PUBLISHED

UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

No. 20-1661

UNITED STATES EX REL. CORTNEY TAYLOR,

Plaintiff - Appellant,

v.

MICHAEL J. BOYKO, M.D.; MARK PERNI, D.O.; BESTPRACTICES OF WEST VIRGINIA, INC., an unlicensed West Virginia corporation; MARTIN GOTTLIEB & ASSOCIATES, LLC, a Florida limited liability company; BESTPRACTICES, INC.; HOLIDAY ACQUISITION COMPANY, INC., a Colorado corporation; EMCARE, INC., a Delaware corporation; ENVISION HEALTHCARE CORPORATION, a Delaware corporation,

Defendants - Appellees.

Appeal from the United States District Court for the Southern District of West Virginia, at Charleston. Irene C. Berger, District Judge. (2:17−cv−04213)

Argued: March 10, 2022 Decided: June 29, 2022

Before WYNN, HARRIS, and RICHARDSON, Circuit Judges.

Affirmed by published opinion. Judge Wynn wrote the opinion, in which Judge Harris and Judge Richardson joined.

ARGUED: Richard Allen Monahan, BORDAS & BORDAS, PLLC, Wheeling, West Virginia, for Appellant. Brian D. Roark, BASS, BERRY & SIMS, PLC, Nashville, Tennessee; Robert Vencill Williams, BURR & FORMAN, LLP, Tampa, Florida, for Appellees. **ON BRIEF:** Christopher J. Regan, BORDAS & BORDAS, PLLC, Wheeling,

West Virginia, for Appellant. Elizabeth L. Taylor, THOMAS COMBS & SPANN, PLLC, Charleston, West Virginia, for Appellee Martin Gottlieb & Associates LLC. Angela L. Bergman, BASS, BERRY & SIMS PLC, Nashville, Tennessee, for Appellees Michael Boyko, M.D.; Mark Perni, D.O.; BestPractices of West Virginia, Inc.; BestPractices, Inc.; Holiday Acquisition Company, Inc.; Emcare, Inc.; and Envision Healthcare Corp.

WYNN, Circuit Judge:

Relator Cortney Taylor brought this False Claims Act challenge against two doctors, five medical companies, and an accounting firm, collectively referred to hereinafter as Defendants.[1] She alleged that Defendants (1) knowingly submitted false claims to Medicare following the dissolution of one company's corporate charter and the revocation of its certificate of corporate authorization and (2) engaged in a fraudulent medical upcoding scheme.

But Taylor failed to establish a genuine dispute of material fact regarding the falsity of statements made by Dr. Mark Perni. And she failed to adequately allege scienter, materiality, and the presentment of false claims regarding the remaining seven Defendants.

Accordingly, we affirm the district court's grant of summary judgment to Dr. Perni and the dismissal of Taylor's claims against the other Defendants.

I.

A.

Except as noted below, the facts herein are taken from Taylor's amended complaint. On July 27, 2012, Taylor gave birth to a baby girl via cesarean section. In the days following the procedure, however, Taylor continued to suffer from persistent abdominal

[1] Defendants are Dr. Mark Perni, Dr. Michael Boyko, BestPractices of West Virginia, Inc., BestPractices, Holiday Acquisition Company, Inc., EmCare, Inc., and Envision Healthcare Corporation and Martin Gottlieb & Associates, LLC. They filed two response briefs, one on behalf of Gottlieb & Associates and another on behalf of Dr. Boyko and the other Defendants ("Boyko Response Br."). For convenience, we refer to Defendants collectively when describing positions taken by the Boyko brief.

pain; eventually she could no longer hold her newborn baby. So, on the evening of August 2, 2012, Taylor checked in to the emergency room at the Camden-Clark Medical Center ("Camden-Clark"), located in Parkersburg, West Virginia.

At the time, Camden-Clark's emergency room was staffed by employees of BestPractices of West Virginia, Inc. ("BestPractices of West Virginia"), a clinical-care staffing and management company. BestPractices of West Virginia is an offshoot of a similarly named Virginia corporation, BestPractices, Inc. ("BestPractices"). In 2011, both corporations were "rolled . . . into" the corporate portfolio of Holiday Acquisition Company, Inc. ("Holiday"), EmCare, Inc. ("EmCare"), and Envision Healthcare Corporation ("Envision").[2] Opening Br. at 38.

The night that Taylor arrived at Camden-Clark, she was interviewed and examined by BestPractices of West Virginia employee and nurse practitioner Jennifer Angelilli, who is not a party to this action. Angelilli diagnosed her with cellulitis, a common bacterial skin infection that is generally non-life-threatening with appropriate treatment. Angelilli gave Taylor pain medication, prescribed broad-spectrum antibiotics and an antiemetic, and

[2] The relationship between these entities can best be described as a corporate matryoshka doll. Holiday is owned by EmCare, which is owned by EmCare Holdings, Inc., which is owned by EmCare Holdco, Inc., which is owned by Emergency Medical Services LP Corporation, which is owned by Envision Physician Services, LLC, which is owned by Envision, which is owned by Enterprise Intermediate Holdings, Inc., which is owned by Enterprise Parent Holdings, Inc., which is majority owned by investment vehicles managed by one or more subsidiaries of KKR & Co., Inc. Boyko Response Br. at ii. However, it bears repeating that of these listed entities, only Holiday, EmCare, and Envision are parties to this action.

discharged Taylor around 4:00 a.m. on August 3, noting that Taylor was feeling "much better" and her condition was "stable." J.A. 915.[3]

Later that day, Taylor returned to Camden-Clark after continuing to experience severe abdominal pain. This time, she was diagnosed with necrotizing fasciitis, which, if left untreated, is usually fatal. The next day, Taylor was transferred to Ruby Memorial Hospital in Morgantown, West Virginia, where, according to the record, she received nineteen surgical interventions over the course of thirty-five days that ultimately removed around forty pounds of necrotizing tissue from her abdomen.

B.

Two hours after Taylor was originally discharged from Camden-Clark early on the morning of August 3, Dr. Perni reviewed Taylor's medical chart. Dr. Perni, who was not an employee of BestPractices of West Virginia, provided medical coverage in the emergency room that night as a *locum tenens* (substitute) physician.

Dr. Perni had previously been instructed by BestPractices of West Virginia's on-site medical director, Dr. Anthony Kitchen, "to sign the medical charts for patients seen only by mid-level providers, like Nurse Practitioner Angelilli, so the medical chart could be billed." J.A. 38. So, after reviewing Taylor's chart, Dr. Perni signed and dated her form and "checked the box next to the words 'Template Complete' to assert that the chart was complete and could be sent to the billing department." J.A. 146 (sworn declaration). Just above Dr. Perni's signature on the form is the "Attending Note" box, depicted in Taylor's

[3] Citations to the "J.A." refer to the Joint Appendix filed by the parties in this appeal.

complaint. J.A. 37. That box contains a small check box next to language stating that the patient was "interviewed and examined" by the attending physician. J.A. 37, 915.

