22-0530-cv

United States Court of Appeals

for the

Second Circuit

JANE DOE 1, JANE DOE 2, SW CHALLENGER, LLC,

Plaintiffs-Appellants,

ABC, STATE OF TENNESSEE, STATE OF FLORIDA, STATE OF TEXAS, STATE OF NEW JERSEY, STATE OF ILLINOIS, STATE OF NORTH CAROLINA, STATE OF CONNECTICUT, STATE OF LOUISIANA, STATE OF NEW YORK, STATE OF NEW MEXICO, STATE OF ALASKA, STATE OF OKLAHOMA, STATE OF MONTANA, STATE OF CALIFORNIA, STATE OF MICHIGAN, STATE OF WASHINGTON, UNITED STATES OF AMERICA EX REL. SW CHALLENGER, LLC,

Plaintiffs,

– v. –

EVICORE HEALTHCARE MSI, LLC.,

Defendant-Appellee,

DEF, WELLCARE HEALTH PLANS INC.,

Defendants.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF NEW YORK

REPLY BRIEF FOR PLAINTIFFS-APPELLANTS

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INTRODUCTION

As shown in their opening brief, Plaintiffs sufficiently pled that eviCore violated the False Claims Act ("FCA") when it deceived Government intermediaries into believing eviCore was conducting the medical necessity reviews and making the individualized determinations its contracts required even though, in order to save money, it intentionally was not doing so. eviCore was hired to review *all* claims to ensure only those entitled to reimbursement by Medicare were approved—not just to review some claims. Plaintiffs set forth detailed facts describing this scheme and sufficiently alleged violations of the FCA.

eviCore is subject to liability both for its failure to perform the individualized medical necessity reviews it was hired to perform, and for the resulting unnecessary Medicare reimbursements. Indeed, the very purpose of eviCore's services was to ensure that Medicare was not billed for unnecessary services. It is thus eminently reasonable to infer that eviCore's failure to perform individualized medical necessity reviews would result in unnecessary services being submitted to Medicare—and Plaintiffs alleged specific examples of how that occurred. Because of their

positions at eviCore, Plaintiffs did not have access to copies of eviCore's agreements, but they were generally familiar with their contents. Similarly, Plaintiffs would not have had access to the claims for Medicare reimbursements that were submitted as those claims would have been submitted by the physicians themselves. Courts have recognized under such circumstances that a complaint will not fail under Federal Rule of Civil Procedure 9(b) simply because certain evidence is only in the hands of the Defendant—provided the scheme is sufficiently described, as it was in this case.

The decision below should thus be reversed. Among other errors, the district court misapplied (i) the "worthless services" standard with its conclusion that services under a contract must be uniformly worthless to state an FCA claim (Br. 39-44); and (ii) the Rule 9(b) pleading standard by requiring that Plaintiffs provide, at the outset of the case, unnecessary details about invoices to which they had no access (Br. 44-51).[1]

[1] "Br." denotes references to the Brief for Plaintiffs-Appellants (ECF No. 51). "Opp." denotes references to the Brief for Defendant-Appellee (ECF No. 67). Unless otherwise noted, this reply brief adopts the shorthand terms and abbreviations employed in Plaintiffs' opening brief.

Unable to defend the decision below on the merits, eviCore's response is to avoid the point and muddy the waters. eviCore wrongly asserts that Plaintiffs' decision to seek an appeal rather than amending their already sufficient complaint should count against them here, or that Plaintiffs somehow waived theories of liability which appear in the complaint and were argued below. ARGUMENT Part I.A, *infra*. It defends the district court's worthless services ruling through misdirection. Plaintiffs' claim is that eviCore was contracted to perform medical necessity reviews, but instead auto-approved vast swaths of claims, yet eviCore insists that the Court should adopt a standard suited to a claim alleging eviCore performed the required individualized medical necessity reviews negligently. ARGUMENT Part I.B., *infra*. What is more, eviCore tries to hide the infirmity of the district court's conclusion about the pleading standard with the rank speculation that, because Plaintiffs were clinical reviewers, they therefore *must* have had access to eviCore's contracts with MCOs. ARGUMENT Part II, *infra*.

What is lacking in eviCore's sundry arguments is any substantive, sound reason for sustaining the flawed decision below. Thus, for the

reasons set forth in the opening brief and as detailed below, this Court should reverse the district court's dismissal of the complaint.

