UNITED STATES DISTRICT COURT

DISTRICT OF NEVADA

United States of America ex rel. Tali Arik,

Plaintiff

v.

DVH Hospital Alliance, LLC, et al.,

Defendants

Case No.: 2:19-cv-01560-JAD-VCF

Order Granting Motions to Dismiss and Leave to Amend; Denying Motion to Extend Deadline

[ECF Nos. 69, 70, 72, 86, 94]

Relator Tali Arik brings this qui tam suit under the False Claims Act (FCA) against defendant DVH Hospital Alliance, LLC; Valley Health Systems LLC; Universal Health Services, Inc.; Vista Health Mirza, M.D. P.C.; and hospitalist Irfan Mirza, claiming that they conspired to defraud the federal government by seeking reimbursement for medically unnecessary and improper services, treatments, tests, and hospitalizations.[1] The defendants, led by DVH Hospital, move to dismiss Arik's amended claims, arguing that Arik fails to plead his allegations with sufficient particularity under Federal Rule of Civil Procedure 9(b); alleges nothing more than his subjective disagreement with the hospital staff's treatment plans, hospitalization decisions, and diagnoses; asserts claims barred by the FCA; and fails to adequately allege the existence of a conspiracy.[2] Arik seeks to extend his time to respond to the defendants' motions,[3] maintains that his allegations are sufficient to survive the defendants' Rule 9(b) and 12(b)(6) challenges, and requests leave to file a third amended complaint.[4]

[1] ECF No. 53 (second amended complaint).

[2] ECF Nos. 69, 70, 72 (motions to dismiss).

[3] ECF No. 86 (motion to extend time).

[4] ECF No. 94 (countermotion to amend complaint).

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I find that Arik's claims for violations of the FCA are insufficiently pled because (1) he has failed to clarify whether and how fraudulent claims for reimbursement were submitted to the federal government and (2) some, though not all, of his disagreements with the hospital's treatments fail to show fraudulent conduct. I also find that he does not and cannot allege a conspiracy, given the unified corporate interests of the defendants. So I grant the defendants' motions to dismiss, deny as moot Arik's motion to extend deadlines, and grant Arik's motion for leave to amend his first and second causes of action.

Background[5]

I. Arik's allegations

Arik is an experienced cardiologist who worked at Desert View Hospital in Nye County, Nevada, for roughly three years as a physician, including one year as Medical Chief of Staff.[6] In early 2019, Arik became troubled by certain new practices and policies at the hospital.[7] The hospital's CEO, Susan Davila, had informed Arik that low patient admissions, high patient transfer rates, and conservative testing and treatment practices had plunged the hospital into financial precarity.[8] To remedy this problem, Davila proposed two solutions: contracting with Vista Health and Mirza, and proactively treating more patients at Desert View, thereby increasing patient admissions and decreasing transfers to other hospitals.[9] Davila's solution appeared to work—in the late winter and early spring of 2019, inpatient admissions increased

[5] This is merely a summary of facts alleged in the complaint and should not be construed as findings of fact.

[6] ECF No. 53 at ¶¶ 11–13.

[7] *Id.* at ¶ 106.

[8] *Id.* at ¶ 99.

[9] *Id.* at ¶¶ 89, 104.

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between 37.4% to 68.1% in any given month, and revenue at the hospital grew by 50% for patients covered by Humana Medicare Advantage insurance.[10]

But Arik maintains that the hospital generated this revenue by seeking "cost-based reimbursement" from private and commercial insurers, including Medicare, Medicare Advantage, and Medicaid, for medically unnecessary and improper services and hospital admissions, as well as by altering inpatient-admission times and billing codes and inflating billing for emergency patients.[11] Arik's complaint details 98 patients[12]—identified by number, their medical histories, chief complaints, diagnoses, and, in some cases, their treatments, diagnostic testing, and amount sought in reimbursements from their insurer. Arik claims that each of these patients was mistreated in some way, relying both on his medical experience and the practice standards articulated by medical texts like *Braunwald's Cardiology Practice Standards*, the Medicare Program Integrity Manual, and InterQual Level of Care Criteria 2019.[13] For each patient, he broadly claims that the defendants "knowingly submitted a false claim" to various insurers for "hospitalist services," "unreasonable and medically unnecessary testing," and improper inpatient "admission."[14] For certain patients, he specifies the amount of the "false claim;" for others, he leaves that information blank.[15]

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[10] *Id.* at ¶¶ 101–05, 219.