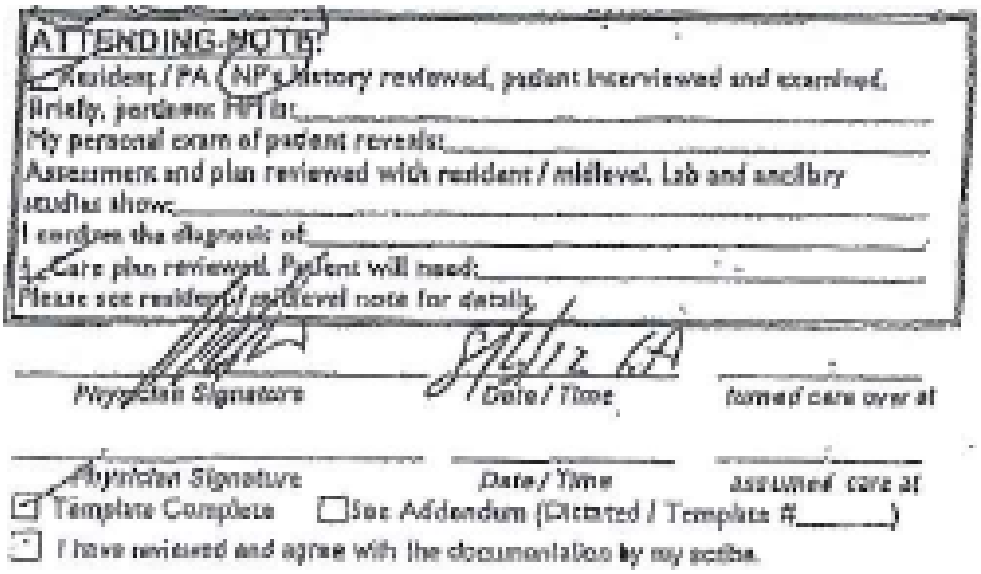
ATTENDING NOTE:
Resident / PA / NP's history reviewed, patient interviewed and examined.
Briefly, pertinent HPI is:
My personal exam of patient reveals:
Assessment and plan reviewed with resident / mid-level. Lab and ancillary studies show:
I confirm the diagnosis of:
Care plan reviewed. Patient will need:
Please see resident / mid-level note for details.
Physician Signature
Date / Time
formal care over at
Physician Signature
Date / Time
assumed care at
Template Complete
See Addendum (Dictated / Template #_____)
I have reviewed and agree with the documentation by my scribe.

Figure 1. A subsection of Taylor's medical chart at Camden-Clark showing Dr. Perni's signature. J.A. 915.

In her amended complaint, Taylor alleges that Dr. Perni himself "appears" to have filled out the Attending Note box, including making a check mark in the internal check box "to indicate that the Attending Physician (Perni) interviewed and examined the patient (Relator)." J.A. 37. However, in subsequent depositions and declarations, Dr. Perni stated that the marks inside Taylor's Attending Note box were not made by him, and that the Attending Note box was blank when he signed Taylor's chart. Taylor has offered no evidence to contradict Dr. Perni's sworn statements.

Taylor's medical chart was eventually submitted to Martin Gottlieb & Associates, LLC ("Gottlieb & Associates"), a medical billing company contracted to provide billing services for BestPractices of West Virginia. Gottlieb & Associates used Taylor's chart to

prepare an invoice for the services rendered to Taylor on August 2 and 3. The record shows that, in total, Taylor was charged $668 for her emergency-room visit, of which $132.46 was reimbursed by Medicare.[4] The hospital wrote off the rest of the bill.

That reimbursement amount was influenced by several factors. To start, Gottlieb & Associates coded the severity of Taylor's injuries and level of care—based on her diagnosis of cellulitis and care provided by Nurse Practitioner Angelilli—using Current Procedural Terminology code 99285, the most severe of five procedural codes (ranging from 99281 to 99285) listed in the American Medical Association's 2012 Current Procedural Terminology manual. Procedural code 99285 is reserved for problems of a "high severity" that "pose an immediate significant threat to life or physiological function." J.A. 35. A problem of a "high severity" is further defined as one where "there is a moderate to high risk of mortality without treatment or high probability of severe, prolonged functional impairment." J.A. 35.

The Medicare reimbursement amount also reflected the identity of the care provider. Though no physician had provided any care to Taylor during her August 2–3 visit, Gottlieb & Associates submitted the bill to Taylor's federal insurers (Medicare Part B and Molina Medicaid) using the National Provider Identifier of Defendant and BestPractices of West Virginia employee Dr. Michael Boyko. Dr. Boyko was not scheduled to work on the dates

[4] The record reveals that, though she was too young to qualify for Medicare on the basis of age when she had her baby, Taylor qualified on the basis of disability due to complications arising from a car accident in 1999.

in question. However, Taylor's bill also included a "Q6" code modifier, indicating that "Dr. Perni served as a *locum tenens* physician in place of Dr. Boyko." J.A. 37.

Because Gottlieb & Associates billed using Dr. Boyko's provider number with a Q6 modifier, the record shows that BestPractices of West Virginia received the full physician-level reimbursement of $132.46. Had Gottlieb & Associates billed using Nurse Practitioner Angelilli's provider number, BestPractices of West Virginia would have received a mid-level reimbursement equivalent to 85% of the physician rate. Thus, instead of reimbursing $132.46 for Taylor's care, Medicare would have reimbursed $112.59, a difference of $19.87.

C.

These discrepancies weren't the only potential issues with the bill submitted to Medicare and Medicaid. As a medical corporation, BestPractices of West Virginia was responsible for maintaining a current corporate charter with the West Virginia Secretary of State. *See* W. Va. Code § 31D-14-1421(c). To maintain an active corporate status, a corporation must file an annual report and pay an annual report fee of $25. *Id.* § 59-1-2a(b), (c). Failure to follow these requirements will result in the administrative dissolution of the corporation after a thirty-day notice period. *Id.* § 59-1-2a(g)(1); *id.* § 31D-14-1420(a). And once a corporation is administratively dissolved, it "may not carry on any business except that necessary to wind up and liquidate its business." *Id.* § 31D-14-1421(c).

BestPractices of West Virginia was also required to hold a valid certificate of authorization from the West Virginia Board of Medicine. *See id.* § 30-3-15(a). When a medical corporation receives such an authorization, the West Virginia Secretary of State

attaches it to the corporate charter. *Id.* § 30-3-15(d). Once a certificate is expired or revoked, it becomes "unlawful for any corporation to practice or offer to practice medicine." *Id.* § 30-3-15(a), (k).

For many years, BestPractices of West Virginia's founder and president, Dr. Thomas Mayer, had signed the annual reports required by the West Virginia Secretary of State. However, on November 1, 2011, the Secretary of State provided written notice to BestPractices of West Virginia that she was administratively dissolving the corporation for failing to file its most recent annual report and pay the annual $25 filing fee. Due to this administrative dissolution, the West Virginia Board of Medicine revoked BestPractices of West Virginia's certificate of authorization for a medical corporation.

As a Medicare-enrolled provider, BestPractices of West Virginia was required to report this dissolution and revocation to the Centers for Medicare and Medicaid Services ("CMS") within thirty or ninety days, depending on how these actions were classified. *Compare* 42 C.F.R. § 424.516(d)(1) (requiring any "adverse legal action" to be reported within "30 days"), *with id.* § 424.516(d)(2) (requiring "other changes in enrollment" to be reported "within 90 days"). After all, "[c]ompliance with Federal and *State licensure*, *certification*, and regulatory requirements" was a condition of BestPractices of West Virginia's "active enrollment status," which allowed it to receive Medicare payments. *Id.* § 424.516(a)(2) (emphasis added). However, BestPractices of West Virginia never reported the dissolution and revocation to CMS. And in the meantime, BestPractices of West Virginia continued to provide medical services at Camden-Clark—and continued to

bill Medicare for those services—until the hospital terminated its contract with the corporation in March 2013.

II.

In 2017, Taylor filed the instant qui tam lawsuit. After the Government declined to intervene, the complaint was unsealed and Taylor proceeded to litigate the lawsuit alone. Her amended complaint[5] alleges two primary theories of recovery[6] under the False Claims Act.

First, she alleges that any claims submitted to Medicare by or on behalf of BestPractices of West Virginia after November 1, 2011, were necessarily false or fraudulent because the corporate Defendants (BestPractices of West Virginia, BestPractices, Envision, EmCare, and Holiday) knew that (1) BestPractices of West Virginia's corporate charter and certificate of authorization were rescinded, and (2) it was illegal for BestPractices of West Virginia's employees to provide medical care following

[5] Taylor's original complaint, which raised similar claims, was dismissed for all Defendants except Dr. Perni. *United States ex rel. Taylor v. Boyko*, No. 2:17-CV-04213, 2019 WL 2423283, at *7 (S.D.W. Va. June 7, 2019).

