IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NORTH DAKOTA

United States of America ex rel. Rafik Benaissa, Plaintiff, v. Trinity Health, Trinity Hospital, Trinity Kenmare Community Hospital, and Trinity Hospital - St. Joseph's, Defendants,	)	**ORDER GRANTING DEFENDANTS' MOTION TO DISMISS** Case No: 4:15-cv-159

Before the Court is the Defendants Trinity Health, Trinity Hospital, Trinity-St. Joseph's, and Trinity Kenmare Community Hospital's "Motion to Dismiss for Failure to State a Claim" filed on December 21, 2016. See Doc. No. 37. Rafik Benaissa, as relator, filed a response in opposition to the motion on January 30, 2017. See Doc. No. 39. The Defendants replied on February 10, 2017. See Doc. No. 40. For the reasons set forth below, the Defendants' motion is granted.

I. BACKGROUND

Dr. Rafik Benaissa filed this *qui tam* action against Trinity Health, Trinity Hospital, Trinity Kenmare Community Hospital, and Trinity Hospital – St. Joseph's,[1] and John Does 1-100 on November 6, 2015. See Doc. No. 3. On November 14, 2016, Dr. Benaissa filed an amended complaint.[2] See Doc. No. 34. In the amended complaint, Dr. Benaissa alleges Trinity Health

[1] Trinity Health, Trinity Hospital, Trinity Kenmare Community Hospital, and Trinity Hospital – St. Joseph's are collectively referred to as "Trinity Health."

[2] The amended complaint did not name John Does 1-100 as Defendants. See Doc. No. 34, p. 1.

violated the False Claims Act ("FCA") by submitting false and/or fraudulent claims to the United States. Specifically, Dr. Benaissa alleges violations of 31 U.S.C. §§ 3729(a)(1)(A), 3729(a)(1)(B), 3729(a)(1)(C), and 3729(a)(1)(G) as well as relief from retaliatory actions pursuant to 31 U.S.C. 3730(h) in eight separate causes of action. At the heart of Dr. Benaissa's amended complaint are allegations that Trinity Health violated Stark and Anti-Kickback statutes when Trinity Health over-compensated physicians based upon referrals, with physicians referring patients for and/or conducting unnecessary procedures. Additionally, the amended complaint alleges Trinity Health physicians 'upcoded' – a practice in which a physician bills at a higher than appropriate code level for patient consultations and receives a greater reimbursement through Medicare than the physician would have received billing at a lower code level. Dr. Benaissa also alleges Trinity Health terminated him in retaliation for challenging Trinity Health's compensation system.

Dr. Benaissa brought this action as a relator, in the name of the United States. See 31 U.S.C. § 3730(b)(1). After receipt of a relator's complaint, the United States may elect to intervene and proceed with the action. 31 U.S.C. § 3730(b)(2). The United States declined to intervene in this action on July 12, 2016. See Doc. No. 15. Consequently, Dr. Benaissa now has the "right to conduct the action," subject to the United States reserved right "to order any deposition transcripts, to intervene in this action, for good cause, at a later date, and if, appropriate, to seek the dismissal of the relator's action . . . ." See Doc. No. 15, p. 2.

In the amended complaint, Dr. Benaissa alleges Trinity Health violated the Stark statute and Anti-Kickback statute. Specifically, Benaissa alleges "Trinity Health has engaged in a scheme to pay improper compensation to physicians to induce them illegally to refer patients, including Medicare, Medicaid, and TriCare patients, to Trinity Health hospitals and clinics for inpatient,

outpatient, and ancillary services." See Doc. No. 34, p. 2. Benaissa continues his description of the scheme that violates Stark and Anti-Kickback statutes:

> 22. Physicians with whom Trinity Health has entered into illegal financial relationships refer large volumes of patients, including Medicare and Medicaid patients to Trinity hospitals and clinics in violation of federal law. Trinity has and continues to submit false or fraudulent claims based on these referrals to the United States to obtain millions of dollars in Medicare, Medicaid, and TriCare payments that they were not legally entitled to receive.
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> 23. By way of introduction, the department of surgery and the related surgical disciplines in most community hospitals are responsible for substantial annual profit margins generated by the hospital. That fact is true at Trinity Health. Revenues from perioperative services or ancillary revenues related to surgical procedures account for a major portion of annual profits at Trinity Health.
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> 24. Trinity Health has recruited and employed surgeons with a focus on employing certain surgical specialists who are more profitable in producing ancillary hospital revenues for perioperative services. Such specialties include orthopedic surgery and interventional cardiology.
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> 25. In violation of federal *Stark* laws, Trinity Health has induced and financially rewarded certain employed surgeons based on the volume and value of referrals for surgical procedures and perioperative services such surgeons generate for the hospital system. Trinity Health continued this profiteering scheme even with knowledge that employed surgeons were ordering unnecessary hospital admissions or outpatient visits and performing unnecessary surgeries on patients covered under federal healthcare programs such as Medicare and TriCare. The scheme at Trinity Health represents major violations of federal *Stark* laws and a major threat to the safety and health of patients.
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> 26. Trinity Health's scheme to over-compensate employed physicians based on referrals is not limited to surgeons, but extends to other clinicians with substantial referrals to Trinity hospitals and clinics. Trinity Health has compensated their employed physicians at levels to generate massive losses over the last 6 years. Such losses have been more than offset by the revenues from referrals by employed physicians being over-compensated.

