UNITED STATES DISTRICT COURT FOR THE MIDDLE DISTRICT OF GEORGIA

UNITED STATES OF AMERICA *ex rel.* STATE OF GEORGIA *ex rel.* RICHARD BARKER.,	:	
Plaintiffs	:	Civil Action No. 4-12-cv-108(CDL)
v.	:	**FILED UNDER SEAL** pursuant to
COLUMBUS REGIONAL HEALTHCARE SYSTEM, THE MEDICAL CENTER, JOHN B. AMOS CANCER CENTER, REGIONAL ONCOLOGY, LLC., THOMAS J. TIDWELL, and COLUMBUS RADIATION ONCOLOGY TREATMENT CENTER	:	31 U.S.C. § 3729 *et seq.*
Defendants.	:	

AMENDED COMPLAINT

Relator-Plaintiff Richard Barker, by and through undersigned counsel, brings this False Claims Act Complaint, on behalf of the United States of America and the State of Georgia, against Defendants Columbus Regional Healthcare System ("CRHS"), The Medical Center ("TMC"), the John B. Amos Cancer Center ("JBACC"), Regional Oncology, LLC ("RO"), Thomas J. Tidwell, and Columbus Radiation Oncology Treatment Center ("CROTC") (collectively "the Defendants"). This action is brought by plaintiff to recover

civil penalties and treble damages under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-33 and the Georgia False Medicaid Claims Act (the "GAFMCA"), GA. CODE ANN. § 49-4-168.1.

INTRODUCTION

1. This is an action to recover treble damages and civil penalties on behalf of the United States of America and the State of Georgia arising from false and/or fraudulent statements, records and claims made, or caused to be made, by the Defendants and/or their agents and employees.

2. This *qui tam* case is brought against the Defendants for submitting and/or causing the submission of false claims by knowingly submitting reimbursement claims to Medicare, 42 U.S.C. § 1395 *et seq.*, Medicaid, 42 U.S.C. § 1396 *et seq.*, TRICARE/CHAMPUS 10 U.S.C. § 1071 *et seq.*, and Federal Employee Health Benefits Program, 5 U.S.C. §§ 8901, *et seq.* (hereinafter collectively referred to as "Federal Healthcare Programs") for medically unnecessary office visits.

JURISDICTION AND VENUE

3. This action arises under the False Claims Act, as amended, 31 U.S.C. §§ 3729-3733. This Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331, and subject matter jurisdiction under the federal False Claims Act, 31 U.S.C. § 3732, including state law claims under 31 U.S.C. § 3732(b). This

court also has supplemental jurisdiction over state law claims pursuant to 28 U.S.C. § 1367.

4. Venue lies in this district under 28 U.S.C. § 1391(b) & (c) and 31 U.S.C. § 3732(a) because the Defendants transact business and have committed acts in violation of 31 U.S.C. § 3729 in this district.

THE PARTIES

5. Relator-Plaintiff Richard Barker ("Relator") is an adult citizen and resident of the State of Georgia. Relator has been, since September 26, 2011, Administrative Director of the JBACC. In that position, Mr. Barker oversees day-to-day operations of the medical and radiation oncology, integrative medicine, pharmacy, front office and business offices services and facilities. Mr. Barker has twenty years experience in oncology medicine practice administration, including extensive experience with billing and reimbursement. In his prior position, with Cancer Care Partners in Mishawaka, Indiana, he served as the compliance officer for the practice, managed all quality assurance and performance improvement projects and was responsible for the entire billing process. Mr. Barker has been periodically trained and updated on proper billing procedures, and regularly reviews Medicare and Medicaid bulletins. Mr. Barker has independent knowledge of all of the allegations against the Defendant and is the original source of the allegations contained in this Complaint. Before filing this Amended Complaint,

Mr. Barker made a disclosure of all material evidence and information in his possession to the Government as required by 31 U.S.C. § 3730(b)(2).

6. Defendant CRHS is a non-profit, health care system serving communities in Alabama and Georgia. CRHS owns two acute care hospitals, both located within Columbus, Georgia, The Medical Center ("TMC") and the Doctor's Hospital, which is not a defendant in this action. CRHS's corporate office and principal place of business is located at 707 Center Street, Columbus, Georgia.

7. TMC is an acute care hospital with its principal place of business at 710 Center Street, Columbus, Georgia.

8. The John B. Amos Cancer Center ("JBACC") is a division of TMC, but is physically separate from TMC. JBACC facilities are located at 1831 5th Avenue, Columbus, Georgia.

9. Columbus Regional Oncology Treatment Center is a wholly owned subsidiary of CRHS with its principal place of business at 2121-B Warm Springs Road, Columbus, Georgia 31904.