[6] Taylor's amended complaint alleges two additional theories of recovery. First, she suggests that the invoice generated for her care was false or fraudulent because Dr. Boyko was not scheduled to work at Camden-Clark on August 2–3, 2012, so no *locum tenens* physician could properly be substituted for him on the bill. Second, she claims that Defendants had violated certain internal contracts. Since she has failed to pursue either theory on appeal, we consider them waived. *Grayson O Co. v. Agadir Int'l LLC*, 856 F.3d 307, 316 (4th Cir. 2017) ("A party waives an argument by failing to present it in its opening brief[.]").

those invalidations. Second, she alleges that, as illustrated by her own experience, the Defendants engaged in a fraudulent upcoding scheme to bill Medicare at inflated rates.

Defendants moved to dismiss, arguing that, except for a single claim against Dr. Perni, Taylor had failed to plausibly allege scienter or plead fraud with adequate particularity. The district court agreed and granted the motion to dismiss as to all Defendants apart from Dr. Perni.

In doing so, the district court first found that Taylor inadequately pleaded scienter and materiality regarding her allegation that BestPractices of West Virginia's administrative dissolution rendered all Medicare claims it submitted for Camden-Clark patients between November 1, 2011, and March 2013 false or fraudulent. *United States ex rel. Taylor v. Boyko*, No. 2:17-CV-04213, 2020 WL 520933, at *6 (S.D.W. Va. Jan. 31, 2020). Next, it dismissed Taylor's allegations of fraudulent upcoding for seven of the eight Defendants on scienter and presentment grounds. *Id.* at *7–8. However, the court allowed the claim against Dr. Perni to proceed to discovery because Taylor "adequately alleged that Dr. Perni knowingly created a false record material to a false or fraudulent claim made to Medicare." *Id.* at *7.

After discovery, Taylor and Dr. Perni filed cross-motions for summary judgment. Though the district court rejected Dr. Perni's argument that the False Claims Act's public-disclosure bar foreclosed Taylor's lawsuit, it sided with Dr. Perni on the merits. *United States ex rel. Taylor v. Perni*, No. 2:17-CV-04213, 2020 WL 2499544, at *3, *5–6 (S.D.W. Va. May 14, 2020). Specifically, it found that Taylor had "presented no evidence that Dr. Perni made any false statement and no evidence that any overbilling resulted from anything

more than a mistake." *Id.* at *6. Nor did Taylor adequately establish scienter because there was "no evidence that Dr. Perni knew Ms. Taylor received Medicare, had any input into the coding or billing for her care, or knew that a claim based on the physician rate was generated in her case." *Id.* at *5.

Taylor timely appealed both orders.

III.

The False Claims Act imposes liability on "any person" who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval" or who "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(A), (B).

In general, a False Claims Act relator is required to allege four elements:[7] (1) "there was 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')." *Harrison v. Westinghouse Savannah River Co.*, 176 F.3d 776, 788 (4th Cir. 1999). Failure to adequately allege any of these elements dooms a claim. *Id.*

As noted above, Taylor's appeal involves two distinct False Claims Act challenges. First, she claims that Defendants knowingly submitted false claims to Medicare after

[7] As noted below, there is some debate within this Circuit whether relators alleging a violation of § 3729(a)(1)(A) are required to plead the same four elements as those alleging a violation of § 3729(a)(1)(B), but we need not resolve that issue in this case. *See infra* note 12.

BestPractices of West Virginia lost its corporate charter and certificate of authorization—a requirement to receive federal funding—yet continued to bill the Medicare program. Second, she alleges that Defendants knowingly engaged in a fraudulent upcoding scheme to charge Medicare physician-level rates for mid-level care. Defendants urge us to reject these challenges for the reasons articulated by the district court. Alternatively, they argue that we can affirm on the ground that Taylor's action is foreclosed by the False Claims Act's public-disclosure bar.

In the analysis that follows, we find no merit to Defendants' public-disclosure-bar argument. But we nonetheless affirm the dismissal of the claims against all Defendants except Dr. Perni and the grant of summary judgment in favor of Dr. Perni.

A.

Preliminarily, we address Defendants' argument that Taylor's action is forestalled by the False Claims Act's public-disclosure bar. The statute provides that a court must dismiss an action "if substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed" by a qualifying source, such as a "Federal report, hearing, audit, or investigation," unless the "person bringing the action is an original source of the information." 31 U.S.C. § 3730(e)(4)(A). "We review this jurisdictional question de novo, and examine the district court's jurisdictional findings of fact for clear error." *United States ex rel. Rostholder v. Omnicare, Inc.*, 745 F.3d 694, 699 (4th Cir. 2014).

Defendants argue that a 2013 investigation of Camden-Clark conducted by the West Virginia Department of Health and Human Resources at CMS's behest publicly disclosed the basis for Taylor's claims. We reject this contention for the same reason as the district

court: the 2013 investigation and resulting report did not involve "substantially the same allegations or transactions" as Taylor's present lawsuit. 31 U.S.C. § 3730(e)(4)(A); *see Perni*, 2020 WL 2499544, at *3. "Nothing in the [report] or investigation touched on billing or alleged fraud." *Perni*, 2020 WL 2499544, at *3. Instead, "they focused entirely on asserted deficiencies in medical care." *Id.* And to the extent that the report discussed medical records, it did so only in reference to delays in generating records or a failure to document medical conditions.

Therefore, we decline to affirm on the alternative ground advanced by Defendants and proceed to analyze the district court's dismissal and summary-judgment orders.

B.

Next, we consider Taylor's argument that the district court erred by dismissing Taylor's claims against all Defendants except Dr. Perni under Federal Rule of Civil Procedure 12(b)(6). We review that decision de novo. *United States ex rel. Nathan v. Takeda Pharms. N. Am., Inc.*, 707 F.3d 451, 455 (4th Cir. 2013). In doing so, "we must view the facts alleged in the light most favorable to the plaintiff," though we need not accept "legal conclusions couched as facts or unwarranted inferences, unreasonable conclusions, or arguments." *Id.* (quoting *Wag More Dogs, LLC v. Cozart*, 680 F.3d 359, 365 (4th Cir. 2012)).

To survive a Rule 12(b)(6) motion to dismiss for failure to state a claim, a complaint must "state a claim to relief that is plausible on its face." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)) (citing Fed. R. Civ. P. 8(a)(2)). When "alleging fraud or mistake," however, a plaintiff must not only meet

"the plausibility standard of" Rule 8, but also satisfy the heightened pleading standard of Rule 9(b). *Nathan*, 707 F.3d at 455 (quoting Fed. R. Civ. P. 9(b)).

Rule 9(b) requires a plaintiff alleging fraud or mistake, like a False Claims Act relator, to "state with particularity the circumstances constituting fraud or mistake," though knowledge "may be alleged generally." Fed. R. Civ. P. 9(b). These circumstances are often "referred to as the 'who, what, when, where, and how' of the alleged fraud." *United States ex rel. Wilson v. Kellogg Brown & Root, Inc.*, 525 F.3d 370, 379 (4th Cir. 2008) (quoting *United States ex rel. Willard v. Humana Health Plan of Tex. Inc.*, 336 F.3d 375, 384 (5th Cir. 2003)). A "lack of compliance with Rule 9(b)'s pleading requirements is treated as failure to state a claim under Rule 12(b)(6)." *Dunn v. Borta*, 369 F.3d 421, 426 (4th Cir. 2004) (quoting *Harrison*, 176 F.3d at 783 n.5).

The district court in the instant case found that Taylor had failed to adequately plead either of her two theories of recovery as to all Defendants except Dr. Perni. After reviewing Taylor's administrative-revocation theory and the adequacy of her upcoding-scheme allegations, we agree with the district court.

