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NEWSLETTER

False Claims Act Qui Tam Action Over Billing Practices Does Not Involve Professional Services; Claim Is Barred by Fraud Exclusion

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Applying Washington law, the United States District Court for the Western District of Washington has determined that a False Claims Act (FCA) *qui tam* lawsuit against a medical management services organization regarding billing practices was not covered under the organization's professional liability policy because it did not allege a negligent act, error or omission arising from the organization's "professional services" and because the policy's fraud and dishonesty exclusion precluded coverage. *MSO Washington, Inc. v. RSUI Group, Inc.*, 2013 WL 1914482 (W.D. Wash. May 8, 2013). Additionally, the court ruled that the insurer had no duty to indemnify or defend and that common law and statutory bad faith counts asserted against the insurer therefore failed.

The insured provided administrative and management services to health care providers, including billing and collection services. A federal FCA *qui tam* complaint was filed against the insured alleging that it engaged in a scheme to defraud programs such as Medicare and Medicaid by over-representing the cost of services supplied to patients. The complaint was filed under seal, however, and the insured was served with subpoenas from the U.S. Department of Health and Human Services seeking documents "in connection with an investigation regarding the submission of possibly false, fraudulent or improper claims."

The insured submitted the subpoenas to its professional liability insurer for coverage, and, following settlement of the *qui tam* lawsuit, provided notice of that action as well. The medical professional liability policy at issue afforded coverage for sums the insured became legally obligated to pay as damages or claim expenses arising out of a negligent act, error and omission for claims first made during the policy period. It excluded coverage for any claim based upon or arising out of dishonest, fraudulent, criminal or intentional acts, errors or omissions. The insurer denied coverage for the subpoenas and the lawsuit, and the insured filed a lawsuit against the insurer for declaratory judgment, as well as common law and statutory "bad faith" and negligence.

The court determined that no coverage was available because "courts in this District and elsewhere have unanimously concluded that the submission of billing claims under the [FCA] does not qualify as a 'professional service.'" The insured contended that billing and collections were among its primary services, in

contrast with medical providers, for whom billing is an ancillary activity. The court rejected this argument because the insured had represented to the insurer that it provided primary care as a medical outpatient facility, and the insured issued the medical professional liability policy on that basis.

The court also concluded that an FCA claim did not fall within the policy's coverage grant for damages arising out of a negligent act, error or omission, because "[a] party cannot be held liable pursuant to the [FCA] for mere negligence." Instead, "there must be a knowing presentation of what is known to be false." For the same reason, the court concluded that the policy's dishonesty exclusion precluded coverage. Accordingly, the court determined that the insurer had no duty to defend or to indemnify.

In light of its determination that no coverage was available, the court dismissed the insured's counts against the insurer for "bad faith" and for violation of Washington's Insurance Fair Conduct Act (IFCA) and Consumer Protection Act and for negligence. The court reasoned that, in the absence of coverage, the insured could not show harm, which is an essential element of a bad faith or negligence claim. In addition, the insured lacked a cause of action under the IFCA or Consumer Fraud Act because it could not show an unreasonable denial of coverage or payment of benefits.