See Doc. No. 34, pp. 6-7.

In sum, Dr. Benaissa alleges Trinity's fraudulent scheme rewards physicians for referrals and results in physicians conducting unnecessary surgeries. In the amended complaint, Dr.

Benaissa includes allegations specific to five patients. See Doc. No. 34, pp. 8-11. Dr. Benaissa alleges that in February of 2012, another orthopedic surgeon, Dr. Ravindra Joshi, interfered with Dr. Benaissa's treatment of a patient when Dr. Joshi took the patient back to surgery for "another irrigation debridement and supposed 'adjustment' of the external fixator." Id. at 8. According to Dr. Benaissa, "the surgery was not indicated as the patient had already received three irrigations and debridements." Id. The amended complaint also alleges Dr. Joshi and Dr. Benaissa disagreed about the treatment of an elderly Medicare patient who had recently undergone cardiac bypass and had a minimally displaced shoulder fracture. Id. at 10. Dr. Benaissa alleges he was part of a meeting discussing the death of a patient who had undergone hip fracture surgery in December 2014. Id. Dr. Benaissa alleges facts specific to a fourth patient, an elderly Medicare patient with a non-displaced fracture of the humerus. According to the amended complaint, Dr. Benaissa recommended conservative treatment, but Dr. Joshi performed a shoulder surgical fixation, which failed, and a subsequent shoulder replacement, that similarly failed. Id. at 11. Last, Dr. Benaissa describes Dr. Joshi's care of a worker's compensation patient who suffered a "segmental femur fracture." Id. Dr. Benaissa alleges these types of fractures are usually treated with a reamed nail, but Dr. Joshi did an open reduction, added cables, and performed a bone graft. Dr. Joshi's treatment increased the chances of the patient developing complications. Id.

Dr. Benaissa's amended complaint includes allegations he notified Trinity Health executives of his concerns about unnecessary surgeries and was eventually terminated as a result. Id. at 7. Dr. Benaissa alleges he discussed Dr. Joshi's unnecessary surgeries with supervising physicians on several occasions, only to be rebuffed or threatened. Id. at 10-13. Dr. Benaissa's amended complaint also contains allegations that a number of other individuals communicated to Dr. Benaissa their thoughts that Dr. Joshi's surgeries were unnecessary, contrary to the standard

of care, disturbing, or concerning. Dr. Benaissa specifically alleges he received a letter from Dr. Joshi's full-time nurse that stated:

> "His unnecessary surgeries really concerned me as I finally brought it up to him." "He would see a patient and an assessment and MRI would be done, and they would simply tell us nurses he does not see anything wrong with this patient, however he told us that he wanted to schedule surgery as soon as possible on them because they are in pain." "As I confronted him he did not respond and I believe that he thought I knew too much information, and wanted to get rid of me." "Recently he has done a couple of 'unnecessary' surgeries and the patients have died." "The work environment became very hostile as I would get pulled behind closed doors and reprimanded for not meeting his quota for the day with patients or having enough surgeries scheduled during the week." "Trinity and the DON [Department of Nursing] simply covered up all his mistakes and let them go."

See Doc. No. 34, p. 15. According to the amended complaint, Dr. Joshi's nurse was fired when she raised her concerns regarding Dr. Joshi's surgeries to Trinity Health's administration. Id. at 16.

As a second issue, Dr. Benaissa alleges Trinity Health physicians engaged in "upcoding" by billing at a level five for patient consults, when billing at a lower level would have been more appropriate, causing Trinity Health to receive a greater reimbursement through Medicare compared to the reimbursement Trinity Health would have received had Dr. Joshi billed at a lower level. Id. at 17. Trinity's Chief of Surgery, Dr. Kindy, monitored the codes/levels at which physicians sought reimbursement through Medicare. Dr. Benaissa alleges that Dr. Kindy pressured Dr. Benaissa to up-code his consultations from a level two to at least a level three to receive greater reimbursement through Medicare. Id. Dr. Benaissa alleges Trinity Health terminated him as a result of his actions challenging the compensation scheme, namely questioning Dr. Joshi's unnecessary surgeries. Id. 20-21.

Trinity Health filed this motion to dismiss pursuant to Rules 8(a), 9(b), and 12(b)(6) on December 21, 2016. See Doc. No. 37. Trinity Health asserts Dr. Benaissa's amended complaint

fails to plead specific, particularized facts in accordance with Rule 8 and 9(b) of the Federal Rules of Civil Procedure to support the allegation Trinity Health violated the FCA by submitting false and/or fraudulent claims to the United States. Dr. Benaissa disagrees and contends the amended complaint outlines details of Trinity Health's fraud, identifying unlawful payments, the parties who received them, and the time periods of the unlawful payments sufficiently to satisfy the contours of Rules 8 and 9(b).