1.

We first address Taylor's administrative-revocation challenge under 31 U.S.C. § 3729(a)(1)(A) based on an "implied certification theory" of liability. *United States ex rel. Badr v. Triple Canopy, Inc.*, 857 F.3d 174, 176 (4th Cir. 2017). According to this accepted theory, "when a defendant submits a claim, it impliedly certifies compliance with all conditions of payment. But if that claim fails to disclose the defendant's violation of a material statutory, regulatory, or contractual requirement, . . . the defendant has made a

misrepresentation that renders the claim 'false or fraudulent[.]'" *Universal Health Servs., Inc. v. United States ex rel. Escobar*, 579 U.S. 176, 180 (2016) (quoting 31 U.S.C. § 3729(a)(1)(A)). Taylor alleges that the corporate Defendants did just that when they continued to bill Medicare while failing to disclose BestPractices of West Virginia's administrative dissolution and revoked certificate of authorization. She claims that this failure ran afoul of two Medicare regulations, which, in pertinent part, require BestPractices of West Virginia to: (1) maintain "[c]ompliance with Federal and *State licensure, certification*, and regulatory requirements," 42 C.F.R. § 424.516(a)(2) (emphasis added); and (2) report "[a]ny adverse legal action" to CMS within thirty days, *id.* § 424.516(d)(1).

The district court dismissed Taylor's administrative-revocation claim after finding that she had failed to adequately plead scienter or materiality. Because we agree that Taylor failed to adequately plead materiality under this theory of recovery, we affirm without reaching the scienter issue.

i.

Materiality, like other non-scienter elements of a False Claims Act claim, must be pleaded with particularity under Rule 9(b). *See Escobar*, 579 U.S. at 195 n.6 (noting that False Claims Act plaintiffs must plead "facts to support allegations of materiality" with "plausibility and particularity"); *Wilson*, 525 F.3d at 379 (affirming the dismissal of a complaint on materiality grounds for failure to comply with Rule 9(b)'s particularity requirement). This means that a relator's complaint must contain "specific facts" regarding

"*how* the [fraudulent conduct or false statement] influenced the government's decision" to pay. *Wilson*, 525 F.3d at 379.

Even without the heightened burden imposed by Rule 9(b), the False Claims Act's materiality standard is a "rigorous" and "demanding" one. *Escobar*, 579 U.S. at 192, 194. If a relator is alleging fraud under an implied-certification theory based on statutory, contractual, or regulatory noncompliance, failure to follow a "minor or insubstantial" requirement will not suffice to show materiality. *Id.* at 194. Instead, the provision at issue must be "so central" to the services provided that the Government "would not have paid these claims had it known of these violations." *Id.* at 196.

Whether a provision is "so central" that it goes "to the very essence of the bargain" is a functional, rather than formalistic, inquiry. *Id.* at 193 n.5, 196 (quoting *Junius Constr. Co. v. Cohen*, 178 N.E. 672, 674 (N.Y. 1931)). Thus, violations of "statutory, regulatory, and contractual requirements are not automatically material, *even if they are labeled conditions of payment*." *Id.* at 191 (emphasis added). In other words, the mere fact "that the Government would have the option to decline to pay if it knew of the defendant's noncompliance" is insufficient to establish materiality—though it is certainly "relevant" to our inquiry. *Id.* at 194. Similarly, "if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material." *Id.* at 195. But on the flip side, allegations "that the Government *consistently* refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement" can establish materiality. *Id.* (emphasis added).

ii.

In the present case, Taylor bets the farm on this last factor, claiming that the Government has consistently refused to pay claims when faced with similar failures to maintain licenses or certifications. Specifically, she alleges that CMS "routinely revokes" Medicare billing privileges for "providers that lose their licenses," including "corporate providers whose State licenses to practice medicine as a corporation are revoked." J.A. 26; Opening Br. at 24–25. As support, she cites a slew of U.S. Department of Health and Human Services Appeals Board decisions.

Though Taylor warns that it would be error "to pick apart the[se] agency decisions" at the Rule 12(b)(6) stage, Opening Br. at 25, we are not required to "accept the legal conclusions drawn" from these administrative decisions in Taylor's complaint, nor are we required to "accept as true unwarranted inferences, unreasonable conclusions, or arguments" made in her complaint, *Giarratano v. Johnson*, 521 F.3d 298, 302 (4th Cir. 2008) (quoting *E. Shore Mkts., Inc. v. J.D. Assocs. Ltd. P'ship*, 213 F.3d 175, 180 (4th Cir. 2000)). And a quick review of the administrative decisions she cites reveals that nearly all of them involved suspensions and revocations of *personal medical licenses*—often for reasons relating directly to medical care—not revocations of *corporate certificates of authorization*.

Though Taylor repeatedly conflates these two categories, they are very different. Personal medical licenses are issued to individual physicians or medical personnel, subject to the exacting strictures of state law. *See* W. Va. Code § 30-3-10(b). To obtain such a license, an individual generally must acquire a medical degree, complete years of residency

or graduate clinical training, pass the Medical Licensing Examination, demonstrate "good moral character" and physical and mental fitness, and submit a complete application, including fees. *Id.* BestPractices of West Virginia, in contrast, was issued a "[c]ertificate of authorization for [an] in-state medical corporation." *Id.* § 30-3-15(b). To obtain such a certificate, a medical corporation must file an application, pay fees, and furnish proof that each shareholder is a licensed physician. *Id.*

Almost all of the administrative decisions that Taylor cites involve the former category, not the latter. For example, in one decision the Appeals Board affirmed the revocation of the petitioner's Medicare billing privileges after his personal medical license was suspended when one of his patients died from a drug overdose caused by medications he prescribed. *Meindert Niemeyer, M.D.*, DAB No. 2865 (H.H.S. Apr. 4, 2018). In another, the Appeals Board upheld a revocation of billing privileges where the petitioner's personal medical license was suspended because he posed an "immediate and serious danger to the health, safety or welfare to the public." *Akram A. Ismail, M.D.*, DAB No. 2429 (H.H.S. Dec. 20, 2011). In yet another, the Appeals Board affirmed the revocation of the petitioner's Medicare billing privileges because he was convicted of felony conspiracy to distribute anabolic steroids, which he failed to report to CMS. *Mark Koch, D.O.*, DAB No. 2610 (H.H.S. Dec. 18, 2014). All but one of the remaining cases are of a piece.[8]

[8] *See Sandra E. Johnson, CRNA*, DAB No. 2708 (H.H.S. June 2, 2016) (affirming the revocation of the petitioner's billing privileges when she failed to disclose her adverse history of legal action—including two license suspensions and a revocation—in her enrollment application); *Gulf S. Med. & Surgical Inst., & Kenner Dermatology Clinic, Inc.*, DAB No. 2400 (H.H.S. July 21, 2011) (upholding the revocation of the petitioner's billing

That single decision, *Acute Care Homenursing Services, Inc.*, DAB No. 2837 (H.H.S. Dec. 19, 2017), did involve the revocation of billing privileges due—in part—to the loss of a corporate charter and certificate of authority. But it is both readily distinguishable[9] and ultimately of no help to Taylor's routine-revocation theory.

That's because an allegation that CMS decided, *on a single occasion*, to revoke a company's Medicare billing privileges for failure to comply with state corporate-licensing requirements hardly shows "that the Government *consistently* refuses to pay claims in the mine run of cases based on" such failures. *Escobar*, 579 U.S. at 195 (emphasis added). An allegation that a single decision reflects "routine" practice is highly implausible.

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privileges because they failed to report the revocation of their personal medical license); *Angela R. Styles, M.D.*, DAB No. 2882 (H.H.S. July 24, 2018) (sustaining the revocation of the petitioner's billing privileges when her personal medical license was suspended and she failed to report the suspension).