ARGUMENT

I. EVICORE FAILS TO DISTURB THE CONCLUSION THAT THE COMPLAINT SUFFICIENTLY PLEADS FALSE OR FRAUDULENT CLAIMS

As Plaintiffs showed in their opening brief, the complaint alleges facts that satisfy the false or fraudulent claim submission element of the FCA under several different theories. Br. 34-39. These theories all flow from the same conduct: eviCore's systematic failure to perform medical necessity reviews it was contracted to perform. Br. 18 (citing A-156-59 (¶¶ 99-112), A-159-62 (¶¶ 113-123)). eviCore offers no argument, on procedure or substance, to disturb this conclusion.

A. eviCore's Procedural Arguments Are Unavailing

eviCore advances a pair of procedural arguments, neither of which avail it. *First*, eviCore maintains that Plaintiffs' decision not to replead implies that their complaint's allegations were legally insufficient. *See* Opp. 32-34. That negative inference misfires. Because Plaintiffs "believe [their claims were] … adequately pled in the [complaint]," they are "fully entitled to stand on the allegations of the [complaint], and to appeal the dismissal of that claim … rather than to attempt to replead … to the

district court." *United States ex rel. Chorches v. Am. Med. Response, Inc.*, 865 F.3d 71, 95 (2d Cir. 2017).

Second, eviCore's waiver argument also falls flat. *See* Opp. 46-49. eviCore appears to claim that Plaintiffs did not present their false claims submission theories below. Opp. 46 (eviCore asserting Plaintiffs presented theories "*for the first time on appeal*"); Opp. 49 (eviCore chiding that it is not "proper to raise these issues for the first time in this appeal"). That contention is meritless: the same theories of liability that Plaintiffs present now were alleged in the complaint and argued below. *Compare* Br. 35-39 (presenting liability theories) *with* Pls.' Mem. of Law in Opp. to Def. eviCore's Mot. to Dismiss Realtors' Second Am. Compl. (S.D.N.Y. ECF No. 31) ("Pls.' MTD Opp.") at 31 ("[I]f eviCore misrepresents that it is providing appropriate clinical review of claims when, in fact, it is not, then MCOs are (1) paying Government healthcare funds for potentially unnecessary medical services (SAC ¶ 111) (discussing autoapproval of 200 physical therapy sessions for a simple ankle sprain), and (2) paying Government healthcare funds to eviCore to

provide utilization services that are not being rendered.")[2]; *and*, *e.g.*, A-118 (¶ 121) ("eviCore made false or fraudulent records or statements underlying the false claims to its client MCOs … knowing that the auto-approval process violated federal laws[ ] … [and] the worthless services rendered as a result of the auto-approval process would be material to the payment decision of the Government in regards to whether it would continue to contract with and pay its MCOs.").[3]

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[2] *See also* Pls.' MTD Opp. at 8 ("EviCore is obligated to perform functions under the Medicare Integrity Program, 42 U.S.C. § 1395kk-1(a), which include any or all program integrity functions described in 42 C.F.R. § 421.304, such as '[c]onducting medical reviews, utilization reviews, and reviews of potential fraud related to activities of providers of services,' and '[a]uditing, settling and determining cost report payments for providers of services, or other individuals or entities … as necessary to help ensure proper Medicare payment.' … Relators' claims are based not on eviCore's deficient prior authorization program but, rather, on the fraudulent claims for reimbursement that eviCore submitted to MCOs for worthless services in exchange for Government money. *E.g.*, SAC ¶ 133. Relators allege that eviCore fraudulently certified that worthless services were medically necessary in order to receive Government money, and the statute that eviCore caused to be violated is the FCA. *E.g.*, SAC ¶¶ 21, 32-35, 87, 131-33, 168-72.").

[3] *See also* A-164 (¶ 133) ("As a result of eviCore's fraudulent conduct, CMS and the Qui Tam States have been paying and continue to pay millions of dollars annually for worthless medical review services which were and are not medically appropriate. At the very least, Defendant eviCore should be disgorged of the Government payments it has fraudulently received through its sub-contracts with MCOs."); A-154 (¶ 87) ("The various schemes described herein, under which eviCore

Demonstrating the hollowness of its waiver argument, eviCore even acknowledges that the liability theories it now maintains were waived were, in fact, argued below. Opp. 47 ("the District Court *did* consider whether the SAC alleged false claims based on the submission of bills for medically unnecessary treatment"); Opp. 48 ("Relators' second theory [of false claim submission, that] … eviCore bills for medical necessity reviews not performed … appears to simply rephrase Relators' 'worthless services' claim."). eviCore's brief in support of its motion to dismiss below tells the same story. Mem. of Law in Support of eviCore's Mot. to Dismiss Relators' Second Am. Compl. (S.D.N.Y. ECF No. 22) at 12 ("Relators' theory of 'falsity' relies on [purportedly] unspecified contractual and regulatory violations, *or* allegations with [purportedly] no factual support that eviCore provided 'worthless services' to health plans.") (emphasis