10. All of the medical oncologists employed by and providing services at JBACC are employed by Regional Oncology, LLC ("RO"). RO has its principal place of business at 1831 5th Avenue, Columbus, Georgia.

11. Thomas J. Tidwell, M.D. is the former owner of Tidwell Cancer Treatment Center ("TCTC"). He retired from the practice of radiation oncology in

December, 2012. In July, 2010, Dr. Tidwell sold his practice TCTC to CRHS. He continued to practice there until his retirement in 2012. Dr. Tidwell resides at 312 Cascade Court, Columbus, Georgia 31904.

STATUTORY AND REGULATORY FRAMEWORK

I. The Federal False Claims Act

12. The False Claims Act provides that 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 to the Government is liable for damages in the amount of three (3) times the amount of loss the Government sustained and penalties which range between $5,500 and $11,000 per claim. 31 U.S.C. § 3729(a); 28 C.F.R. § 85.3. For purposes of the FCA, "the terms 'knowing' and 'knowingly' mean that a person, . . . (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information." *Id.* at § (b). "[N]o proof of specific intent to defraud is required" for a successful claim under the FCA. *Id.*

II. The Georgia False Medicaid Claims Act

13. The GAFMCA provides that any person who knowingly makes or causes to be made any false statement or representation of a material fact for use in

determining right to a payment from the Georgia Medicaid Program is liable for a civil penalty of between five thousand five hundred dollars ($5,500) and eleven thousand dollars ($11,000) for each violation, plus three (3) times the amount of all payments judicially found to have been fraudulently received from Medicaid, or its fiscal agents because of the act of that person. GA. CODE. ANN. § 49-4-168.1. The GAFMCA defines "knowingly" to mean that a person "has actual knowledge of the information or acts in deliberate ignorance or reckless disregard of the truth or falsity of the information." GA. CODE. ANN. § 49-4-168.

III. Federal Healthcare Programs

A. *Medicare*

14. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* establishes the Health Insurance for the Aged and Disabled Program, more popularly known as the Medicare program. The Medicare program is a federally operated and funded program. It is administered by the Secretary of Health and Human Services ("HHS") through the Centers for Medicare and Medicaid Services ("CMS"), a department of HHS.

15. The Medicare program is comprised of four parts, but only Medicare Parts A and B are relevant in this action. Part B is a federally subsidized, voluntary insurance program that covers a percentage (typically eighty percent) of

the fee schedule amount of physician and laboratory services. 42 U.S.C. §§ 1395k, 1395l, 1395x(s).

16. To participate in Medicare, providers must certify that their services are provided economically and only when, and to the extent medically required, or that the services are "reasonable and necessary," as required by statute. 42 U.S.C. § 1395n; 42 U.S.C. § 1395y(a)(1)(A). A service is expressly excluded from coverage if it is "not reasonable and necessary" for "the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 C.F.R. § 411.15(k)(1). In other words, it is an express condition of payment that the treatment sought under Medicare must be medically necessary. *Id.*; 42 C.F.R. § 411.15 (delineating "[p]articular services excluded from coverage"); *id.* at § 411.1(b)(1) (stating that "[t]his subpart identifies: (1) The particular types of services that are excluded" from coverage); *see also* 42 C.F.R. Subpart 411 (titled "Exclusions From Medicare and Limitations on Medicare Payment").

B. *Medicaid*

17. Medicaid is a joint federal-state program that provides health care benefits for certain groups; primarily the poor and disabled. Each state administers its own Medicaid program, under federal regulations that generally govern what services should be provided, under what conditions. CMS monitors the state-run programs and establishes requirements for service delivery, quality, funding, and

eligibility standards. The federal government provides a portion of each state's Medicaid funding. The portion provided is known as the Federal Medical Assistance Percentage ("FMAP") and is based on the state's per capita income compared to the national average. 42 U.S.C. § 1396d(b). In Georgia, the rate in effect from October 1, 2011 through September 30, 2012 is 66 %.

18. Like Medicare, a "claim" under Medicaid is only reimbursable if it is "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member". 42 C.F.R. § 402.3.

C. *TRICARE/CHAMPUS*.

19. In 1967, the Department of Defense created the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS"), which is a federally funded medical program created by Congress. 10 U.S.C. § 1071. CHAMPUS beneficiaries include active military personnel, retired personnel, and dependents of both active and retired personnel. *Id*.