[9] Unlike BestPractices of West Virginia, the petitioner in *Acute Care* filed a Medicare revalidation application, as required of providers every five years, in which he falsely substituted the name of another business with a similar address in seven places on the document. DAB No. 2837 at *2, *4. The petitioner then failed to correct this misrepresentation when directly asked to by a Medicare contractor. *Id.* at *3–4. Though the Appeals Board also faulted the petitioner for applying "for revalidation while its legal corporate status has been revoked by state authorities," *id.* at *9, it specifically noted that the revocation of the petitioner's billing privileges did "*not rest solely* on Petitioner's factually false representations that it was a valid corporation authorized to do business in Ohio at the time it filed the application," *id.* at *10 (emphasis added). Taylor's citations to *Acute Care* overlook these compounding factors. But because of that intermixing, *Acute Care* does not tell us whether CMS would have revoked the petitioner's billing privileges solely for losing their corporate status or failing to report such a dissolution—which are the only violations that Taylor alleges here.

iii.

However, that is not the end of our materiality inquiry. After all, in pleading materiality, a relator "*can include, but is not necessarily limited to*, [allegations] that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases." *Id.* at 194–95 (emphasis added). So, Taylor is free to point to other factual allegations that establish materiality with sufficient particularity.

But Taylor fails to do so here. Instead of identifying other pertinent and specific factual allegations in her amended complaint, Taylor makes a common-sense appeal to notions of materiality. Specifically, she argues that "[a] medical license is [so] central to the practice of medicine and to the right to lawfully bill for medical services . . . [that its materiality] does not even need to be inferred." Opening Br. at 25. Though she argues this is so obvious that she "should not even have had to plead it," she claims that "she did." *Id.* at 19. As support, she points to language in her amended complaint stating that "Medicare requires, as a *material* requirement of enrollment and for billing, that all medical providers be licensed in accordance with applicable state law." J.A. 54 (emphasis added); *see also* J.A. 24 ("CMS considers the licensing of . . . corporate providers to be a material condition to enrollment and billing."); J.A. 49 ("[A] basic requirement of enrollment and payment from Medicare for providing medical services . . . is maintaining all required legal licenses . . . to provide such services."). Thus, Taylor's allegations boil down to a bald declaration that "the lack of a medical license is *plainly material* when billing CMS for medical services." Opening Br. at 23 (emphasis added).

But conclusory assertions like these are inadequate. *See Iqbal*, 556 U.S. at 678 ("Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice."). "[N]aked[ly] assert[ing]" that a requirement is "material," without "further factual enhancement," is simply "a formulaic recitation of the elements of a cause of action." *Twombly*, 550 U.S. at 555, 557. Such assertions do not permit us "to infer more than the mere possibility of misconduct," which necessarily "stops short of the line" required by Rule 8, and thus far short of that required by Rule 9. *Iqbal*, 556 U.S. at 678–79 (quoting *Twombly*, 550 U.S. at 557).

Even if conclusory allegations like the ones in Taylor's complaint *were* sufficient, BestPractices of West Virginia did not lose its "medical license." Rather, according to Taylor's own complaint, the State dissolved the company's corporate charter and consequently revoked its certificate of authorization. That is a distinction with a difference. A personal medical license is only issued to individual medical personnel who have undergone years of study, practice, and supervision. W. Va. Code § 30-3-10(b). A certificate of authorization, on the other hand, can be obtained by any company that files an application, pays a fee, and proves that its shareholders hold personal medical licenses. *Id.* § 30-3-15(b).

Common sense tells us that a personal medical license would probably be "central" to the provision of medical services, and by extension, Government payments for such services. *See, e.g.*, *United States ex rel. Escobar v. Universal Health Servs., Inc.*, 842 F.3d 103, 108, 111 (1st Cir. 2016) (holding, on remand from the Supreme Court, that a mental-health facility's "flagrant" failure to comply with state regulations requiring its staff to

either maintain professional licenses or be supervised by accredited staff was material because "[a]t the core of the [state] regulatory program in this area of medicine is the expectation that mental health services are to be performed by licensed professionals, not charlatans"). After all, there are strong reasons why we ask doctors to undergo a rigorous licensing process before, for example, conducting open-heart surgery or prescribing potentially dangerous medications to patients. *See id.* at 108 (describing how the relators' daughter died from a seizure after she experienced an adverse reaction to a drug prescribed by a nurse masquerading as a board-licensed psychiatrist, when in fact that nurse "could prescribe medications only if properly supervised by a board[-]certified psychiatrist").

But common sense does not tell us why BestPractices of West Virginia's failures to file an annual report and pay a $25 fee—and the consequent loss of its certificate of corporate authorization and attendant regulatory violations—were "so central" to the medical services provided at Camden-Clark that the "Medica[re] program would not have paid these claims had it known of these violations." *Escobar*, 579 U.S. at 196. Tellingly, Taylor does not allege that these failures impacted or influenced the medical services provided at Camden-Clark or the medical qualifications of the physicians employed by BestPractices of West Virginia—which is what the Government was paying for all along.

The mechanism for resolving the failures Taylor identifies also undercuts her "common-sense" argument. Unlike a revoked personal medical license,[10] a dissolved

[10] If an individual's medical license automatically expires for failure to pay renewal fees or satisfy the continuing-medical-education requirement, a former licensee can reinstate their license by providing proper documentation and paying certain fees. W. Va.

corporate charter can be reinstated in such a way that it "relates back to and takes effect as of the effective date of the administrative dissolution and the corporation resumes carrying on its business *as if the administrative dissolution had never occurred*."[11] W. Va. Code § 31D-14-1422(c) (emphasis added). That tends to support the district court's assessment that BestPractices of West Virginia's failure was bureaucratic rather than material. *Boyko*, 2020 WL 520933, at *6 (concluding that the "reasonable inference" arising from the amended complaint is that BestPractices of West Virginia "acted negligently in failing to complete required paperwork, much as an individual might negligently fail to renew her car registration after receiving mailed notice").

iv.

Taylor counters that the district court's materiality assessment was fatally flawed because it erroneously gave "great weight" to the Government's decision not to intervene in her lawsuit. Opening Br. at 28. To the extent that the district court did rely on this factor, *see Boyko*, 2020 WL 520933, at *5 (simply noting, while listing factors relevant to materiality, that "[t]he United States declined to intervene in this matter"), we agree that that was error, *see United States ex rel. Prather v. Brookdale Senior Living Cmtys., Inc.*,

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Code § 30-3-12(g). However, the reinstatement does not relate back to the time the license expired. *Id.*; *see also* § 30-3-13(g), (h) ("A person who engages in the unlawful practice of medicine and surgery or podiatry while holding a[n expired] license . . . is guilty of a misdemeanor" or felony.).

[11] Presumably, once this reinstatement took effect, a company could then reapply for a certificate of authorization from the Board of Medicine. *See* W. Va. Code § 30-3-15(g).

892 F.3d 822, 836 (6th Cir. 2018) ("If relators' ability to plead sufficiently the element of materiality were stymied by the government's choice not to intervene, this would undermine the purposes of the Act.").

While the Government's decision to "immediately intervene[]" tends to demonstrate materiality, *Triple Canopy*, 857 F.3d at 179, the inverse is not true. The Government may decide not to intervene simply because its attorneys are swamped, or political considerations are at stake. We cannot presume lack of materiality from such vagaries of fate. Nor does the Supreme Court. After all, in "*Escobar* itself, the government chose not to intervene, and the Supreme Court did not mention this as a relevant factor in its materiality analysis." *Prather*, 892 F.3d at 836.

But even if the district court *did* erroneously rely on the Government's non-intervention, that error is inconsequential. As we have already concluded—without looking to this erroneous factor—Taylor's complaint failed to adequately plead materiality. And we may "affirm on any ground appearing in the record." *Scott v. United States*, 328 F.3d 132, 137 (4th Cir. 2003).

