could be explained by the region in which BSW hospitals are located, notwithstanding that Integra had already controlled for a variety of county demographic factors described above. App. 133-135a, ¶¶ 100-02. To that end, Integra compared BSW's MCC rates to other hospitals within the relevant metropolitan statistical area. *Id.* BSW had a higher rate of each of the three MCCs in every MSA where its hospitals were located. *Id.*

The results of Integra's analyses—as well as Integra's documentary evidence and information learned from witness interviews—all point to the same conclusion: BSW carried out their scheme to inflate their Medicare revenue to great effect. Integra calculated that, as a result of this scheme, BSW received an unwarranted $61.8 million in false claims across all principal diagnosis categories. App. 137a, ¶ 106.

B. Procedural Background

Integra commenced this *qui tam* action in the District Court for the Western District of Texas on September 12, 2017, and the United States declined to either intervene or move to dismiss Integra's claims. Integra filed its operative Second Amended Complaint on August 7, 2018, which alleges that, through their system-wide scheme to pressure coders and doctors to apply unwarranted MCCs, BSW (i) knowingly presented, or caused to be presented, false claims to Medicare for payment or approval (31 U.S.C. § 3729(a)(1)(A)); (ii) knowingly made, used, or caused to be made or used, a false record or statement material to false claims to Medicare (31 U.S.C. § 3729(a)(1)(B)); and (iii) knowingly avoided an obligation to re-pay Medicare for overpayments (31 U.S.C. § 3729(a)(1)(G)). App. 54a; App. 140a, ¶ 112.

BSW moved to dismiss the Second Amended Complaint under Rule 12(b)(6), arguing in relevant part that Integra's allegations were not plausible under Rule 8(a), nor sufficiently particular under Rule 9(b). App. 42-43a. The District Court granted the motion. App. 44a. In doing so, the District Court found that Integra's complaint "allege[d] a scheme . . . to increase the number of claims submitted that include CCs and MCCs and contain[ed] reliable indicia leading to a strong inference that claims were actually submitted based on that scheme." App. 45a. The District Court went on to conclude, however, that this scheme was not necessarily one to submit false claims, as CMS allows

hospitals to undertake efforts to ensure that it is properly coding Medicare claims. App. 45-46a. The District Court addressed only a handful of Integra's specific factual allegations, finding that standing alone they did not meet either the plausibility standard of Rule 8(a) or the particularity standard of Rule 9(b). App. 49-50a. And while the District Court noted that Integra's statistical analyses demonstrated that BSW's CC and MCC rates were far out of step with their peers, the District Court nevertheless found that Integra failed to eliminate the "obvious alternative explanation" that "Defendants were simply better than their peers in their efforts to ensure their medical documentation and coding maximized the opportunities for legitimate reimbursement." App. 50a (citing *Bell Atl. Corp.*, 550 U.S. at 567–69).

Integra appealed. On May 28, 2020, the Fifth Circuit affirmed the District Court's decision. App. 2a. Just like the District Court below, the Fifth Circuit's opinion reviewed individual allegations in isolation. App. 7-11a (examining statistical data), 11-13a (examining other factual allegations of upcoding scheme), 15-16a (examining allegations of unnecessary treatment). And the Fifth Circuit brushed aside Integra's quantitative analyses because of the same "obvious alternative explanation" first suggested by the District Court. App. 10a.

Pursuant to Order 589, this Court extended Integra's deadline to file a petition for certiorari to 150 days, or October 26, 2020. *See* Sup. Ct. R. 30.1

(In the computation of any period of time specified by statute or court order, the last day of a period does not count if it is a Saturday or Sunday.). Integra now files this timely petition.

REASONS FOR GRANTING THE PETITION

The decision below underscores a split between the Fifth Circuit and Third Circuit over the pleading standard for FCA claims that rely in part on statistical analyses. The Court should clarify that the Third Circuit's approach is correct. In addition, the decision below incorrectly applied Rule 8 and Rule 9(b) to each allegation in the pleading individually rather than viewing the complaint as a whole. The Court should thus grant certiorari.

I. The Fifth Circuit's opinion below heightens the pleading standard for FCA claims set out by the Third Circuit.

A majority of circuit courts now follow the Fifth Circuit in holding that an FCA relator may meet federal pleading standards by alleging "particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *U.S. ex rel. Grubbs v. Kanneganti*, 565 F.3d 180, 190 (5th Cir. 2009). In *U.S. ex rel. Customs Fraud Investigations, LLC v. Victaulic Co.*, the Third Circuit found that a non-insider relator plausibly alleged reliable indicia of the submission of false claims through a statistical analysis of eBay listings. 839 F.3d 242, 256-

58 (3d Cir. 2016). Compared to the relator in *Victaulic*, Integra has offered far more thorough quantitative, statistical, and econometric analyses and has based its analyses on profoundly more reliable data. But while the Fifth Circuit purported not to reject the *Victaulic* court's decision to allow statistical analyses as reliable indicia of fraud, it went on to embrace the *Victaulic* dissent by seeking to impeach the validity of Integra's statistical analyses through its own ad hoc interpretations of cherry-picked data. This signals an impossible pleading standard for FCA relators relying on statistical analyses by compelling them to anticipate and negate any lawful alternative explanations that a court deems "obvious" from the face of the pleadings without the benefit of a factual record.

A. The Third and Fifth Circuits are split on the inferences that should be drawn from statistical analyses used by FCA relators to allege reliable indicia of fraud.

In *Victaulic*, relator Customs Fraud Investigations ("CFI") brought an FCA claim against a pipe-fitting company for avoiding import duties by not marking the country of origin on its fittings. *Id.* at 246. CFI's complaint provided a list of Victaulic's public shipments and estimated from shipping data that between 54% and 91% of Victaulic's pipe fittings were imported and required to be marked. *Id.* at 257 & n.71. Then, CFI conducted a statistical analysis of photographs on 221 eBay listings, *id.* at

265 (Fuentes, J., concurring in part, dissenting in part, and dissenting from the judgment), and concluded that only 2% of the fittings were properly marked—far fewer than would be expected, *id.* at 257. CFI alleged that because the eBay listings were representative of the entire market for Victaulic pipe fittings, Victaulic was almost certainly committing fraud. *Id.*

The Third Circuit fully credited CFI's statistical analysis at the pleading stage, even as it acknowledged the potential flaws in CFI's approach. Both the district court and the dissent discounted CFI's statistical analysis because of potential flaws in the methodology. *See id.* at 259-72. The majority agreed that there were potential flaws, but this was not disqualifying at the pleading stage:

> The District Court was skeptical of the validity of CFI's methods of determining whether Victaulic had imported unmarked goods. We, too, are skeptical. There is little evidence to show that CFI's unusual procedure of reviewing eBay listings is an accurate proxy for the universe of Victaulic's products available for sale in the United States. Yet, such skepticism is misplaced at the Rule 12(b)(6) stage.

Id. at 257. The majority concluded that the complaint plausibly alleged an FCA violation because it "lays out in great detail each shipment of pipe fittings Victaulic imported during the requisite time period, as well as the methodology" underlying its

conclusions. *Id.* at 256. Because the court was required to construe all facts in CFI's favor—including its statistical analyses—it had no trouble concluding that CFI plausibly alleged reliable indicia that false claims had been submitted. *Id.*

Just like CFI, Integra alleged the particulars of a fraudulent scheme together with statistical analyses offered as reliable indicia that the scheme was carried out. Indeed, compared to CFI's, Integra's statistical analyses were far more thorough. Whereas CFI merely extrapolated a sample of 221 eBay listings, Integra developed a unique econometric methodology to analyze millions of Medicare claims. App. 80-83a, 108a, ¶¶ 40-45, 70. Whereas CFI took few apparent efforts to control its results, Integra conducted extensive causal analyses to control for and exclude innocent explanations, including doctor/patient characteristics, geographic location, and urban/rural differences. App. 106-35a, ¶ 69-102. But unlike the Third Circuit, the panel below did not credit Integra's statistical analyses as reliable indicia of fraud because of what it deemed to be an "obvious alternative explanation" that BSW was better than its peers at Medicare coding. App. 10a (citing *Ashcroft v. Iqbal*, 556 U.S. 662, 682 (2009)). In particular, the panel seized on graphs that it cherry-picked from the complaint that it believed showed a trend line to support its hypothesis. App. 9-10a. It would be hard to imagine a clearer example of failing to "draw all reasonable inferences from the complaint in [the plaintiff's] favor." *Am. Fed'n of Gov't Employees Local 1 v.*

Stone, 502 F.3d 1027, 1032 (9th Cir. 2007); *see also Iqbal*, 556 U.S. at 678 ("A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged.").

Notably, the majority in *Victaulic* rejected similar efforts by the dissent to propose numerous alternative hypotheses to explain relator's findings. For instance, the dissent suggested that the low number of markings on the sample of eBay listings gathered by the relator could be explained by the seller's motivation not to use photographs demonstrating that the pipe fitting being sold was manufactured outside of the United States. 839 F.3d at 263. The district court decision being appealed in that case similarly reasoned that "if U.S. products can command higher prices, one would also expect to observe a higher percentage of U.S.-made products in the secondary sale market." *U.S. ex rel. Customs Fraud Investigations, LLC v. Victaulic Co.*, No. 13-2983, 2015 WL 1608455, at *5 (E.D. Pa. Apr. 10, 2015). The majority in the Third Circuit, however, rightly rejected this reasoning, noting that a motion to dismiss—without the benefit of any discovery—is not the stage to weigh evidence and assess credibility of sophisticated expert opinions. 839 F.3d at 257.

Nothing in *Iqbal* supports the opposite result reached by the Fifth Circuit in this case. While *Iqbal* finds that, when making a plausibility determination, a court may draw on its "experience and

common sense," 556 U.S. at 679, it does not mandate that courts conduct what amounts to a non-evidentiary *Daubert* review of statistical analyses within a pleading. As the Third Circuit recognized in *Victaulic*, that is not only outside the court's expertise, it is outside the bounds of a motion to dismiss under Rule 12(b)(6). 839 F.3d at 257. Clarification is thus necessary to ensure that plaintiffs relying on statistical analyses in the Fifth Circuit do not face a significantly higher pleading standard than similarly situated plaintiffs in the Third Circuit.

B. The ruling below underscores a deepening split across numerous circuits regarding the meaning of *Iqbal* and *Twombly's* reference to "obvious alternative explanations."

This Court has not defined when an "obvious alternative explanation" for alleged conduct renders a claim implausible under Rule 8, but the Court used the phrase in both *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 567 (2007), and *Iqbal*, 556 U.S. at 682. In *Twombly*, the Court reasoned that, in an antitrust case, parallel conduct alone was not sufficient to state a claim for conspiracy. 550 U.S. at 557. The Court explained that there was an "obvious alternative explanation" for the alleged conduct: independent action based on economic self-interest. *Id.* at 567. In *Iqbal*, the court held that a complaint alleging racial discrimination by the FBI against Arab Muslims after the 9/11

terrorist attacks should be dismissed where the complaint contained only bare allegations of the defendants' states of mind. 556 U.S. at 680-81. An "obvious alternative explanation" again existed: the FBI was targeting men possibly associated with the 9/11 terrorist attacks, and the people who organized such attacks were Arab Muslims. *Id.* at 682. Although the Court considered alternative explanations in its analysis, it underscored that such considerations do not turn the plausibility standard into a probability standard. *Id.* at 678. Indeed, even a case with a remote chance of success survives dismissal so long as the claims are plausible. *Twombly*, 550 U.S. at 556.

With only *Iqbal* and *Twombly* as guidance, dozens of circuit court decisions and hundreds of district court decisions have imbued the phrase "obvious alternative explanation" with varying levels of significance while setting out different standards for how such explanations may render a plaintiff's claim implausible. This leaves plaintiffs to guess whether and to what degree the trial court will be searching for alternative explanations for alleged conduct. This Court should grant certiorari in order to clarify the proper way to assess whether and how courts are to identify and weigh such explanations.

The Second Circuit and the D.C. Circuit have held that an alternative explanation falls short of being "obvious" when it fails to eliminate the possibility that the plaintiff's explanation is true. In *New Jersey Carpenters Health Fund v. Royal Bank*

of Scotland Group, PLC, the Second Circuit held that the defendant's argument "does not provide an 'obvious alternative explanation'" because it "does not impugn the [plaintiff's] central allegation . . . ." 709 F.3d 109, 124 (2d Cir. 2013). The court further explained, "even crediting the Defendants–Appellants' explanations, the [plaintiff's] inference of liability remains reasonable." *Id.* at 121 n. 5. In *In re U.S. Office of Personnel Management Data Security Breach Litigation*, the D.C. Circuit also reasoned that where plaintiff's explanation and defendant's explanation were "not mutually exclusive," defendant's likely explanation "hardly renders implausible [] Plaintiffs' claim . . . ." 928 F.3d 42, 57 (D.C. Cir. 2019). In contrast, dismissal in *Twombly* and *Iqbal* was warranted because the "obvious alternative explanations were necessarily incompatible with the plaintiffs' versions of events." *Id.* In other words, for an alternative explanation to be so "obvious" that it renders a plaintiff's claims implausible, it must, at the very least, be incompatible with plaintiff's allegations.

The Eighth Circuit has adopted an approach similar to that of the Second Circuit and the D.C. Circuit. In *Braden v. Wal-Mart Stores, Inc.*, an employee brought suit against his employer alleging violation of fiduciary duties under ERISA because the employer had chosen funds with significantly higher fees than other options. 588 F.3d 585, 597 (8th Cir. 2009). The defendants argued that there were obvious alternative explanations

for their choice of funds. The Eighth Circuit noted that a "concrete, 'obvious alternative explanation' for defendant's conduct," like those in *Twombly* and *Iqbal*, renders a plaintiff's claims implausible "if the facts [plaintiff] points to are precisely the result one would expect from lawful conduct in which the defendant is known to have engaged." *Id.* However, the court explained why such an explanation did not exist in that case:

> Not every potential lawful explanation for the defendant's conduct renders the plaintiff's theory implausible. Just as a plaintiff cannot proceed if his allegations are merely consistent with a defendant's liability, so a defendant is not entitled to dismissal if the facts are merely consistent with lawful conduct. And that is exactly the situation in this case. Certainly appellees could have chosen funds with higher fees for various reasons, but this speculation is far from the sort of concrete, obvious alternative explanation Braden would need to rebut in his complaint. Requiring a plaintiff to rule out every possible lawful explanation for the conduct he challenges would invert the principle that the complaint is construed most favorably to the nonmoving party, and would impose the sort of "probability requirement" at the pleading stage which *Iqbal* and *Twombly* explicitly reject.

Id. (internal quotation marks and citations omitted); *see also Watson Carpet & Floor Covering, Inc.*

v. Mohawk Indus., Inc., 648 F.3d 452, 458 (6th Cir. 2011) (finding that even an "eminently plausible" alternative explanation for defendant's conduct "does not render all other reasons implausible" or warrant dismissal); *Woods v. City of Greensboro*, 855 F.3d 639, 649 (4th Cir. 2017) (explaining that an alternative explanation must be "so obviously an irrefutably sound and unambiguously" lawful explanation to render plaintiff's claim implausible).

A decision from the Ninth Circuit highlights the other end of the spectrum, where courts have often placed the burden on the plaintiff to plead facts that rule out lawful or obvious alternative explanations regardless of whether such explanations are mutually exclusive with the alleged misconduct. *See Eclectic Properties E., LLC v. Marcus & Millichap Co.*, 751 F.3d 990, 996 (9th Cir. 2014) (holding that fraud allegation was implausible because plaintiffs did not plead facts that "tend[ed] to exclude" innocent explanation that a national recession drove defendants' actions). Likewise, the Eleventh Circuit has held that auto body shops' claim of illegal steering by insurers was not plausible where "any number of legitimate market forces" could "just as plausibly" explain the loss in business. *Auto. Alignment & Body Serv., Inc. v. State Farm Mut. Auto. Ins. Co.*, 953 F.3d 707, 729 (11th Cir. 2020) (listing "obvious alternative explanations" such as competition, decreased demand for repairs, fluctuations in consumer choice, and that large fluctuations were "the norm"). In effect, these circuits require the plaintiff to show that its allega-

tions are more plausible than whatever "obvious" alternative explanations the defendant or the court can think up.

In its decision below, the Fifth Circuit now joins this line of reasoning to deepen the split. The panel stated the law as follows: "A claim is merely conceivable and not plausible if the facts pleaded are consistent with both the claimed misconduct and a legal and 'obvious alternative explanation.'" App. 8a. Affirming dismissal, the panel surmised that an "obvious alternative explanation" for the fraud alleged was that BSW was simply better at coding than all of its peers by orders of magnitude. App. 10a. Notably, the panel did not explain how its theory that BSW is better than its peers at coding for Medicare reimbursement renders Integra's factual allegations *implausible*. Indeed, the panel's hypothesis does not necessarily exclude Integra's allegations: BSW could be better at obtaining lawful Medicare reimbursement than its peers *and* be fraudulently upcoding three lucrative MCCs.

Because these explanations are not mutually exclusive, the Second Circuit and D.C. Circuit would reject the Fifth's circuit's conclusion that the alternative explanation of lawful coding is "obvious" and renders Integra's claims implausible. The Court should grant certiorari to clarify that the Second Circuit and the D.C. Circuit have it right.

II. No matter what importance is given to "obvious alternative explanations," the decision below is wrong.

Whatever circuit is correct in interpreting how to assess "obvious alternative explanations," the Fifth Circuit's ruling was incorrect. When considering whether a complaint meets federal pleading standards, it "should be read as a whole, not parsed piece-by-piece to determine whether each allegation, in isolation, is plausible." *Braden*, 588 F.3d at 594 (citing *Vila v. Inter-Am. Inv. Corp.*, 570 F.3d 274, 285 (D.C. Cir. 2009)). As stated by the Fourth Circuit, "in applying *Iqbal*, we are to 'draw on [our] judicial experience and common sense' to determine whether plaintiffs' well-pleaded non-conclusory allegations *collectively* nudge [a claim] 'across the line from conceivable to plausible.'" *Evans v. Chalmers*, 703 F.3d 636, 657 (4th Cir. 2012) (quoting *Iqbal*, 556 U.S. at 679–80)) (emphasis in original). Even assuming the Court adopts the highest bar used by the circuit courts of appeals, a complaint should only be dismissed based on an alternative explanation if the plaintiff has not offered other facts that "tend[] to exclude the possibility that the alternative explanation is true." *Eclectic Props.*, 751 F.3d at 996.

Instead of assessing Integra's statistical analyses in conjunction with the complaint's factual allegations, the Fifth Circuit (following the District Court's lead) considered only whether the analyses supported Integra's claims in isolation. App. 7a ("We first examine the statistical data presented by

Integra Med, reviewing whether it sufficiently shows that Baylor's Medicare reimbursement claims were fraudulent."). Again, without resort to Integra's factual allegations, the Fifth Circuit concluded that the analyses are subject to the "obvious alternative explanation" that BSW "was simply ahead of the healthcare industry at implementing the Medicare reimbursement guidelines supplied by CMS." App. 10a. In fact, Integra alleged extensive factual allegations that not only tend to exclude but also directly refute the Fifth Circuit's theory. For instance, the notion that BSW is simply better at Medicare coding does not comport with allegations that they employed a one-way ratchet to train doctors to use specific "magic words" for the coding of specific MCCs while not training doctors to code non-MCCs and non-CCs for other possible conditions. App. 68a, ¶ 24. Training materials cited by Integra in the complaint demonstrate BSW pushing specific MCCs and mocking the notion that other non-MCC related causes may be the appropriate diagnosis. App. 69-70a, ¶ 26. The Fifth Circuit's theory is further refuted by allegations that BSW repeatedly used leading queries to pressure doctors to change their diagnoses to specific MCCs, with BSW staff "insisting" to doctors that they document MCCs. App. 71-74a, ¶¶ 28-31; App. 76a, ¶ 35.

Moreover, Integra's statistical analyses themselves affirmatively excluded the Fifth Circuit's theory. First, Integra conservatively limited its claims to MCC/principal diagnosis groupings that

BSW used significantly more than their peers—often more than twice the national rate. App. 81a, ¶42. This renders the Fifth Circuit's hypothesis less plausible because the theory could only be true if BSW's peers are *significantly* undercharging Medicare, even though many of those hospital systems also have CDI programs. Integra also analyzed claims from doctors that treated patients at both a BSW and a non-BSW hospital and found that a patient being treated by the same doctor at a BSW hospital is far more likely to be diagnosed with the three specific MCCs identified by Integra. App 117-18a, ¶83. This also renders the Fifth Circuit's alternative theory less plausible because it suggests that doctors forget their BSW training and change the way they diagnose patients simply by virtue of being at a non-BSW hospital. In short, viewed in the light most favorable to Integra, the complaint contains factual allegations that undermine the Fifth Circuit's alternative explanation, rendering it far from "obvious." *Cf. Woods,* 855 F.3d at 649.

Notably, Integra alleged far more factual detail than the relator in *Victaulic*, CFI, supplied in attempting to comply with Rules 8 and 9(b). Nevertheless, the panel below tried to factually distinguish *Victaulic* because CFI's statistical data were "paired with an expert's declaration analyzing the facts of that case, specific examples of unmarked pipes with photographs, a witness statement about receiving improperly marked pipes, and detailed records about the shipments at issue."

App. 10-11a, n.19. But none of these distinctions explain the divergence between the courts' opinions. Integra not only provided far more thorough statistical analyses, but it also provided far more details about the alleged scheme and significantly more substantive witness statements than were offered in *Victaulic*. Finally, the "specific examples of unmarked pipes" were only eBay samplings, a portion of which CFI suspected to be fraudulent. That is no different from the examples of potentially upcoded claims that Integra provided in its complaint. The Fifth Circuit's effort to distinguish the cases does not withstand scrutiny.

Finally, aside from the evidence alleged in the complaint, the Fifth Circuit's theory also ignores inferences that can be drawn from past FCA settlements. To believe the "obvious alternative explanation" that BSW was leading the way in correct coding—which the court based entirely on a slightly increasing trend in MCC coding at other facilities—implicitly assumes that the increase in MCCs over time at other facilities was due to legitimate uses. App. 9-10a. Yet, the Department of Justice has fined many other large facilities for MCC upcoding practices over the same time period.[4] Moreover, there simply is no "obvious alternative explanation" for Integra's allegations that BSW steered doctors to document MCCs through leading

[4] *See, e.g.*, Press Release, U.S. Dept. of Justice, Prime Healthcare Services and CEO to Pay $65 Million to Settle False Claims Act Allegations (Aug. 3, 2018), *available at* https://bit.ly/3ogPJQv.

queries. App. 71-74a, ¶¶ 28-31. While improving coding accuracy is a common and acceptable practice, leading queries designed to push doctors toward MCCs and CCs are established bases for FCA liability. When a leading query is found by a CMS contractor, CMS requires the contractor to subject the claims to heightened scrutiny.[5] And when the government detects a pattern of leading queries, it will step in.[6]

This Court should thus grant certiorari to provide greater clarity as to how FCA relators may comply with federal pleading standards in light of what a court deems an "obvious alternative explanation" of alleged misconduct.

CONCLUSION

For the foregoing reasons, the petition for certiorari should be granted.

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[5] CMS Manual Sys., Pub. 100-10 Medicare Quality Improvement Organization, Oct. 10, 2014, *available at* https://goo.gl/RBNCau.

[6] *See*, *e.g.*, Press Release, U.S. Dept. of Justice, Good Samaritan Hospital Agrees to Pay $793,548 to Settle FCA Allegations (Mar. 28, 2012) ("employees used leading questions so that the physician would answer that the patient was malnourished, which was the result [defendant] wanted to achieve"), *available at* https://goo.gl/5tshx2.

Dated: October 26, 2020

Respectfully submitted,

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APPENDIX

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 19-50818

Filed May 28, 2020

UNITED STATES OF AMERICA, ex rel.,
INTEGRA MED ANALYTICS, L.L.C.,

Plaintiff–Appellant,

v.

BAYLOR SCOTT & WHITE HEALTH;
BAYLOR UNIVERSITY MEDICAL CENTER–DALLAS;
HILLCREST BAPTIST MEDICAL CENTER;
SCOTT & WHITE HOSPITAL–ROUND ROCK;
SCOTT & WHITE MEMORIAL HOSPITAL TEMPLE,

Defendants–Appellees.

Appeal from the United States District Court
for the Western District of Texas
USDC No. 5:17-CV-886

Before OWEN, Chief Judge, and HIGGINBOTHAM and WILLETT, Circuit Judges.

PER CURIAM:*

Integra Med Analytics, L.L.C., filed a qui tam suit[1] on behalf of the United States against Baylor Scott & White Health system and its affiliates under the False Claims Act for allegedly using inflated codes to bill Medicare. The district court dismissed Integra Med's claims. We affirm.

I

The Baylor Scott & White Health system and its affiliates (Baylor) operate a network consisting of around twenty inpatient short-term acute care hospitals in Texas. A significant number of patients served by Baylor are covered by Medicare. Thus, Baylor regularly submits reimbursement claims to Medicare. In this case, Integra Med Analytics, L.L.C. (Integra Med) alleges that Baylor submitted $61.8 million in fraudulent claims to Medicare, in violation of the False Claims Act (FCA).[2]

Medicare reimburses hospitals like Baylor on a per-discharge basis, which means Baylor gets paid

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* Pursuant to 5TH CIR. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

[1] At the federal level, qui tam suits are those that are filed "for the person and for the United States Government" and "brought in the name of the Government." 31 U.S.C. § 3730(b)(1). Thus, in qui tam suits, the government is the real party in interest. *United States v. Tex. Tech Univ.,* 171 F.3d 279, 289 (5th Cir. 1999).

[2] 31 U.S.C. § 3729.

each time a patient stays at the hospital. The exact amount that Medicare reimburses primarily depends on a hospital's diagnoses of Medicare-covered patients. Medicare classifies similar diagnoses by putting them into a diagnosis related group (DRG). Each DRG is determined by several kinds of codes, including the principal diagnosis code and secondary diagnosis codes. The principal diagnosis code is for the "condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."[3] Secondary diagnosis codes are for "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay."[4] Reimbursement can also be affected, to a lesser extent, by other hospital-specific factors, such as market conditions in the hospital's city.

Integra Med's allegations specifically concern Baylor's use of secondary diagnosis codes. The Centers for Medicare and Medicaid Services (CMS) publishes a list of secondary codes each year that can modify a claim to include a complication or comorbidity (CC) or a major complication or comorbidity (MCC). The inclusion of CCs and MCCs can add thousands of dollars to a Medicare reimbursement claim. Integra Med alleges that Baylor, led by

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[3] *See* Centers for Disease Control, *ICD-9-CM Official Guidelines for Coding and Reporting,* Oct. 1, 2011 at 88, available at https://goo.gl/DC55Wx.

[4] *See* Centers for Disease Control, *ICD-9-CM Official Guidelines for Coding and Reporting,* Oct. 1, 2011 at 91, available at https://goo.gl/DC55Wx.

its clinical documentation improvement (CDI) program, fraudulently used higher-value CCs and MCCs than were justified by actual medical diagnoses to increase its revenues. Integra Med contends that Baylor's scheme had three main components.

First, Integra Med contends that Baylor trained its physicians and CDI employees to "upcode" MCCs. According to Integra Med, Baylor trained its physicians to focus on key words, provided lists of high-value MCCs to physicians to reinforce that training, and emphasized that using certain terms would increase their performance pay. Integra Med also contends that Baylor had its CDI employees seek opportunities to use higher-value secondary codes.

Second, Integra Med alleges that Baylor pressured physicians to alter their original diagnoses by providing documents and asking them to "specify" or change their diagnosis if the diagnosis did not include CCs or MCCs. According to Integra Med, these clarification documents that requested physicians to "specify" their diagnoses would often "suggest either specific revenue-increasing CCs or MCCs or provide options listing several possible CCs and MCCs." Integra Med contends these clarification documents "reveal a clear intent towards influencing doctors to code higher-paying CCs and MCCs."

Third, Integra Med alleges that Baylor provided unnecessary treatment in order to code high-value MCCs. Specifically, Integra Med contends that "Baylor purposefully placed and kept post-opera-

tive patients on ventilator support" when it was medically unnecessary. Integra Med bases this allegation on the fact "that Baylor patients undergoing major heart surgery were placed on mechanical ventilation [at rates] over twice the national average."

Integra Med analyzed inpatient claims data for the 2011-2017 period from CMS to discover that Baylor had been claiming certain MCCs significantly above the national average for other hospitals. Specifically, Integra Med found that Baylor coded for the MCCs of encephalopathy, respiratory failure, and severe malnutrition at much higher rates than other hospitals. Integra Med contends that its statistical analyses show that Baylor's higher rate of coding cannot be explained by patient characteristics, county demographic data, the patient's attending physician, or regional differences. According to Integra Med, its "analyses prove that the excessive rates of [certain] MCCs can be directly attributed to [Baylor's] fraudulent activity as opposed to external factors, indicating that the fraud was known by the system and was intentional."

Besides statistical data, Integra Med also relied on several statements from a former Baylor medical coder in concluding that Baylor had defrauded Medicare. According to Integra Med, this medical coder recalled a then-Baylor executive "telling CDIs things that were totally not true" as a part of a "deliberate effort to promote the coding of MCCs." This medical coder also allegedly received specific instructions on how to code. Integra Med claims

that this medical coder quit her job with Baylor because she was unable to work where she "was continually getting directives to compromise her integrity." Integra Med also relied on certain statements about increasing hospital revenues from a former Baylor executive's social media.

Based on these statistics and statements, Integra Med sued Baylor under the FCA in federal district court in April 2018. After Integra Med amended its complaint twice, Baylor moved under Federal Rule of Civil Procedure Rule 12(b)(6) to dismiss Integra Med's complaint. The district court granted Baylor's motion to dismiss, holding that Integra Med's complaint failed to state a particularized claim for which relief could be granted as required by Federal Rules of Civil Procedure 8(a) and 9(b). This appeal followed.