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provided prior authorization for services in certain cases with no review at all, not only violated eviCore's own internal policies and procedures, but, more importantly, resulted in the submission of false claims for payment of services as eviCore was providing worthless services of no value as a subcontractor on a Government-contract."); A-170-71 (¶ 171) (alleging eviCore knew it was submitting false claims because of the "worthless services it was rendering as a result of its auto-approval process, and because, as utilization review manager for its insurer clients, eviCore was obligated by contract as well as under federal regulations to undertake a proper medical review of each case before it.").

added). For eviCore to now claim these theories are waived is thus a non-starter.

To be sure, Plaintiffs' theories on falsity all flow from eviCore's underlying conduct of systemically failing to conduct contracted-for medical necessity reviews—*i.e.*, eviCore's worthless services—and Plaintiffs responded to eviCore's defense of its worthless services below. *See* Pls.' MTD Opp. at 11 (refuting "eviCore['s] argue[ment] that if it provides some services correctly and some fraudulently, then it has not performed 'worthless services' because some of the services had, in fact, a measure of worth."). But Plaintiffs did not abandon or waive any particular theory of liability flowing from this conduct merely by the manner they responded to eviCore's motion to dismiss below. *See Manza v. Newhard*, 470 F. App'x 6, 11 n.3 (2d Cir. 2012) (plaintiff's theory was "evident from the complaint, and so we do not view his failure to respond to defendants' very cursory discussion of the issue in their motion to dismiss as a waiver") (citing *N.J. Carpenters Pension & Annuity Funds v. Biogen IDEC Inc.*, 537 F.3d 35, 54 (1st Cir. 2008)).

* * *

At bottom, eviCore's insistence on advancing untenable procedural arguments simply highlights that the decision below is indefensible. Plaintiffs showed, and eviCore does not refute, that the complaint states a classic FCA violation on several grounds, with specific allegations of eviCore's worthless auto-approval services, and that the district court erred in holding that merely because *some* of eviCore's services had *some* value, no FCA violation was possible. Br. 39.

B. eviCore Fails to Disturb the Conclusion That the District Court Improperly Dismissed the Complaint Based on an Erroneous Construction of the Worthless Services Standard

As Plaintiffs showed, the district court dismissed the complaint because it misread this Court's precedent in *Mikes v. Straus*, 274 F.3d 687 (2d Cir. 2001), as holding that a party is not liable under the FCA for providing worthless services unless *all* of the services it provides under a contract are uniformly worthless. Br. 39-44. In *Mikes*, this Court held, on appeal from summary judgment, that there was insufficient evidence to create a triable issue that the defendants knew that certain spirometry tests, which were performed, were medically worthless. Br. 39-40 (citing *Mikes*, 274 F.3d at 703-04). Here, in contrast, eviCore was contracted to provide "individualized determinations based on Medicare's coverage

rules," but did not do so—instead, it instituted swinging-gate auto-approvals on a systematic basis. Br. 37 (citing 42 C.F.R. § 422.566(d); *United States ex rel. Nedza v. Am. Imaging Mgmt.*, No. 15 C 6937, 2020 WL 1469448, at * 8, 2020 U.S. Dist. LEXIS 52415, at *30 (N.D. Ill. Mar. 26, 2020)); Br. 15-23. The district court thus erred in concluding that "no false claim had been submitted because 'eviCore provided *some* legitimate prior authorization and utilization management services.'" Br. 27 (quoting A-246). That eviCore needed to provide individual medical necessity determinations which it did not, in fact, perform sufficiently states an FCA claim. Br. 41-44 (citing, *e.g.*, *United States ex rel. Spay v. CVS Caremark Corp.*, 913 F. Supp. 2d 125, 160-65 (E.D. Pa. 2012)).

eviCore largely fails to engage with this argument. *See* Opp. 34-45. Its cited cases (Br. 36-37) confirm that the bundling theory it again advances stems from cases in which the "quality of care" is challenged, in circumstances where it would be impossible to disaggregate the allegedly poor-quality care from other valuable services performed. *United States v. Dialysis Clinic, Inc.*, No. 5:09-CV-00710 (NAM/DEP), 2011 WL 167246, at *21, 2011 U.S. Dist. LEXIS 4862, at *62 (N.D.N.Y. Jan. 19, 2011)