* * * * *

In the end, while Taylor has plausibly alleged that compliance with certain state-law requirements was a condition of payment, that alone is insufficient to plead materiality with particularity. Because Taylor has failed to allege any further details that would be needed to satisfy Rule 9(b)'s stringent particularity requirement, we affirm the dismissal of her administrative-revocation challenge.

2.

We turn next to Taylor's allegation that Defendants engaged in a billing upcoding scheme for an unspecified number of patients, including herself. The district court dismissed this claim on presentment and scienter grounds for all Defendants other than Dr. Perni. We agree, and therefore affirm.

i.

First, we analyze whether Taylor adequately pleaded presentment of false claims for patients other than herself. We conclude she did not.

"In order for a false statement to be actionable under [the False Claims Act], it must be made as part of a false or fraudulent claim." *United States ex rel. Grant v. United Airlines Inc.*, 912 F.3d 190, 196 (4th Cir. 2018). The term "claim" is defined in relevant part as "any request or demand . . . for money or property . . . that . . . is *presented* to an officer, employee, or agent of the United States." 31 U.S.C. § 3729(b)(2)(A)(i) (emphasis added). "Therefore, a central question in all [False Claims Act] cases is whether the defendant ever [directly or indirectly] presented a false or fraudulent claim to the government, resulting in a 'call upon the government fisc.'"[12] *Grant*, 912 F.3d at 196 (quoting *Harrison*, 176 F.3d at 785–86).

[12] We note that this proposition has been the subject of recent debate in this Circuit. In at least three decisions, we have suggested that the Supreme Court's opinion in *Allison Engine Co. v. United States ex rel. Sanders*, 553 U.S. 662 (2008), compels the conclusion that relators are not required to plead the presentment element when alleging a § 3729(a)(1)(B) violation. *See United States ex rel. Badr v. Triple Canopy, Inc.*, 775 F.3d 628, 639 (4th Cir. 2015) (rejecting an interpretation that would "import a presentment requirement from § 3729(a)(1)(A) that is not present in § 3729(a)(1)(B)"), *cert. granted,*

There are "two ways to adequately plead presentment under Rule 9(b)." *Id.* at 197. "First, a plaintiff can 'allege with particularity that specific false claims actually were presented to the government for payment.'" *Id.* (quoting *Nathan*, 707 F.3d at 457). This requires the relator to, "at a minimum, describe the time, place, and contents of the false representations, as well as the identity of the person making the misrepresentation and what he obtained thereby." *Id.* (internal quotation marks omitted) (quoting *Wilson*, 525 F.3d at 379). Second, a relator "can allege a pattern of conduct that would '*necessarily* have led to

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judgment vacated, 136 S. Ct. 2504 (2016), *and opinion reinstated in part*, 857 F.3d 174; *United States ex rel. DRC, Inc. v. Custer Battles, LLC*, 562 F.3d 295, 308 (4th Cir. 2009) ("The district court's holding that [the precursor to § 3729(a)(1)(B)] has a 'presentment' requirement has subsequently been rejected by the Supreme Court in *Allison Engine*[.]"); *United States ex rel. Ahumada v. NISH*, 756 F.3d 268, 280 n.8 (4th Cir. 2014) (noting that *Allison Engine* clarified that a presentment or causation requirement is not an element of a false statement or record claim).

However, Congress specifically abrogated *Allison Engine* in 2009 when it amended the relevant section of the False Claims Act. *See* Pub. L. No. 111-21, § 4(a), 123 Stat. 1617, 1621 (2009); S. Rep. No. 111-10, at 10 (2009), *as reprinted in* 2009 U.S.C.C.A.N. 430, 438 ("This section amends the [False Claims Act] to clarify and correct erroneous interpretations of the law that were decided in *Allison Engine*[.]"). And in at least two decisions postdating that amendment, we have held or suggested that presentment remains an element of a § 3729(a)(1)(B) claim. *See Grant*, 912 F.3d at 196 n.1, 200 (holding that "the requirement that a false claim be submitted to the government applies to all [False Claims Act] claims," including both §§ 3729(a)(1)(A) and (B) claims); *Rostholder*, 745 F.3d at 700 n.6 (suggesting in dicta that the precursors to §§ 3729(a)(1)(A) and (B) claims both require presentment).

We need not wade into this debate today. Though Taylor's amended complaint does not clearly specify whether Defendants' alleged upcoding scheme violates 31 U.S.C § 3729(a)(1)(A) or (B), she concedes that she must allege presentment for her upcoding challenge. Therefore, we assume without deciding that Taylor must adequately plead the presentment of false claims for said challenge.

submission of false claims' to the government for payment." *Id.* (cleaned up) (quoting *Nathan*, 707 F.3d at 457).

Under the first option for pleading presentment—pleading with particularity that specific false claims actually were presented to the Government for payment—Taylor alleges no facts about other patients and false invoices at all, much less about the "time, place, and contents of the false representations, . . . the identity of the person making the misrepresentation[,] [or] what he obtained thereby." *Id.* (quoting *Wilson*, 525 F.3d at 379).

That leaves the second option—alleging a "pattern of conduct that would '*necessarily* have led to submission of false claims' to the government for payment." *Id.* (cleaned up) (quoting *Nathan*, 707 F.3d at 457). Again, Taylor does not meet that burden here. To be sure, her amended complaint does allege that BestPractices of West Virginia, acting through Dr. Kitchen, "directed Dr. Perni and other emergency medicine physicians at Camden-Clark Medical Center to sign the medical charts for patients seen only by mid-level providers, to obtain payments at a higher reimbursement rate than was otherwise lawful and/or warranted." J.A. 42. But an allegation that the company *directed* doctors to sign something for a fraudulent purpose is not the same thing as an allegation that false claims were actually *submitted*. *See Grant*, 912 F.3d at 197 (holding that while the relator's allegations suggested that the defendant "engaged in at least some fraudulent conduct, the [relator] fails to provide the last link which is critical for [False Claims Act] liability to attach: namely, that this scheme necessarily led to the presentment of a false claim to the government for payment"). And Taylor has failed to "connect the dots" between Dr. Kitchen's direction and the eventual "government payment." *Id.* at 199.

Specifically, as to patients other than herself, she neglects to allege that (1) those patients were seen by only mid-level providers; (2) doctors employed by BestPractices of West Virginia followed Dr. Kitchen's directive and signed medical charts for patients they did not see; and (3) these signatures necessarily prompted Gottlieb & Associates to submit fraudulent invoices for physician-level care. That is fatal under our precedent.

Taylor counters that "it is impossible to believe that other [fraudulent] billings were not made [and submitted to the Government] . . . in the upcoding scheme." Opening Br. at 41. But "inherently speculative" assertions like this one "are insufficient" under Rule 9(b). *Nathan*, 707 F.3d at 461. That Rule "does not permit a False Claims Act plaintiff merely to describe a private scheme in detail but then to allege simply and without any stated reason for his belief that claims requesting illegal payments *must* have been submitted, were *likely* submitted or *should* have been submitted to the Government." *Id.* at 456–57 (emphases added) (quoting *United States ex rel. Clausen v. Lab. Corp. of Am.*, 290 F.3d 1301, 1311 (11th Cir. 2002)). Therefore, we affirm the district court's dismissal of Taylor's upcoding challenge for all false claims other than the bill for her own medical care.

ii.

That leaves the allegedly false bill for Taylor's medical care. Assuming that she is required to plead presentment for such a claim,[13] there is no doubt that she has done so here. *See* J.A. 69 ("Gottlieb [& Associates] used Relator's medical record to prepare the claim presented to Medicare on behalf of [BestPractices of West Virginia]."). However,

[13] *See supra* note 12.

because Taylor's amended complaint fails to adequately allege scienter for Defendants other than Dr. Perni, we affirm the district court's Rule 12(b)(6) dismissal as to those Defendants.