II

To survive a motion to dismiss an FCA claim, Integra Med must plead the following four elements: (1) "a false statement or fraudulent course of conduct;" (2) that was "made or carried out with the requisite scienter;" (3) "that was material;" and (4) "that caused the government to pay out money or to forfeit moneys due (i.e., that involved a claim)."[5] Integra Med's case on appeal hinges on whether Integra Med sufficiently pleaded facts showing that Baylor's claims were fraudulent. Thus,

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[5] *United States ex rel. King v. Solvay Pharm., Inc.,* 871 F.3d 318, 324 (5th Cir. 2017) (quoting *United States ex rel. Longhi v. United States,* 575 F.3d 458, 467 (5th Cir. 2009)).

we will examine each of Integra Med's bases for its claims, including its statistical data generally, the documents it has gathered from Baylor, statements by a former Baylor medical coder, and the claim that Baylor provided unnecessary medical care to boost its Medicare reimbursements.

A

We first examine the statistical data presented by Integra Med, reviewing whether it sufficiently shows that Baylor's Medicare reimbursement claims were fraudulent. "[A] complaint filed under the False Claims Act must meet the heightened pleading standard of Rule of 9(b)."[6] Federal Rule of Civil Procedure 9(b) provides, "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake."[7] Although the particularity Rule 9(b) demands "differs with the facts of each case,"[8] it does generally

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[6] *See, e.g., United States ex rel. Grubbs v. Kanneganti,* 565 F.3d 180, 185 (5th Cir. 2009) (first citing *United States ex rel. Russell v. Epic Healthcare Mgmt. Grp.,* 193 F.3d 304, 308-09 (5th Cir. 1999), *abrogated on other grounds by United States ex rel. Eisenstein v. City of New York,* 556 U.S. 928 (2009); and then citing *United States ex rel. Karvelas v. Melrose–Wakefield Hosp.,* 360 F.3d 220, 228 (1st Cir. 2004), *abrogated on other grounds by Allison Engine Co. v. United States ex rel. Sanders,* 553 U.S. 662 (2008)).

[7] FED. R. CIV P. 9(b); *see also Kanneganti,* 565 F.3d at 185-86.

[8] *Hart v. Bayer Corp.,* 199 F.3d 239, 247 n.6 (5th Cir. 2000) (citing *Guidry v. Bank of LaPlace,* 954 F.2d 278, 288 (5th Cir. 1992)).

require that a complaint detail "the who, what, when, and where . . . before access to the discovery process is granted."[9] Rule 9(b)'s particularity requirement supplements Rule 8(a)'s demand that "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'"[10] Rule 8(a) prohibits any claims that are merely conceivable rather than plausible.[11] A claim is merely conceivable and not plausible if the facts pleaded are consistent with both the claimed misconduct and a legal and "obvious alternative explanation."[12]

Here, Integra Med's statistical analysis is consistent with both Baylor having submitted fraudulent Medicare reimbursement claims to the government and with Baylor being ahead of most healthcare providers in following new guidelines from CMS. In 2007, CMS reduced the standardized amount paid out to hospitals for Medicare reimbursement claims but increased the number of secondary diagnoses identified as CCs and MCCs, and coding more CCs and MCCs can increase hospital reimbursements.[13]

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[9] *Id.* (alteration in original) (quoting *Williams v. WMX Techs., Inc.,* 112 F.3d 175, 178 (5th Cir. 1997)).

[10] *Ashcroft v. Iqbal,* 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 570 (2007)); *see also Kanneganti,* 565 F.3d at 185.

[11] *Iqbal,* 556 U.S. at 680 (quoting *Twombly,* 550 U.S. at 570).

[12] *Id.* at 682 (quoting *Twombly,* 550 U.S. at 567).

[13] *See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008*

In response to public comments expressing concern that the new rules would lead to lower reimbursements, CMS stated that it expected reimbursements to increase under the system.[14] CMS believed it was "clear" that hospitals would "change their documentation and coding practices and increase case mix consistent with the payment incentives that are provided by the" then new coding system.[15] In fact, CMS encouraged hospitals to adopt CDI programs "in order to increase reimbursement" and highlighted an article touting the effectiveness of CDI programs at increasing Medicare reimbursement rates.[16] CMS unequivocally stated in its guidelines that, "[w]e do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record."[17]

The conclusion that Baylor was simply ahead of the healthcare industry in following CMS guidelines is supported by the data in Integra Med's own complaint. Integra Med's complaint shows that the

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Rates, 72 Fed. Reg. 47,130, 47,135-39 (Aug. 22, 2007) (final rule).

[14] *See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates,* 72 Fed. Reg. at 47,180-82.

[15] *Id.* at 47,182.

[16] *Id.*

[17] *Id.* at 47,180.

rate at which non-Baylor hospitals were using the MCCs for encephalopathy, respiratory failure, and severe malnutrition was increasing every year. These increases were causing the MCC usage rates of both Baylor and non-Baylor hospitals to converge. Moreover, for severe malnutrition, non-Baylor hospitals were coding it at a higher rate in 2017 than Baylor was in 2015. Similarly, for respiratory failure, non-Baylor hospitals were coding it at a higher rate in 2017 than Baylor was in 2011. These show that the healthcare industry as a whole was following Baylor in its trajectory and by 2017, other hospitals' coding was within a few percentage points of Baylor's.

These facts strongly indicate that a legal and "obvious alternative explanation" for the statistical data presented by Integra Med is that Baylor was simply ahead of the healthcare industry at implementing the Medicare reimbursement guidelines supplied by CMS.[18] We note that this conclusion does not exclude statistical data from being used to meet the pleading requirements of Federal Rule of Civil Procedure 8(a) and, when paired with particular details, Rule 9(b).[19] Our conclusion merely

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[18] *See Ashcroft v. Iqbal,* 556 U.S. 662, 682 (2009) (quoting *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 567 (2007)).

[19] *See, e.g., United States ex rel. Customs Fraud Investigations, LLC v. Victaulic Co.,* 839 F.3d 242, 247-48, 258 (3d Cir. 2016) (concluding, in the Rule 8(a) and 9(b) context, that statistical data about the lack of markings on a company's pipe fittings was sufficient to state an FCA claim for avoiding import duties when paired with an expert's declaration analyzing the facts of that case, specific examples of unmarked

means that statistical data cannot meet those pleading requirements if, among other possible issues, it is also consistent with a legal and obvious alternative explanation.[20]

Insofar as Integra Med purports to give specific examples of fraudulent claims, it also fails to meet the pleading requirements of Rules 8(a) and 9(b). Integra Med's examples simply give some identifying patient information and pair it with a diagnosis. No example gives any indication about what makes it a false claim. The claims of falsity are simply conclusory.[21]

B

1

We next examine whether Integra Med's allegations that Baylor trained and pressured its physicians and CDI employees to "upcode" MCCs are sufficient to establish that Baylor was engaging in

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pipes with photographs, a witness statement about receiving improperly marked pipes, and detailed records about the shipments at issue); *Boykin v. Georgia-Pac. Corp.,* 706 F.2d 1384, 1390-94 (5th Cir. 1983) (concluding, in the Rule 8(a) context, that plaintiff's presentation of statistical data successfully stated a prima facie case of racial discrimination).

[20] *See Iqbal,* 556 U.S. at 678.

[21] *See Taylor v. Books A Million, Inc.,* 296 F.3d 376, 378 (5th Cir. 2002) ("[C]onclusory allegations or legal conclusions masquerading as factual conclusions will not suffice to prevent a motion to dismiss." (quoting *S. Christian Leadership Conference v. Supreme Court of the State of La.,* 252 F.3d 781, 786 (5th Cir. 2001))).

a scheme to submit fraudulent claims to Medicare. We conclude that they are not. In publishing the new DRG coding rules, CMS explicitly expected hospitals to work with their physicians and medical coders, including through training, to "focus on understanding the impact of the revised CC list."[22] According to Integra Med, Baylor trained physicians to focus on keywords, provided tip sheets reminding physicians of how to report high-value MCCs, had CDI employees look for opportunities where high-value MCCs might be present, and would sometimes send physicians documents asking them to clarify their diagnoses. Integra Med argues that these practices show Baylor was involved in a scheme to defraud Medicare. But CMS encouraged hospitals to employ practices like these after it implemented the new DRG rules.[23] Far from a fraudulent scheme, Baylor's implementation of such practices is entirely consistent with the new DRG rules.[24]

For example, Baylor's use of tip sheets is consistent with the fact that coding and clinic terminology are often different. Tip sheets help hospitals align the two. Likewise, non-leading documents asking

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[22] *See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates,* 72 Fed. Reg. at 47,182 ("[H]ospitals may focus on understanding the impact of the revised CC list, training and educating their coders, and working with their physicians for any documentation improvements required to allow the reporting of more specific codes where applicable.").

[23] *See id.*

[24] *Id.*

physicians to clarify their diagnoses are also consistent with implementing the new DRG rules since the new DRG rules moved hospitals away from focusing on general diagnoses and codes to frequently using more specific diagnoses and codes.[25] Physicians were likely still accustomed to the old, more general system. These clarification documents had numerous suggestions, a simple box to check to decline clarification, and a disclaimer not to take implications from the fact clarification was asked for. Additionally, some of the clarification documents provided by Integra Med in its complaint show that clarification was requested in instances in which physicians wrote down symptoms but failed to provide a diagnosis for the cause of those symptoms. These clarification documents also did not ask leading questions. Considering diagnoses are critical for Medicare reimbursements and these specific clarification documents were not leading, they are consistent with Baylor engaging in legal activity.

Therefore, we conclude that these allegations are also consistent with a legal and "obvious alternative explanation."[26]

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In its complaint, Integra Med also cites the statements of a medical coder who said that a then-

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[25] *See id.* at 47,130-82 (Aug. 22, 2007) (final rule).

[26] *See Ashcroft v. Iqbal,* 556 U.S. 662, 682 (2009) (quoting *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 567 (2007)).

Baylor executive told "CDIs things that were totally not true" as a part of a "deliberate effort to promote the coding of MCCs." According to Integra Med, this medical coder said she was given specific instructions on how to code, and that medical coders "receive[d] pressure directly from . . . leadership to code unethically." This medical coder also allegedly quit her job because she "was continually getting directives to compromise her integrity." But these allegations fail to satisfy the heightened pleading standards required by Federal Rule of Civil Procedure 9(b) because they fail to state the content of these allegedly unethical and fraudulent directives, trainings, and guidance.[27] Thus, the dis-

[27] *See Hart v. Bayer Corp.,* 199 F.3d 239, 247 n.6 (5th Cir. 2000) (concluding that to meet the pleading requirements of Rule 9(b) a complaint must state "the who, what, when, and where" of a claim. (quoting *Williams v. WMX Techs., Inc.,* 112 F.3d 175, 178 (5th Cir. 1997))). Integra Med claims that the situation here is "strikingly similar" to the situation in *United States ex rel. Integra Med Analytics, LLC v. Creative Solutions in Healthcare, Inc.,* No. SA-17-CV-1249-XR, 2019 WL 5970283 (W.D. Tex. Nov. 13, 2019). We disagree. In *Creative Solutions,* the employee witness interviews actually revealed the contents of a specific fraudulent scheme. *Id.* at *4. That opinion notes, "a physical therapist at Fairfield recalled being instructed to allot 15 minutes for evaluation, even though it required 45 minutes, with the rest of the evaluation session charged at therapy rates." *Id.* (internal quotation omitted). The interview responses given by Integra Med here, while alleging a vague scheme to "promote the coding of MCCs," do not provide the who, what, when, and where of such scheme as required by Rule 9(b). The vague allegation here contrasts with the *Creative Solutions* interview responses, which included the requisite particularity and specificity.

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We next look at Integra Med's allegations that Baylor provided unnecessary treatment to patients in order to use higher-value MCCs. Specifically, Integra Med contends that "Baylor purposefully placed and kept post-operative patients on ventilator support" when it was medically unnecessary. The allegations here are based solely on the fact "that Baylor patients undergoing major heart surgery were placed on mechanical ventilation over twice the national average." These allegations do not withstand the heightened pleading requirements for fraud under Rule 9(b).

Integra Med fails to plead particular details of a scheme to defraud Medicare. Even when plaintiffs in an FCA case use statistics, which can be reliable indicia of fraud, they must still plead particular details of a fraudulent scheme for each claim.[28]

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Here, Integra Med's complaint contains a conclusory allegation that Baylor was providing unnecessary treatment to its patients and supports it with a single statistic—that Baylor patients undergoing major heart surgery were put on a mechanical ventilator at a rate over twice the national average. Integra Med does not present sufficient particular details of this alleged fraud claim. The district court correctly dismissed the FCA claim based on Integra Med's allegation that Baylor provided unnecessary treatment to patients to increase its Medicare reimbursements.

In conclusion, Integra Med has failed to meet its pleading requirements under Rules 8(a) and 9(b). The district court did not, as Integra Med contends, view the complaint in the light most favorable to Baylor—it simply correctly held Integra Med to the higher pleading standard required for an FCA claim.

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Integra Med contends that the district court improperly held its allegations to a more rigorous scienter requirement than was required by the FCA. But we need not address scienter because the

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evidence to strengthen the inference of fraud beyond mere possibility, without necessarily providing details as to each false claim. This standard nonetheless requires the relator to provide other reliable indications of fraud and to plead a level of detail that demonstrates that an alleged scheme likely resulted in bills submitted for government payment." (emphasis and citations omitted)).

district court correctly dismissed Integra Med's claims for failing to meet the pleading requirements required by Rules 8(a) and 9(b) for pleading the FCA's element that there be "a false statement or fraudulent course of conduct."[29]

Integra Med also contends that the district court improperly applied a probability standard at the pleadings stage instead of a plausibility standard. But regardless of whether the district court mistakenly applied a probability standard rather than a plausibility standard, our conclusion is the same.[30] Since "[we] may affirm the district court on any grounds supported by the record and argued in the court below," any misapplication that might have occurred here would not require us to vacate or reverse the district court's judgment.[31]

* * *

For these reasons, the district court's judgment is AFFIRMED.

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[29] *United States ex rel King v. Solvay Pharm., Inc.,* 871 F.3d 318, 324 (5th Cir. 2017) (quoting *United States ex rel. Longhi v. United States,* 575 F.3d 458, 467 (5th Cir. 2009)).

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IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 19-50818

Filed May 28, 2020

D.C. Docket No. 5:17-CV-886

United States of America, ex rel,
INTEGRA MED ANALYTICS, L.L.C.,

Plaintiff-Appellant

v.

BAYLOR SCOTT & WHITE HEALTH;
BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS;
HILLCREST BAPTIST MEDICAL CENTER;
SCOTT & WHITE HOSPITAL – ROUND ROCK;
SCOTT & WHITE MEMORIAL HOSPITAL TEMPLE,

Defendants-Appellees

Appeal from the United States District Court
for the Western District of Texas

Before OWEN, Chief Judge, and HIGGINBOTHAM and Willett, Circuit Judges.

JUDGMENT

This cause was considered on the record on appeal and the briefs on file.

It is ordered and adjudged that the judgment of the District Court is affirmed.

IT IS FURTHER ORDERED that appellant pay to appellees the costs on appeal to be taxed by the Clerk of this Court.

United States Court of Appeals
Fifth Judicial Circuit

[SEAL]

Certified as a true copy and issued as the mandate on Jun 19, 2020

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FOR THE FIFTH CIRCUIT

No. 19-50818

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Plaintiff–Appellant,

v.

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Defendants–Appellees.

Appeal from the United States District Court
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USDC No. 5:17-CV-886

Before OWEN, Chief Judge, and HIGGINBOTHAM and WILLETT, Circuit Judges.

PER CURIAM:*

Integra Med Analytics, L.L.C., filed a qui tam suit[1] on behalf of the United States against Baylor Scott & White Health system and its affiliates under the False Claims Act for allegedly using inflated codes to bill Medicare. The district court dismissed Integra Med's claims. We affirm.

I

The Baylor Scott & White Health system and its affiliates (Baylor) operate a network consisting of around twenty inpatient short-term acute care hospitals in Texas. A significant number of patients served by Baylor are covered by Medicare. Thus, Baylor regularly submits reimbursement claims to Medicare. In this case, Integra Med Analytics, L.L.C. (Integra Med) alleges that Baylor submitted $61.8 million in fraudulent claims to Medicare, in violation of the False Claims Act (FCA).[2]

Medicare reimburses hospitals like Baylor on a per-discharge basis, which means Baylor gets paid

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* Pursuant to 5TH CIR. R. 47.5, the court has determined that this opinion should not be published and is not precedent except under the limited circumstances set forth in 5TH CIR. R. 47.5.4.

[1] At the federal level, qui tam suits are those that are filed "for the person and for the United States Government" and "brought in the name of the Government." 31 U.S.C. § 3730(b)(1). Thus, in qui tam suits, the government is the real party in interest. *United States v. Tex. Tech Univ.,* 171 F.3d 279, 289 (5th Cir. 1999).

[2] 31 U.S.C. § 3729.

each time a patient stays at the hospital. The exact amount that Medicare reimburses primarily depends on a hospital's diagnoses of Medicare-covered patients. Medicare classifies similar diagnoses by putting them into a diagnosis related group (DRG). Each DRG is determined by several kinds of codes, including the principal diagnosis code and secondary diagnosis codes. The principal diagnosis code is for the "condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."[3] Secondary diagnosis codes are for "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay."[4] Reimbursement can also be affected, to a lesser extent, by other hospital-specific factors, such as market conditions in the hospital's city.

Integra Med's allegations specifically concern Baylor's use of secondary diagnosis codes. The Centers for Medicare and Medicaid Services (CMS) publishes a list of secondary codes each year that can modify a claim to include a complication or comorbidity (CC) or a major complication or comorbidity (MCC). The inclusion of CCs and MCCs can add thousands of dollars to a Medicare reimbursement claim. Integra Med alleges that Baylor, led by

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[3] *See* Centers for Disease Control, *ICD-9-CM Official Guidelines for Coding and Reporting,* Oct. 1, 2011 at 88, available at https://goo.gl/DC55Wx.

[4] *See* Centers for Disease Control, *ICD-9-CM Official Guidelines for Coding and Reporting,* Oct. 1, 2011 at 91, available at https://goo.gl/DC55Wx.

its clinical documentation improvement (CDI) program, fraudulently used higher-value CCs and MCCs than were justified by actual medical diagnoses to increase its revenues. Integra Med contends that Baylor's scheme had three main components.

First, Integra Med contends that Baylor trained its physicians and CDI employees to "upcode" MCCs. According to Integra Med, Baylor trained its physicians to focus on key words, provided lists of high-value MCCs to physicians to reinforce that training, and emphasized that using certain terms would increase their performance pay. Integra Med also contends that Baylor had its CDI employees seek opportunities to use higher-value secondary codes.

Second, Integra Med alleges that Baylor pressured physicians to alter their original diagnoses by providing documents and asking them to "specify" or change their diagnosis if the diagnosis did not include CCs or MCCs. According to Integra Med, these clarification documents that requested physicians to "specify" their diagnoses would often "suggest either specific revenue-increasing CCs or MCCs or provide options listing several possible CCs and MCCs." Integra Med contends these clarification documents "reveal a clear intent towards influencing doctors to code higher-paying CCs and MCCs."

Third, Integra Med alleges that Baylor provided unnecessary treatment in order to code high-value MCCs. Specifically, Integra Med contends that "Baylor purposefully placed and kept post-opera-

tive patients on ventilator support" when it was medically unnecessary. Integra Med bases this allegation on the fact "that Baylor patients undergoing major heart surgery were placed on mechanical ventilation [at rates] over twice the national average."

Integra Med analyzed inpatient claims data for the 2011-2017 period from CMS to discover that Baylor had been claiming certain MCCs significantly above the national average for other hospitals. Specifically, Integra Med found that Baylor coded for the MCCs of encephalopathy, respiratory failure, and severe malnutrition at much higher rates than other hospitals. Integra Med contends that its statistical analyses show that Baylor's higher rate of coding cannot be explained by patient characteristics, county demographic data, the patient's attending physician, or regional differences. According to Integra Med, its "analyses prove that the excessive rates of [certain] MCCs can be directly attributed to [Baylor's] fraudulent activity as opposed to external factors, indicating that the fraud was known by the system and was intentional."

Besides statistical data, Integra Med also relied on several statements from a former Baylor medical coder in concluding that Baylor had defrauded Medicare. According to Integra Med, this medical coder recalled a then-Baylor executive "telling CDIs things that were totally not true" as a part of a "deliberate effort to promote the coding of MCCs." This medical coder also allegedly received specific instructions on how to code. Integra Med claims

that this medical coder quit her job with Baylor because she was unable to work where she "was continually getting directives to compromise her integrity." Integra Med also relied on certain statements about increasing hospital revenues from a former Baylor executive's social media.

Based on these statistics and statements, Integra Med sued Baylor under the FCA in federal district court in April 2018. After Integra Med amended its complaint twice, Baylor moved under Federal Rule of Civil Procedure Rule 12(b)(6) to dismiss Integra Med's complaint. The district court granted Baylor's motion to dismiss, holding that Integra Med's complaint failed to state a particularized claim for which relief could be granted as required by Federal Rules of Civil Procedure 8(a) and 9(b). This appeal followed.

II

To survive a motion to dismiss an FCA claim, Integra Med must plead the following four elements: (1) "a false statement or fraudulent course of conduct;" (2) that was "made or carried out with the requisite scienter;" (3) "that was material;" and (4) "that caused the government to pay out money or to forfeit moneys due (i.e., that involved a claim)."[5] Integra Med's case on appeal hinges on whether Integra Med sufficiently pleaded facts showing that Baylor's claims were fraudulent. Thus,

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[5] *United States ex rel. King v. Solvay Pharm., Inc.,* 871 F.3d 318, 324 (5th Cir. 2017) (quoting *United States ex rel. Longhi v. United States,* 575 F.3d 458, 467 (5th Cir. 2009)).

we will examine each of Integra Med's bases for its claims, including its statistical data generally, the documents it has gathered from Baylor, statements by a former Baylor medical coder, and the claim that Baylor provided unnecessary medical care to boost its Medicare reimbursements.

A

We first examine the statistical data presented by Integra Med, reviewing whether it sufficiently shows that Baylor's Medicare reimbursement claims were fraudulent. "[A] complaint filed under the False Claims Act must meet the heightened pleading standard of Rule of 9(b)."[6] Federal Rule of Civil Procedure 9(b) provides, "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake."[7] Although the particularity Rule 9(b) demands "differs with the facts of each case,"[8] it does generally

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[6] *See, e.g., United States ex rel. Grubbs v. Kanneganti,* 565 F.3d 180, 185 (5th Cir. 2009) (first citing *United States ex rel. Russell v. Epic Healthcare Mgmt. Grp.,* 193 F.3d 304, 308-09 (5th Cir. 1999), *abrogated on other grounds by United States ex rel. Eisenstein v. City of New York,* 556 U.S. 928 (2009); and then citing *United States ex rel. Karvelas v. Melrose–Wakefield Hosp.,* 360 F.3d 220, 228 (1st Cir. 2004), *abrogated on other grounds by Allison Engine Co. v. United States ex rel. Sanders,* 553 U.S. 662 (2008)).

[7] FED. R. CIV P. 9(b); *see also Kanneganti,* 565 F.3d at 185-86.

[8] *Hart v. Bayer Corp.,* 199 F.3d 239, 247 n.6 (5th Cir. 2000) (citing *Guidry v. Bank of LaPlace,* 954 F.2d 278, 288 (5th Cir. 1992)).

require that a complaint detail "the who, what, when, and where . . . before access to the discovery process is granted."[9] Rule 9(b)'s particularity requirement supplements Rule 8(a)'s demand that "a complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'"[10] Rule 8(a) prohibits any claims that are merely conceivable rather than plausible.[11] A claim is merely conceivable and not plausible if the facts pleaded are consistent with both the claimed misconduct and a legal and "obvious alternative explanation."[12]

Here, Integra Med's statistical analysis is consistent with both Baylor having submitted fraudulent Medicare reimbursement claims to the government and with Baylor being ahead of most healthcare providers in following new guidelines from CMS. In 2007, CMS reduced the standardized amount paid out to hospitals for Medicare reimbursement claims but increased the number of secondary diagnoses identified as CCs and MCCs, and coding more CCs and MCCs can increase hospital reimbursements.[13]

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[9] *Id.* (alteration in original) (quoting *Williams v. WMX Techs., Inc.,* 112 F.3d 175, 178 (5th Cir. 1997)).

[10] *Ashcroft v. Iqbal,* 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 570 (2007)); *see also Kanneganti,* 565 F.3d at 185.

[11] *Iqbal,* 556 U.S. at 680 (quoting *Twombly,* 550 U.S. at 570).

[12] *Id.* at 682 (quoting *Twombly,* 550 U.S. at 567).

[13] *See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008*

In response to public comments expressing concern that the new rules would lead to lower reimbursements, CMS stated that it expected reimbursements to increase under the system.[14] CMS believed it was "clear" that hospitals would "change their documentation and coding practices and increase case mix consistent with the payment incentives that are provided by the" then new coding system.[15] In fact, CMS encouraged hospitals to adopt CDI programs "in order to increase reimbursement" and highlighted an article touting the effectiveness of CDI programs at increasing Medicare reimbursement rates.[16] CMS unequivocally stated in its guidelines that, "[w]e do not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record."[17]

The conclusion that Baylor was simply ahead of the healthcare industry in following CMS guidelines is supported by the data in Integra Med's own complaint. Integra Med's complaint shows that the

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Rates, 72 Fed. Reg. 47,130, 47,135-39 (Aug. 22, 2007) (final rule).

[14] *See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates,* 72 Fed. Reg. at 47,180-82.

[15] *Id.* at 47,182.

[16] *Id.*

[17] *Id.* at 47,180.

rate at which non-Baylor hospitals were using the MCCs for encephalopathy, respiratory failure, and severe malnutrition was increasing every year. These increases were causing the MCC usage rates of both Baylor and non-Baylor hospitals to converge. Moreover, for severe malnutrition, non-Baylor hospitals were coding it at a higher rate in 2017 than Baylor was in 2015. Similarly, for respiratory failure, non-Baylor hospitals were coding it at a higher rate in 2017 than Baylor was in 2011. These show that the healthcare industry as a whole was following Baylor in its trajectory and by 2017, other hospitals' coding was within a few percentage points of Baylor's.

These facts strongly indicate that a legal and "obvious alternative explanation" for the statistical data presented by Integra Med is that Baylor was simply ahead of the healthcare industry at implementing the Medicare reimbursement guidelines supplied by CMS.[18] We note that this conclusion does not exclude statistical data from being used to meet the pleading requirements of Federal Rule of Civil Procedure 8(a) and, when paired with particular details, Rule 9(b).[19] Our conclusion merely

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[18] *See Ashcroft v. Iqbal,* 556 U.S. 662, 682 (2009) (quoting *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 567 (2007)).

[19] *See, e.g., United States ex rel. Customs Fraud Investigations, LLC v. Victaulic Co.,* 839 F.3d 242, 247-48, 258 (3d Cir. 2016) (concluding, in the Rule 8(a) and 9(b) context, that statistical data about the lack of markings on a company's pipe fittings was sufficient to state an FCA claim for avoiding import duties when paired with an expert's declaration analyzing the facts of that case, specific examples of unmarked

means that statistical data cannot meet those pleading requirements if, among other possible issues, it is also consistent with a legal and obvious alternative explanation.[20]

Insofar as Integra Med purports to give specific examples of fraudulent claims, it also fails to meet the pleading requirements of Rules 8(a) and 9(b). Integra Med's examples simply give some identifying patient information and pair it with a diagnosis. No example gives any indication about what makes it a false claim. The claims of falsity are simply conclusory.[21]

B

1

We next examine whether Integra Med's allegations that Baylor trained and pressured its physicians and CDI employees to "upcode" MCCs are sufficient to establish that Baylor was engaging in

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pipes with photographs, a witness statement about receiving improperly marked pipes, and detailed records about the shipments at issue); *Boykin v. Georgia-Pac. Corp.,* 706 F.2d 1384, 1390-94 (5th Cir. 1983) (concluding, in the Rule 8(a) context, that plaintiff's presentation of statistical data successfully stated a prima facie case of racial discrimination).

[20] *See Iqbal,* 556 U.S. at 678.

[21] *See Taylor v. Books A Million, Inc.,* 296 F.3d 376, 378 (5th Cir. 2002) ("[C]onclusory allegations or legal conclusions masquerading as factual conclusions will not suffice to prevent a motion to dismiss." (quoting *S. Christian Leadership Conference v. Supreme Court of the State of La.,* 252 F.3d 781, 786 (5th Cir. 2001))).

a scheme to submit fraudulent claims to Medicare. We conclude that they are not. In publishing the new DRG coding rules, CMS explicitly expected hospitals to work with their physicians and medical coders, including through training, to "focus on understanding the impact of the revised CC list."[22] According to Integra Med, Baylor trained physicians to focus on keywords, provided tip sheets reminding physicians of how to report high-value MCCs, had CDI employees look for opportunities where high-value MCCs might be present, and would sometimes send physicians documents asking them to clarify their diagnoses. Integra Med argues that these practices show Baylor was involved in a scheme to defraud Medicare. But CMS encouraged hospitals to employ practices like these after it implemented the new DRG rules.[23] Far from a fraudulent scheme, Baylor's implementation of such practices is entirely consistent with the new DRG rules.[24]

For example, Baylor's use of tip sheets is consistent with the fact that coding and clinic terminology are often different. Tip sheets help hospitals align the two. Likewise, non-leading documents asking

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[22] *See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates,* 72 Fed. Reg. at 47,182 ("[H]ospitals may focus on understanding the impact of the revised CC list, training and educating their coders, and working with their physicians for any documentation improvements required to allow the reporting of more specific codes where applicable.").