("Plaintiff does not allege that defendant failed to provide any services to their patients. Rather, plaintiff challenges the quality of care arguing that defendant's services did not conform with the guidelines set forth in 42 C.F.R. § 494. This allegation is not the 'equivalent of no performance at all' and thus, does not fit within the worthless services category.") (citing cases); *Sweeney v. ManorCare Health Servs., Inc.*, No. C03-5320RJB, 2005 WL 4030950, at *6, 2005 U.S. Dist. LEXIS 45216 (W.D. Wash. Mar. 4, 2005) ("The Court agrees … that it would be impossible to determine whether particular services provided were worthless without finding that the care as a whole was worthless."). In contrast here, Plaintiffs' claim is that eviCore needed to make individualized determinations based on Medicare's coverage rules, but it did not do so. Br. 15-23, 39; 42 C.F.R. § 422.566(d); *Nedza*, 2020 WL 1469448, at *8, 2020 U.S. Dist. LEXIS 52415, at *30.

eviCore thus misplaces reliance (Opp. 39-43) on the nursing home FCA cases *United States ex rel. Absher v. Momence Meadows Nursing Ctr., Inc.*, 764 F.3d 699, 709 (7th Cir. 2014), and *United States ex rel. Swan v. Covenant Care*, 279 F. Supp. 2d 1212 (E.D. Cal. 2002). In those cases, the relators alleged, in essence, that the defendant nursing home

operators had failed to meet a minimum statutory standard of care. *See Absher*, 764 F.3d at 709 ("The relators' arguments to the jury were primarily focused on the theory that Momence violated the FCA by providing woefully inadequate care to the facility's residents."); *Swan*, 279 F. Supp. 2d at 125 (relators "generally allege that Covenant Care fails to meet the minimum statutory quality of care requirements for participation in federal Medicare and Medicaid programs"). Unlike those cases, here Plaintiffs alleged that eviCore was contracted to perform a medical necessity review at to *each* claim, but systematically failed to do so. Br. 41-44; *cf. Luckey v. Baxter Healthcare Corp.*, 183 F.3d 730, 732 (7th Cir. 1999) (distinguishing between "ineffective testing" and "no testing" in FCA context).[4]

Straining to distinguish *Chesbrough v. VPA. P.C.*, 655 F.3d 461 (6th Cir. 2011), eviCore is forced to concede that, as Plaintiffs stated, the nondiagnostic x-rays "*could* constitute 'worthless services' if such tests

[4] Likewise, eviCore fails to refute Plaintiffs' point that because "Plaintiffs' allegations [are] that eviCore failed to provide contracted-for pre-authorization medical necessity reviews," it was inappropriate for the district court to apply decisions going to medical providers' quality of care ex post. Br. 43; *see* Opp. 43-45 (eviCore's response, which draws irrelevant distinction but fails to engage the point).

had no medical value[]" (Opp. 41 (quoting *Chesbrough*, 655 F.3d at 468)), irrespective of the fact other tests may have been submitted. *See* Br. 41-42. So, too, with *United States v. Houser*, 754 F.3d 1335 (11th Cir. 2014), which—as eviCore concedes (Opp. 4243)—upheld liability on a worthless services theory where, despite the provision of *some* services, certain services "including those mandated by statute, were not provided to residents at all." *Houser*, 754 F.3d at 1347. This holding fits the facts here because eviCore, despite being required by the governing regulations to perform individualized medical necessity reviews, failed to do so. Br. 39-44.

eviCore similarly engages in misdirection about Plaintiffs' claims when it asserts that the decision below should be affirmed because Plaintiffs do "not even identify a single example of an 'auto-approved' prior authorization request that should have been denied because it was medically unnecessary." Opp. 38. Plaintiffs' FCA claim is that eviCore falsely represented that it was providing individualized pre-authorization medical necessity determinations. That some auto-approved claims *may* have turned out to be justified, had they been properly examined, is irrelevant. It is as if eviCore were a security guard

excusing sleeping on the job by asserting that some of the people who entered the building while he was slumbering actually had permission to enter.

When all of its dodges are stripped away, eviCore is left with an untenable argument that—despite regulations in place demanding individual pre-authorization medical necessity reviews—Plaintiffs can state an FCA claim only by proving on the pleadings that "*all* prior authorization services performed by eviCore were 'worthless[.]'" Opp. 38. That is not, and never has been, the law.