Under the False Claims Act, a person acts with the requisite scienter if they (1) have "actual knowledge of the [falsity of the] information"; (2) act "in deliberate ignorance of the truth or falsity of the information"; or (3) act "in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1)(A). "[N]o proof of specific intent to defraud" is required. *Id.* § 3729(b)(1)(B).

In the instant case, Taylor does not allege scienter under any particular standard. But no matter which standard we consider—actual knowledge, deliberate ignorance, or reckless disregard—her allegations of scienter are inadequate.[14]

To start, Taylor fails to adequately plead scienter for the corporate Defendants: BestPractices of West Virginia, BestPractices, Holiday, EmCare, and Envision.[15] Her

[14] The district court seemed to believe that Taylor's scienter allegations were subject to Rule 9(b)'s heightened pleading requirements. *See Boyko*, 2020 WL 520933, at *7 ("*Particularly in light of the Rule 9(b) standard*, the complaint does not contain factual support for the conclusory allegations that the remaining Defendants knew that the medical records were false." (emphasis added)). However, Rule 9(b) expressly provides that "[m]alice, intent, *knowledge, and other conditions of a person's mind* may be alleged generally." Fed. R. Civ. P. 9(b) (emphasis added). Therefore, to the extent that the district court imposed an "elevated pleading standard" on Taylor's allegations of scienter, it was mistaken. *Iqbal*, 556 U.S. at 686. This error is of no moment, however, because we nevertheless conclude that Taylor has failed to meet Rule 8's "still operative" plausibility standard, *id.* at 687, and we may "affirm on any ground appearing in the record, including theories not relied upon or rejected by the district court," *Scott*, 328 F.3d at 137.

[15] In Taylor's opening brief, she makes a few passing remarks on the disparity between the relatively benign diagnosis she initially received (cellulitis) and the "high

theory of scienter for these Defendants goes something like this: (1) BestPractices of West Virginia, acting through its employees, knew about the disparity between Taylor's care and her bill; and (2) BestPractices of West Virginia's knowledge, in turn, can be imputed to the remaining corporations "through their [shared] ownership and control" and "direct or indirect contractual arrangements with" each other, nonparty Camden-Clark, and Defendant Gottlieb & Associates. J.A. 74, 77, 80.

Taylor's theory runs into problems at both steps. At step one, Taylor fails to allege that Best Practices of West Virginia had actual knowledge of the disparity between the mid-level care Taylor received and the physician-level care she was billed for. Perhaps sensing this disconnect, her opening brief offers several theories of actual knowledge not found in her amended complaint. To start, she argues that Dr. Perni was acting as an "agent" of BestPractices of West Virginia, so his actual knowledge of the disparity can be "imputed" to the company. Opening Br. at 40. But the amended complaint contains no such allegation; in fact, it explains that Dr. Perni was actually employed by a different company, Weatherby Locums, Inc. Taylor counters that, alternatively, actual knowledge of falsity

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severity" procedural code on her bill. *See* Opening Br. at 7 (describing the disparity); *id.* at 37 (noting that "coding for major care when only minor issues are handled" was alleged in the complaint); *id.* at 38 n.117 ("Gottlieb admits it relied on the record, but submitted a bill for a level of care the record does not support (complex life-saving treatment)."). However, she never explains why she believes this diagnosis/invoice disparity was anything more than mere negligence, nor does she discuss how knowledge of this disparity can be imputed to Defendants other than Gottlieb. Instead, her upcoding argument focuses almost entirely on the disparity between her actual care provider (Nurse Practitioner Angelilli) and the provider marked on her invoice (Dr. Perni via the "Q6" modifier). Because Taylor fails to develop her diagnostic-disparity argument, we consider it waived. *See Grayson O Co.*, 856 F.3d at 316.

can be imputed to BestPractices of West Virginia from its employee Nurse Practitioner Angelilli, since "Angelilli knew Taylor never saw a doctor." *Id.* But Taylor's amended complaint does not allege that Angelilli was aware that Taylor's medical chart was later invoiced to reflect that she *did* see a doctor.

However, Taylor's failure to plead BestPractices of West Virginia's actual knowledge is not fatal. The False Claims Act expressly extends liability to parties acting in "deliberate ignorance" or with "reckless disregard" of the truth or falsity of a given statement—situations where an entity "has 'buried [its] head in the sand' and failed to make simple inquiries which would alert [it] that false claims are being submitted." *United States v. Bourseau*, 531 F.3d 1159, 1168 (9th Cir. 2008) (quoting S. Rep. No. 99-345, at 21 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 5266, 5286).

Though she fails to use this terminology, Taylor hints that that is what happened here. In her amended complaint, she alleges that BestPractices of West Virginia, acting through Dr. Kitchen, "directed Dr. Perni and other emergency medicine physicians at Camden-Clark Medical Center to *sign* the medical charts for patients seen only by mid-level providers, to obtain payments at a higher reimbursement rate than was otherwise lawful and/or warranted." J.A. 42 (emphasis added). She then alleges that, consistent with this directive, Dr. Perni marked the "Attending Note Box" on Taylor's chart as her "Attending Physician," even though he had not, in fact, attended to Taylor. J.A. 37, 69. Gottlieb & Associates then used this "false medical record" to prepare an invoice for submission to Medicare. J.A. 66. In her reply brief, Taylor seems to argue that the reasonable inference we can draw from these allegations is that Best Practices of West

Virginia either deliberately ignored or recklessly disregarded the possibility that its directive would lead to the submission of false claims like Taylor's.

But this is not a warranted inference, primarily because there is a disconnect between this theory of scienter and the false statement alleged in the amended complaint. Taylor seems to be suggesting that BestPractices of West Virginia directed its physicians to *sign* medical charts for a nefarious purpose. But as Taylor's counsel conceded at oral argument, there is no allegation in the amended complaint that Gottlieb & Associates relies on the physician's *signature* to code a bill at a physician-level rate. Instead, the thrust of her argument is that Dr. Perni falsely indicated that he was her attending physician by marking or failing to mark *the Attending Note box*.[16] But Taylor's amended complaint contains no allegations that BestPractices of West Virginia directed its doctors to do

[16] To be sure, Taylor's complaint does muddy this issue. For example, Taylor also alleges that Dr. Perni "*signed*" the "Attending Note Box" or that "Dr. Perni *signed* Relator's medical chart as her Attending Physician." J.A. 37, 69 (emphases added). But as her snapshot of her medical chart—included in the amended complaint—makes clear, Dr. Perni did *not* sign the Attending Note box, but rather signed below it. *See* J.A. 37. And the text below the line where Dr. Perni signed Taylor's medical chart simply states "Physician Signature," not "Attending Physician Signature." *See* J.A. 915. So, once we dispose of these factual misrepresentations, all that is left is Taylor's allegation that Dr. Perni "appear[ed]" to complete the Attending Note box. J.A. 37*; see Goines v. Valley Cmty. Servs. Bd.*, 822 F.3d 159, 165–66 (4th Cir. 2016) (noting that, while our evaluation of a motion to dismiss is "generally limited to a review of the allegations of the complaint itself," "we also consider documents that are explicitly incorporated into the complaint by reference and those attached to the complaint as exhibits" (citation omitted)); *Massey v. Ojaniit*, 759 F.3d 343, 353 (4th Cir. 2014) (holding that, in resolving a motion to dismiss, "we are not obliged to accept allegations that 'represent unwarranted inferences, unreasonable conclusions, or arguments,' or that 'contradict matters properly subject to judicial notice or by exhibit'" (quoting *Blankenship v. Manchin*, 471 F.3d 523, 529 (4th Cir. 2006))).

anything with that box, or otherwise falsely indicate that they had attended to a patient when they had not. In the end, her theory of scienter just does not fit the false statements she claims were made.