[23] *See id.*

[24] *Id.*

physicians to clarify their diagnoses are also consistent with implementing the new DRG rules since the new DRG rules moved hospitals away from focusing on general diagnoses and codes to frequently using more specific diagnoses and codes.[25] Physicians were likely still accustomed to the old, more general system. These clarification documents had numerous suggestions, a simple box to check to decline clarification, and a disclaimer not to take implications from the fact clarification was asked for. Additionally, some of the clarification documents provided by Integra Med in its complaint show that clarification was requested in instances in which physicians wrote down symptoms but failed to provide a diagnosis for the cause of those symptoms. These clarification documents also did not ask leading questions. Considering diagnoses are critical for Medicare reimbursements and these specific clarification documents were not leading, they are consistent with Baylor engaging in legal activity.

Therefore, we conclude that these allegations are also consistent with a legal and "obvious alternative explanation."[26]

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In its complaint, Integra Med also cites the statements of a medical coder who said that a then-

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[26] *See Ashcroft v. Iqbal,* 556 U.S. 662, 682 (2009) (quoting *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 567 (2007)).

Baylor executive told "CDIs things that were totally not true" as a part of a "deliberate effort to promote the coding of MCCs." According to Integra Med, this medical coder said she was given specific instructions on how to code, and that medical coders "receive[d] pressure directly from . . . leadership to code unethically." This medical coder also allegedly quit her job because she "was continually getting directives to compromise her integrity." But these allegations fail to satisfy the heightened pleading standards required by Federal Rule of Civil Procedure 9(b) because they fail to state the content of these allegedly unethical and fraudulent directives, trainings, and guidance.[27] Thus, the dis-

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Here, Integra Med's complaint contains a conclusory allegation that Baylor was providing unnecessary treatment to its patients and supports it with a single statistic—that Baylor patients undergoing major heart surgery were put on a mechanical ventilator at a rate over twice the national average. Integra Med does not present sufficient particular details of this alleged fraud claim. The district court correctly dismissed the FCA claim based on Integra Med's allegation that Baylor provided unnecessary treatment to patients to increase its Medicare reimbursements.

In conclusion, Integra Med has failed to meet its pleading requirements under Rules 8(a) and 9(b). The district court did not, as Integra Med contends, view the complaint in the light most favorable to Baylor—it simply correctly held Integra Med to the higher pleading standard required for an FCA claim.

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Integra Med also contends that the district court improperly applied a probability standard at the pleadings stage instead of a plausibility standard. But regardless of whether the district court mistakenly applied a probability standard rather than a plausibility standard, our conclusion is the same.[30] Since "[we] may affirm the district court on any grounds supported by the record and argued in the court below," any misapplication that might have occurred here would not require us to vacate or reverse the district court's judgment.[31]

* * *

For these reasons, the district court's judgment is AFFIRMED.

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS
SAN ANTONIO DIVISION

No. 5:17-CV-886-DAE

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Plaintiff,

vs.

BAYLOR SCOTT & WHITE HEALTH,
BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS,
HILLCREST BAPTIST MEDICAL CENTER,
SCOTT & WHITE HOSPITAL – ROUND ROCK,
SCOTT & WHITE HOSPITAL TEMPLE,
Defendants.

ORDER GRANTING DEFENDANTS' MOTION TO DISMISS (DKT. # 21)

Before the Court is a Motion to Dismiss filed by Defendants Baylor Scott & White Health, Baylor University Medical Center-Dallas, Hillcrest Baptist Medical Center, Scott & White Hospital-Round Rock, and Scott & White Hospital Temple (collectively "Defendants"). (Dkt. # 21.) Pursuant to Local Rule CV-7(h), the Court finds these matters suitable for disposition without a hearing. After careful consideration of the memoranda filed in support of and in opposition to the motion, the

Court—for the reasons that follow—**GRANTS** Defendants' Motion to Dismiss. (*Id.*)

BACKGROUND

I. *Factual Background*

Defendants in this *qui tam* action are the operator of a network of inpatient short-term acute care hospitals and four of its affiliated hospitals. (Dkt. # 15[1] at 3.) Part of the services Defendants perform are for patients covered by Medicare, and therefore Defendants regularly submit requests to Medicare for reimbursement for these services. (*Id.*) As such, these request for reimbursement are subject to the False Claims Act ("FCA"), and knowingly presenting false or fraudulent claims to the Government for reimbursement is illegal and incurs civil liability.[2] 31 U.S.C. § 3729. Plaintiff alleges that Defendants have submitted "more than $61.8 million in false claims for Medicare reimbursement over the past seven years." (Dkt. # 15 at 5.)

In order to determine the proper amount of reimbursement for services rendered to patients,

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[1] Because Plaintiff's complaint contains certain patient medical information, Plaintiff filed both a sealed, unredacted version of its complaint (Dkt. # 17) as well as an unsealed, redacted version (Dkt. # 15). In this order, when citing to the complaint, the Court will refer to the unsealed, redacted version.

[2] The Government has declined to intervene in this action. (Dkt. # 9.)

Medicare groups patients with similar clinical problems that are expected to require similar amounts of hospital resources into what are called Diagnoses Related Groups ("DRG"). (*Id.* at 6.) The DRG is primarily determined by three types of codes from a Medicare claim: (1) the principle diagnosis code[3]; (2) any surgical procedure code[4]; and (3) any secondary diagnosis codes[5]. (*Id.* at 7.) The DRG can then be further adjusted based on hospital specific factors like market conditions in the hospital's city. (*Id.*)

The allegations in this case concern Defendants' coding of secondary diagnosis codes, which determine the severity level of the DRG. The Centers for Medicare and Medicaid Services ("CMS") publishes a list of codes each year that, when added to a claim, result in the claim being considered a "Complication or Comorbidity" ("CC") or a "Major Complication or Comorbidity" ("MCC"). (*Id.*) When a CC or MCC secondary code is added to claim, the value of that claim can increase anywhere from $1,000 to $25,000. (*Id.*)

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[3] The principal diagnosis code is the "condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care." (Dkt. # 15 at 6.)

[4] The surgical procedure code represents surgical procedures performed in an operating room setting at the hospital. (*Id.*)

[5] The secondary diagnosis code represents "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or length of stay." (*Id.*)

Plaintiff alleges that Defendants engaged in a scheme to fraudulently upcode CCs and MCCs that were not justified by the underlying medical diagnosis in order to increase hospital revenue. (*Id.* at 9.) According to Plaintiff, effectuation of this scheme took many forms, spearheaded by Anthony Matejicka, Defendants' Medical Director for Coding and Utilization, through Defendants' Clinical Documentation Improvement ("CDI") program[6]. (*Id.* at 8.)

Plaintiff first alleges that Defendants trained its doctors and CDI staff by emphasizing coding for MCCs. (*Id.* at 9.) Such training included encouraging staff to use certain key words that would trigger or permit MCC coding, disseminating a list of MCCs to focus on, and having employees walk around with a list of MCCs to look for opportunities to assign them as secondary diagnoses. (*Id.*) Defendants also allegedly emphasized to its doctors the importance of their coding efforts to both Defendants' revenue and the doctors pay for performance metrics. (*Id.* at 10–11.) Defendants also allegedly distributed tip sheets called "Teal Quickies" that provided doctors with guidance on how to clinically document diagnoses in a way that is codable by CMS. (*Id.* at 11–12.)

Plaintiff next alleges that Defendants pressured doctors to change diagnoses by sending them

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[6] CDI programs themselves are common in the industry and are typically designed to promote accurate documentation of patient diagnoses and treatments so that hospitals can be properly reimbursed for services rendered. (*Id.* at 8.)

"queries" encouraging doctors to "specify" or amend their diagnoses when the initial diagnoses did not warrant a CC or an MCC. (*Id.* at 12–16.) According to Plaintiff, these "document clarification sheets" reveal an intent towards influencing doctors to code higher-paying CCs and MCCs because the query sheets largely provide only options that could permit coding for a CC or and MCC. (*Id.*)

Finally, Plaintiff alleges that Defendants provided unnecessary treatment in order to permit them to code for MCCs. (*Id.* at 19.) In particular, Plaintiff alleges Defendants purposefully places patients on post-operative ventilator support, which enabled them to code for the MCC of acute respiratory failure. (*Id.* at 19–20.)

Plaintiff's allegations primarily revolve around the coding of three particular MCCs ("Allegedly Misstated MCCs"): encephalopathy; respiratory failure; and severe malnutrition. (*Id.* at 23.) In order to support its allegations, Plaintiff requested and received from CMS inpatient claims data for short term acute care hospitals from 2011 through 2017 and applied various proprietary methods of statistical analysis on this data set. (*Id.* at 21.) The upshot of this analysis is that Defendants coded for the Allegedly Misstated MCCs at rates significantly higher than the average of other hospitals. (*Id.* at 23–57.) According to Plaintiff, their statistical analysis further demonstrates that alternative hypothesis such as patient characteristics and demographics, the preferences or treatment decisions of physicians who work with patients at

Defendants' hospitals, unique characteristics of Defendants patients, or regional factors cannot explain differences in coding rates of the Allegedly Misstated MCCs. (*Id.* at 55–83.) On the strength of this analysis, Plaintiff alleges Defendants improperly received $61.8 million dollars from false claims due to fraudulent upcoding of the Allegedly Misstated MCCs. (*Id.* at 85.)

Based on these allegations, Plaintiff assert one cause of action against Defendants for violations of the False Claims Act. Plaintiff alleges that Defendants: (1) knowingly presented, or caused to be presented, false or fraudulent claims for payment of approval, in violation of 31 U.S.C. § 3729(a)(1)(A); (2) knowingly made, used or caused to be made or used, a false record or statement material to a false or fraudulent claim, in violations of 31 U.S.C. § 3729(a)(1)(B); and (3) knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay of transmit money or property to the government, or know-ingly concealing or knowingly and improperly avoiding or decreasing and obligation to pay or transmit money or property to the government, in violation of 31 U.S.C. § 3729(a)(1)(G). (*Id.* at 88–89.)

II. *Procedural Background*

Defendants filed the instant motion to dismiss under the FCA's public disclosure bar, and under Rule 12(b)(6) for failing to plead fraud with partic-

ularity as required by Rule 9(b) and for failure to state a plausible claim for relief under Rule 8(a). (Dkt. # 21.) Plaintiff filed a response in opposition to Defendants' motion. (Dkt. # 23.) Defendants then filed a reply in support of their motion. (Dkt. # 24.)

This motion before the Court is fully briefed and ripe for review.

LEGAL STANDARD

Federal Rule of Civil Procedure 12(b)(6) authorizes dismissal of a complaint for "failure to state a claim upon which relief can be granted." Review is limited to the contents of the complaint and matters properly subject to judicial notice. *See Tellabs, Inc. v. Makor Issues & Rights, Ltd.,* 551 U.S. 308, 322 (2007). In analyzing a motion to dismiss for failure to state a claim, "[t]he court accept[s] 'all well-pleaded facts as true, viewing them in the light most favorable to the plaintiff.'" *In re Katrina Canal Beaches Litig.,* 495 F.3d 191, 205 (5th Cir. 2007) (quoting *Martin K. Eby Constr. Co. v. Dallas Area Rapid Transit,* 369 F.3d 464, 467 (5th Cir. 2004)).

To survive a Rule 12(b)(6) motion to dismiss, the plaintiff must plead "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly,* 550 U.S. 544, 570 (2007). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v.*

Iqbal, 556 U.S. 662, 678 (2009).

DISCUSSION

In order to prevail on FCA claim, a Plaintiff must plead and ultimately prove four elements: (1) "a false statement or fraudulent course of conduct; (2) made or carried out with the requisite scienter; (3) that was material; and (4) that caused the government to pay out money or to forfeit moneys due (i.e., that involved a claim)." *United States ex re. Longhi v. United States,* 575 F.3d 458, 467 (5th Cir. 2009) (quoting and adopting *United States ex rel. Wilson v. Kellogg Brown & Root, Inc.,* 525 F.3d 370, 376 (4th Cir. 2008).

As previously stated, Defendants asserts three grounds for the dismissal of Plaintiff's complaint: (1) Plaintiff's claim is barred by the FCA's Public Disclosure Bar; (2) Plaintiff has failed to plead fraud with particularity as required by Rule 9(b); and (3) Plaintiff has failed to state a plausible claim for relief as required by Rule 8(a). (Dkt. # 21 at 9.) Because the Court concludes that dismissal is appropriate under Rule 8(a) working in conjunction with rule 9(b), the Court declines to reach Defendant's public disclosure bar arguments.

I. *FCA Pleading Requirements*

Rule 9(b) requires that "[i]n alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake." "[A] complaint filed under the False Claims act must meet the heightened pleading standard of Rule

9(b)[.]" *United States ex rel. Grubbs v. Kanneganti,* 565 F.3d 180, 190 (5th Cir. 2009). Under Fifth Circuit law, "the particularity demanded by Rule 9(b) differs with the facts of each case, [but] a plaintiff pleading fraud must set forth 'the who, what, when, and where . . . before access to the discovery process is granted." *Hart v. Bayer Corp.,* 199 F.3d 239, 247 (5th Cir. 2000) (internal citations omitted). However, the Fifth Circuit later clarified that "the 'time, place, contents, and identity' standard is not a straitjacket for Rule 9(b). Rather, the rule is context specific and flexible and must remain so to achieve the remedial purpose of the False Claims Act." *Kanneganti,* 565 F.3d at 190. As applied in the context of an FCA claim, "to plead with particularity the circumstances constituting fraud for a False Claims Act . . . claim, a relator's complaint, if it cannot allege the details of an actually submitted false claim, may nevertheless survive by alleging particular details of a scheme to submit false claims paired with reliable indicia that lead to a strong inference that claims were actually submitted." *Id.*

Applying this standard, the Court concludes that Plaintiff's complaint, as discussed above, alleges a scheme, spearheaded by Anthony Matejicka, to increase the number of claims submitted that include CCs and MCCs and contains reliable indicia leading to a strong inference that claims were actually submitted based on that scheme. However, that conclusion does not end the inquiry. Plaintiff's complaint must allege that the scheme was to submit *false* claims. *Id.* And that is where

Plaintiff's allegations fail.

The essence of Plaintiff's allegations is that Anthony Matejicka enacted a scheme to increase the number of patients whose services were coded for CCs and MCCs. That alleged scheme took several forms, including training doctors to document the medical record in a way that would permit coding for CCs and MCCs, training staff to be on the lookout for opportunities to code for CCs and MCCs and providing doctors with tip sheets and diagnosis clarification sheets that encouraged them to diagnose in ways that could permit coding for CCs and MCCs. (Dkt. # 15 at 9–19.) But such a scheme is not in and of itself one to submit false claims and is equally consistent with a scheme to improve hospital revenue through accurate coding of patient diagnoses in a way that will be appropriately recognized and reimbursed by CMS commensurate with the type and amount of services rendered.

CMS "encourage[s] hospitals to engage in complete and accurate coding" and has "reaffirm[ed its] view that hospitals focus their documentation and coding efforts to maximize reimbursement." Medicare Program, Changes to the Hospital Inpatient Prospective Payment systems and Fiscal Year 2008 Rates, 72 FR 47130, 4718 1[7]. CMS is well aware of the existence of hospital "methods

[7] To the extent necessary, the Court takes judicial notice of this report as a matter of public record. The Court may take judicial notice of matters of public record. *See Swindol v. Aurora Flight Sciences Corp.,* 805 F.3d 516, 518–19 (5th Cir. 2015)

for improving clinical documentation in order to increase reimbursement" and that hospitals "utiliz[e] clinical documentation specialists that work on the hospital treatment floors to encourage improvements in clinical documentation" to "improve coding and increase payment." *Id.* at 47182.

Moreover, CMS has directly disavowed "the notion . . . that CMS believes changes in how services are documented or coded that [are] consistent with the medical record [are] inappropriate or otherwise unethical." *Id.* at 47181. CMS does "not believe there is anything inappropriate, unethical or otherwise wrong with hospitals taking full advantage of coding opportunities to maximize Medicare payment that is supported by documentation in the medical record." *Id.* CMS was fully aware that hospitals would "change their documentation and coding practices and increase case mix consistent with the payment incentives that are provided by the" then newly implemented MS-DRG system and fully supported this practice. *Id.* at 47182.

Consequently, the mere fact that Defendants took targeted steps to increase their coding of CCs and MCCs to increase hospitals revenues is neither fraudulent, nor improper per se. *See United States ex rel. Bennet v. Medtronic, Inc.,* 747 F. Supp. 2d 745, 783 (S.D. Tex. 2010) (concluding that Defendant's encouraging hospitals to exploit an opportunity for legitimate profits "does not create a reasonable inference that physicians and hospitals knowingly summitted false claims"). To

state a claim for relief, there must be an allegation that a defendant knew that using a particular code was incorrect. *Id.* Plaintiff has failed to make any such allegation.

At most, Plaintiff's complaint reveals is that Defendants made targeted efforts to encourage and incentivize diagnosing patients in a way that permitted the coding of CCs and MCCs. But nothing in Plaintiff's complaint implicates a conclusion that these targeted efforts requested, demanded, or encouraged doctors and staff to diagnose in a way that was not justified by the physicians own medical opinions, judgments, and the medical record, beyond Plaintiff's mere conclusion that that is what the efforts reveal. *See Iqbal,* 556 U.S. 678 (holding that a pleading that offers merely "labels and conclusions" is insufficient under Rule 8). As previously stated, CMS takes the opposite view as Plaintiff.

The only allegations made by Plaintiff in any way implying that Defendants' coding efforts were in any way improper are the assertions that "medical coders then began to increasingly receive pressure directly from . . . leadership to code unethically" and that one former medical coder quit because she "was continually getting directives to compromise her integrity." (Dkt. # 15 at 9.) But these allegations do not specify what the pressure was, who applied the pressure, or how the desired coding was unethical or fraudulent, and does not give any specific examples of any requests for unethical, inappropriate, or fraudulent coding. Such "naked assertions devoid of further factual

enhancement" are insufficient under Rule 8's pleading standards. *Iqbal,* 556 U.S. at 678.

Further, Plaintiff's allegations are equally consistent with the conclusion that Defendants were taking steps to improve the accuracy and consistency of their medical documentation and coding so as to align it with terminology that CMS would recognize and reimburse appropriately. "[W]here a complaint pleads facts that are "merely consistent with" a defendant's liability, it "stops short of the line between possibility and plausibility of 'entitlement to relief.'" *Id.* at 678; *see also Bell Atl. Corp.,* 550 U.S. at 567–69 (holding that where there is an "obvious alternative explanation" that is legal, the complaint fails to state a claim for relief). Emphasizing to doctors that they should diagnose and document in a way that CMS's coding scheme would recognize, as opposed to the clinical terminology the doctors were used to using, is not in and of itself fraudulent, and can be adequately explained as merely "taking full advantage of coding opportunities to maximize Medicare payment," something CMS has expressly endorsed. *See* 72 FR at 47181.

This conclusion is even supported by some of the data provided in Plaintiff's complaint. For each of the three Allegedly Misstated MCCs, as well as for all three collectively, Plaintiff's complaint provides bar graphs comparing Defendants use of the MCC as compared with the average of other hospitals, for the years 2011 through 2017. (*See* Dkt. # 15 at 22, 25, 35, 46.) In all four instances, the trend reveals that the average use of the Allegedly

Misstated MCC's by other hospitals increased every year from 2011 to 2017, and by 2017 was within a few percentage points of Defendants' use of the MCC's. (*See Id.*) This data is thus as consistent with the conclusion that Defendants were merely ahead of the industry in improving the accuracy of their coding as far as CMS reimbursements are concerned, and that the rest of the industry slowly but surely improved the accuracy of its own coding, closing the gap in the use of the Allegedly Misstated MCCs, as it is consistent with the conclusion that Defendants were submitting fraudulently coded reimbursement requests. Once again, "facts that are 'merely consistent with' a defendant's liability, . . . stop[] short of the line between possibility and plausibility of entitlement to relief." *Iqbal,* 556 U.S. at 678.

Plaintiff's statistical analysis allegedly demonstrating that no other explanation but fraud accounts for the data it analyzed overlooks one major alternative hypothesis: Defendants were simply better than their peers in their efforts to ensure their medical documentation and coding maximized the opportunities for legitimate reimbursement from CMS. *See Bell Atl. Corp.,* 550 U.S. at 567–69 (holding that where there is an "obvious alternative explanation" that is legal, the complaint fails to state a claim for relief). Ultimately, Plaintiff's allegations are "not only compatible with" but arguably "more likely explained by" lawful conduct. *Id.* at 680. In such instances, Rule 8 has not been satisfied. *See Id.*; *see also United States v. Catholic Health Initiative,* 312 F. Supp.

3d 584, 598 (S.D. Tex. 2018) (finding that where a defendant's alleged conducted "was legitimate, it renders implausible Relators' assertion that Defendants 'knowingly and willfully'" violated the FCA).

The closest Plaintiff's complaint comes to plausibly alleging a claim for relief is its assertion that Defendants provided unnecessary treatment, in particular mechanical ventilation for patients after undergoing major heart surgery, enabling them to code for the MCC of acute respiratory failure. (Dkt. # 15 at 19–21.) However, this conclusion appears to be based entirely on the mere fact that Defendants provided this service at rates higher than average. (*See id.*) On Rule 12(b)(6) review, the Court does not "accept conclusory allegations, unwarranted deductions, or legal conclusions." *Southland Sec. Corp. v. INSpire Ins. Solutions,* Inc., 365 F.3d 353, 361 (5th Cir. 2004). And ultimately, medical diagnoses and the proper course of treatment are "expressions of opinion of scientific judgments about which reasonable minds may differ" and such "opinion[s] cannot be 'false' for the purposes of the FCA" because "a lie is actionable but not an error." *United States ex rel. Riley v. St. Luke's Episcopal Hosp.,* 335 F.3d 370, 376 (5th Cir. 2004).

Plaintiff makes no allegations that any doctors were told, ordered, or even encouraged to provide mechanical ventilator treatment in contradiction to their own independent medical judgments. (*See* Dkt. # 15 at 19–21.) That Defendants provided a certain treatment at rates higher than average,

even significantly higher than average, is not by itself indicative of fraud or unnecessary treatment. *See Iqbal,* 556 U.S. 678 ("Where a complaint pleads facts that are merely consistent with a defendant's liability, it stops short of the line between possibility and plausibility of entitlement to relief.") (internal quotation marks omitted). Plaintiff's bare allegation that Defendants provided medically unnecessary procedures to permit them to fraudulent code MCCs is thus insufficient to state a claim for relief. *See Id.* (holding that "a pleading that offers labels and conclusions" and merely "tenders naked assertions" is insufficient under Rule 12(b)(6).)

Accordingly, the Court finds that Defendants Motion to Dismiss should be **GRANTED.** (Dkt. # 21.) Further, because the operative complaint is Plaintiff's second amended complaint, meaning Plaintiff has had at least two opportunities to reformulate their allegations to state a claim for relief that satisfied federal pleading standards, Plaintiff's claims are **DISMISSED WITH PREJUDICE.**

CONCLUSION

For the reasons stated, the Court **GRANTS** Defendants' Motion to Dismiss. (Dkt. # 21.) Plaintiff's claims are **DISMISSED WITH PREJUDICE,** and this case is **CLOSED.**

IT IS SO ORDERED.

DATED: San Antonio, Texas, August 5, 2019.

/s/ DAVID ALAN EZRA
David Alan Ezra
Senior United States District Judge

UNITED STATES DISTRICT COURT
for the
Western District of Texas

Civil Action No. SA-17-CV-886-DAE

Filed August 06, 2019

United States of America ex rel. et al

Plaintiff

v.

Baylor Scott

Defendant

JUDGMENT IN A CIVIL ACTION

The court has ordered that (*check one*):

❒ the plaintiff (*name*) _____ recover from the defendant (*name*) _____ the amount of _____ dollars ($ ____), which includes pre-judgment interest at the rate of ____ %, plus post-judgment interest at the rate of ____ %, along with costs.

❒ the plaintiff recover nothing, the action be dismissed on the merits, and the defendant (*name*) _____ recover costs from the plaintiff (*name*) _____.

☑ other: The operative complaint is Plaintiff's second amended complaint, meaning Plaintiff has had at least two opportunities to reformulate their allegations to state a claim for relief that satisfied federal pleading standards, Plaintiff's claims are DISMISSED WITH

This action was (check one):

❒ tried by a jury with Judge _____ presiding, and the jury has rendered a verdict.

❒ tried by Judge _____ without a jury and the above decisionwas reached.

☑ decided by Judge David A. Ezra

Date: 08/06/2019

CLERK OF COURT

JEANNETTE J. CLACK

/s/ [ILLEGIBLE] RAMOS
Signature of Clerk or Deputy Clerk

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS

Case No.: 17-CV-0886-DAE

UNITED STATES OF AMERICA, *ex rel.*
INTEGRA MED ANALYTICS LLC,

Plaintiff,

v.

1. BAYLOR SCOTT & WHITE HEALTH,
2. BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS,
3. HILLCREST BAPTIST MEDICAL CENTER,
4. SCOTT & WHITE HOSPITAL – ROUND ROCK,
5. SCOTT & WHITE MEMORIAL HOSPITAL – TEMPLE

Defendants.

SECOND AMENDED COMPLAINT

JURY TRIAL DEMANDED

TABLE OF CONTENTS

This is an action brought by Plaintiff/Relator Integra Med Analytics LLC ("**Relator**") on behalf of the United States of America pursuant to the Federal False Claims Act, 31 U.S.C. § 3729, et seq. In support thereof, Relator alleges as follows:

I. INTRODUCTION

1. Through a proprietary analysis of all claims submitted to Medicare nationwide since 2011, Relator uncovered that Baylor Scott & White Health and its affiliated hospitals (collectively, "**Baylor**" or the "**Baylor Defendants**") routinely used unwarranted Major Complication and Comorbidity secondary codes, which falsely inflated claims submitted to Medicare. A multi-faceted investigation of Baylor and its leadership—which included interviewing former employees, reviewing training and marketing materials, and extensive econometric analysis—confirmed that Baylor's false Medicare claims were not only intentional,

but were part of a systematic effort by Baylor management to boost its Medicare revenue. Relator now brings this action to recover over $61.8 million paid by the United States as a result of Baylor's fraud.

2. Baylor was created from the combination of two Texas healthcare systems, Baylor Health Care System and Scott & White Healthcare. Together, these organizations formed one of the nation's largest health systems, operating approximately 20 inpatient short-term acute care hospitals with inpatient Medicare claims throughout central and north Texas. Baylor operates this system through a number of wholly-owned and/or controlled entities, including the defendant facilities. Baylor received approximately $639 million in Medicare reimbursements for inpatient stays at its short term acute care facilities in fiscal year 2015, accounting for approximately half of its gross revenue.

3. To establish amounts billed to Medicare for patient services, hospital systems like Baylor must properly code such services according to preapproved standards. Baylor's Code of Conduct publicly espouses lofty coding standards through which it vows to implement "controls to prevent, detect and correct actions that do not comply with applicable federal and state laws," and "to submit claims to government . . . that reflect truth and accuracy."[1]

[1] Compliance with Billing and Coding Laws and Regulations, Baylor Scott & White Health Code of Conduct (2017), *available at* https://goo.gl/KKhSaq.

In reality, Baylor's own corporate leadership disregarded these standards and created a systemwide culture that promoted increasing Medicare billing without regard for accuracy. Baylor's efforts ranged from extensive training on how to spike Medicare revenue, to pushing doctors to change their original diagnoses in ways that would lead to unwarranted MCCs.

4. In addition to identifying the Defendants' false claims through its proprietary analysis—and then confirming its findings through exhaustive investigation—Relator also performed extensive econometric analysis designed to eliminate conceivable innocent explanations. Thus, for instance, Relator's analysis rules out the possibility that the Defendants' inflated Medicare billings arise from an issue with the treating doctors or the type of patient that Baylor treats. Moreover, to be conservative, only the most extreme, statistically significant cases of upcoding have been identified by the Relator as fraudulent.

5. In short, Relator has determined that Baylor has submitted more than $61.8 million in false claims for Medicare reimbursement over the past seven years.

II. JURISDICTION AND VENUE

6. This Court has subject matter jurisdiction over this action pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1331.

7. This Court has personal jurisdiction over each named Defendant because, inter alia, the Defendants transacted business in this District; reside in this District; engaged in wrongdoing in this District; and/or caused the submission of false or fraudulent claims in this District. Moreover, 31 U.S.C. § 3732(a) provides for nationwide service of process, which is an independent ground for personal jurisdiction.

8. Venue is proper in this District under 31 U.S.C. § 3732(a) and 28 U.S.C. § 1391(b) and (c). During the relevant time period, a substantial portion of the events complained of that gave rise to Plaintiff's claims occurred in this District in violation of 31 U.S.C. § 3729 and § 3730.

9. There has been no public disclosure of the allegations herein. To the extent that there has been a public disclosure unknown to Relator, Relator is an "original source" under 31 U.S.C. § 3730(e)(4). Relator has direct and independent knowledge of the information on which the allegations are based and voluntarily provided the information to the Government before filing this qui tam action based on that information. *See* 31 U.S.C. § 3730(e)(4).

III. PARTIES

10. Relator Integra Med Analytics LLC is a Texas limited liability company with its principal place of business in Austin, Texas.

11. Relator is an associated company of Integra Research Group LLC, which specializes in using statistical analysis to uncover and prove fraud. Integra Research Group LLC's sister company, Integra REC LLC, has extensive experience using statistical analysis to detect and prove fraud, specifically in mortgage-backed securities and other financial markets. Integra REC LLC has successfully initiated numerous cases under the False Claims Act.

