Whistleblower Defense Alert: Seventh Circuit's Latest Interpretation of Rule 9(b) Sets the Pleading Bar Higher for Relators

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Earlier this month, the United States Court of Appeals for the Seventh Circuit established a standard for application of Fed. R. Civ. P. 9(b) that significantly strengthens the bar imposed by the heightened pleading requirements of that rule. In *United States and the State of Wisconsin ex rel. Presser v. Acacia Mental Health Clinic, LLC*, Case No. 14-2804, 2016 U.S. App. LEXIS 16224 (7th Cir. Sep. 1, 2016), the court overturned the trial court's dismissal of claims under the False Claims Act (FCA) (and Wisconsin's own state False Claims Act, which has been repealed since the filing of the initial suit), but at the same time (1) rejected the relator's claims that did not provide the necessary "context" to support allegations of inappropriate medical treatment, and (2) rejected the relator's "personal estimation" and "subjective evaluation" as a basis for those allegations.

In *Presser*, the relator was an experienced nurse hired to work at Acacia, a freestanding mental health clinic. According to the relator, the defendant health center required patients to see four individuals—a receptionist, a medical nurse practitioner (who could not conduct medical examinations), a psychotherapist, and then a nurse practitioner—before they would be prescribed medication. *Id*. at *3. The relator claimed that patients incurred separate charges for the interactions with each individual. *Id*. The relator also claimed she was instructed to use an AMA billing procedure code (code 90801) for her work, which she claimed should be applied to full psychological assessments by therapists or psychiatrists, not services by receptionists and nurse practitioners. *Id*. at **3-4. Relator also alleged that patients were required to undergo mandatory urine drug screenings on each visit (which were billed), purportedly to determine whether patients were taking their medication; and that patients were required to come to the clinic in person to obtain a prescription refill or speak with a physician, and if they missed an appointment, the patient would be "discharged" and have to restart the assessment process before receiving additional treatment (resulting in additional billings). *Id*. at **4-5.

The relator asserted that these various practices resulted in "unnecessary medical billings," and provided examples of specific patients that she believed received unnecessary or unsupportable care. *Id*. at **6-7. In her complaint, she also offered her own "calculation," based on her experience and knowledge, as to what she felt the "appropriate annual revenue" would be for Acacia—a figure that was half of the clinic's actual revenue. *Id*. at *7. When relator complained, she was told that the clinic owner insisted on these billing practices, which she claimed demonstrated his knowledge of billings contrary to procedures for Medicare and Medicaid. *Id*.

The defendants moved to dismiss all of the relator's claims, asserting that she failed to plead her FCA claims with the particularity required by Rule 9(b), and that she failed to state a claim under Rule 12(b)(6). The district court agreed, holding that the relator failed to "identify with specificity *to whom* bills for Acacia's services were allegedly presented," and that the complaint only identified how patient bills were submitted, without any definitive allegation that "at least one patient's bill was submitted to the United States or the State of Wisconsin. *Id*. at *9.

On appeal, the Seventh Circuit quickly rejected the lower court's analysis that the relator did not comply with Rule 9(b)'s pleading requirements because she did not identify *to whom* the claims by the clinic were submitted. The Seventh Circuit noted that for purposes of the FCA—and as required by the heightened pleading standard of Rule 9(b)—a relator must ordinarily describe the "who, what, when, where, and how" of the fraud. *Id*. at *11. But, according to the court, the case law "establishes that a plaintiff does not need to present, or even include allegations about, a specific document or bill that the defendants submitted to the government. *Id*. at *14. Rather, a relator's complaint need only include "alleged facts [that] necessarily led one to the conclusion that the defendant had presented claims to the government." *Id*. at *15. Because Presser's allegations included claims that the clinic's patients were on Medicare and that the questionable procedures applied throughout the clinic, the inference of false claims presented to the government was sufficient to survive a motion to dismiss. *Id*.

The Seventh Circuit took a decidedly less generous approach to the complaint's description of the alleged fraudulent activity at the clinic, however. Initially, the court found that the relator's allegations regarding the use of billing code 90801—where she claimed that the code was routinely used by individuals who could not conduct such psychological assessments—was specific and clear, and sufficiently alleged that "the defendants misused a billing code and falsely represented to the state and federal governments that a certain treatment was given by certain medical staff when in fact it was not." *Id*. at *19.

But the Seventh Circuit rejected the remainder of the relator's claims challenging the propriety of the four-person evaluation process, mandatory drug screenings, and policies on prescription refills and appointments, which relator claimed sought reimbursement for services which "are not reasonable and necessary for the diagnosis or treatment of illness or injury," in violation of 42 U.S.C. § 1395y(a)(1)(A). In so doing, the court found that the relator had not provided the necessary "context" to support her allegations. Specifically, the court found that relator had provided "no medical, technical, or scientific context which would enable a reader of the complaint to understand why Acacia's alleged actions amount to unnecessary care forbidden by the statute." *Id*. at *19. The court went further, concluding that there could be "entirely innocent explanations" for the policies about which the relator complained, and that, without the context that explained just why these policies were "unusual" or inappropriate, there was not sufficient particularity to survive the requirements of Rule 9(b). *Id*. at *21.

Finally, the court concluded that relator's claim depended too much on her own "personal estimation" and analysis of the services in question to survive the pleading requirements of Rule 9(b):

> Not only does the lack of context make these allegations too indefinite, but each of the allegations depends entirely on Ms. Presser's personal estimation—an estimation that is not supported in any concrete manner. Many potential relators could claim that 'in my experience, this is not the way things are done.' However, relators may not be in a position to see the entire picture or may simply have a subjective disagreement with the other party on the most prudent course of action. Further, their perspective may be colored by considerable bias or self-interest, such as in the case of a disgruntled employee. The heightened possibility of mistake or bias supports the need for a higher standard of specificity for fraud compared to other civil litigation....Ms. Presser's subjective evaluation, standing alone, is not a sufficient basis for a fraud claim. *Id*. at **22-23.

The ramifications of the *Presser* decision, particularly for FCA defendants, are significant. In *Presser*, the Seventh Circuit has imbued the Rule 9(b) particularity requirements with powerful heft, particularly in the healthcare arena. Allegations that do not offer context to explain why particular billing or care practices are inappropriate or fraudulent may well fail under *Presser*. Perhaps even more significantly, the proscription against pleading based solely on an individual's "personal estimation" or "subjective evaluation" of the alleged wrongdoing of a provider or contractor will present a significant hurdle to most relators bringing claims under the FCA.

Indeed, Judge Hamilton's dissent in the *Presser* decision recognized that the court may be imposing a higher bar, which he claimed went "beyond the requirements of Rule 9(b)" and instead applied a pleading standard akin to that included in the Private Securities Litigation Reform Act. *Id*. at **28-29. In his view, given the vagaries of pleading in the FCA arena and in the post-*Iqbal* and post-*Twombly* universe, the "best approach is to let the plaintiff try her best, and then to be liberal in allowing amendments ('when justice so requires') once the court has indicated what is necessary." *Id*. at *33.

Judge Hamilton's concerns notwithstanding, with *Presser*, the Seventh Circuit has placed weighty hurdles in front of potential FCA relators, particularly those who would bring claims based on violations of various healthcare statutes and regulations (including the Stark Law and the Anti-Kickback Statute). The *Presser* decision provides ammunition for FCA defendants at the pleading stage, invigorates the heightened requirements of Rule 9(b), and—particularly if it gains traction with other circuits—may ultimately help healthcare providers and other Government contractors reduce the number of suits, or narrow the scope of the claims, they may face under the FCA.