Issues with step one aside, Taylor's theory of scienter also falls apart at step two. Her amended complaint offers only bald and vague allegations that the corporate Defendants "knowingly made, used, or caused to be made or used, a false record" for Taylor's medical care "through their [shared] ownership and control" and "direct or indirect contractual arrangements with" each other, Camden-Clark, and Gottlieb & Associates. J.A. 74, 77, 80. These "bare assertions" of knowledge "are conclusory and not entitled to be assumed true." *Iqbal*, 556 U.S. at 681.

Taylor counters that even if some of her allegations are conclusory, "knowledge is permitted to be alleged generally" under Rule 9(b). Opening Br. at 38. But "Rule 9 merely excuses a party from pleading [knowledge] under an elevated pleading standard. It does not give him license to evade the less rigid—though still operative—strictures of Rule 8." *Iqbal*, 556 U.S. at 686–87. And as the Supreme Court assiduously made clear in *Iqbal*, Rule 8 "do[es] not require courts to credit a complaint's conclusory statements." *Id.* at 686.

That leaves Dr. Boyko (the doctor listed on Taylor's bill) and Gottlieb & Associates (the accounting firm that prepared her bill). Taylor's opening brief does not dispute the district court's finding that she inadequately pleaded scienter for Dr. Boyko. Therefore, she has waived appellate review of this claim. *Grayson O Co. v. Agadir Int'l LLC*, 856 F.3d 307, 316 (4th Cir. 2017) ("A party waives an argument by failing to present it in its opening brief or by failing to 'develop [its] argument—even if [its] brief takes a passing shot at the

issue.'" (quoting *Brown v. Nucor Corp.*, 785 F.3d 895, 923 (4th Cir. 2015) (Agee, J., dissenting))).

As for Gottlieb & Associates, Taylor alleges that scienter can plausibly be inferred from the discrepancy between her medical record and the invoice prepared by the firm. Specifically, she alleges that "[a]lthough the face of the medical records of Relator appear to demonstrate that Ms. Angelilli provided the care to Relator (and not Dr. Perni or Dr. Boyko), Gottlieb [& Associates] still used the name and/or [Medicare Provider] number of Dr. Boyko to bill for and for Relator's care rather than use the name and/or [Medicare Provider] number for Ms. Angelilli, which would result in a reimbursement rate of 85% of the physician rate, in accordance with federal law and regulations." J.A. 74. So, Taylor's theory of scienter for Gottlieb & Associates, distilled to its essence, is that knowledge can be inferred from the firm's negligent failure to read between the lines of Taylor's bill and surmise that only Angelilli provided care to Taylor, even though the Attending Note box allegedly indicated otherwise. That is not a plausible theory. *See United States ex rel. Owens v. First Kuwaiti Gen. Trading & Contracting Co.*, 612 F.3d 724, 728 (4th Cir. 2010) (holding the False Claims Act does "not punish honest mistakes or incorrect claims submitted through mere negligence" (quoting *United States ex rel. Hochman v. Nackman*, 145 F.3d 1069, 1073 (9th Cir.1998))).

In conclusion, we agree with the district court that Taylor's "conclusory" and implausible allegations fail to adequately plead scienter. *Boyko*, 2020 WL 520933, at *7. Therefore, we affirm the dismissal of Taylor's upcoding claim for her bill against all Defendants except Dr. Perni.

C.

That brings us to Taylor's claim against Dr. Perni. Unlike the other Defendants, the district court found that Taylor's allegations involving Dr. Perni were sufficient to survive the motion-to-dismiss stage. However, the district court ultimately granted summary judgment to Dr. Perni on falsity and scienter grounds. *Perni*, 2020 WL 2499544, at *6.

We review the district court's grant of summary judgment to Dr. Perni de novo. *Owens*, 612 F.3d at 728. Summary judgment is appropriate if "there is no genuine dispute as to any material fact" and Dr. Perni "is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). "In making this determination, we must view all facts and reasonable inferences in the light most favorable to [Taylor], the non-moving party." *Owens*, 612 F.3d at 728.

We begin by assessing whether Taylor has established a genuine dispute regarding the falsity of Dr. Perni's statement. Because we conclude she has not, we affirm on this basis without analyzing the other elements of a False Claims Act claim.

1.

The False Claims Act prohibits the knowing presentment of a "false or fraudulent claim" or a "false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(A), (B). However, as the Supreme Court explained in *Escobar*, "Congress did not define what makes a claim 'false' or 'fraudulent.'" 579 U.S. at 187. When that is the case, it is a "settled principle of interpretation that, absent other indication, Congress intends to incorporate the well-settled meaning of the common-law terms it uses." *Id.* (quoting *Sekhar v. United States*, 570 U.S. 729, 732 (2013)). And "because there are no

textual indicia to the contrary" here, Congress must have intended for the term "false or fraudulent" to incorporate its "common-law meaning." *Id.* at 187 & n.2.

At common law, a false statement encompassed any "words or conduct" that "amount[] to an assertion not in accordance with the truth," Restatement (Second) of Torts § 525 cmt. b (1977), including a "representation stating the truth so far as it goes but which the maker knows or believes to be materially misleading because of his failure to state additional or qualifying [information]," *id.* § 529. But even under the broad, common-law definition of falsity embraced in *Escobar*, Taylor has failed to establish a genuine issue of material fact regarding the allegedly false statement made by Dr. Perni.

It doesn't help that Taylor inconsistently describes what that false statement was. At times, she suggests that Dr. Perni himself filled out the Attending Note box, which stated that the attending care provider had "interviewed and examined" the patient. Opening Br. at 6. If he had, that would have been an obviously false statement since no one disputes that Dr. Perni neither interviewed nor examined Taylor. But in Dr. Perni's sworn declaration and deposition testimony, he repeatedly stated that he did not fill out the Attending Note box, that that box "is used for billing purposes" only and he has "nothing to do with the box," J.A. 171, and that "there were no marks in the 'Attending Note' box at the time that [he] completed [Taylor's] chart," J.A. 146.

As support, Dr. Perni pointed out that the check marks he made on the "Template Complete" box are noticeably different than those found in the Attending Note box—while the mark he admits to making consists of a single straight line, the marks in the Attending Note box appear to be more traditional, v-shaped check marks. Even if we discount this

writing-based evidence, Taylor's own expert also confirmed that there was nothing "inaccurate" about what Dr. Perni marked on Taylor's chart. Because Taylor has failed to produce any evidence to the contrary, this theory of falsity is a dead end.

At other times, Taylor argues that while Dr. Perni may not have made any demonstrably false statements on Taylor's chart, the fact that he left the Attending Note box blank "substantially aided the Defendants by leaving the door open for Gottlieb [& Associates] to code the claim as a physician encounter." Opening Br. at 45. However, Taylor has failed to introduce any evidence to support her theory. Dr. Perni testified that the Attending Note box did not have to be filled out by a physician before they signed and submitted a medical chart for billing. Taylor offers no evidence to dispute this, other than the testimony of her expert, Dr. David Forrester, who merely opined that it would have been "*reasonable* for [Dr. Perni] to specify whether or not he saw the patient because that's the pivotal requirement associated with how the claim is billed." J.A. 566 (emphasis added). While it may indeed have been "reasonable" for Dr. Perni to do so, that does not mean that leaving blank a portion of a medical form *that he did not have to complete* rises to the level of a false or fraudulent statement under the False Claims Act.

Finally, Taylor argues that Dr. Perni made a materially false statement by signing her chart and marking the "Template Complete" box when the Attending Note box was—by his own admission—not filled out at the time. Opening Br. at 46. We note at the outset that Taylor advanced no such claim in her amended complaint. But even if she had, we would again point her to Dr. Perni's undisputed testimony that the Attending Note box did not need to be filled out for the chart to be signed and submitted for billing.

For these reasons, we affirm the district court's grant of summary judgment to Dr. Perni on falsity grounds.

IV.

At the end of the day, our binding precedent requires us to conclude that Taylor did not clear the high hurdles erected by the False Claims Act. Accordingly, the decisions of the district court are

AFFIRMED.