12. Defendant Baylor Scott & White Health is a Texas corporation with its principal place of business located at 3500 Gaston Avenue, Dallas, TX 75246, and its registered agent listed as CT Corporation System, 1999 Bryan Street, Suite 900, Dallas, TX 75201.

13. Defendant Baylor University Medical Center – Dallas is a Texas corporation with its principal place of business located at 3500 Gaston Avenue, Dallas, TX 75246, and its registered agent listed as CT Corporation System, 1999 Bryan Street, Suite 900, Dallas, TX 75201.

14. Defendant Hillcrest Baptist Medical Center is a Texas corporation with its principal place of business located at 100 Hillcrest Medical Boulevard, Waco, TX 76712, and its registered agent listed as CT Corporation System, 1999 Bryan Street, Suite 900, Dallas, TX 75201.

15. Defendant Scott & White Hospital – Round Rock is a Texas corporation with its principal place of business located at 300 University Boulevard,

Round Rock, TX 78665, and its registered agent listed as CT Corporation System, 1999 Bryan Street, Suite 900, Dallas, TX 75201.

16. Defendant Scott & White Memorial Hospital – Temple is a Texas corporation with its principal place of business located at 2401 South 31st Street, Temple, TX 76508, and its registered agent listed as CT Corporation System, 1999 Bryan Street, Suite 900, Dallas, TX 75201.

IV. SUBSTANTIVE ALLEGATIONS

A. Overview of Medicare Reimbursement and Upcoding

17. Medicare makes payments to hospitals on a per-discharge basis, *i.e.,* one payment for each inpatient hospital stay. The payment is designed to cover the average cost of resources needed to treat each patient's needs. To account for the patient's needs, Medicare assigns each discharge to a diagnosis related group (a "**DRG**"), which groups patients with similar clinical problems that are expected to require similar amounts of hospital resources.[2] The DRG is the single most impactful factor in determining the average payment for a claim, which can be further adjusted by hospital-specific factors such as market conditions in the hospital's city, indirect medical education payments, and disproportionate share payments.

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[2] *See* Medpac, *Hospital Acute Inpatient Services Payment System Payment Basics*, Oct. 2014.

18. The DRG is primarily determined by three types of codes from a Medicare claim: the principal diagnosis code, surgical procedure codes, and secondary diagnosis codes. The principal diagnosis code is defined as the "condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care."[3] Surgical procedure codes represent surgical procedures performed in an operating room setting at the hospital. Secondary diagnoses represent "all conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay."[4]

19. There are more than 330 base DRGs, and each base DRG can have up to three severity levels: (i) without Complication or Major Complication, (ii) with Complication, and (iii) with Major Complication.[5] The secondary diagnoses on the claim determine the severity level of a DRG. The Centers for Medicare and Medicaid Services (the "**CMS**") publishes a list of codes each year that, when added to a claim, result in the claim being considered a Complication or Comorbidity (a "**CC**") or Major Complication or Comorbidity (an "**MCC**"). Adding a CC secondary code to a claim can increase

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[3] *See* Centers for Disease Control, *ICD-9-CM Official Guidelines for Coding and Reporting*, Oct. 1, 2011 at 88, *available at* https://goo.gl/DC55Wx.

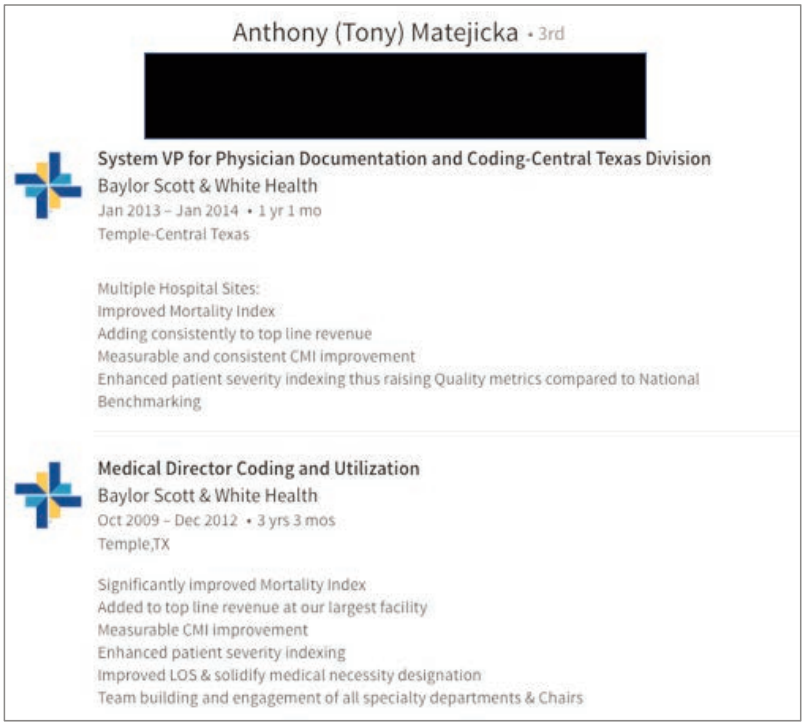
[4] *Id.* at 91.

[5] *See* Medpac, *Hospital Acute Inpatient Services Payment System Payment Basics*, Oct. 2014.

the value of the claim from anywhere between approximately $1,000 and $10,000. Adding an MCC secondary code can increase the value $1,000 to $25,000. Hospitals are thus incentivized to add unwarranted secondary diagnosis codes to Medicare reimbursement claims.

B. Relator has uncovered a culture of non-compliance at Baylor, whose leadership actively encouraged doctors to apply unnecessary MCCs

20. Like most hospital groups, Baylor has a clinical documentation improvement ("**CDI**") program. These programs are typically designed to promote the accurate documentation of a patient's diagnoses and treatments such that they can be properly coded for reimbursement. At Baylor, however, CDI efforts are primarily geared toward inflating the hospital system's Medicare revenue. Indeed, the former head of Baylor's CDI program in Central Texas, Anthony Matejicka, boasts that he "add[ed] consistently to top line revenue" and brought about "improvement" in Baylor's Case Mix Index ("**CMI**"), which is influenced by a hospital's CC and MCC rates. Matejicka also boasted about "raising Quality metrics" through "enhanced patient severity," which is likewise increased through coding higher CC and MCC rates.



Anthony (Tony) Matejicka • 3rd

[redacted]

System VP for Physician Documentation and Coding-Central Texas Division
Baylor Scott & White Health
Jan 2013 – Jan 2014 • 1 yr 1 mo
Temple-Central Texas

Multiple Hospital Sites:
Improved Mortality Index
Adding consistently to top line revenue
Measurable and consistent CMI improvement
Enhanced patient severity indexing thus raising Quality metrics compared to National Benchmarking

Medical Director Coding and Utilization
Baylor Scott & White Health
Oct 2009 – Dec 2012 • 3 yrs 3 mos
Temple,TX

Significantly improved Mortality Index
Added to top line revenue at our largest facility
Measurable CMI improvement
Enhanced patient severity indexing
Improved LOS & solidify medical necessity designation
Team building and engagement of all specialty departments & Chairs

21. Matejicka effectively executed his multifaceted scheme to improve revenue and quality metrics by increasing the coding of MCCs (including personally training CDI specialists and doctors), disseminating tip sheets to guide doctors towards coding MCCs, and deploying a team of CDI specialists whose job was to persuade doctors to change their documentation to reflect higher severity of illness than warranted.

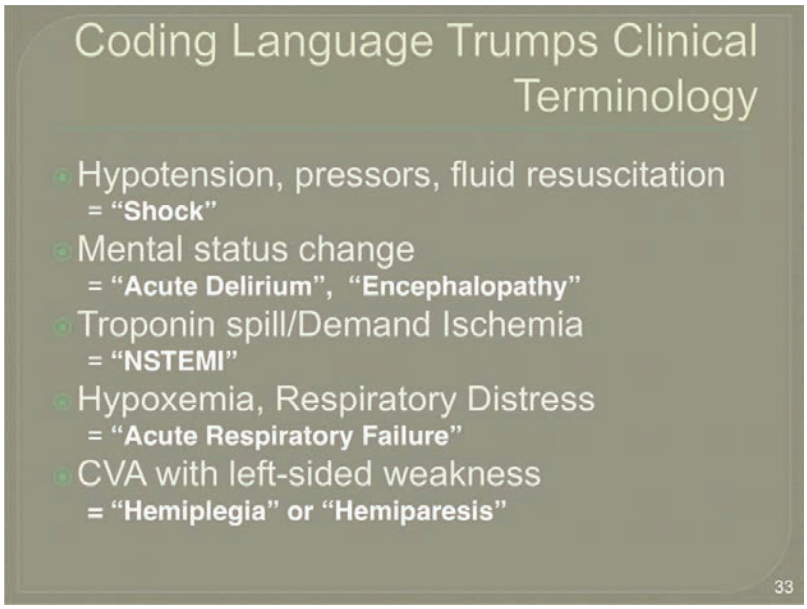
22. Medical coders also received pressure from Baylor HIM (Health Information Management) leadership to upcode. After Matejicka left Baylor in January 2014, the rate of MCCs declined slightly.

But medical coders then began to increasingly receive pressure directly from HIM leadership to code unethically. According to a former medical coder, the HIM department at Baylor issued directives to her coding supervisor to code a certain way, even if it was not appropriate. This coder overheard her supervisor saying "that's not right" during conversations with Baylor HIM management. The medical coder received instructions that her supervisor forwarded to her from Baylor management with directives to code in a specific way, and eventually quit because she could no longer continue to work in an environment where she "was continually getting directives to compromise her integrity." Analysis by Relator is consistent with this behavior, with rates of misstated MCCs identified by Relator decreasing after Matejicka's departure, then increasing in recent years corresponding to increasing pressure from Baylor's HIM team to code unethically.

1. Baylor trained its doctors and CDI staff to upcode MCCs

23. Under Matejicka, Baylor's employee training was singularly focused on coding for MCCs. A former Baylor CDI employee confirmed that Matejicka personally trained staff on key words to increase Medicare reimbursements and received a list of MCCs to focus on. Similarly, a former medical coder disclosed that Matejicka trained CDI employees to walk around with a list of MCCs to look for opportunities to assign MCCs as secondary diagnoses.

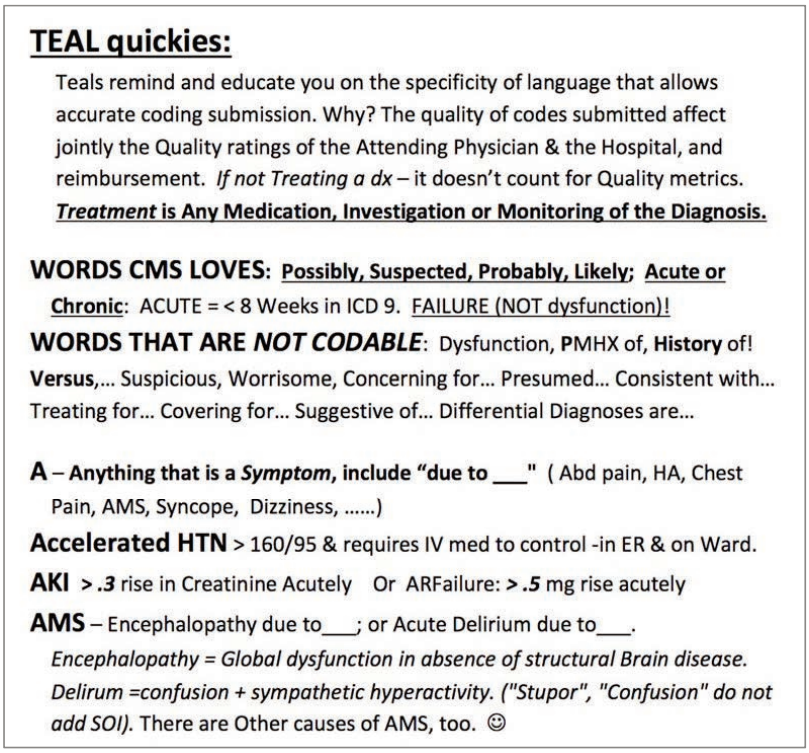
24. Baylor also made clear to its doctors how important their coding efforts were to both the Defendants' and the doctors' bottom line and quality metrics. Matejicka even gave presentations specifically training doctors on why and how they should upcode. In an August 20, 2012 presentation titled "Fundamentals of Hospital Medicine: What No One Taught Us!," Matejicka encouraged doctors to use "magic words" to "provide triggers for reimbursement," leading to higher paying CCs and MCCs. These "magic words" included "encephalopathy" and "acute respiratory failure," two of the MCCs that Relator's analysis identified as being misused by Baylor. Matejicka encouraged doctors to use these words even if they might not be clinically appropriate, arguing that "Coding Language Trumps Clinical Terminology."



25. Matejicka made sure to emphasize that following his guidelines for coding would increase not only Baylor's revenue but also doctors' salary. Indeed, his presentation flatly states, "Your hospital data will determine your income!" He then closes the presentation by asking them, "Do you want to 'see one more patient' or take one minute to improve your documentation ???," suggesting that using "magic words" would generate equivalent revenue to seeing an additional patient. This presentation also described an example where adding an MCC would both increase hospital reimbursement by $8,444.94 as well as improve pay for performance ("**P4P**") metrics for doctors, resulting in "SO MUCH WIN."

26. Matejicka's program openly steered doctors away from non-MCC diagnoses toward specific, higher-paying MCCs. This effect is seen in a doctor tip sheet called "Teal Quickies,"[6] which provided guidance for doctors to clinically document in a way that maximizes Medicare revenue. For instance, in training doctors on how to document altered mental status (or "**AMS**"), Baylor encouraged doctors to diagnose encephalopathy or acute delirium, explaining that doing so would allow coders to increase the patient's severity of illness (or "**SOI**"). Baylor blithely added that "there are Other causes of AMS, too ☺."

[6] Teal is the color of Scott & White Healthcare's logo.



TEAL quickies:

Teals remind and educate you on the specificity of language that allows accurate coding submission. Why? The quality of codes submitted affect jointly the Quality ratings of the Attending Physician & the Hospital, and reimbursement. *If not Treating a dx* – it doesn't count for Quality metrics. ***Treatment* is Any Medication, Investigation or Monitoring of the Diagnosis.**

WORDS CMS LOVES: **Possibly, Suspected, Probably, Likely; Acute or Chronic**: ACUTE = < 8 Weeks in ICD 9. FAILURE (NOT dysfunction)!

WORDS THAT ARE *NOT CODABLE*: Dysfunction, **P**MHX of, **History** of! **Versus**,... Suspicious, Worrisome, Concerning for... Presumed... Consistent with... Treating for... Covering for... Suggestive of... Differential Diagnoses are...

A – Anything that is a *Symptom*, include "due to ___" (Abd pain, HA, Chest Pain, AMS, Syncope, Dizziness, ...)

Accelerated HTN > 160/95 & requires IV med to control -in ER & on Ward.

AKI > .3 rise in Creatinine Acutely Or ARFailure: **> .5** mg rise acutely

AMS – Encephalopathy due to___; or Acute Delirium due to___.

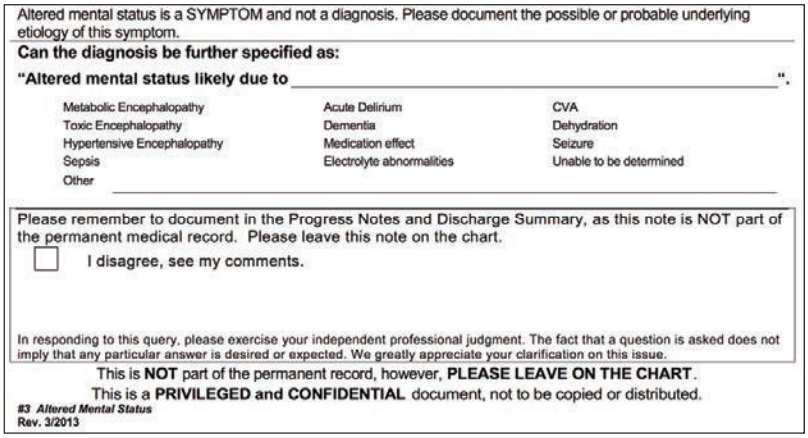
Encephalopathy = Global dysfunction in absence of structural Brain disease. Delirum =confusion + sympathetic hyperactivity. ("Stupor", "Confusion" do not add SOI). There are Other causes of AMS, too. ☺

2. Baylor pressured doctors to change their diagnoses

27. Baylor did not stop pushing doctors after their original diagnoses. If, despite training from Matejicka, a doctor's initial diagnosis did not warrant a CC or MCC, Baylor would often send the doctor a "query" encouraging doctors to amend the assessment. Baylor's queries would ask doctors to "specify" their diagnoses, and would suggest either specific revenue-increasing CCs or MCCs or provide options listing several possible CCs and

MCCs—often including conditions wholly unrelated to the patient's primary diagnosis.

28. Relator has obtained "documentation clarification sheets" used by Baylor CDIs to query physicians for additional documentation. These sheets reveal a clear intent towards influencing doctors to code higher-paying CCs and MCCs. In the query sheet for altered mental status, doctors are asked to document the underlying cause and are only provided with options which could yield a CC or MCC. Of the 11 options listed, 5 can directly be coded as MCCs (metabolic encephalopathy, toxic encephalopathy, hypertensive encephalopathy, sepsis and CVA) and 3 can directly be coded as CCs (acute delirium, dementia, and seizure). The remaining 3 (medication effect, electrolyte abnormalities and dehydration) can be used with altered mental status to code for toxic or metabolic encephalopathy.



Altered mental status is a SYMPTOM and not a diagnosis. Please document the possible or probable underlying etiology of this symptom.

Can the diagnosis be further specified as:

"Altered mental status likely due to _____".

Metabolic Encephalopathy	Acute Delirium	CVA
Toxic Encephalopathy	Dementia	Dehydration
Hypertensive Encephalopathy	Medication effect	Seizure
Sepsis	Electrolyte abnormalities	Unable to be determined

Other _____

Please remember to document in the Progress Notes and Discharge Summary, as this note is NOT part of the permanent medical record. Please leave this note on the chart.

☐ I disagree, see my comments.

In responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected. We greatly appreciate your clarification on this issue.

This is **NOT** part of the permanent record, however, **PLEASE LEAVE ON THE CHART**.

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#3 Altered Mental Status
Rev. 3/2013

29. There are other common causes for altered mental status *that do not yield an CC or MCC* and are not included in the Scott & White documentation clarification sheet. For example, in a documentation tip card issued by the Department of Veterans Affairs, other, non-CC or non-MCC, causes for altered mental status are listed such as "Alzheimer's Disease," "Lewy body dementia," or "Psychiatric Illness."

Documentation Tip Card:
Documenting Altered Mental Status

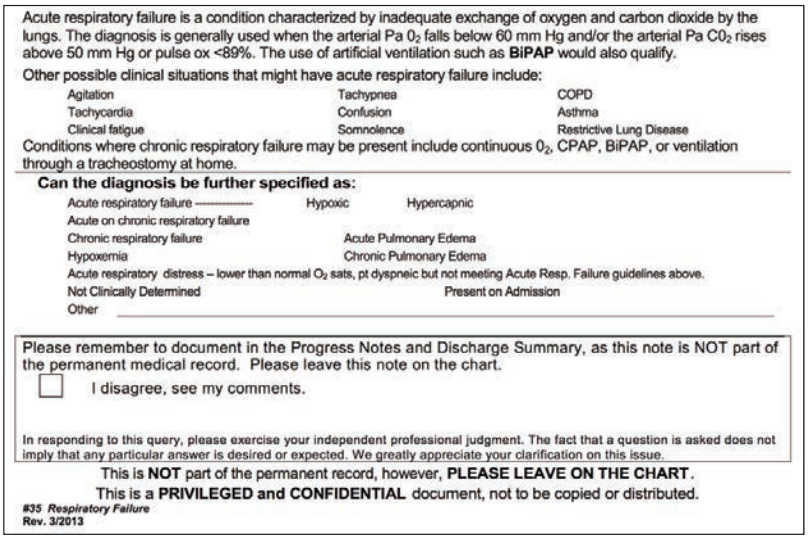
Documenting an alteration in mental status is vague and may not accurately represent the underlying condition or suspected cause. For the continuity of care of our Veterans it is important to be as precise as possible. The three things to consider when documenting an alteration in mental status are:

Chronicity	Acute, Chronic, Acute on Chronic, Other, or Unable to determine
Nature:	Dementia, Delirium, Psychosis, Obtundation, Other, or Unable to Determine.
Underlying Cause:	Alzheimer's Disease, Encephalopathy (indicate the type and underlying cause), Lewy body dementia, Acute stroke, Late effect of stroke, Transient Ischemic Attack (TIA), Generalized cerebral edema, Seizure disorder (indicate its nature and whether status epilepticus is present or if symptoms are intractable), Normal pressure hydrocephalus, Psychiatric Illness (specify type if possible), Other, or Unable to Determine

If you don't know the cause, indicate what you are working up or ruling out.

30. A similar bias towards coding MCCs is found in the Scott & White documentation clarification sheet for "Diseases of the Respiratory System," an excerpt of which is found in the following figure. Even the name Baylor gave to the document, "#35 Respiratory Failure" indicates that CDIs used this sheet in order to get doctors to document respiratory failure as opposed to other non-CC or non-MCC

respiratory diseases. The sheet specifically defines acute respiratory failure, an MCC, and not any other respiratory disease. All of the options listed except for "Hypoxemia" are CCs or MCCs, and even Hypoxemia is simply a symptom that may indicate the patient has one of the other respiratory diagnoses listed. Notably, the list leaves off a number of other respiratory system diagnoses which are not CCs or MCCs, including "Postinflammatory pulmonary fibrosis," "Other emphysema," and "Allergic rhinitis."



Acute respiratory failure is a condition characterized by inadequate exchange of oxygen and carbon dioxide by the lungs. The diagnosis is generally used when the arterial Pa 0_2 falls below 60 mm Hg and/or the arterial Pa $C0_2$ rises above 50 mm Hg or pulse ox <89%. The use of artificial ventilation such as **BiPAP** would also qualify.

Other possible clinical situations that might have acute respiratory failure include:

Agitation	Tachypnea	COPD
Tachycardia	Confusion	Asthma
Clinical fatigue	Somnolence	Restrictive Lung Disease

Conditions where chronic respiratory failure may be present include continuous 0_2, CPAP, BiPAP, or ventilation through a tracheostomy at home.

Can the diagnosis be further specified as:

Acute respiratory failure ---------- Hypoxic Hypercapnic
Acute on chronic respiratory failure
Chronic respiratory failure Acute Pulmonary Edema
Hypoxemia Chronic Pulmonary Edema
Acute respiratory distress – lower than normal O_2 sats, pt dyspneic but not meeting Acute Resp. Failure guidelines above.
Not Clinically Determined Present on Admission
Other _____

Please remember to document in the Progress Notes and Discharge Summary, as this note is NOT part of the permanent medical record. Please leave this note on the chart.

☐ I disagree, see my comments.

In responding to this query, please exercise your independent professional judgment. The fact that a question is asked does not imply that any particular answer is desired or expected. We greatly appreciate your clarification on this issue.

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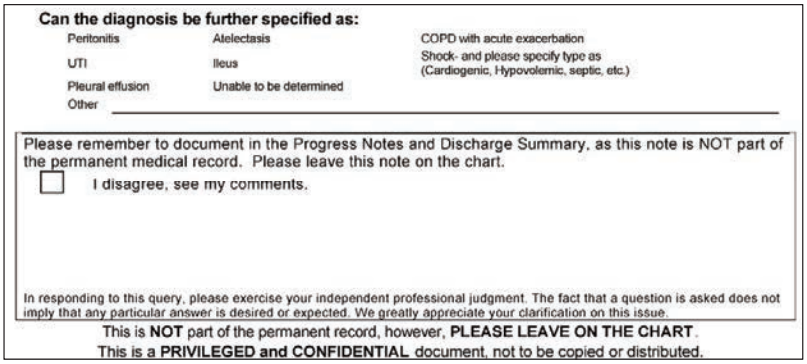
#35 Respiratory Failure
Rev. 3/2013

31. In another example, the documentation tip sheet for comorbidities contains completely unrelated CC or MCC inducing diagnoses, ranging from peritonitis (a gastrointestinal disorder) to UTI (urinary tract infection). Moreover, none of the options on the tip sheet have related and are thus designed

to lead doctors to choose certain diagnoses. For example, the sheet mentions "pleural effusion," which is a CC or MCC, but fails to suggest "pleurisy without effusion," which is neither a CC nor an MCC.



Can the diagnosis be further specified as:

Peritonitis — Atelectasis — COPD with acute exacerbation
UTI — Ileus — Shock- and please specify type as (Cardiogenic, Hypovolemic, septic, etc.)
Pleural effusion — Unable to be determined
Other _____

Please remember to document in the Progress Notes and Discharge Summary, as this note is NOT part of the permanent medical record. Please leave this note on the chart.

☐ I disagree, see my comments.

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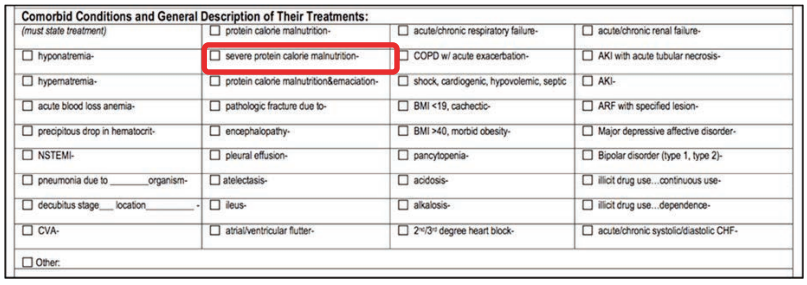
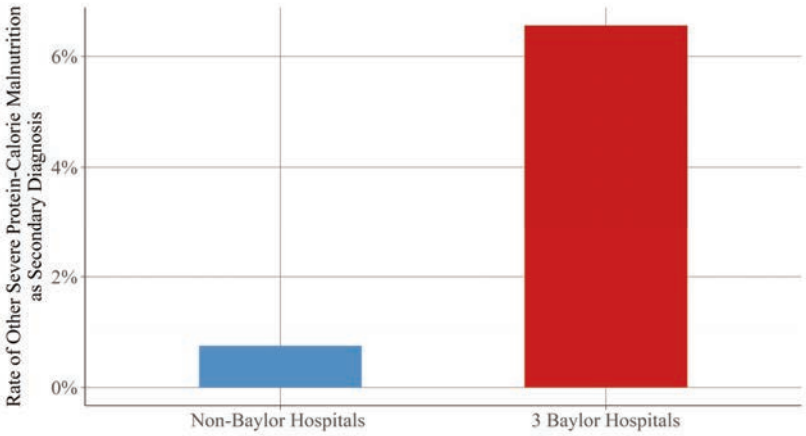
32. Baylor also prompted doctors to document CCs and MCCs with post-surgery progress notes, some with particularly uncommon pairings. For instance, in its progress notes for plastic surgery patients, Baylor gave doctors a multiple-choice option to include severe protein calorie malnutrition.



Comorbid Conditions and General Description of Their Treatments:

(must state treatment)	☐ protein calorie malnutrition-	☐ acute/chronic respiratory failure-	☐ acute/chronic renal failure-
☐ hyponatremia-	☐ severe protein calorie malnutrition-	☐ COPD w/ acute exacerbation-	☐ AKI with acute tubular necrosis-
☐ hypernatremia-	☐ protein calorie malnutrition&emaciation-	☐ shock, cardiogenic, hypovolemic, septic	☐ AKI-
☐ acute blood loss anemia-	☐ pathologic fracture due to-	☐ BMI <19, cachectic-	☐ ARF with specified lesion-
☐ precipitous drop in hematocrit-	☐ encephalopathy-	☐ BMI >40, morbid obesity-	☐ Major depressive affective disorder-
☐ NSTEMI-	☐ pleural effusion-	☐ pancytopenia-	☐ Bipolar disorder (type 1, type 2)-
☐ pneumonia due to _____organism-	☐ atelectasis-	☐ acidosis-	☐ illicit drug use...continuous use-
☐ decubitus stage___ location_____-	☐ ileus-	☐ alkalosis-	☐ illicit drug use...dependence-
☐ CVA-	☐ atrial/ventricular flutter-	☐ 2nd/3rd degree heart block-	☐ acute/chronic systolic/diastolic CHF-
☐ Other:			

33. Not surprisingly, Relator's analysis shows that the Baylor's rate of severe protein malnutrition in plastic surgery claims dwarfs the national rate. In fact, a staggering 6.56% of the plastic surgery patients treated by three Baylor Defendants were given the secondary diagnosis of severe protein-calorie malnutrition, over 8 times the national average.[7]



34. Leading queries and progress notes were only part of Baylor's strategy to influence doctors to inappropriately code CCs and MCCs. According to a former medical coder, CDIs were effectively "trained in sales" to generate revenue by convincing doctors to change their clinical documentation

[7] The 3 Baylor Hospitals in the chart refer to: Hillcrest Baptist Medical Center, Scott & White Hospital—Round Rock and Scott & White Memorial Hospital—Temple. Relator's analysis is based on plastic surgery claims from 2011 through the third quarter of 2015.