[11] *Id.* at ¶¶ 216–17, 220, 229, 250.

[12] *See id.* at ¶¶ 112–214.

[13] *See, e.g.*, *id.* at ¶¶ 60, 112–13, 125, 139–40, 147.

[14] *Id.* at ¶¶ 112–214.

[15] *Compare id.* at ¶ 125 ("Desert View Hospital . . . knowingly submitted a false claim to Medicare/Tricare in the amount of $22,145.42 for the admission of the subject patient."), *with* ¶ 197 ("Desert View Hospital . . . knowingly submitted a false claim to Medicare in the amount of $_____ for the admission and the unreasonable and medically unnecessary testing performed on the subject patient.").

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Arik's assessments of these patients' treatments are not uniform—some describe specific discrepancies between symptom presentation and diagnosis/treatment,[16] others express his disagreement with certain diagnoses,[17] and still others show his frustration with the hospital's decision to admit patients.[18] Many of these accounts are quite detailed. For example, Arik describes patient 12's stroke; improper admission to Desert View, which lacks a primary or comprehensive stroke center; and resultant, fraudulent claim to "Medicare/Tricare" for $22,145.42.[19] But other accounts are vague, like that of patient 35(q), who complained of "generalized weakness due to [the] side effects of a new medication" and received a "medically unnecessary," unspecified "test"—resulting, apparently, in admission to the hospital, hospitalist services, and an unspecified claim to "Medicare" for an uncertain amount.[20]

II. Desert View Hospital, Medicare, and Medicaid

The Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) designated Desert View Hospital a "critical access hospital" (CAH), which receives significant federal funding to maintain access to and reduce the financial vulnerability

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[16] *See, e.g.*, *id.* at ¶ 167 ("Patient 35(f) presented . . . dizziness, weakness, and dark stools . . . . [He] underwent . . . a carotid ultrasound, echocardiogram, a T of the brain, and a blood transfusion[, which] were not indicated and were medical unnecessary based on the patient's complaints, a diagnosis of hemorrhoidal bleeding, and hemoglobin of 9.").

[17] *See, e.g.*, *id.* at ¶ 214 ("Patient 78 presented . . . pressure-like dull chest discomfort[, but] cardiac enzymes [and] EKG [were] negative[; t]here was no medical indication for an inpatient admission of this patient" for "three [] days with a diagnosis for acute coronary syndrome.").

[18] *See, e.g.*, *id.* at ¶¶ 170, 213 ("Patient 37 presented . . . with symptoms of bronchitis . . . based on the medical chart, there was no medical indication for an impatient admission of Patient 38."); (Patient 77 presented . . . progressive neurologic issues including left-sided weakness consistent with a stroke . . . [and] was admitted as an inpatient . . . for three [] days . . . . Desert View Hospital was not equipped to treat the patient.").

[19] *Id.* at ¶ 125.

[20] *Id.* at ¶ 167.

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of hospitals serving rural communities.[21] It also receives payments under Medicare and Medicaid for patients that it treats with those programs' insurance.[22] The Medicare program provides basic health insurance for individuals who are 65 or older, disabled, or have end-stage renal disease.[23] Under Medicare, "no payments may be made . . . for any expenses incurred for items or services . . . [that] are not reasonable and necessary for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member[.]"[24] Medicare reimburses providers for inpatient hospitalization only if "a physician certifies that such services are required to be given on an inpatient basis for such individual's medical treatment, or that inpatient diagnostic study is medically required and such services are necessary for such purpose."[25]

CMS defines a "reasonable and necessary" service as one that "meets, but does not exceed, the patient's medical need" and is furnished "in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition . . . in a setting appropriate to the patient's medical needs and condition."[26] Medically necessary services are those "needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine."[27] The Medicare program expects doctors to exercise their clinical judgment based on "complex medical factors" but does not give them unfettered

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[21] *Id.* at ¶¶ 78–81.

[22] *Id.* at ¶¶ 50–53.

[23] 42 U.SC. § 1395c.

[24] *Id.* § 1395y(a)(1)(A).

[25] *Id.* § 1395f(a)(3).

[26] CMS, Medicare Program Integrity Manual § 13.5.4 (2019).

[27] CMS, Medicare & You 2020: The Official U.S. Government Medicare Handbook 114 (2019).

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