II. EVICORE FAILS TO DISTURB THE CONCLUSION THAT THE COMPLAINT SATISFIES RULE 9(b)

As Plaintiffs showed, the complaint satisfies Rule 9(b) because Plaintiffs alleged specific facts detailing eviCore's scheme of auto-approving treatment requests without performing the medical necessity review required by the governing regulations and eviCore's contracts—this scheme inevitably led to the submission of many false claims, yet the details of those claims (e.g., the invoices and eviCore's contracts with MCOs offering MA plans) are "peculiarly within eviCore's knowledge." Br. 45 (quoting *Chorches*, 865 F.3d at 86); *see also*, *e.g.*, *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153, 155-56 (3d Cir. 2014) (collecting

cases and rejecting argument that relator must plead specific false claims where scheme is alleged). The district court's contrary conclusion is infirm because, among other things, it unreasonably demanded unnecessary details about individual claims to which Plaintiffs were not privy. Br. 45-51.

eviCore's arguments do not cure the district court's error. It makes much of the absence of allegations in the complaint about invoice submissions (Opp. 22-24), but it does not even try to refute the substantive point that Plaintiffs have alleged an overarching scheme that inexorably led to the submission of many false claims. Br. 47-48 (citing, *e.g., United States ex rel. Lusby v. Rolls-Royce Corp.*, 570 F.3d 849, 854 (7th Cir. 2009) (rejecting argument that FCA plaintiff should have to "produce the invoices (and accompanying representations) at the outset of the suit"). Likewise, eviCore cannot salvage the decision below by contending that Plaintiffs do not "identify … any specific rule that eviCore allegedly violated when approving [a] … treatment request," Opp. 25, because Plaintiffs' claim is that eviCore violated *regulations* requiring it to make individualized medical necessity determinations in approving treatment requests. Br. 10-23.

No more persuasive is eviCore's defense (Opp. 28-32) of the district court's erroneous application of the *Chorches* pleading requirement that information that particulars about the claims submitted be "peculiarly within the opposing party's knowledge." *Chorches*, 865 F.3d at 86. eviCore's tortured logic rests on the shaky premise that because Plaintiffs were clinical reviewers, they therefore *must* have had access to eviCore's contracts with MCO's and invoices. *See* Opp. 29-32 (arguing, *inter alia*, that it is "implausible" that Plaintiffs, as "clinical reviewers tasked with both following rules established by the MCOs and with developing and improving review guidelines for prior authorization determinations, would not have access to the specific facts they would need to allege regarding their claims."). This premise is false, and eviCore cannot firm it up by citing cases in which, unlike here, the relators pled themselves out of court because their allegations demonstrated that they, in fact, *had* access to the claims at issue but had failed to provide any specific information. *See* Opp. 32 (citing *United States ex rel. O'Toole v. Cmty. Living Corp.*, No. 17 Civ. 4007 (KPF), 2020 WL 2512099, at *9, 2020 U.S. Dist. LEXIS 85443, at *27 (S.D.N.Y. May 14, 2020) (complaint made clear that relator had access to defendant's "records and documents and was

privy to detailed information regarding [its] operations," had access to program documentation, and had himself been asked to fraudulently initial checklists)).

Otherwise, all that remains of eviCore's defense of the judgment below is its tortured, fact-specific justification of its auto-approval procedures. For example, it characterizes certain auto-approvals as "approve as requested" because clients supposedly directed it to wave through certain categories of claims. Opp. 28; *see also* Opp. 37 (eviCore justifying various categories of auto-approval; e.g., "approvals for the specific plan Blue Cross Blue Shield of Texas were limited to '*pediatric* treatment requests' due to 'provider noise') (quoting A-246). It is questionable if such a "fraud-on-demand" or "sanctioned-fraud" practice could legitimate eviCore's knowing failure to provide the requisite individualized medical necessity reviews. Undoubtedly, though, such a factual inquiry is properly resolved at the summary judgment or trial stage, not the Rule 12(b)(6) stage. *E.g.*, *Financial Guar. Ins. Co. v. Putnam Advisory Co.*, 783 F.3d 395, 405 (2d Cir. 2015) (resolution of fact dispute inappropriate on motion to dismiss).

CONCLUSION

For the foregoing reasons and those set forth in Plaintiffs' opening brief, the district court's judgment should be reversed.

Dated: October 28, 2022

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), the undersigned hereby certifies that:

1. This reply brief complies with the type-volume limitations prescribed in Federal Rule of Appellate Procedure 32(a)(7)(B). As measured by the word processing system used to prepare this brief, Microsoft Word 2019, there are 3,480 words in the brief, exclusive of items listed in Federal Rule of Appellate Procedure 32(f).

2. This reply brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5)(A) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because the brief has been prepared in a proportionally spaced typeface (14 point Century Schoolbook) using Microsoft Word 2019.

Dated: October 28, 2022

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