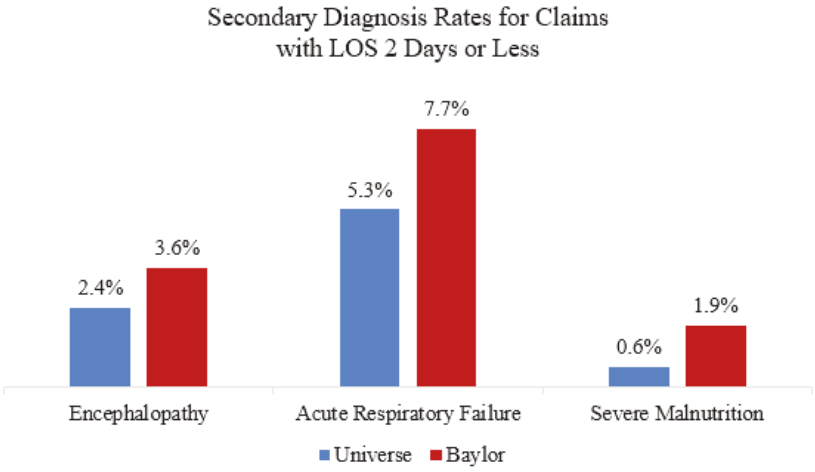
in inappropriate ways. This coder recalls Matejicka "telling CDIs things that were totally not true," and as a result of the deliberate effort to promote the coding of MCCs, some MCCs were inappropriately applied.

35. According to another former coding and compliance staff member at Scott & White, CDIs pressured doctors to record MCCs in an effort to increase revenue. For example, CDIs influencing doctors to record acute respiratory failure (an MCC identified by Relator for excessive use) instead of COPD exacerbation because that is what "[CDIs] want to hear . . . doctors have been told and told and told so they do." The staff member added, "CDIs should be questioning acute respiratory failure instead of insisting." He also observed the inappropriate documentation of other MCCs for patients with length of stay of two days or less, even though such diagnoses would require longer lengths of stay for treatment.

36. These findings are consistent with Baylor's culture of pushing doctors to apply CCs and MCCs without regard for accuracy or necessity to boost the hospital's bottom line and improve its quality rating. Relator's analysis of Medicare claims shows that Baylor doctors complied with this encouragement, leading to the excessive coding of Misstated MCCs identified in this action. Indeed, Baylor carried out this targeted scheme to upcode Medicare claims (evidenced in part by Matejicka's focus on Medicare billing in his presentations to Baylor doctors), while avoiding detection by Medicare audi-

tors. A former coding and compliance staff at Baylor recalls Medicare being the most lenient among health insurance payors, noting, "If [patients] stay here two days and you put acute respiratory failure on that chart I guarantee you, unless it's Medicare, you are going to get audited . . . you are least likely to get audited by traditional Medicare because RACs [recovery audit contractors] are not doing medical necessity reviews. I don't think they have done those in several years." Indeed, Relator analyzed the rates of diagnoses for the three MCCs identified for excessive use, and found that Baylor coded them up to 3 times more than the national average for patients with length of stay of two days or less, as seen in Figure 1.

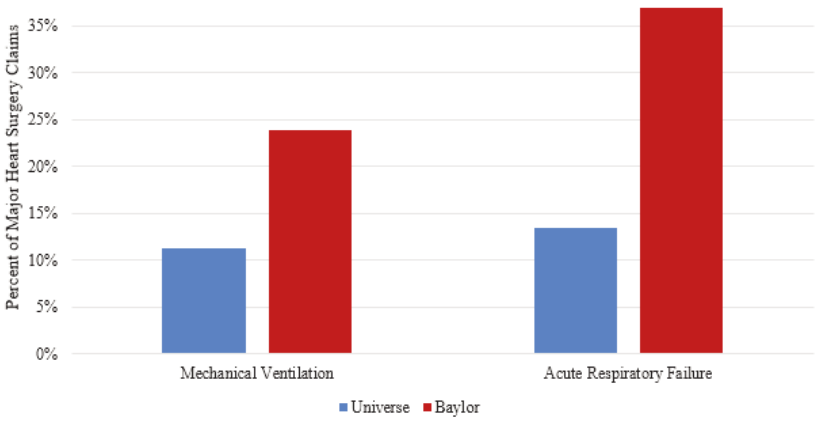
Figure 1: Secondary Diagnosis Rates for Claims with Length of Stay 2 Days or less



3. Baylor provided unnecessary treatment, which enabled it to code MCCs

37. Baylor's zeal to increase revenue through coding MCCs even included the provision of unnecessary treatment. Baylor purposefully placed and kept post-operative patients on ventilator support, thus enabling it to document one of the clinical indicators for acute respiratory failure, one of the MCCs identified by Relator for excessive usage. As an example, Relator found that Baylor patients undergoing major heart surgery were placed on mechanical ventilation over twice the national average. Correspondingly, for post-operative heart surgery patients Baylor coded acute respiratory failure (not present on admission) at 36.9% which is 2.75 times higher than the national average of 13.4%, as seen in Figure 2.

Figure 2: Rates of Mechanical Ventilation and Respiratory Failure (Not Present on Admission) for Major Heart Surgery Claims



38. The high rate of post-operative respiratory failure at Baylor is even more dubious since according to clinical documentation expert Dr. Robert Gold, post-operative respiratory failure should be extremely rare and he cautions against coding it. Another CDI expert, Dr. Cesar Limjoco, notes, "patients being purposely maintained on the ventilator after heart surgery or any surgery because of weakness, chronic lung disease, massive trauma are NOT in acute respiratory failure." What is not dubious is that diagnosing post-operative acute respiratory failure can lead to large increases in reimbursement. According to another CDI expert, Dr. Richard Pinson, "'Postop'. . . respiratory failure is classified as one of the most severe, life-threatening reportable surgical complications a patient can have. The diagnosis of respiratory failure following surgery often results in a huge payment increase to the hospital—sometimes $20,000 to $30,000 or even more."

39. Relator's analysis reveals that in spite of the high bar for accurately coding acute respiratory failure, Baylor was much more liberal in its application. In its documentation clarification sheet to doctors for "Diseases for the Respiratory System", doctors are told that "The use of artificial ventilation such as BiPAP would also qualify" for diagnosing acute respiratory failure. To execute this scheme, Baylor trained its staff to code acute respiratory failure based on the use of a ventilator, even though other clinical indicators might have suggested otherwise.

C. Relator's Methodology

40. Relator uncovered Baylor's fraud by employing unique algorithms and statistical processes to analyze inpatient claims data for short term acute care hospitals from 2011 through June 2017,[8] obtained from CMS. These proprietary methods have allowed Relator to identify with specificity the false claims made by Baylor to fraudulently inflate revenue on Medicare claims. Relator's analysis focused on identifying certain secondary diagnoses codes—MCCs—that were fraudulently added by Baylor to Medicare claims to increase reimbursements.

41. Relator first formed groupings corresponding to 184 specific principal diagnosis codes. To control for the patient's principal diagnosis, Relator used these groupings as comparative "bins." Within each bin, Relator compared the usage rate of specific MCCs at hospitals in the Baylor system to usage rates in other acute care inpatient hospitals. In addition, to ensure that only the truly fraudulent claims were analyzed, Relator excluded any claims for which adding an MCC did not increase the value.[9] Similarly, Relator excluded any claims involving patients who died in the course of their

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[8] Only claims through the second quarter of 2017 were analyzed by Relator. Claims after June 30, 2017 have not yet been made available to Relator.

[9] Some diagnosis related groups do not have an MCC severity level, and as such, adding an MCC does not increase the reimbursement amount.

treatment, as these claims tend to involve patients that are sicker and have higher rates of MCCs.

42. Given that some natural variation in usage rates among hospitals is expected, Relator used two filters to further ensure that it identified truly abnormal usage. First, only instances where MCCs were used *more than twice the national rate* or were used at a rate *three percentage points higher than in the other hospitals* were considered false claims. Second, Relator validated the results of its analysis by determining the statistical significance of each fraudulent pattern used by Baylor. Relator only flagged claim groupings where there was less than a 1 in 1,000 chance of Relator's findings being due to chance. Under this approach, Relator identified 209 combinations of principal diagnosis codes and Misstated MCCs in which Baylor excessively upcodes. Relator included in this complaint only the principal diagnosis code groups that met these criteria and were used excessively by Baylor.

43. For example, Baylor and other hospitals have a large number of claims involving a Nonrheumatic Aortic Valve Disorders. Relator has found that among Baylor's more than 838 claims involving a Nonrheumatic Aortic Valve Disorders, 59 had had an accompanying secondary MCC of encephalopathy,[10] representing 7.04 percent of their Nonrheumatic Aortic Valve Disorders claims. The other non-Baylor hospitals, used by Relator for benchmarking, had more than 200,000 Nonrheumatic Aortic Valve Disorders claims, but only 2.67 percent of those claims reported

encephalopathy as an MCC. In other words, Baylor coded encephalopathy on these claims at a rate that is 2.64 times higher than comparable hospitals—and profited nearly $13,000 each time it did so.

44. While Relator's precise benchmarking of medical billing is unique, experts have developed and applied similar benchmarks in financial return literature.[11] Benchmarking has the advantage of allowing for very specific and comparative groupings. This avoids imposing specific linearity on the data, which in turn gives Relator's methodology more statistical power and precision.

45. To further validate its conclusions and control for other explanations, Relator ran a bin-based fixed effect linear regression model. Separate regressions were run for claims under each principal diagnosis bin and Relator included variables to control for patient characteristics such as age, gender, and race, as well as county demographic factors such as the unemployment rate, median

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[10] See section IV.D.1.A for a description of encephalopathy and the relevant codes that are included.

[11] See the widely-used methodology developed by Kent Daniel, Mark Grinblatt, Sheridan Titman, Russ Wermers, *Measuring Mutual Fund Performance with Characteristic-Based Benchmarks,* The Journal of Finance, vol. 52(3) (1997), at 1035–58. This methodology is first applied to measuring hedge-fund performance by, John M. Griffin and Jin Xu, *How Smart Are the Smart Guys? A Unique View from Hedge Fund Stock Holdings,* Review of Financial Studies, Vol. 22.7 (2009), at 2531–70.

income, and urban-rural differences. Additionally, variables for the length of stay and discharge status were included to control for the patient's health and overall claim severity. Relator also tested for the potential impact that doctors, individual patients, and a hospital's region could have on MCC rates. Even when considering all of these factors, Baylor's MCC usage rate is significantly higher than at other hospitals.

D. Defendants' False Claims

1. The False Claims made by Baylor

46. Relator has determined that Baylor primarily used three categories of secondary MCC codes to increase the value of its claims: encephalopathy (including toxic encephalopathy), respiratory failure (which also includes pulmonary insufficiency), and severe malnutrition (collectively, the "**Misstated MCCs**").[12] These will be discussed in more detail in the following sections.

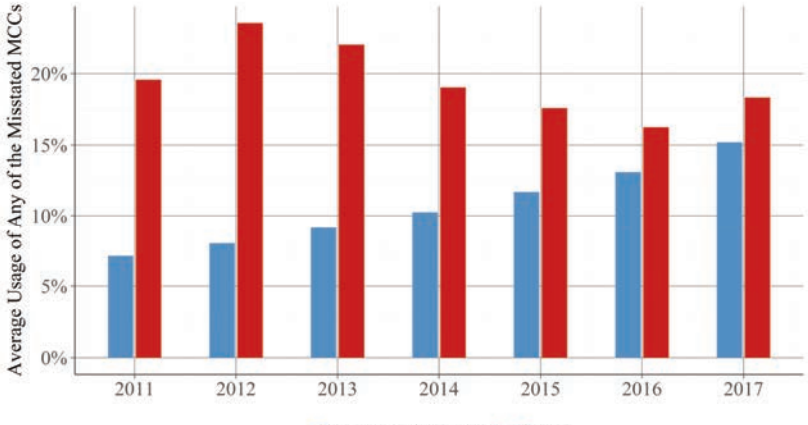
47. As illustrated in Figure 3, Baylor used the Misstated MCCs at a significantly higher rate than other hospitals. Specifically, non-Baylor hospitals

[11] Three of Baylor's hospitals (Hillcrest Baptist Medical Center, Scott & White Hospital – Round Rock, and Scott & White Memorial Hospital) excessively used all three major complications. A fourth hospital (Baylor University Medical Center – Dallas) is only alleged in this complaint to have upcoded encephalopathy to make a false claim. Hence, Baylor University Medical Center – Dallas is only included in the encephalopathy analysis.

used one of these three codes on approximately 10.27 percent of claims from 2011 through June 2017, while Baylor hospitals used one of these three codes on 19.39 percent of such claims—or 1.89 times the rate at other hospitals.

Figure 3. Rate of Misstated MCC Upcoding by Year for Baylor Versus Other Hospitals.

This figure shows the rate at which Baylor is using one of the Misstated MCCs relative to other hospitals over time. This analysis is based on the principal diagnosis codes listed in each section for the specific fraudulent patterns.

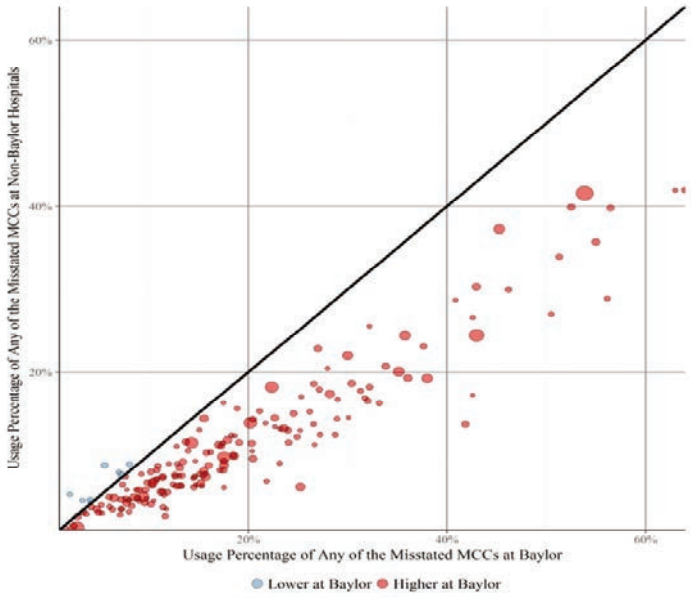


48. Figure 4 below shows that Baylor used a higher rate of Misstated MCC codes not just in the principal diagnosis categories analyzed by Relator, but across a large variety of principal diagnosis codes. Specifically, Figure 4 shows a dot for each principal diagnosis category, with the rate of Misstated MCC at Baylor on the x-axis and the rate of Misstated MCC at other non-Baylor hospitals on the y-axis. Dots to the right of the 45-degree line indicate a higher rate of Misstated MCCs at Baylor within that principal diagnosis category

than at other non-Baylor hospitals. As the figure shows, Baylor has higher rates of Misstated MCCs across 176 of 184 (95.65%) principal diagnosis categories. The extent to which Baylor excessively upcoded on the categories identified by Relator was not offset by a relative downcoding for other categories as Baylor consistently upcodes relative to other hospitals across a variety of principal diagnosis codes.

Figure 4. Rate of Misstated MCCs by Principal Diagnosis Code at Baylor Versus Other Hospitals.

For the 184 principal diagnoses with at least 100 claims at Baylor (each represented by a dot), this figure compares the rate of Misstated MCCs at Baylor versus non-Baylor hospitals. Red dots to the right of the 45-degree line indicate Baylor is coding the Misstated MCCs higher than average.



A. Encephalopathy

49. The first Misstated MCC fraudulently used by Baylor to make false claims is encephalopathy. The codes included with encephalopathy are listed in Table 1. Encephalopathy is a term for brain disease or damage to the brain where the brain is regarded as "altered in its structure or function." The telltale symptom is an altered mental state, but altered mental state alone is insufficient for diagnosing encephalopathy. Encephalopathy can be acute or chronic, so the related signs and symptoms can be varied as well. This condition commonly manifests as confusion, agitation, or lethargy, but may include aphasia (altered speech), ataxia (altered gait) and memory loss.

Table 1. List of Encephalopathy ICD-9 and ICD-10 Diagnosis Codes.

ICD-9 Diagnosis Code	Description
34830	Encephalopathy, unspecified
34831	Metabolic encephalopathy
34839	Other encephalopathy
34982	Toxic encephalopathy

ICD-10 Diagnosis Code	Description
G92	Toxic encephalopathy
G9340	Encephalopathy, unspecified
G9341	Metabolic encephalopathy
G9349	Other encephalopathy
I6783	Posterior reversible encephalopathy syndrome

50. The most common causes of encephalopathy are liver damage, cerebral anoxia (severe lack of oxygen to the brain) or kidney failure. Because the causes are extremely varied, no single lab test can prove the presence of encephalopathy. Therefore,

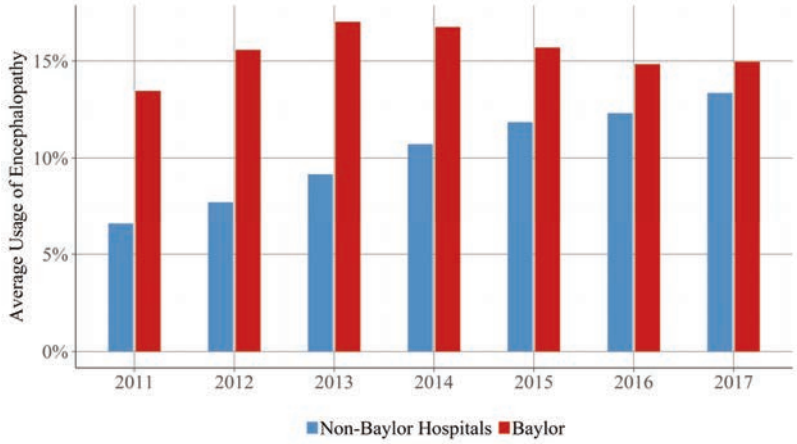
in diagnosing the condition, a medical practitioner must keep multiple considerations in mind. The challenge is to properly identify the root cause of the symptoms observed and eliminate unlikely causes based on objective signs.

51. Encephalopathy is distinguishable from conditions that have similar symptoms. In elderly hospital patients, for instance, temporary instances of lethargy, agitation and confusion are commonly observed, often right after an intense surgery or as the result of a urinary tract infection. These same signs can be observed in patients as "sundowning" or "late-day confusion" in the late afternoon or evening, but these effects are temporary and are actually related to chronic dementia, not encephalopathy.

52. Between 2011 and June 2017, Baylor was 1.54 times more likely to code encephalopathy than other hospitals. During this period, Baylor coded encephalopathy on 15.50 percent of all its claims, compared to 10.10 percent at other hospitals. Baylor's usage of encephalopathy over time, relative to the nationwide average, is shown in Figure 5.

Figure 5. Rate of Encephalopathy by Year for Baylor Versus Other Hospitals.

This figure shows the rate of encephalopathy at Baylor and at other hospitals from 2011 through June 2017, when added to the relevant principal diagnosis codes listed in Table 2.



i. Specific Patterns of Fraud with Encephalopathy

53. Table 2 provides a list of the principal diagnosis codes used by Baylor to upcode with encephalopathy. Relator identified 37 principal diagnosis codes in conjunction with which Baylor coded encephalopathy at a rate at least two times and/or three percentage points higher than the nationwide average. Relator has included only patterns that were statistically significant at the 99.9% level, meaning it is virtually impossible the patterns are due to chance.

Table 2. Patterns Used by Baylor to Upcode with Encephalopathy.

The following table lists the principal diagnosis categories in which Baylor excessively upcodes with encephalopathy. 1 principal diagnosis category with fewer than 11 fraudulent claims at Baylor has been omitted from the table.

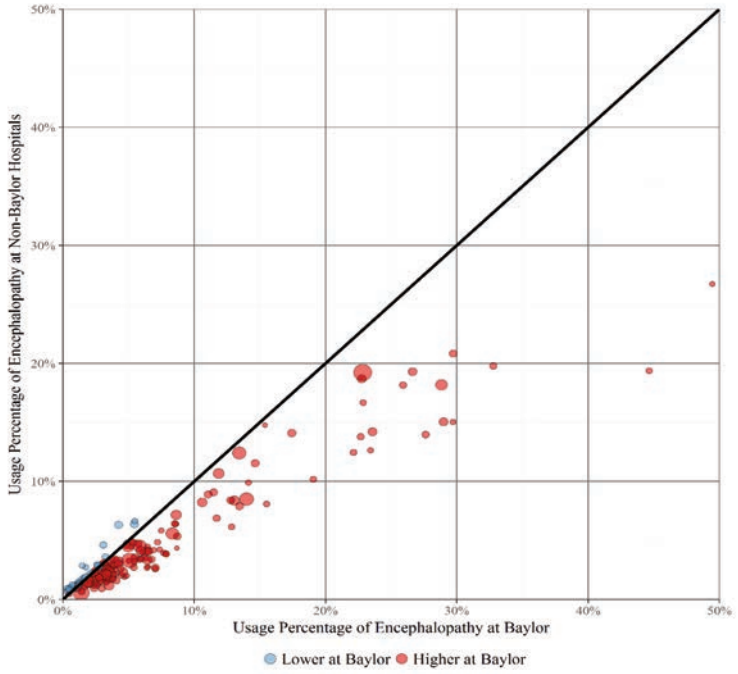
Principal Diagnosis	% with MCC at Other Hospitals	% with MCC at Baylor	Baylor Rate Relative to Nationwide Average	Num. of Fraud Claims at Baylor
Unspecified Septicemia	19.21%	22.83%	119%	399
Urinary Tract Infection; Site Not Specified	18.17%	28.82%	159%	347
Occlusion of Cerebral Arteries	8.50%	14.00%	165%	301
Epilepsy	15.04%	29.00%	193%	180
Intracranial Hemorrhage	14.20%	23.58%	166%	119
Other Intracranial Injury	8.37%	13.06%	156%	97
Substance-related Disorders	19.36%	44.66%	231%	90
Other Gram Negative Septicemia	19.29%	26.63%	138%	81
Cystitis and Urethritis	13.97%	27.62%	198%	74
Staphylococcal Septicemia	20.81%	29.72%	143%	71
Poisoning by Other Medications and Drugs	19.79%	32.77%	166%	69
Osteoarthritis; Localized	0.56%	1.38%	247%	68
E. Coli Septicemia	18.68%	22.75%	122%	54
Other Diseases of the Circulatory System	3.32%	6.43%	194%	50
Coronary Atherosclerosis	1.18%	3.50%	298%	49
Streptococcal Septicemia	18.16%	25.90%	143%	45
Other Endocrine Disorders	13.78%	22.68%	165%	43
Other Diseases of the Nervous System and Sense Organs	7.87%	13.45%	171%	43
Poisoning by Psychotropic Agents	26.71%	49.47%	185%	43
Convulsions	12.45%	22.14%	178%	37
Nonrheumatic Aortic Valve Disorders	2.67%	7.04%	264%	37
Secondary Malignancy of Brain/spine	10.17%	19.06%	187%	36
Delirium Dementia and Amnestic and Other Cognitive Disorders	15.02%	29.71%	198%	35
Other Fluid and Electrolyte Disorders	8.40%	12.77%	152%	31
Disorders of Mineral Metabolism	12.62%	23.44%	186%	28
Alcohol-related Disorders	6.89%	11.69%	170%	27
Other Endocrine; Nutritional; and Metabolic Diseases and Immunity Disorders	5.35%	8.70%	163%	24
Other and Unspecified Hereditary and Degenerative Nervous Conditions	8.09%	15.51%	192%	23
Other Injuries and Conditions Due to External Causes	6.14%	12.84%	209%	22

Principal Diagnosis	% with MCC at Other Hospitals	% with MCC at Baylor	Baylor Rate Relative to Nationwide Average	Num. of Fraud Claims at Baylor
Infective Arthritis and Osteomyelitis (except that Caused by TB or STD)	3.39%	6.75%	199%	21
Diabetes with Circulatory Manifestations	3.88%	7.82%	201%	16
Another Aneurysm	3.84%	7.86%	205%	15
Spinal Stenosis; Lumbar Region	1.68%	3.54%	211%	15
Fracture of Tibia and Fibula	2.60%	7.03%	270%	14
Chemotherapy	0.98%	2.38%	243%	14
Other Bone Disease and Musculoskeletal Deformities	1.58%	4.09%	259%	12

54. Figure 6 below shows that Baylor not only used a higher rate of encephalopathy in the few categories listed above, but also across a large variety of principal diagnosis codes. The red dots to the right of the 45-degree line indicate higher rates of encephalopathy at Baylor versus the nationwide average. This figure shows that Baylor has a higher rate of encephalopathy for 160 out of 184 (86.96%) principal diagnosis categories. In other words, the extent to which Baylor excessively upcoded encephalopathy on the categories listed in Table 2 above was not offset by relative downcoding in other principal diagnosis categories.

Figure 6. Rate of Encephalopathy by Principal Diagnosis Code at Baylor Versus Other Hospitals.

For the 184 principal diagnoses with at least 100 claims at Baylor (each represented by a dot), this figure compares the rate of encephalopathy at Baylor versus non-Baylor hospitals. Red dots to the right of the 45-degree line indicate Baylor is coding encephalopathy at a rate higher than the nationwide average.



ii. Specific False Claims with Encephalopathy

55. The Relator has identified many specific false Medicare claims submitted by Baylor involving encephalopathy. The following table includes 50 examples.

[Table 3 Redacted for PII]

B. Respiratory Failure

56. The second Misstated MCC that Baylor used at an excessive rate is respiratory failure, which includes pulmonary insufficiency. The codes classified as respiratory failure are listed in Table 4 below. Respiratory failure is a syndrome characterized by poor gas transfer in the lungs at the alveolar and capillary levels as a result of a problem making it difficult to breathe. It can be acute or chronic. There are two types: the first and most common is hypoxemia ("oxygenation failure"), and the second type demonstrates both hypoxemia and hypercapnia ("ventilatory failure"). Respiratory failure can be acute and life-threatening, or chronic and manageable with modifications.

Table 4. List of Respiratory Failure ICD-9 and ICD-10 Diagnosis Codes.

ICD-9 Diagnosis Code	Description
5184	Acute edema of lung, unspecified
5185	Pulmonary insufficiency following trauma and surgery
51851	Acute respiratory failure following trauma and surgery
51852	Other pulmonary insufficiency not elsewhere classified following trauma/surgery
51853	Acute and chronic respiratory failure following trauma and surgery
51881	Acute respiratory failure
51884	Acute and chronic respiratory failure

ICD-10 Diagnosis Code	Description
J810	Acute pulmonary edema
J951	Acute pulmonary insufficiency following thoracic surgery
J952	Acute pulmonary insufficiency following nonthoracic surgery
J953	Chronic pulmonary insufficiency following surgery
J95821	Acute postprocedural respiratory failure
J95822	Acute and chronic postprocedural respiratory failure
J9600	Acute respiratory failure, unspecified whether with hypoxia or hypercapnia
J9601	Acute respiratory failure with hypoxia
J9602	Acute respiratory failure with hypercapnia
J9620	Acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia
J9621	Acute and chronic respiratory failure with hypoxia
J9622	Acute and chronic respiratory failure with hypercapnia
J9690	Respiratory failure, unspecified, unspecified whether with hypoxia or hypercapnia
J9691	Respiratory failure, unspecified with hypoxia
J9692	Respiratory failure, unspecified with hypercapnia

57. The possible root causes are myriad, and may include poor circulation, neuromuscular disease, chronic bronchitis, COPD, obesity or drug use, an obstructing object, or an injury to the brain or spinal cord. The signs and symptoms are bluish skin, shortness of breath, labored breathing and feeling unable to get enough air. The patient may also become very sleepy, lose consciousness, be confused, or have arrhythmia. After listening to the patient's heartbeat and lungs, a pulse oximetry test, an arterial blood gas test from a blood draw, and a chest x-ray can together help determine a proper diagnosis.

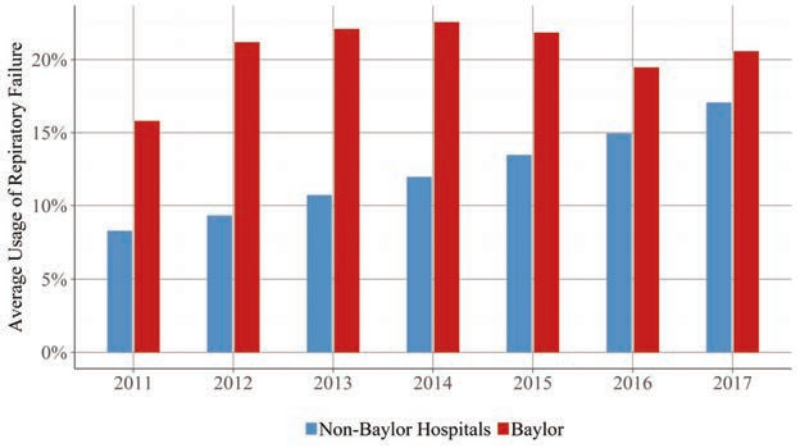
58. Respiratory failure is distinguishable from conditions that have similar symptoms. Elderly patients, for example, frequently breathe shallowly during sleep. Chronic conditions such as structural and neuromuscular issues can lead to slow decline in breathing quality. Also, elderly patients who have recently undergone surgery may experience symptoms that are similar to those of respiratory failure. Though they may necessitate mechanical oxygenation assistance, it is unlikely that these conditions are sufficient for an acute respiratory failure diagnosis.

59. As shown in Figure 7, Baylor coded at a significantly higher rate of respiratory failure than other hospitals. From 2011 through June 2017, across the relevant codes, Baylor coded respiratory failure at 1.73 times the rate at other hospitals, using it on 20.54 percent of claims, versus 11.87

percent at other hospitals. Baylor's rate of respiratory failure increases again in 2017.

Figure 7. Rate of Respiratory Failure by Year for Baylor Versus Other Hospitals.

This figure shows the rate of respiratory failure at Baylor and at other hospitals from 2011 through June 2017, when added to the suspicious principal diagnosis codes listed in Table 5 below.



i. Specific Patterns of Fraud with Respiratory Failure

60. The following table provides a list of the principal diagnosis codes used by Baylor to upcode with respiratory failure. Relator identified 56 principal diagnosis codes in conjunction with which Baylor coded respiratory failure at a rate at least two times and/or three percentage points higher than the nationwide average. Only patterns that were statistically significant at the 99.9% level, meaning virtually impossible to be due to chance, are included.