II. STANDARD OF REVIEW

Trinity Health moves to dismiss the amended complaint pursuant to Rules 12(b)(6), 9(b), and 8(a) of the Federal Rules of Civil Procedure. To survive a motion to dismiss, a pleading must provide "a short and plain statement of the claim that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). The purpose of this requirement is to "give the defendant fair notice of what the . . . claim is and the grounds upon which it rests." Erickson v. Pardus, 551 U.S. 89, 93 (2007) (quoting Bell Atl. Corp. v. Twombly, 550 U.S. 544, 555 (2007)). When ruling on motions under either Rule 12(b)(6) or Rule 9(b), the Court accepts the factual allegations in the complaint as true, drawing all reasonable inferences in favor of Dr. Benaissa, as the non-moving party. Drobnak v. Anderson Corp., 561 F.3d 778, 781 (8th Cir. 2008).

Rule 12(b)(6) of the Federal Rules of Civil Procedure mandates the dismissal of a claim if there has been a failure to state a claim upon which relief can be granted. To survive a motion to dismiss under Rule 12(b)(6), "a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." Ashcroft v. Iqbal, 556 U.S. 662, 678 (2009). A plaintiff must show that success on the merits is more than a "sheer possibility." Id. A complaint is sufficient if its "factual content . . . allows the court to draw the reasonable inference that the

defendant is liable for the misconduct alleged." Id. The court need not accept legal conclusions or "formulaic recitation of the elements of a cause of action" in the complaint as true. Id. at 681. A complaint does not "suffice if it tenders a naked assertion devoid of further factual enhancement." Ashcroft, 556 U.S. at 678 (2009). The determination of whether a complaint states a claim upon which relief can be granted is "a context-specific task that requires the reviewing court to draw on its judicial experience and common sense." Id. at 679. Dismissal will not be granted unless it appears beyond doubt the plaintiff can prove no set of facts entitling the plaintiff to relief. Ulrich v. Pope Cnty, 715 F.3d 1054, 1058 (8th Cir. 2013).

"Because the FCA is an anti-fraud statute, complaints alleging violations of the FCA must comply with Rule 9(b)." United States ex rel. Joshi v. St. Luke's Hospital, Inc., 441 F.3d. 552, 556 (8th Cir. 2006). "Rule 9(b)'s 'particularity requirement demands a higher degree of notice than that required for other claims,' and 'is intended to enable the defendant to respond specifically and quickly to the potentially damaging allegations.'" Id. (quoting United States ex rel. Costner v. URS Consultants, Inc., 317 F.3d 883, 888 (8th Cir. 2003)). When determining whether a complaint complies with Rule 9(b), the Court must consider whether the complaint states "with particularity the circumstances constituting fraud or mistake." Fed. R. Civ. P. 9(b). A plaintiff must plead such matters as the time, place and contents of the allegedly false representations, as well as the identity of the person making the representations and what was obtained or given up. Schaller Tel. Co. v. Golden Sky Systems, Inc., 298 F.3d 736, 746 (8th Cir. 2002). "Conclusory allegations that a defendant's conduct was fraudulent and deceptive are not sufficient" to satisfy Rule 9(b). Id. (quoting Commercial Prop. v. Quality Inns, 61 F.3d 639, 644 (8th Cir. 1995)).

III. LEGAL DISCUSSION

In the motion to dismiss, Trinity Health contends Dr. Benaissa's amended complaint should be dismissed because he has failed to plead specific, particularized facts to support the allegations Trinity Health defrauded federal healthcare programs in violation of the FCA. In response to the motion, Dr. Benaissa contends the amended complaint sufficiently states a claim upon which relief can be granted and satisfies Rule 9(b) by stating with particularity the circumstances constituting Trinity Health's violations of the FCA. The Court begins its analysis of whether the amended complaint satisfies Rules 8 and 9(b) by looking to to the False Claims Act and Anti-Kickback and Stark statutes.

A. Anti-Kickback and Stark Statutes and the False Claims Act

Dr. Benaissa alleges Trinity Health violated the Anti-Kickback and Stark statutes by excessively compensating physicians in exchange for referrals for surgical procedures and engaging in upcoding. The Anti-Kickback statute ("AKS") imposes criminal liability on a defendant who "knowingly or willfully solicits or receives any remuneration" (such as a kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, "in return for referring an individual to a person for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program." 42 U.S.C. § 1320a-7b(b)(1). In addition, AKS imposes criminal liability on a defendant who "knowingly and willfully offers or pays any remuneration directly or indirectly, overtly or covertly, in cash or in kind" for a referral. 42 U.S.C. § 1320a-7b(b)(2). In 2010, Congress amended the AKS to explicitly state that "a claim that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim" under the False Claims Act. 42 U.S.C. § 1320a-7b(g).

B. Particularity Requirement of Rule 9(b)

In most cases detailed factual alle ations are not necessary to satisfy the Rule pleadin standard. Bell Atl. Corp. . T ombly 550 U.S. 544 555 (2007) e er a complaint alle in