Table 5. Patterns Used by Baylor to Upcode with Respiratory Failure.

The following table lists the principal diagnosis categories in which Baylor excessively upcodes with respiratory failure. One principal diagnosis category with fewer than 11 fraudulent claims at Baylor has been omitted from the table.

Principal Diagnosis	% with MCC in Other Hospitals	% with MCC in Baylor	Baylor Rate Relative to Other Hospitals	Num. of Fraud Claims at Baylor
Congestive Heart Failure; Nonhypertensive	21.97%	39.51%	180%	835
Unspecified Septicemia	25.66%	35.82%	140%	725
Obstructive Chronic Bronchitis	17.73%	36.51%	206%	363
Coronary Atherosclerosis	5.24%	23.81%	454%	230
Acute Myocardial Infarction	11.27%	17.24%	153%	193
Pneumonia; Organism Unspecified	18.97%	26.58%	140%	159
Nonrheumatic Aortic Valve Disorders	11.68%	38.75%	332%	156
Hypertensive Heart and/or Renal Disease	18.27%	26.35%	144%	133
Pulmonary Heart Disease	16.78%	30.88%	184%	130
Fracture of Neck of Femur (hip)	4.72%	8.57%	182%	123
Other Gram Negative Septicemia	18.04%	33.25%	184%	118
Staphylococcal Septicemia	21.81%	36.30%	166%	78
Other Bacterial Pneumonia	30.81%	34.45%	112%	76
Atrial Fibrillation	3.07%	6.40%	208%	73
Other Diseases of the Circulatory System	6.65%	14.07%	212%	67
Cancer of Bronchus; Lung	14.22%	23.99%	169%	65
E. Coli Septicemia	13.02%	20.05%	154%	61
Other Neoplasms	6.38%	11.94%	187%	58
Osteoarthritis; Localized	0.67%	1.67%	249%	56
Epilepsy	7.69%	15.31%	199%	54
Aspiration Pneumonitis; Food/vomitus	27.25%	34.91%	128%	52
Other Specified Septicemia	27.54%	42.86%	156%	43
Streptococcal Septicemia	17.73%	27.55%	155%	41
Influenza	17.64%	29.71%	168%	41
Other Pneumonia	22.40%	41.26%	184%	39
Chronic Obstructive Asthma with Acute Exacerbation	11.59%	28.77%	248%	38
Other Diseases of the Respiratory System	12.24%	20.22%	165%	37

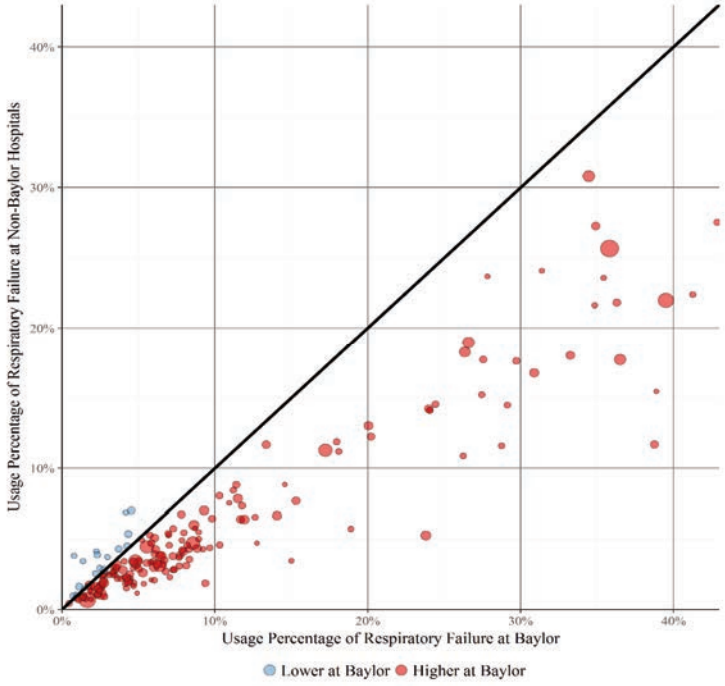
Principal Diagnosis	% with MCC in Other Hospitals	% with MCC in Baylor	Baylor Rate Relative to Other Hospitals	Num. of Fraud Claims at Baylor
Other Central Nervous System Disorders	7.85%	11.51%	147%	36
Other Injury and Poisoning	4.35%	8.85%	203%	35
Other Aneurysm	14.48%	29.13%	201%	34
Sickle Cell Anemia	1.86%	9.38%	505%	33
Malfunction of Device; Implant; and Graft	2.98%	6.02%	202%	32
Other Complications of Surgical and Medical Procedures	6.40%	11.67%	182%	32
Congestive Heart Failure	10.87%	26.24%	241%	31
Poisoning by Other Medications and Drugs	14.55%	24.42%	168%	30
Substance-related Disorders	15.22%	27.46%	180%	30
Urinary Tract Infection; Site Not Specified	1.11%	2.51%	226%	28
Pleurisy; Pleural Effusion	14.12%	24.05%	170%	26
Nonrheumatic Mitral Valve Disorders	15.45%	38.89%	252%	25
Diabetes with Other Manifestations	2.61%	5.29%	203%	25
Fracture of Vertebral Column without Mention of Spinal Cord Injury	4.11%	7.93%	193%	22
Disorders of the Peripheral Nervous System	5.70%	18.90%	331%	22
Empyema and Pneumothorax	21.62%	34.84%	161%	20
Pathological Fracture	3.87%	7.72%	200%	18
Other Endocrine; Nutritional; and Metabolic Diseases and Immunity Disorders	3.13%	8.11%	259%	18
Other Complications of Internal Prosthetic Device; Implant; and Graft	3.78%	7.25%	192%	18
Unstable Angina (Intermediate Coronary Syndrome)	4.58%	10.31%	225%	17
Fracture of Pelvis	2.71%	6.79%	250%	16
Other Diseases of the Nervous System and Sense Organs	3.20%	6.61%	206%	15
Other Endocrine Disorders	2.84%	7.35%	259%	14
Secondary Malignancy of Bone	3.46%	15.00%	433%	14
Diabetes with Circulatory Manifestations	3.08%	7.66%	248%	13
Other Cardiac Dysrhythmias	1.96%	4.32%	220%	12
Hemorrhage or Hematoma Complicating a Procedure	3.57%	8.33%	233%	12
Cancer of Pancreas	4.38%	9.66%	220%	11

61. Figure 8 below shows that Baylor used a higher rate of respiratory failure not just in the few categories listed above, but across a large variety of principal diagnosis codes. The red dots to the right of the 45-degree line indicate higher rates of respiratory failure at Baylor versus the nationwide average. This figure shows that Baylor has a higher rate of respiratory failure for 167 out of 184 (90.76%) principal diagnosis categories. In other

words, the extent to which Baylor excessively upcoded respiratory failure on the categories listed in Table 5 above was not offset by relative down-coding in other principal diagnosis categories.

Figure 8. Rate of Respiratory Failure by Principal Diagnosis Code at Baylor Versus Other Hospitals.

For the 184 principal diagnoses with at least 100 claims at Baylor (each represented by a dot), this figure compares the rate of respiratory failure at Baylor versus non-Baylor hospitals. Red dots to the right of the 45-degree line indicate Baylor is coding respiratory failure at a rate higher than the nationwide average.



ii. Specific False Claims with Respiratory Failure

62. The Relator has identified many specific false Medicare claims submitted by Baylor involving respiratory failure. The following table includes 50 examples.

[Table 6 Redacted for PII]

C. Severe Malnutrition

63. The final Misstated MCC that Baylor used to commit fraud at a higher rate was severe malnutrition. There are three severe malnutrition codes, listed in Table 7, that are considered MCCs. Severe protein-calorie malnutrition in the elderly is a disorder of extreme lack of nutrition involving the highest level of protein-energy malnutrition and protein-calorie malnutrition. Another rare form, Kwashiorkor malnutrition, is common in Sub-Saharan Africa, and is unlikely to be present in the elderly in the United States. Nutritional marasmus is caused by insufficient nutrients and is most common in children. In the elderly, malnourishment can manifest for a variety of reasons including anorexia, dehydration, and malabsorption.

Table 7. List of Severe Malnutrition ICD-9 and ICD-10 Diagnosis Codes.

ICD-9 Diagnosis Code	Description
260	Kwashiorkor
261	Nutritional Marasmus
262	Other Severe Protein-Calorie Malnutrition

ICD-10 Diagnosis Code	Description
E40	Kwashiorkor
E41	Nutritional marasmus
E42	Marasmic kwashiorkor
E43	Unspecified severe protein-calorie malnutrition

64. Patients may initially present malnutrition signs to a healthcare provider, but the patient may simply be underweight (and may not need to be coded as malnutrition at all), or the condition may not be severe. If so, other codes are available for malnutrition of a moderate degree (ICD-9 code 2630) and other protein-calorie malnutrition (ICD-9 code 2638). Kwashiorkor malnutrition has been overdiagnosed in the past and is now usually contra-indicated in American elderly.[13] Additionally, interventions for malnutrition can often be used that supply calories and ameliorate the issue at a low cost, alleviating the need for tremendous

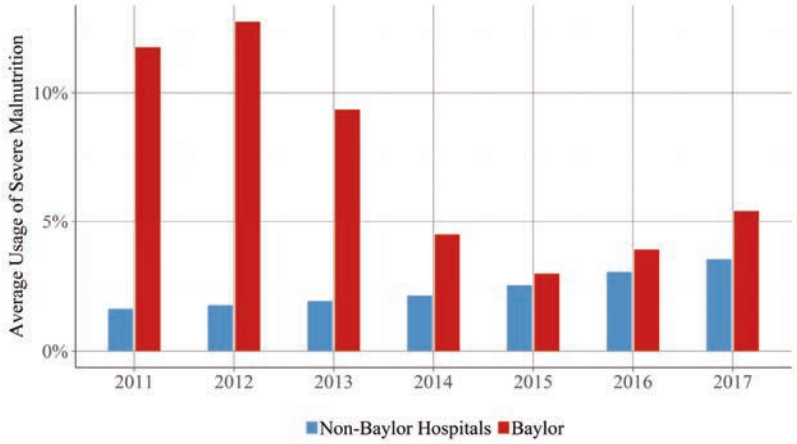
[13] California Watch, *Prime Healthcare Reports Outsized Rates of Unusual Conditions, available at* https://goo.gl/9G8MW4 (last accessed Apr. 17, 2018). Dep't of Health and Human Servs., *Rex Hospital Incorrectly Billed Medicare Inpatient Claims with Kwashiorkor, available at* https://goo.gl/RbEWY7 (last accessed Apr. 17, 2018). HCPro, *News: OIG Fines Another Facility for Inappropriate Kwashiorkor Claims, available at* https://goo.gl/chCT3c (last accessed Apr. 17, 2018).

resources associated with MCC codes. Furthermore, certain emergency measures are now considered overused and often unhelpful.

65. As shown in Figure 9, Baylor coded a significantly higher rate of severe malnutrition than other hospitals. The rate was highest during the time Anthony Matejicka worked at Baylor and is increasing again in 2017. From 2011 through June 2017, hospitals nationwide used severe malnutrition on 2.26 percent of claims, while Baylor used it on 7.07 percent of claims—or 3.14 times as often.

Figure 9. Rate of Severe Malnutrition by Year for Baylor Versus Other Hospitals.

This figure shows the rate of severe malnutrition at Baylor and at other hospitals from 2011 through June 2017, when added to the suspicious principal diagnosis codes listed in Table 8 below.



i. Specific Patterns of Fraud with Severe Malnutrition

66. The following table provides a list of the principal diagnosis codes used by Baylor to upcode with severe malnutrition. Relator identified 116 principal diagnosis codes in conjunction with which Baylor coded severe malnutrition at a rate at least two times and/or at three percentage points higher than the nationwide average. Only patterns that were statistically significant at the 99.9% level, meaning virtually impossible to be due to chance, are included.

Table 8. Patterns Used by Baylor to Upcode with Severe Malnutrition.

The following table lists the principal diagnosis categories in which Baylor excessively upcodes with severe malnutrition. 22 principal diagnosis categories with fewer than 11 fraudulent claims at Baylor have been omitted from the table.

Principal Diagnosis Code	% with MCC Code in Other Hospitals	% with MCC Code at Baylor	Baylor Rate Relative to Other Hospitals	Num. of Fraud Claims at Baylor
Unspecified Septicemia	5.68%	13.99%	246%	594
Fracture of Neck of Femur (hip)	1.61%	5.72%	355%	132
Acute Renal Failure	3.28%	6.97%	212%	122
Congestive Heart Failure; Nonhypertensive	1.18%	3.74%	316%	122

Principal Diagnosis Code	% with MCC Code in Other Hospitals	% with MCC Code at Baylor	Baylor Rate Relative to Other Hospitals	Num. of Fraud Claims at Baylor
Infection and Inflammation--Internal Prosthetic Device; Implant; and Graft	3.52%	12.74%	362%	119
Other Bacterial Pneumonia	3.66%	8.55%	234%	102
Urinary Tract Infection; Site Not Specified	1.62%	6.66%	411%	102
Other Diseases of the Digestive System	2.24%	8.97%	401%	100
Other Gram Negative Septicemia	6.27%	17.98%	287%	91
Other Neoplasms	5.07%	13.09%	258%	84
Pneumonia; Organism Unspecified	1.87%	5.79%	309%	82
Aspiration Pneumonitis; Food/vomitus	5.82%	17.31%	297%	78
E. Coli Septicemia	4.23%	12.44%	294%	71
Postoperative Infection	3.21%	13.18%	410%	71
Intestinal Infection	3.55%	10.01%	282%	66
Staphylococcal Septicemia	7.53%	19.26%	256%	63
Occlusion of Cerebral Arteries	0.81%	2.73%	338%	62
Acute Myocardial Infarction	0.74%	2.60%	352%	60
Other Intestinal Obstruction	2.78%	7.19%	258%	51
Acute Pancreatitis	2.08%	8.49%	408%	51
Peritoneal or Intestinal Adhesions	4.71%	17.71%	376%	46
Other Specified Septicemia	7.59%	22.50%	296%	42
Other Complications of Surgical and Medical Procedures	3.39%	10.33%	305%	42
Other and Unspecified Gastrointestinal Disorders	3.55%	10.41%	294%	42
Other Disorders of Stomach and Duodenum	3.80%	12.86%	339%	41
Other Infectious and Parasitic Diseases	4.30%	15.69%	365%	41
Cancer of Colon	4.22%	12.12%	287%	38
Streptococcal Septicemia	5.13%	14.01%	273%	37
Malfunction of Device; Implant; and Graft	1.13%	4.49%	399%	35
Hemorrhage from Gastrointestinal Ulcer	2.52%	8.18%	325%	35
Other Secondary Malignancy	6.77%	21.55%	318%	34
Pulmonary Heart Disease	1.53%	5.20%	339%	34
Other Central Nervous System Disorders	3.32%	6.72%	202%	33
Other Intracranial Injury	1.20%	4.27%	355%	32
Atrial Fibrillation	0.62%	2.04%	330%	31
Hyposmolality	2.23%	6.63%	297%	30
Other Peripheral and Visceral Atherosclerosis	2.88%	10.92%	379%	29
Cancer of Pancreas	7.99%	21.26%	266%	27
Other Endocrine; Nutritional; and Metabolic Diseases and Immunity Disorders	4.03%	11.08%	275%	26
Cancer of Bronchus; Lung	3.46%	7.35%	212%	26
Liver Abscess and Sequelae of Chronic Liver Disease	4.84%	12.28%	254%	25
Hypertensive Heart and/or Renal Disease	1.27%	2.80%	220%	25

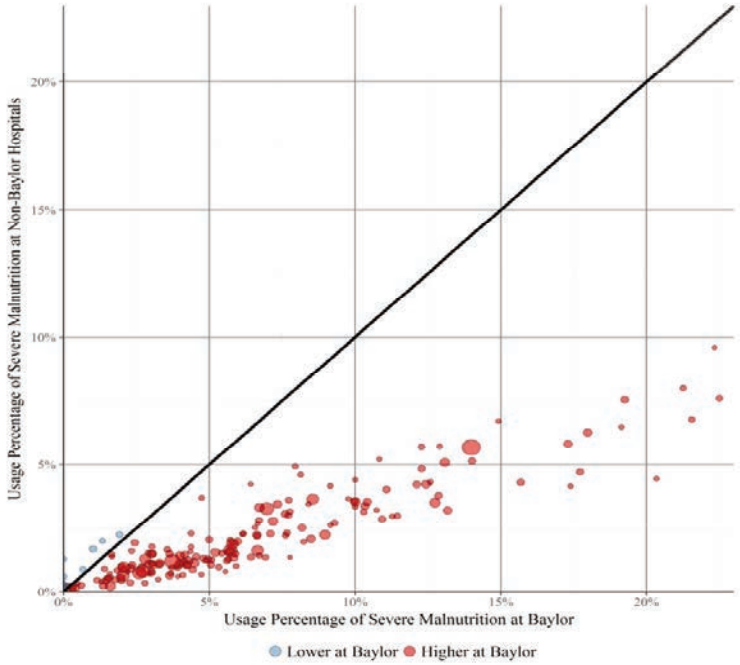
Principal Diagnosis Code	% with MCC Code in Other Hospitals	% with MCC Code at Baylor	Baylor Rate Relative to Other Hospitals	Num. of Fraud Claims at Baylor
Other Venous Embolism and Thrombosis	1.32%	5.85%	444%	25
Pathological Fracture	2.27%	7.10%	312%	23
Hypovolemia	3.58%	9.97%	278%	23
Other Injury and Poisoning	1.10%	3.97%	362%	22
Pleurisy; Pleural Effusion	3.00%	11.45%	382%	22
Obstructive Chronic Bronchitis	0.96%	2.07%	216%	21
Hemorrhage of Gastrointestinal Tract	1.97%	5.98%	303%	21
Melena	1.59%	5.71%	358%	21
Intracranial Hemorrhage	1.13%	4.11%	365%	20
Other Diseases of the Circulatory System	1.11%	3.30%	296%	20
Alcohol-related Disorders	2.71%	9.30%	343%	20
Diverticulitis	1.42%	3.99%	282%	19
Other Fluid and Electrolyte Disorders	3.07%	7.60%	247%	19
Acute Posthemorrhagic Anemia	2.18%	6.65%	305%	19
Respiratory Failure	4.44%	20.34%	458%	19
Diverticulosis	1.03%	4.23%	412%	18
Calculus of Bile Duct	1.36%	6.42%	474%	18
Coronary Atherosclerosis	0.21%	1.61%	758%	17
Nonrheumatic Aortic Valve Disorders	0.64%	3.63%	568%	17
Diseases of White Blood Cells	3.15%	10.30%	327%	17
Noninfectious Gastroenteritis	1.34%	6.92%	516%	16
Other Connective Tissue Disease	1.29%	4.80%	373%	16
Infective Arthritis and Osteomyelitis (except That Caused by TB or STD)	3.02%	7.72%	256%	16
Other and Unspecified Liver Disorders	4.16%	17.39%	418%	15
Diabetes with Ketoacidosis or Uncontrolled Diabetes	1.43%	4.16%	291%	15
Other Complications of Internal Prosthetic Device; Implant; and Graft	0.98%	3.92%	401%	15
Gastrointestinal Complications	5.70%	12.28%	216%	15
Diabetes with Circulatory Manifestations	2.31%	7.66%	331%	15
Cancer of Other GI Organs; Peritoneum	6.49%	19.13%	295%	15
Epilepsy	1.05%	3.09%	294%	15
Cellulitis and Abscess of Leg	0.92%	2.30%	251%	14
Diabetes with Other Manifestations	1.47%	3.02%	205%	14
Infections of Kidney	1.07%	5.06%	474%	14
Other Diseases of the Nervous System and Sense Organs	1.37%	4.56%	332%	14
Poisoning by Other Medications and Drugs	1.21%	5.61%	463%	13
Decubitus Ulcer	9.61%	22.33%	232%	13
Aplastic Anemia	4.32%	12.58%	291%	12
Other Endocrine Disorders	2.82%	6.71%	238%	12
Atherosclerosis of Arteries of Extremities	0.86%	4.42%	516%	12
Other Nervous System Symptoms and Disorders	2.04%	5.00%	246%	12

Principal Diagnosis Code	% with MCC Code in Other Hospitals	% with MCC Code at Baylor	Baylor Rate Relative to Other Hospitals	Num. of Fraud Claims at Baylor
Other Biliary Tract Disease	2.98%	11.27%	378%	12
Other Esophageal Disorders	3.62%	7.72%	213%	12
Crushing Injury or Internal Injury	1.53%	5.63%	369%	12
Fracture of Pelvis	1.14%	4.18%	366%	12
Anal and Rectal Conditions	1.96%	8.24%	421%	11
Diabetes with Neurological Manifestations	1.27%	4.97%	390%	11
Empyema and Pneumothorax	5.71%	12.90%	226%	11
Peritonitis and Intestinal Abscess	6.71%	14.93%	222%	11
Other Diseases of the Genitourinary System	1.48%	3.64%	246%	11
Fracture of Vertebral Column without Mention of Spinal Cord Injury	1.09%	2.93%	269%	11
Secondary Malignancy of Brain/Spine	2.21%	7.61%	345%	11
Substance-related Disorders	0.97%	5.33%	551%	11

67. Figure 10 below shows that Baylor used a higher rate of severe malnutrition not just in the few categories listed above, but across a large variety of principal diagnosis codes. The red dots to the right of the 45-degree line indicate higher rates of severe malnutrition at Baylor versus the nationwide average. This figure shows that Baylor has a higher rate of severe malnutrition for 173 out of 184 (94.02%) principal diagnosis categories. In other words, the extent to which Baylor excessively upcoded severe malnutrition on the categories listed in Table 8 above was not offset by relative downcoding in other principal diagnosis categories.

Figure 10. Rate of Severe Malnutrition by Principal Diagnosis Code at Baylor Versus Other Hospitals.

For the 184 principal diagnoses with at least 100 claims at Baylor (each represented by a dot), this figure compares the rate of severe malnutrition at Baylor versus non-Baylor hospitals. Red dots to the right of the 45-degree line indicate Baylor is coding severe malnutrition at a rate higher than the nationwide average.



ii. Specific False Claims with Severe Malnutrition

68. The Relator has identified many specific false Medicare claims submitted by Baylor involving severe malnutrition. The following table includes 50 examples.

[Table 9 Redacted for PII]

2. Alternative Hypotheses for Excessive Rates of Misstated MCCs Do Not Stand and Confirm that Baylor Fraudulently Billed Medicare

69. To further demonstrate the Defendants' fraud and determine responsibility for the excessively high rates of Misstated MCCs, Relator has analyzed whether the statistically aberrant rates of Misstated MCCs described above could be attributed to a variety of other factors. First, Relator ran a fixed effect linear regression model to control for a variety of possible explanations for MCCs, including patient characteristics and county demographic data. Second, Relator considered whether the patient's attending physician is responsible for the excessive MCCs by analyzing a subset of claims where Baylor and other hospitals shared a common physician. Third, Relator analyzed a subset of claims where Baylor and other hospitals shared common patients. Finally, Relator analyzed the upcoding rate for Baylor and other hospitals in the same metropolitan statistical area ("**MSA**") to determine whether the MCC upcoding is due to regional differences. As discussed further below, these analyses prove that the excessive rates of Misstated MCCs can be directly attributed to the Defendants' fraudulent activity as opposed to external factors, indicating that the fraud was known by the system and was intentional.

A. Patient Characteristics and Demographics do not Explain the Excessive Rates of Misstated MCCs at Baylor

70. The Relator developed a proprietary linear regression model to control for the possibility that there are certain patient characteristics which might indicate a higher likelihood a patient would have a MCC, allowing Relator to isolate and calculate the specific impact Defendants had on the abuse of a Misstated MCC code after controlling for other characteristics. These characteristics include basic patient characteristics, such as the age, gender, and race, as well as characteristics relating to the patient's inpatient stay, including principal diagnosis, length of stay, and discharge status. Relator also used county-level demographic data, such as unemployment rate, percent of population without a high school diploma, median income, and the rural-urban continuum codes from the Department of Agriculture as control variables.[14] These county demographic variables provided Relator with a proxy for the income levels, education levels, and access to care available to each patient. Regression analysis is well established and has been used to pinpoint actors behind misreporting in financial and economic contexts.[15]

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[14] The Rural-Urban Continuum Codes measure whether each county is in a metro or non-metro area and reflect the overall size of the metropolitan area.

[15] *See, for example,* Tomasz Piskorski, Amit Seru, and James Witkin, *Asset Quality Misrepresentation by Financial Intermediaries: Evidence from the RMBS Market,* The Jour-

Relator's regression analysis analyzed millions of claims and thousands of possible fraudulent patterns to calculate the total fraud committed by Baylor.

71. In this section, Relator employs three different regression analysis methodologies, each of which demonstrate how Defendant billed for the Misstated MCCs at fraudulently excessive rates. First, Relator uses a principal diagnosis bin-based fixed effect linear regression model to calculate the excessive Misstated MCCs in each principal diagnosis category. Second, Relator runs a fixed effect linear regression across all claims. Third, Relator calculates the residual for each system and hospital to determine the unexplained rate of Misstated MCCs across all systems and then across all hospitals.

i. Principal Diagnosis Bin-Based Fixed Effect Linear Regression

72. First, Relator continued with the principal diagnosis bin approach by running separate regressions for each principal diagnosis category. This approach provides a number of benefits. First, it allows for non-linear relationships so that the effect of each of the control variables can vary between principal diagnosis codes. For example, the impact length of stay has on the likelihood of an MCC might vary from one principal diagnosis code to another. Second, it allows for the specific

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nal of Finance, Vol. 70.6 (2015), at 2635 –2678; Griffin, John M., and Gonzalo Maturana, *Who Facilitated Misreporting in Securitized Loans?,* Review of Financial Studies, Vol. 29.2 (2016), at 384–419.

quantification of the defendants' impact on MCC rates for claims within each principal diagnosis category.

73. Lastly, Relator included a fixed effect control variable for Baylor in the regression model, which represents the incremental amount of excessive MCC rates at Baylor beyond what could be explained by other variables. Equation 1 shows the fixed effect linear regression model used by Relator.

Equation 1. Relator's Fixed Effect Linear Regression Model.

The following equation presents the fixed effect linear regression model used by Relator. The variable of interest is β_1, which is the coefficient for Baylor. Panel A provides the equation, and Panel B explains the variables included in the model. The *i* refers to a specific claim and *j* refers to the potential options for the categorical variables.

Panel A: Fixed Effect Regression Model

$$MCC_i = \beta_0 + \beta_1.Providence_i + \sum_{j=2}^{6} \beta_{2j}.Age_{ij} + \sum_{j=2}^{7} \beta_{3j}.Race_{ij} + \beta_4.Male_i + \beta_5.\log LOS_i + \sum_{j=2}^{3} \beta_{6j}.Discharge_{ij} + \sum_{j=2}^{4} \beta_{7j}.Season_{ij} + \sum_{j=2}^{9} \beta_{8j}.RUCC_{ij} + \beta_9.Pov_i + \beta_{10}.Unemp_i + \beta_{11}.Income_i + \varepsilon_i$$

Panel B: Explanation of Regression Variables

Variable	Description
β_0	Intercept
MCC_i	Whether the claim included a MCC
$Providence_i$	Whether the patient was treated at Baylor
Age_{ij}	Patient's age on the claim (6 age groups)
$Race_{ij}$	Patient's race on the claim (7 race categories)
$Male_i$	Patient's gender
LOS_i	The patient's log length of stay at the hospital for claim *i*
$Discharge_i$	The patient's discharge status
$Season_{ij}$	Season control variable for the claim (Winter, Spring, Summer, Fall)
$RUCC_{ij}$	Patient's rural urban continuum code based on the county
Pov_i	County poverty rate in 2014
$Unemp_i$	County unemployment rate in 2014
$Income_i$	County log median income in 2014
ε_i	Error term

74. By controlling for these characteristics, the regression model allowed Relator to isolate the impact that being treated at a Baylor hospital

would have on a patient's expected likelihood of being diagnosed with one of the Misstated MCCs. For example, given two patients with abdominal pain, with the same age and gender, from the same county, admitted during the same season, and with the same length of stay, the patient treated at Baylor would be 337.21% as likely to be diagnosed with encephalopathy.

75. The results for the Misstated MCCs are shown in Figure 11. Each bar represents the marginal effect of Baylor on the MCC rate relative to other hospitals within each principal diagnosis bin. As can be seen in Panel A for encephalopathy, the coefficients for each principle diagnosis bin are all above 100% which indicates that encephalopathy rates are higher at Baylor, even after controlling for other characteristics. Statistical significance of a coefficient that is less than one in a thousand is in orange, while if the rate is even more rare at one in a million or less it is in pink, and if the probability that the coefficient could happen by chance is even lower at less than one in a hundred million then the bar is in red. As can be seen in Panel A of Figure 11, 67.6% of the bars have a probability of being due to chance of less than 1 in 1 million. Notably, only two of the 37 patterns have a significance level less than 1 in 1 thousand.[16]

76. Respiratory failure is shown in Panel B, and severe malnutrition is shown in Panel C. For respi-

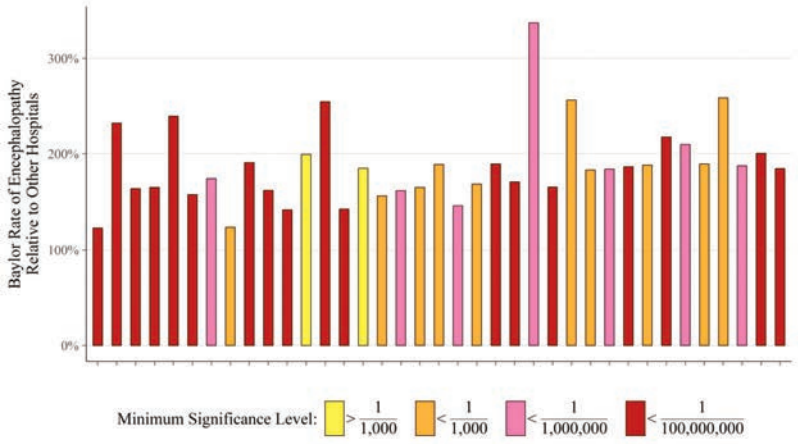
[16] Even the principal diagnosis codes that were not statistically significant at less than 1 in 1,000 were still significant at a 99% confidence level.

ratory failure, 69.6% of the 56 patterns are significant at less than 1 in 100 million, and all have a significance of at least 1 in 1 thousand. For severe malnutrition, 85.3% of the 116 patterns are significant at less than 1 in 1 million, and all 116 are significant at less than 1 in 1 thousand. There are fewer bars for encephalopathy and respiratory failure because there are fewer relevant patterns in which Baylor's coding of Misstated MCCs was deemed excessive. This evidence demonstrates the excessive coding of Misstated MCCs at Baylor, even after controlling for other characteristics.

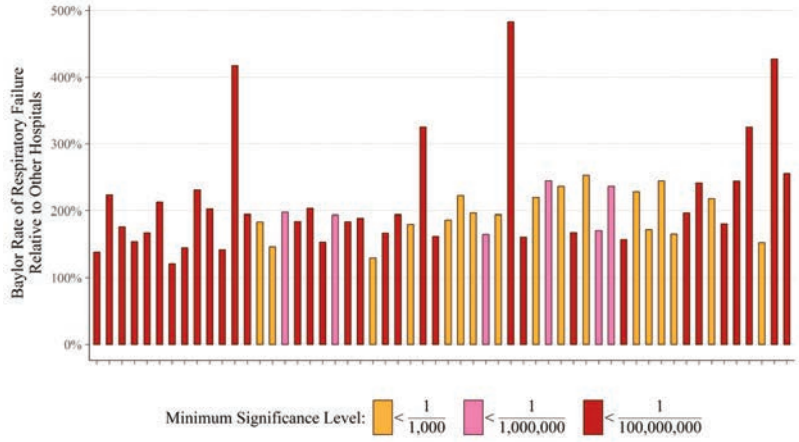
Figure 11. Regression-Adjusted Misstated MCC Usage at Baylor Relative to Non-Baylor Hospitals for Each Principle Diagnosis Bin.

Relator used principal diagnosis bin-based fixed effect linear regressions to analyze approximately 50 million claims at Baylor and other hospitals. The results for each principal diagnosis bin are presented in the following figure. The vertical lines represent Baylor's marginal effect on the rate of Misstated MCCs relative to the rate at other hospitals nationwide, where values above 100% indicate excessive MCC upcoding. The bins are ordered from left to right consistent with the order of principal diagnosis codes in Table 2, Table 5, and Table 8. The statistical significance is denoted by the coloring described in the legend. All but 2 were statistically significant at less than 0.1% chance the difference is random, and most were significant at a probability of less than 1 in 100 million.

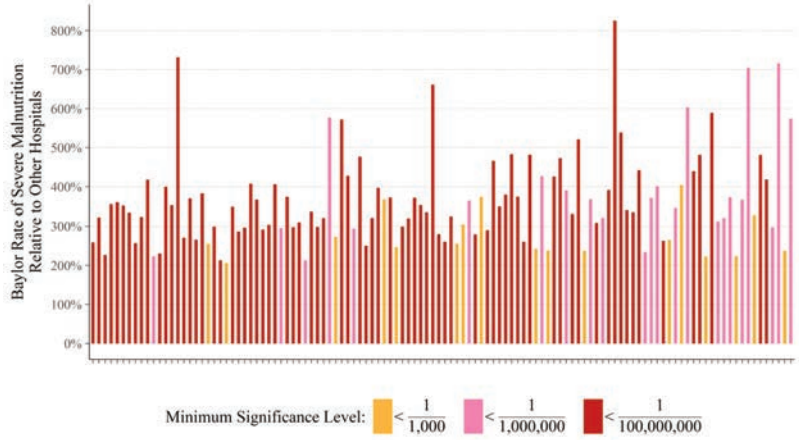
Panel A: Encephalopathy Regression Results by Principal Diagnosis Bin



Panel B: Respiratory Failure Regression Results by Principal Diagnosis Bin



Panel C: Severe Malnutrition Regression Results by Principal Diagnosis Bin



ii. Aggregate Fixed Effect Regression Model

77. Second, Relator also ran a regression to calculate the cumulative effect of Baylor's rate of Misstated MCCs across all claims in the relevant patterns. The same regression described in Equation 1 is used for this analysis, except relator

runs one regression for all of the principal diagnosis codes in each MCC and adds a control variable for the inpatient principal diagnosis category. The length of stay variable is interacted with the principal diagnosis code to account for variation in the expected length of stay given a principal diagnosis code.

78. As shown in Table 10, after controlling for other factors, the Baylor coefficient for the Misstated MCCs is 0.0885. This means that 8.85 percent of Baylor claims are coded with one of the Misstated MCCs when they would not have been coded as such at another hospital. Given the baseline usage rate of the Misstated MCCs at other hospitals is 10.27 percent, Baylor's calculated rate of Misstated MCCs is 19.12 percent. In other words, *Baylor's usage rate of the Misstated MCCs is 186.17% that of other hospitals*, even after controlling for patient, medical, and demographic characteristics. This result is statistically significant with more than 99.9999 percent confidence—*i.e.*, almost certainly not random.

79. Not surprisingly, the individual coefficients for encephalopathy, respiratory failure, and severe malnutrition are also large in magnitude. Baylor's usage rate for encephalopathy was 151.88% of the rate at other hospitals, respiratory failure was 167.17%, and severe malnutrition was 315.56%.[17]

[17] For robustness analysis, Relator also considered the possibility that certain surgical procedure codes or admission sources (such as being admitted from the emergency room) might explain the higher rates of Misstated MCCs at Baylor.

Table 10. Results of Fixed Effect Linear Regression Model.

Relator used the fixed effect linear regression discussed in Equation 1, except instead of running individual regressions for each principal diagnosis bin, Relator ran one regression for each Misstated MCC and included a control variable for the individual principal diagnosis categories. Relator analyzed approximately 50 million claims at Baylor and other hospitals. The results are presented in the following table. The coefficient is listed first and the p-value is in parenthesis, which represents the statistical significance of the coefficient. A lower p-value means the result is more statistically significant. Coefficients were not included for categorical variables. The Baylor coefficient is added to the rate at other hospitals to get the expected Baylor rate of excessive MCCs after including controls.

	Any of the MCCs	**Encephalopathy**	**Respiratory Failure**	**Severe Malnutrition**
Poverty Rate	-0.001 (<0.0001)	-0.0014 (<0.0001)	-0.0017 (<0.0001)	0.0003 (<0.0001)
Unemployment Rate	-0.0014 (<0.0001)	0.0011 (<0.0001)	-0.0019 (<0.0001)	-0.0006 (<0.0001)
Log (Median Income)	-0.0469 (<0.0001)	-0.0459 (<0.0001)	-0.0648 (<0.0001)	-0.0038 (<0.0001)
No High School Diploma Rate	-0.0008 (<0.0001)	-0.0006 (<0.0001)	-0.0009 (<0.0001)	-0.0001 (<0.0001)
Intercept	0.363 (0.1956)	0.4586 (0.1099)	0.5006 (0.179)	-0.0059 (0.9772)
Principal Diagnosis	Yes	Yes	Yes	Yes
Principal Diagnosis X Log(LOS[18])	Yes	Yes	Yes	Yes
Season Control Variables	Yes	Yes	Yes	Yes
Age Control Variables	Yes	Yes	Yes	Yes
Sex Control Variables	Yes	Yes	Yes	Yes
Race Control Variables	Yes	Yes	Yes	Yes
Discharge Status Control	Yes	Yes	Yes	Yes
Principal Diagnosis Category	Yes	Yes	Yes	Yes
RUCC Control	Yes	Yes	Yes	Yes
Baylor Coefficient	0.0885 (<0.0001)	0.0524 (<0.0001)	0.0800 (<0.0001)	0.0485 (<0.0001)
Nationwide Average	10.27%	10.10%	11.91%	2.25%
Baylor Rate	**19.12%**	**15.34%**	**19.91%**	**7.10%**
Baylor Rate Relative to Other Hospitals	**186.17%**	**151.88%**	**167.17%**	**315.56%**

Relator ran the fixed-effect regression analysis while also including controls for surgical procedures and admission source. With these coefficients, Baylor's rate of Misstated MCCs was 168.27% relative to other non-Baylor hospitals. Similarly, the Baylor Systems' usage rate for encephalopathy was 148.24% of the rate at non-Baylor hospitals, respiratory failure was 138.69%, and severe malnutrition was 318.08%.

18 LOS stands for length of stay.

iii. System and Hospital Residuals for Misstated MCCs

80. Third, another regression method to analyze Baylor's coding of Misstated MCCs is to calculate the unexplained rate of Misstated MCCs attributed to Baylor claims. To calculate this, Relator ran the regression without the fixed effect control variable for Baylor and calculated the probability each claim would have one of the Misstated MCCs. For each hospital system and for each individual hospital, the average difference between the predicted probability (or rate) of Misstated MCCs is compared to the actual rate of Misstated MCCs, which is referred to as a residual. The difference between these two values represents the rate of Misstated MCCs that is caused by each hospital system, after controlling for the other characteristics previously described. Panel A of Figure 12 shows the average residual for rate of Misstated MCCs for each hospital system, with Baylor plotted in red. Baylor's average unexplained rate of Misstated MCCs by this measure is 8.80%, making it 7th highest out of 737 hospital systems with at least 10,000 claims in the relevant patterns. Panel B of Figure 12 shows the average residual of each individual hospital, with Baylor hospitals plotted in red. The average residual of the Baylor hospitals ranges from 6.56% to 9.72%, and the 3 Baylor hospitals[19] are in the top 90th percentile of hospitals for unexplained rate of Misstated MCCs.

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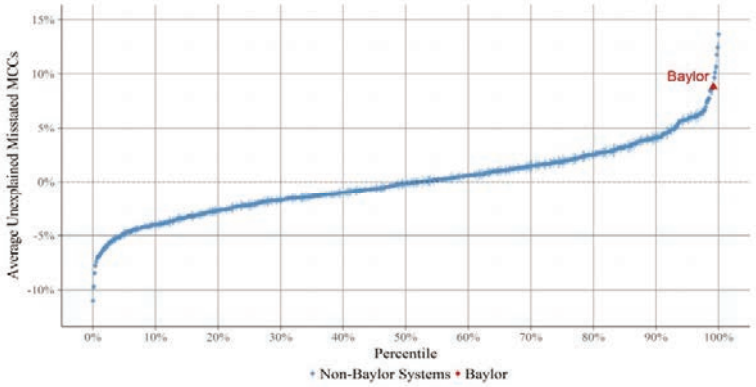
[19] Relator only alleges that Baylor University Medical Center – Dallas has been excessively using encephalopathy, so this hospital has been left out of this analysis which is

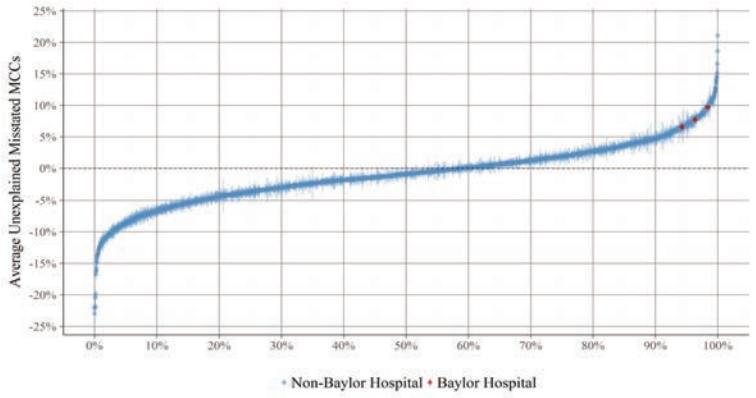
Figure 12. Average Unexplained Misstated MCC Rate for Each Hospital System and Individual Hospital.

The following figure plots the results of the regression from Equation 1, except one regression was run for all principal diagnosis bins, the control variable for principal diagnosis code was added to the regression, and the Baylor fixed effect variable was removed. All other variables included are the same. The graph in Panel A is based on 737 hospital systems with at least 10,000 claims from 2011 through June 2017. The graph in Panel B is based on 3,220 hospitals with at least 500 claims during the same time period. The small vertical lines off of the points represent the confidence interval for each system's unexplained use of Misstated MCCs.

Panel A: Average Residual of Any of the Misstated MCCs for Hospital Systems



Panel B: Average Residual of Any of the Misstated MCCs for Individual Hospitals



based on any of the three Misstated MCCs. However, it is among the highest hospitals by rate of encephalopathy and including it in this calculation would only further demonstrate Baylor's fraudulent activity.

81. Taken together, Relator's regression analysis shows that the excessive rates of Misstated MCCs were not due to unique patient demographic or health characteristics, but were specifically caused by the Defendants' practices.

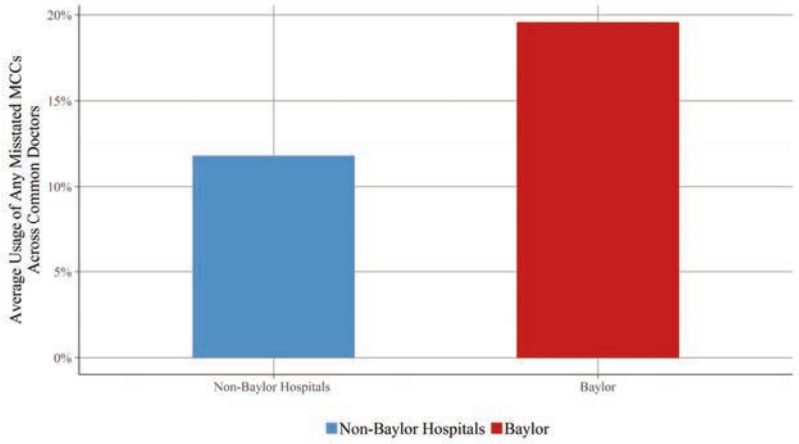
B. Attending Physicians are not Responsible for the Excessively High Rates of Misstated MCCs

82. Relator also considered whether the excessively high rates of Misstated MCCs could be caused by the preferences or treatment decisions of physicians who work with patients at Baylor hospitals, as opposed to some system-wide decision or corporate directive. Could it be that the physicians who attended to Baylor's patients were more disposed to identifying encephalopathy, respiratory failure, and severe malnutrition than other physicians? To address this question, Relator analyzed a subset of claims involving doctors that treated patients at both Baylor and other hospitals.

83. As shown in Figure 13, when considering only claims for doctors with at least 10 claims at both Baylor and other hospitals, the use of encephalopathy, respiratory failure, and malnutrition was still significantly higher at Baylor. Between 2011 and 2017, doctors used one of the Misstated MCCs on 19.57 percent of claims while treating patients at Baylor, but on only 11.80 percent of claims when treating patients at other hospitals.

Figure 13. Rate of Any of The Misstated MCCs at Baylor Relative to Other Hospitals for Claims with Common Doctors.

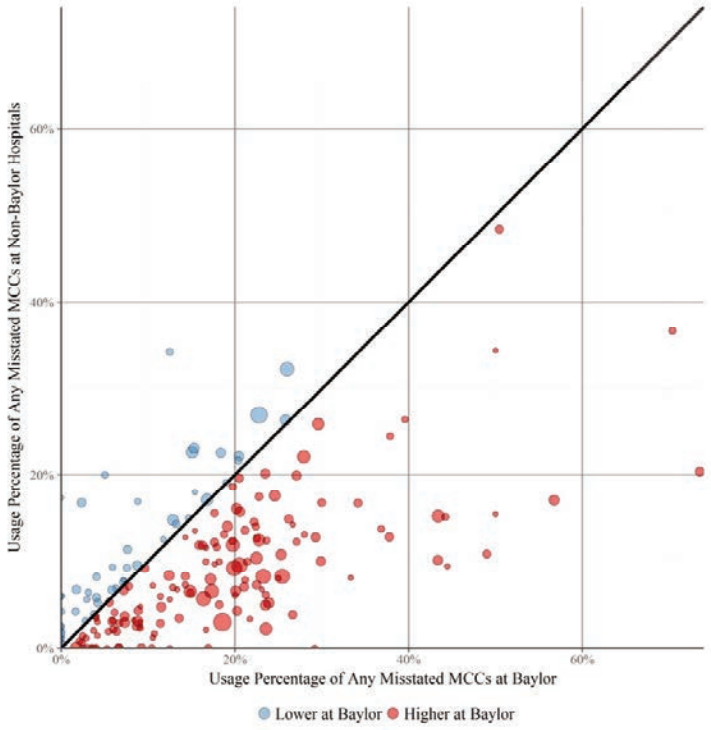
The following figure includes any claims for common doctors between Baylor and another hospital from 2011 through 2017. Even with doctors that work at both hospitals, Baylor used one of the Misstated MCCs on 19.57 percent of claims, while those same doctors only use one of the Misstated MCCs on 11.80 percent of claims while at other hospitals. The analysis is based on 195 doctors with 10 claims at Baylor and 10 claims at a non-Baylor hospital. In total these doctors had more than 25,000 claims at Baylor and more than 47,000 claims at other hospitals.



84. Figure 14 shows that this tendency to have higher rates of Misstated MCCs at Baylor is not limited to a few doctors but is systemic. In the following figure, doctors with the same rate of Misstated MCCs at Baylor and other hospitals would be clustered along the 45-degree line, whereas doctors with higher rates of Misstated MCCs at Baylor would be to the right of the 45-degree line. As shown in Figure 14, 147 out of 195 doctors (or 75.4 percent) had a higher coding rate of the Misstated MCCs at Baylor than at other hospitals.

Figure 14. Rate of Any of the Misstated MCCs for Common Doctors at Baylor Versus Other Hospitals.

The following figure compares the rate of Misstated MCCs for common doctors at Baylor versus other hospitals. In the graph, the red circles to the right of the 45-degree line represent doctors who have higher upcoding at Baylor and the blue circles represent doctors who have higher upcoding at other non-Baylor hospitals. Only doctors with at least 11 claims at Baylor and 11 claims at a non-Baylor hospitals are represented in this figure.

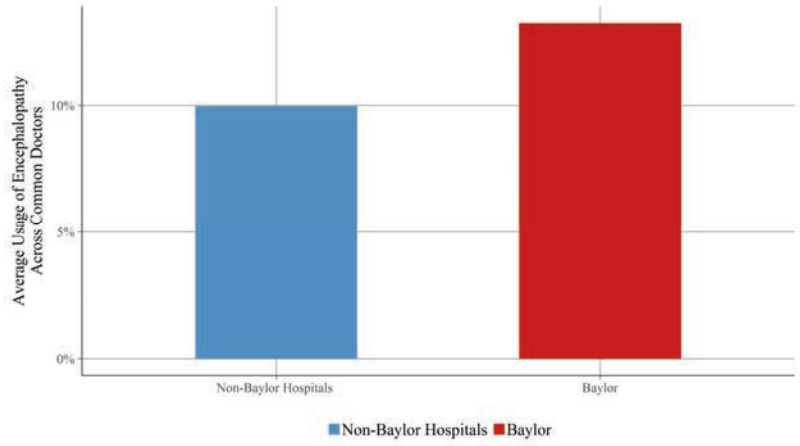


85. This result still holds when looking just at the individual Misstated MCCs. For doctors that serve at both Baylor and other hospitals, the rate of encephalopathy at Baylor was 13.23 percent, while the rate of encephalopathy at other hospitals was 9.97 percent, as demonstrated in Figure 15 below.

This indicates that a doctor was 132.7% as likely to diagnosis a patient with encephalopathy when treating the patient at Baylor than when the same doctor was treating a patient at another hospital.[20]

Figure 15. Rate of Encephalopathy at Baylor Relative to Other Hospitals for Claims with Common Doctors.

The following figure includes any claims for doctors with at least 10 claims at Baylor and 10 claims at a non-Baylor hospital from 2011 through June 2017. Even with doctors that work at both hospitals, Baylor had an encephalopathy rate of 13.23 percent, while those same doctors only use encephalopathy on 9.97 percent of claims while at other hospitals. The analysis is based on 162 doctors with 10 claims at Baylor and 10 claims at a non-Baylor hospital. In total these doctors had more than 12,000 claims at Baylor and more than 16,000 claims at other hospitals.



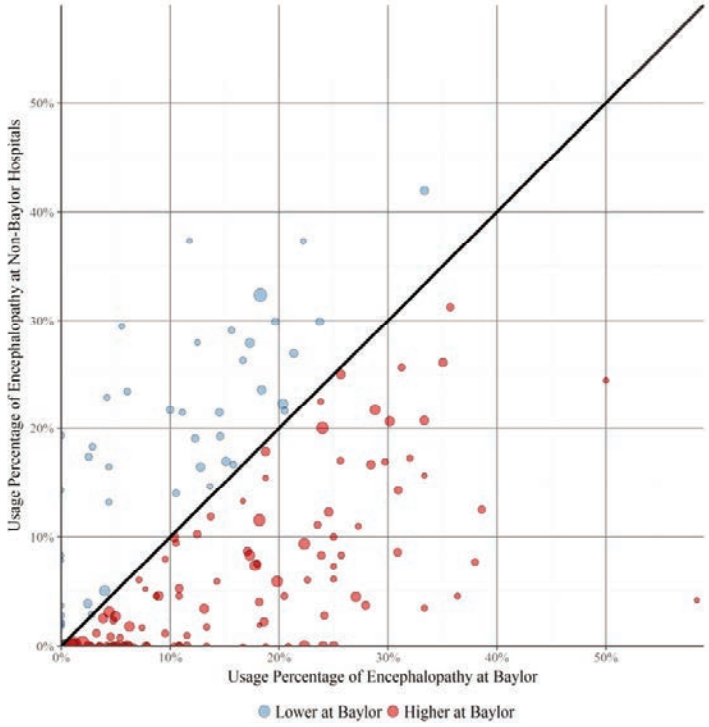
86. Figure 16 shows that a significant number of doctors had higher rates of encephalopathy when they worked at Baylor than at other hospitals. Specifically, it shows that 115 doctors out of 162

[20] This general trend still holds when looking at any doctor that has at least one claim at Baylor and one claim at a non-Baylor hospital. Specifically, the rate of encephalopathy is 14.23% at Baylor and 11.06% at other hospitals.

doctors considered (or 71 percent) had a higher rate at Baylor.

Figure 16. Rate of Encephalopathy for Common Doctors at Baylor Versus Other Hospitals.

The following figure compares the rate of encephalopathy for common doctors at Baylor versus other hospitals. In the graph, the red circles to the right of the 45-degree line represent doctors who have higher upcoding of encephalopathy at Baylor and the blue circles represent doctors who have higher upcoding at other non-Baylor hospitals. Only doctors with at least 11 claims at Baylor and 11 claims at a non-Baylor hospitals are represented in this figure.

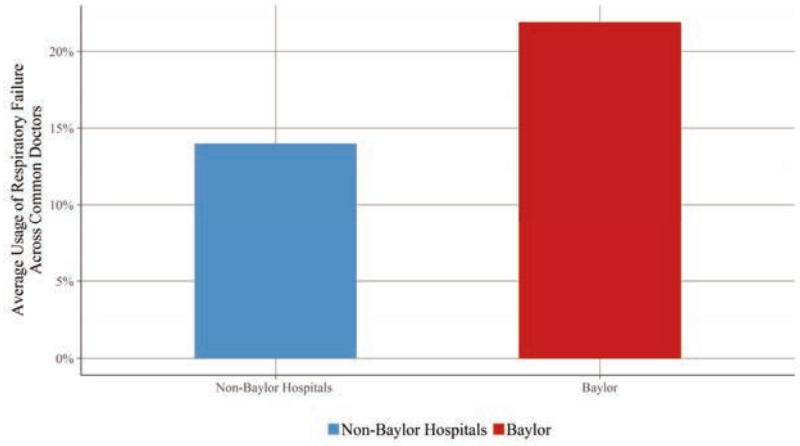


87. For doctors that serve at both hospitals, the rate of respiratory failure at Baylor was 21.9 percent, while the rate of respiratory failure at other hospitals was 14.0 percent, as demonstrated in Figure 17 below. This suggests that a doctor was

156.4% as likely to diagnosis a patient with respiratory failure when treating the patient at Baylor than when the same doctor was treating a patient at a non-Baylor hospital.[21]

Figure 17. Rate of Respiratory Failure at Baylor Relative to Other Hospitals for Claims with Common Doctors.

The following figure includes any claims for doctors with at least 10 claims at Baylor and 10 claims at a non-Baylor hospital from 2011 through June 2017. Even with doctors that work at both hospitals, Baylor had a respiratory failure rate of 21.9 percent, while those same doctors only use respiratory failure on 14.0 percent of claims while at other hospitals. The analysis is based on 154 doctors with 10 claims at Baylor and 10 claims at a non-Baylor hospital. In total these doctors had more than 16,000 claims at Baylor and more than 27,000 claims at other hospitals.

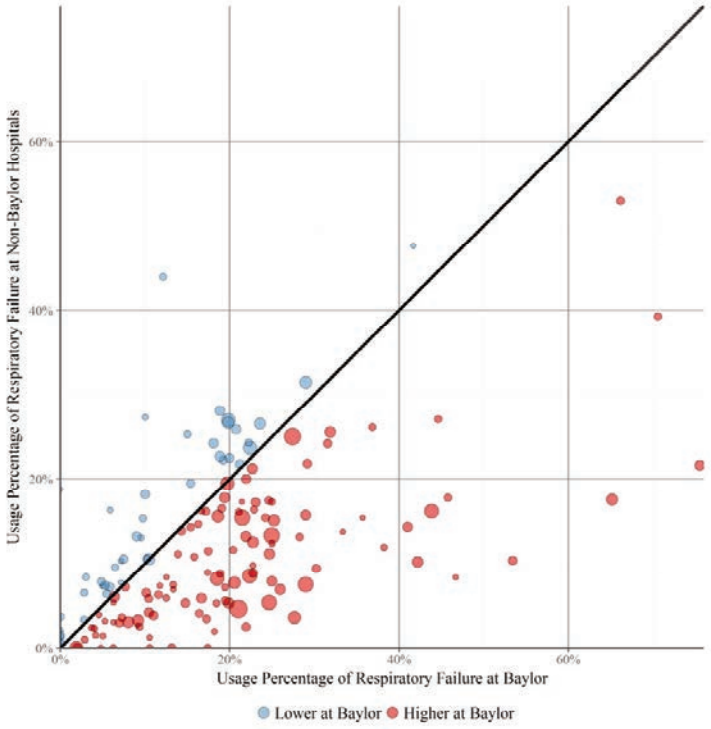


88. Figure 18 shows that a significant number of doctors had higher rates of respiratory failure when they worked at Baylor than at other hospitals. Specifically, the figure shows that 110 out of 154 doctors considered (or 71.4 percent) had a higher rate at Baylor.

[21] This general trend still holds when looking at any doctor that has at least one claim at Baylor and one claim at a non-Baylor hospital. Specifically, the rate of respiratory failure is 21.83% at Baylor and 13.41% at other hospitals.

Figure 18. Rate of Respiratory Failure for Common Doctors at Baylor Versus Other Hospitals.

The following figure compares the rate of respiratory failure for common doctors at Baylor versus other hospitals. In the graph, the red circles to the right of the 45-degree line represent doctors who have higher upcoding of respiratory failure at Baylor and the blue circles represent doctors who have higher upcoding at other non-Baylor hospitals. Only doctors with at least 11 claims at Baylor and 11 claims at a non-Baylor hospitals are represented in this figure.

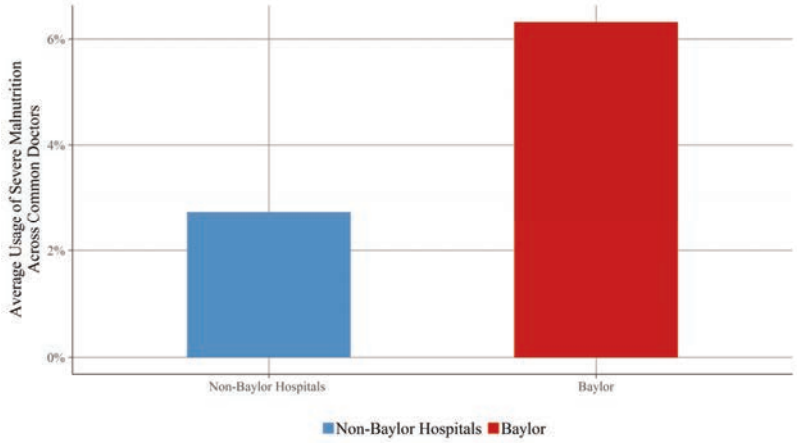


89. For doctors that serve at both hospitals, the rate of severe malnutrition at Baylor was 6.32 percent, while the rate of severe malnutrition at other hospitals was 2.73 percent, as demonstrated in Figure 19 below. This indicates that a doctor was 231.5% as likely to diagnosis a patient with severe malnutrition when treating the patient at Baylor

than when the same doctor was treating a patient at a non-Baylor hospital.[22]

Figure 19. Rate of Severe Malnutrition at Baylor Relative to Other Hospitals for Claims with Common Doctors.

The following figure includes any claims for doctors with at least 10 claims at Baylor and 10 claims at a non-Baylor hospital from 2011 through June 2017. Even with doctors that work at both hospitals, Baylor had a severe malnutrition rate of 6.32 percent, while those same doctors only use severe malnutrition on 2.73 percent of claims while at other hospitals. The analysis is based on 161 doctors with 10 claims at Baylor and 10 claims at a non-Baylor hospital. In total these doctors had 23,541 claims at Baylor and 40,096 claims at other hospitals.



90. Figure 20 shows that a significant number of doctors had higher rates of severe malnutrition when they worked at Baylor than at other hospitals. For example, the figure shows that 123 doctors out of 161 doctors considered (or 76.4 percent) used a higher rate at Baylor.

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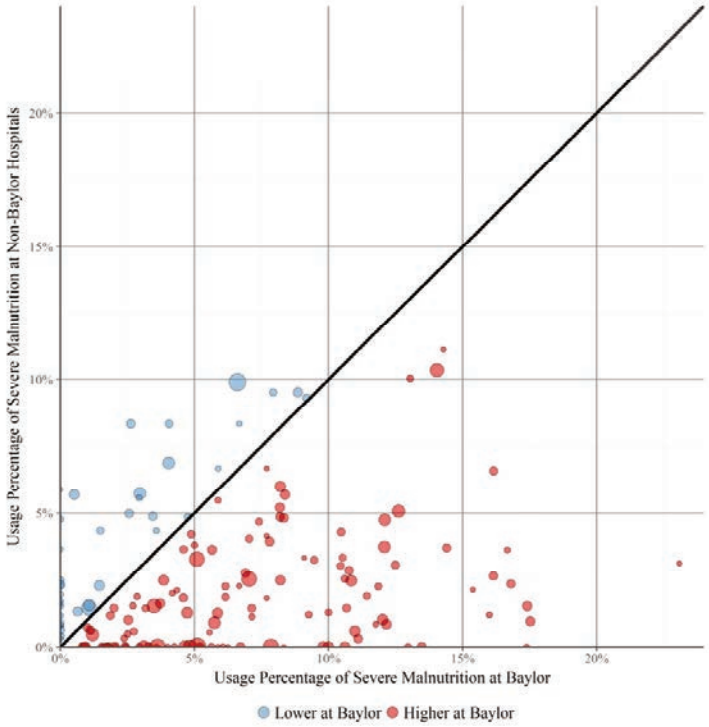
[22] This general trend still holds when looking at any doctor that has at least one claim at Baylor and one claim at a non-Baylor hospital. Specifically, the rate of severe malnutrition is 6.81% at Baylor and 2.64% at other hospitals.

Figure 20. Rate of Severe Malnutrition for Common Doctors at Baylor Versus Other Hospitals.

The following figure compares the rate of severe malnutrition for common doctors at Baylor versus other hospitals. In the graph, the red circles to the right of the 45-degree line represent doctors who have higher upcoding of severe malnutrition at Baylor and the blue circles represent doctors who have higher upcoding at other non-Baylor hospitals. Only doctors with at least 11 claims at Baylor and 11 claims at a non-Baylor hospitals are represented in this figure.



91. Relator identified the specific doctors that had higher rates of severe malnutrition at Baylor relative to other hospitals. Table 11 below lists the ten doctors with the largest disparity in severe malnutrition rates when they worked at Baylor compared to when they worked at other hospitals.

Each of these doctors coded severe malnutrition at a rate at least six times higher when at Baylor.[23]

Table 11. Doctors with the Most Excessive Rates of Severe Malnutrition at Baylor Versus Other Hospitals.

This table shows the difference in severe malnutrition usage for the ten doctors with the highest difference in severe malnutrition usage at Baylor versus other hospitals. The first seven digits of the physician ID have been hidden by Relator so the specific physician will not be identifiable directly from this complaint. Only doctors with at least 11 claims at Baylor and 11 claims at a non-Baylor hospitals are represented in this table.

Physician ID	Percent of Claims w/ Severe Malnutrition at Baylor	Percent of Claims w/ Severe Malnutrition at Other Hospitals	Difference in Percent	Baylor Rate Relative to Other Hospitals	P-Value
XXXXXXX031	23.08%	3.12%	19.95%	738%	0.0069
XXXXXXX184	17.39%	0.00%	17.39%	Infinity	<0.0001
XXXXXXX940	17.53%	0.94%	16.59%	1,858%	<0.0001
XXXXXXX494	17.42%	1.53%	15.89%	1,142%	<0.0001
XXXXXXX278	16.00%	1.19%	14.81%	1,345%	0.0002
XXXXXXX253	16.81%	2.34%	14.47%	720%	<0.0001
XXXXXXX159	16.15%	2.63%	13.52%	614%	<0.0001
XXXXXXX569	13.48%	0.00%	13.48%	Infinity	<0.0001
XXXXXXX301	15.38%	2.13%	13.26%	723%	0.0302
XXXXXXX723	16.67%	3.61%	13.05%	461%	0.0102

92. Relator also re-ran the regression analysis for the subset of claims that have at least 10 claims by a doctor at Baylor and a non-Baylor hospital.[24] Relator used the same controls from the regression described in section IV.D.2.A above, along with a

[23] Relator only included the results for severe malnutrition because it has the most claims among the Misstated MCCs, providing the most thorough comparison.

[24] More than 63,000 claims for severe malnutrition and more than 73,000 claims for Misstated MCC were included in this regression. Severe malnutrition was the only specific Misstated MCC in which Relator ran the regression because it had the largest number of claims.

control for the doctor that treated the patient. This allows Relator to quantify the marginal impact a patient being treated at Baylor has on a patient being diagnosed with a Misstated MCC, beyond what can be explained by patient characteristics, demographic characteristics, as well as the individual doctor. As shown in Table 12, Baylor's rate of any MCC, after these controls, was 155.93 percent of the rate at other hospitals, and Baylor's severe malnutrition rate was 231.14 percent of the rate at other hospitals.[25]

[25] Relator also considered whether the behavior of these doctors is due to their tendency to provide certain procedures at certain hospitals. To do this, Relator also added control variables for the procedure codes and the admission status to identify admissions as from the emergency room, elective, or urgent. For any Misstated MCC and for severe malnutrition, the coefficients were 0.0505 and 0.0358 respectively. In other words, Baylor's rate of Misstated MCC was 142.80 percent of other hospitals, and rate of severe malnutrition was 231.14 percent of other hospitals among claims with common doctors.

Table 12. Fixed Effect Regression Results After Controlling for Attending Physician.

Relator used a linear regression to analyze approximately 73,000 claims with common doctors at Baylor and other hospitals. The results are presented in the following table. The coefficient is listed first and the p-value is in parenthesis, which represents the statistical significance of the coefficient. A lower p-value means the result is more statistically significant. Coefficients were not included for categorical variables.

	Any Misstated MCC	**Severe Malnutrition**
Poverty Rate	-0.002 (0.003)	0 (0.9365)
Unemployment Rate	-0.0041 (0.0111)	-0.0019 (0.0776)
Log (Median Income)	-0.0466 (0.0216)	-0.0221 (0.092)
No High School Diploma Rate	0.0006 (0.1692)	-0.0004 (0.1403)
Intercept	0.5243 (0.0299)	0.2651 (0.0883)
Principal Diagnosis	Yes	Yes
Principal Diagnosis X Log (LOS[26])	Yes	Yes
Season Control Variables	Yes	Yes
Age Control Variables	Yes	Yes
Sex Control Variables	Yes	Yes
Race Control Variables	Yes	Yes
Discharge Status Group Controls	Yes	Yes
Principal Diagnosis Category Controls	Yes	Yes
RUCC Control	Yes	Yes
Doctor Control Variables	Yes	Yes
Baylor Coefficient	0.0660 (<0.0001)	0.0358 (<0.0001)
Nationwide Average	11.80%	2.73%
Baylor Rate	**18.40%**	**6.31%**
Baylor Relative Effect	**155.93%**	**231.14%**

93. This analysis shows that the fraudulent upcoding was not caused by tendencies of certain doctors that treat patients at Baylor but was instead caused by clinical documentation and coding practices that were implemented specifically at Baylor.

[26] LOS stands for length of stay.

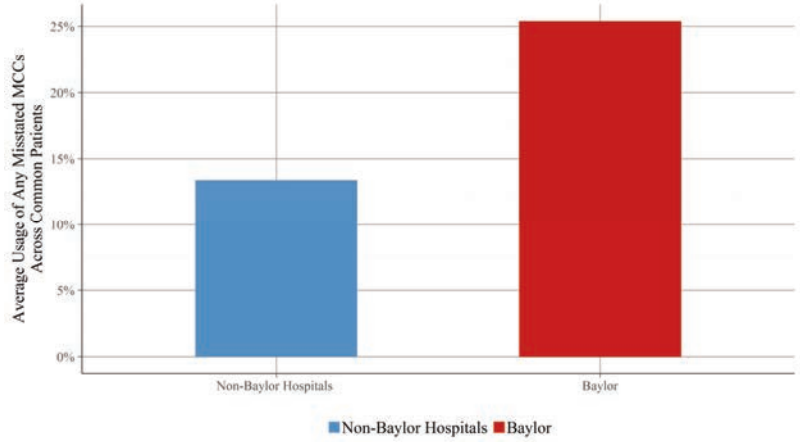
C. Unique Characteristics of Baylor's Patients do not Account for the Excessively High Rates of Misstated MCCs

94. Relator also considered whether it might be something else about Baylor patients that would justify the higher rates of MCCs. Although Relator already considered a variety of patient characteristics in the fixed effect linear regression model, Relator also analyzed the subset of patients that attended both Baylor and at least one other hospital between 2011 and 2017, and then compared the rate of the MCC codes used when these patients were treated at Baylor versus when treated at other hospitals.

95. As shown in Figure 21, when only analyzing patients that have at least 5 claims at both Baylor and other hospitals, the use of encephalopathy, respiratory failure, and malnutrition was still significantly higher at Baylor. Between 2011 and 2017, patients were diagnosed with one of the Misstated MCCs on 25.38 percent of claims while being treated at Baylor, but on only 13.38 percent of claims at other hospitals. A patient being treated at Baylor was coded with the Misstated MCCs at a rate that was 189.7% the rate at other non-Baylor hospitals.

Figure 21. Rate of Any of The Misstated MCCs at Baylor Relative to Other Hospitals for Claims with Common Patients.

The following figure includes any claims for common patients between Baylor and a non-Baylor hospital from 2011 through June 2017. Even with patients at both hospitals, Baylor used one of the Misstated MCCs on 25.38 percent of claims, while those same patients only have one of the Misstated MCCs on 13.38 percent of claims while at other hospitals. The analysis is based on 155 patients with 5 claims at Baylor and 5 claims at a non-Baylor hospital. In total these patients had 1,430 claims at Baylor and 1,547 claims at other hospitals.



96. Figure 22 shows a significant number of patients had higher rates of Misstated MCCs when treated at Baylor. Dots to the right of the 45-degree line indicate the patient was coded with higher rates of the Misstated MCCs at Baylor than at other hospitals. The graph shows that 107 out of 155 patients considered (or 69.0 percent) had a higher usage rate of the Misstated MCCs at Baylor than at other hospitals. This indicates the behavior is not limited to a few patients but is systemic.

[Figure 22 Redacted for PII]

97. This result still holds when looking at just severe malnutrition.[27] For patients that were at both hospitals, the rate of severe malnutrition at Baylor was 21.36 percent, while the rate of severe malnutrition at other hospitals was 7.91 percent, as demonstrated in Figure 23 below. This suggests that a patient was 270% as likely to diagnosis a patient with severe malnutrition when treating the patient at Baylor than when the same patient was treating a patient at a non- Baylor hospital.[28]

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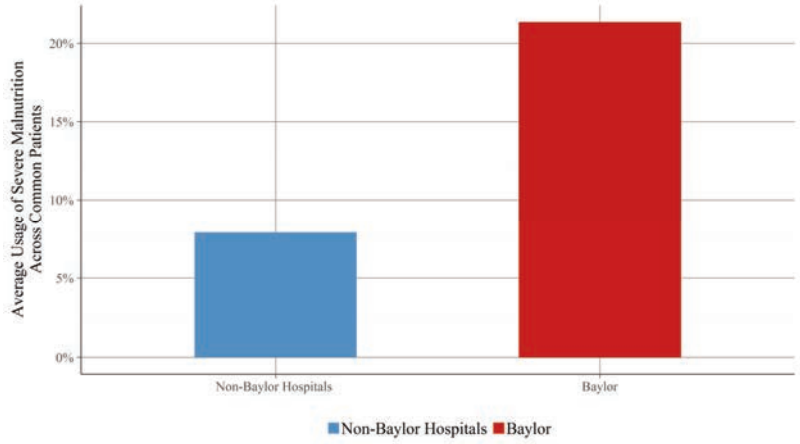
[27] Relator only included the results for severe malnutrition as it was the only Misstated MCC with a sufficient number of claims and common patients to conduct this analysis.

[28] This general trend still holds when looking at any patient that has at least one claim at Baylor and one claim at a non-Baylor hospital. Specifically, the rate of severe malnutrition is 38.1% at Baylor and 12.3% at other hospitals.

Figure 23. Rate of Severe Malnutrition at Baylor Relative to Other Hospitals for Claims with Common Patients

The following figure includes any claims for patients with at least 5 claims at Baylor and 5 claims at a non-Baylor hospital from 2011 through June 2017. Even with patients that are treated at both hospitals, Baylor had a severe malnutrition rate of 21.36 percent, while those same patients only use severe malnutrition on 7.91 percent of claims while at other hospitals. The analysis is based on 71 patients with 5 claims at Baylor and 5 claims at a non-Baylor hospital. In total these patients had 618 claims at Baylor and 746 claims at other hospitals.



98. Figure 24 shows that a significant number of patients had higher rates of severe malnutrition when they worked at Baylor than at other hospitals. For example, Panel A shows that 54 patients out of 71 patients considered (or 76.1 percent) used a higher rate at Baylor.

[Figure 24 Redacted for PII]

99. As this analysis shows, even when looking at the same patient, Baylor has significantly higher rates of Misstated MCCs than other hospitals. This shows that the upcoding behavior cannot be attributable to patient differences.

D. Regional Factors do not Explain Why Baylor Has Higher Rates of MCCs

100. Relator also considered whether the high rates of MCC upcoding at Baylor hospitals might be due to the region in which Baylor's hospitals are located. Although Relator has already controlled for a variety of county demographic factors through the regression, Relator now compares the rate of Misstated MCCs between Baylor and other hospitals within each MSA.

101. As shown in Table 13, Baylor had a significantly higher rate of Misstated MCCs in each MSA, with one MSA showing a rate more than twice as high at Baylor. As shown in Table 14, Baylor had a higher rate of encephalopathy than other hospitals in each MSA, with only one region (Killeen-Temple, TX) having a difference of less than seven percentage points. Table 15 and Table 16 show that Baylor had higher rates of respiratory failure and severe malnutrition, respectively, in each of the MSAs.

Table 13. Rate of Misstated MCCs at Baylor Versus Other Hospitals in the Same MSA.

This table compares the rate of Misstated MCCs in the suspicious patterns for the hospitals in Baylor and other hospitals within the same geographic region.

MSA	Baylor MCC Rate	Nationwide MCC Rate	Baylor Rate Relative to Other Hospitals	Probability
Austin-Round Rock, TX	15.93%	9.35%	170%	<0.0001
Killeen-Temple, TX	20.73%	14.75%	141%	<0.0001
Waco, TX	18.00%	8.85%	203%	<0.0001

Table 14. Rate of Encephalopathy at Baylor Versus Other Hospitals in the Same MSA.

This table compares the encephalopathy rate of the suspicious patterns for the hospitals in Baylor and other hospitals within the same geographic region.

MSA	Baylor Encephalopa -thy Rate	Nationwide Encephalopathy Rate	Baylor Rate Relative to Other Hospitals	Probability
Austin-Round Rock, TX	13.75%	7.41%	186%	<0.0001
Dallas-Fort Worth-Arlington, TX	17.59%	11.47%	153%	<0.0001
Killeen-Temple, TX	14.78%	14.69%	101%	0.3573
Waco, TX	12.20%	1.29%	944%	<0.0001

Table 15. Rate of Respiratory Failure at Baylor Versus Other Hospitals in the Same MSA.

This table compares the respiratory failure rate of the suspicious patterns for the Baylor hospitals and other hospitals within the same geographic region.

MSA	Baylor Respiratory Failure Rate	Nationwide Respiratory Failure Rate	Baylor Rate Relative to Other Hospitals	Probabilit y
Austin-Round Rock, TX	16.62%	10.64%	156%	<0.0001
Killeen-Temple, TX	22.04%	18.44%	120%	<0.0001
Waco, TX	18.94%	11.91%	159%	<0.0001

Table 16. Rate of Severe Malnutrition at Baylor Versus Other Hospitals in the Same MSA.

This table compares the respiratory failure rate of the suspicious patterns for the Baylor hospitals and other hospitals within the same geographic region.

MSA	Baylor Respiratory Failure Rate	Nationwide Respiratory Failure Rate	Baylor Rate Relative to Other Hospitals	Probability
Austin-Round Rock, TX	16.62%	10.64%	156%	<0.0001
Killeen-Temple, TX	22.04%	18.44%	120%	<0.0001
Waco, TX	18.94%	11.91%	159%	<0.0001

102. Based on this regional analysis, Relator has shown that the fraudulent upcoding cannot be attributed to geographic factors unique to Baylor.

E. Summary of Determining What Caused Excessively High Rates of Misstated MCCs at Baylor

103. Relator has considered a number of potential explanations above to determine what phenomenon or which actor could be responsible for the excessively high rates of Misstated MCCs at Baylor. The excessively high rates are highly significant across 133 principal diagnosis categories and 4 Baylor hospitals, indicating that it is not driven by particular patient medical characteristics nor unique to only a few Baylor hospitals. Relator eliminated the possibility that the high Misstated MCC rates might be justified by or due to patient or demographic characteristics, attending physician preferences, or regional differences. Based on this, Relator has demonstrated that the only plausible explanation as to the cause of the

excessively high rates of Misstated MCCs is that Baylor has implemented practices to maximize the amount of revenue it can receive from Medicare by fraudulently upcoding, i.e., adding unsubstantiated MCC secondary diagnosis codes to its claims.

3. Economic Damages

104. Relator employed a robust and conservative methodology to quantify the economic damages caused by the Defendants' fraudulent coding encephalopathy, respiratory failure, and severe malnutrition. Relator has limited this complaint to only the most extreme cases—*i.e.*, where Baylor used a Misstated MCC code at two times the rate of comparable hospitals or at least three percentage points of its entire patient population higher than other hospitals. Additionally, only principal diagnosis bins where the excessive MCC usage rate was statistically significant at a 99.9% rate—or almost certainly not random—were considered fraudulent. The following describes Relator's methodology for aggregating the total dollar value of the fraud committed by Baylor.

105. Relator employs a principal diagnosis bin-based regression methodology for calculating damages. For each principal diagnosis bin, Relator reran its fixed effect linear regression model discussed in Equation 1 but changed the dependent variable to represent the additional revenue due to upcoding. For each claim, Relator calculated the difference in the DRG weight between claims with Misstated MCCs and claims without Misstated

MCCs.[29] Relator then multiplied this difference in weights by Baylor's average base rate from 2011 through 2017, which was $5,554.01.[30] Within the regression for each principal diagnosis bin, the fixed effect for Baylor represents the additional revenue Baylor receives for the misstated MCCs after controlling for possible differences in patient, regional, and claim characteristics. Relator further only attributed damages for the regression results that were statistically significant at a 99.9% level, meaning there is a less in 1 in 1,000 chance the additional revenue received is due to random chance.

106. Based on this bin-based regression, Relator's analysis shows that Baylor received an additional $61.8 million in false claims across all principal diagnosis categories due to fraudulent MCC upcoding. Table 17 demonstrates the additional revenue Baylor received for false claims across each of the Misstated MCCs.

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[29] For claims that could have been a complication or without complication, Relator took a weighted average of DRG weights for the two DRGs and was weighted by Baylor's historical distribution of severity levels. Approximately 14.1% of claims were without complication and 85.9% of claims were with complication. If Baylor also upcodes using CC secondary diagnoses, the damage calculation would be even more conservative.

[30] The labor portion of the base rate was adjusted by the average wage index among Baylor hospitals from 2011 through 2017, and the capital portion was adjusted by the geographic adjustment factor over the same time period, to get a more accurate calculation of additional revenue.

Table 17. Damages by Specific Misstated MCCs.

Hospitals	Secondary MCC	Dollar Value of Fraud
Temple, Round Rock, Waco, and Dallas	Encephalopathy	$11,538,368
Temple, Round Rock, and Waco	Respiratory Failure	$26,998,225
Temple, Round Rock, and Waco	Severe Malnutrition	$23,258,777
	Total	**$61,795,370**

107. Relator's bin-based regression methodology represents a conservative approach for a variety of reasons. First, Relator only included principal diagnosis bins where Baylor used the Misstated MCC code at two times the rate of comparable hospitals or at least three percentage points of the entire patient population higher. A lower threshold could have been used and would result in higher damages. Additionally, Relator only considered claim groupings where there was less than a one-in-a-thousand chance that the difference in major complication rate at Baylor versus other hospitals was due to random causes.

108. Second, Relator's damage calculation is based on comparing Baylor to all other inpatient hospitals. To the extent other hospitals are engaging in the same fraudulent activity, it would make Baylor's actions seem relatively normal and would thus lead to a lower damage estimate.[31] Indeed it is

[31] As an example, the comparison set of hospitals includes Prime Healthcare Services, Inc., which is currently being sued by the US Department of Justice under the False Claims

overly conservative to compare Baylor's fraudulent behavior to other hospitals also engaging in the same fraudulent activity; therefore Relator also undertook a different methodology to identify hospital systems based on the amount of fraudulent activity they have among all of their claims. If Relator were to remove from comparison the top third of hospital systems identified to have excessively billed Medicare and re-run the bin-based regression analysis, damages would total $72 million.

109. Relator's consideration of other possible explanations, such as claim characteristics, patient characteristics, and doctor practices, demonstrates that the excessive coding of Misstated MCCs is due to system-wide practices in place at Baylor. Additionally, the extremely high levels of statistical significance of the analyses across a variety of comparative settings indicate a nearly impossible probability that the practices are due to random chance. Relator's damages estimate of $61.8 million due to Baylor's fraudulent upcoding is conservative and the estimate is robust when controlling for a variety of factors.

Act. *See* https://www.justice.gov/opa/pr/united-states-intervenes-false-claims-act-lawsuit-against-prime-healthcare-services-inc-and.

V. CAUSES OF ACTION

COUNT ONE
Violation of the Federal False Claims Act, 31 U.S.C. § 3729(a)
(Against All Defendants)

110. Relator repeats and realleges each and every allegation contained above as if fully set forth herein.

111. As described above, Defendants have submitted and/or caused to be submitted false or fraudulent claims to Medicare by falsifying material information concerning patient diagnoses, complications, and comorbidities; and by failing to report and return overpayments from Medicare within the required time period.

112. Defendants, by the conduct set forth herein, have violated:

a. 31 U.S.C. § 3729(a)(1)(A) by knowingly presenting, or causing to be presented, false or fraudulent claims for payment or approval; and/or

b. 31 U.S.C. § 3729(a)(1)(B) by knowingly making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim; and/or

c. 31 U.S.C. § 3729(a)(1)(G) by knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transit money or

> property to the government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the government.

113. The United States has suffered and continues to suffer damages as a direct proximate result of Defendants' false or fraudulent claims.

VI. PRAYER FOR RELIEF

WHEREFORE, Relator prays for relief and judgment, as follows:

(a) Defendants pay an amount equal to three times the amount of damages the United States has suffered because of Defendants' actions, plus a civil penalty against Defendants of not less than $10,957 and not more than $21,916 for each violation of 31 U.S.C. § 3729;

(b) Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3729(d);

(c) Relator be awarded all costs of this action, including attorneys' fees, expenses, and costs pursuant to 31 U.S.C. § 3730(d); and

(d) Relator and the United States be granted all such other relief as the Court deems just and proper.

VII. JURY TRIAL DEMANDED

Relator hereby demands a trial by jury.

DATED: August 7, 2018 Respectfully submitted,

/s/ P. Jason Collins
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Integra Med Analytics LLC

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS

Case No.: 17-CV-0886-DAE

UNITED STATES OF AMERICA, *ex rel.*
INTEGRA MED ANALYTICS LLC,

Plaintiff,

v.

1. BAYLOR SCOTT & WHITE HEALTH,
2. BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS,
3. HILLCREST BAPTIST MEDICAL CENTER,
4. SCOTT & WHITE HOSPITAL – ROUND ROCK,
5. SCOTT & WHITE MEMORIAL HOSPITAL – TEMPLE,

Defendants.

STIPULATION TO MAINTAIN CONFIDENTIALITY OF THE UNREDACTED SECOND AMENDED COMPLAINT FILED UNDER SEAL

STIPULATION TO MAINTAIN CONFIDENTIALITY OF THE UNREDACTED SECOND AMENDED COMPLAINT FILED UNDER SEAL

WHEREAS, on September 12, 2017, Integra Med Analytics, LLC ("Relator") initiated this action

under the False Claims Act, 31 U.S.C. § 3729, *et seq.,* by filing its Original Complaint under seal;

WHEREAS, Relator filed its First Amended Complaint under seal on April 19, 2018;

WHEREAS, on June 22, 2018, pursuant to the Court's docket text order of the same date, Relator filed its First Amended Complaint with potential personal identifying information redacted;

WHEREAS, on July 10, 2018, the Court unsealed the redacted First Amended Complaint and gave Relator authorization to serve the same on the Defendants in this action (see Dkt. No. 13);

WHEREAS, on August 7, 2018, the Relator filed a motion for leave to file its Second Amended Complaint under seal, and publicly file a version of the Second Amended Complaint with potential personal identifying information redacted ("Motion for Leave");

WHEREAS, on August 8, 2018, the Court granted the Motion for Leave;

WHEREAS, on August 8, 2018, Relator publicly filed its redacted Second Amended Complaint;

WHEREAS, on August 10, 2018, Relator filed the unredacted Second Amended Complaint under seal;

WHEREAS, Defendants Baylor Scott & White Health, Baylor University Medical Center – Dallas, Hillcrest Baptist Medical Center, Scott & White Hospital – Round Rock, and Scott & White

Memorial Hospital – Temple (collectively, the "Defendants") wish to receive the unredacted version of the Second Amended Complaint;

WHEREAS, the Relator and the Defendants wish to maintain the confidentiality of the potential personal identifying information in the unredacted Second Amended Complaint;

Now, therefore, Relator and the Defendants, by and through their respective counsel, hereby stipulate and agree that:

1. Relator will serve the Defendants with the unredacted version of the Second Amended Complaint;

2. Relator and the Defendants will maintain the confidentiality of the unredacted version of the Second Amended Complaint, and will not disclose the same other than to their respective counsel;

3. Relator and the Defendants will protect the potential personal identifying information redacted from the public version of the Second Amended Complaint in accordance with the Privacy Act of 1974 (5 U.S.C. § 522a), the Health Insurance Portability and Accountability Act of 1996 Privacy Rule (45 C.F.R. Parts 160 and 164), and any applicable state law.

IT IS SO STIPULATED

DATED: August 22, 2018

BY:

/s/ P. Jason Collins
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Counsel for Defendants Baylor Scott & White Health, Baylor University Medical Center – Dallas, Hillcrest Baptist Medical Center, Scott & White Hospital – Round Rock, and Scott & White Memorial Hospital – Temple

CERTIFICATE OF SERVICE

I hereby certify that, on August 22, 2018, the foregoing document was served on the United States in accordance with the Court's Order dated July 10, 2018.

/s/ P. Jason Collins
P. Jason Collins

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF TEXAS

Case No.: 17-CV-0886-DAE

UNITED STATES OF AMERICA, *ex rel.*
INTEGRA MED ANALYTICS LLC,

Plaintiff,

v.

1. BAYLOR SCOTT & WHITE HEALTH,
2. BAYLOR UNIVERSITY MEDICAL CENTER – DALLAS,
3. HILLCREST BAPTIST MEDICAL CENTER,
4. SCOTT & WHITE HOSPITAL – ROUND ROCK,
5. SCOTT & WHITE MEMORIAL HOSPITAL – TEMPLE,

Defendants.

ORDER GRANTING STIPULATION TO MAINTAIN CONFIDENTIALITY OF THE UNREDACTED SECOND AMENDED COMPLAINT

Upon consideration of the Stipulation to Maintain Confidentiality of the Unredacted Second Amended Complaint (the "Stipulation") agreed to by Integra Med Analytics LLC (the "Relator") and Defendants Baylor Scott & White Health, Baylor University Medical Center – Dallas, Hillcrest Baptist Medical Center, Scott & White Hospital –

Round Rock, and Scott & White Memorial Hospital – Temple (the "Defendants"),

IT IS HEREBY ORDERED that the Stipulation is granted:

1. Relator will serve the Defendants with the unredacted version of the Second Amended Complaint;

2. Relator and the Defendants will maintain the confidentiality of the unredacted version of the Second Amended Complaint, and will not disclose the same other than to their respective counsel;

3. Relator and the Defendants will protect the potential personal identifying information redacted from the public version of the Second Amended Complaint in accordance with the Privacy Act of 1974 (5 U.S.C. § 522a), the Health Insurance Portability and Accountability Act of 1996 Privacy Rule (45 C.F.R. Parts 160 and 164), and any applicable state law.

IT IS SO ORDERED

Signed this 23rd day of August, 2018

/s/ DAVID A EZRA
HON. DAVID A EZRA
UNITED STATES DISTRICT JUDGE