20. In 1995, the Department of Defense established TRICARE, a managed healthcare program, which operates as a supplement to CHAMPUS. *See* 32 C.F.R. §§ 199.4, 199.17(a). Since the establishment of TRICARE in 1995, both programs are frequently referred to collectively as TRICARE/CHAMPUS, or just "TRICARE." The purpose of the TRICARE program is to improve healthcare services to beneficiaries by creating "managed care support contracts that include

special arrangements with civilian sector health care providers." 32 C.F.R. § 199.17(a)(1). The TRICARE Management Activity ("TMA") oversees this program.

21. The TRICARE managed healthcare programs are created through contracts with managed care contractors in three geographic regions: North, South, and West. The Defendants serve patients in the South TriCare region. TRICARE health services are provided through both network, and non-network, participating providers. Providers who are Medicare-certified providers are also considered TRICARE-authorized providers. TRICARE-authorized providers are either "Network Providers" or "Non-Network Providers."

22. "Network Providers" include hospitals, other authorized medical facilities, doctors and healthcare professionals, all of whom enter into an agreement with the region's managed care contractor, and provide services for an agreed reimbursement rate. 32 C.F.R. § 199.14(a). "Non-Network Participating Providers" include hospitals, other authorized medical facilities, doctors and healthcare professionals who do not enter an agreement with the region's managed care provider, and are reimbursed at rates established by TRICARE regulations. *Id.*

23. The TRICARE managed care contractor for the South region is Humana Military Healthcare Services, Inc. This contractor currently lists

Defendant JBACC's medical oncologists as Network Providers. To obtain status as a TRICARE Network Provider, Defendant JBACC signed a contract with these managed care contractors accepting payment at TRICARE's negotiated rates.

24. Just as with Medicare and Medicaid, TRICARE providers have an obligation to provide services and supplies at only the appropriate level and "only when and to the extent medically necessary." 32 C.F.R. § 199.6(a)(5).

25. TRICARE's governing regulations, like Medicare's and Medicaid's requirements also are based upon "medical necessity." TRICARE's governing regulations require that services provided be "furnished at the appropriate level and only when and to the extent medically necessary," and such care must "meet[] professionally recognized standards of health care [and be] supported by adequate medical documentation . . . to evidence the medical necessity and quality of services furnished, as well as the appropriateness of the level of care." 32 C.F.R. 199.6(a)(5). In this respect, similar to Medicare and Medicaid, services provided at a level higher than the medically necessary are improper and violations of TRICARE. *Id.*

D. *Federal Employee Health Benefits Program*

26. The Federal Employee Health Benefits Program ("FEHBP") is a federally funded medical insurance program for federal employees, retirees, their spouses and unmarried dependent children under age 22, administered by the

Office of Personnel Management ("OPM") pursuant to 5 U.S.C. §§ 8901, *et seq.* Through the OPM, the Government contracts with private health plans or "carriers" to deliver health benefits to its employees. Monies for the FEHBP are maintained in the Employees' Health Benefits Fund ("Health Fund"), and are administered by OPM. 5 U.S.C. § 8909. Federal agencies and their employees contribute to the Health Fund to cover the total cost of health care premiums. 5 U.S.C. § 8906. The monies from the Health Fund are used to reimburse the carriers for claims they pay on behalf of FEHBP beneficiaries.

27. Like Medicare Part B and TRICARE, FEHBP will not cover any treatment or surgery that is not medically necessary. 5 U.S.C. § 8902(n)(1)(A).

IV. Defendant's Up-coding of Evaluation and Management Services

A. Federal and State Government Healthcare Programs Reimbursement Requirements For Evaluation and Management Services.

28. Both state and Federal Healthcare Programs determine reimbursements to providers based on the medical necessity of procedures, services, and hospital admissions. Medical necessity must be determined prior to the performance of each medical service and must be clearly documented in a physician's order. It cannot be determined retroactively.

29. Federal regulations define a "prior determination of medical necessity" to mean "an individual decision by a Medicare contractor, before a physician's service is furnished, as to whether or not the physician's service is

covered" by the federal healthcare program. 42 C.F.R. § 410.20. If the service is not medically necessary, Federal Healthcare Programs will not reimburse the provider.

30. Doctors submit claims to Medicare, Medicaid, TRICARE and FEHBP on the HCFA 1500 claims form. The Form 1500 requires the doctor to describe the services provided to the patient using standardized numeric codes, called CPT Codes, which are developed by the American Medical Association. The CPT Codes for Evaluation & Management ("E/M") services range from Level I, for the least complicated services for cases of low severity to Level V, for complex services for cases of high severity. The Federal Healthcare Programs reimburse the higher levels of E/M services at a significantly higher rate.

31. For each claim the Defendants submitted to Medicare, Medicaid, TRICARE or FEHBP for reimbursement, the Defendants certified that the services were "medically indicated and necessary for the health of the patient." The Defendants also agreed that if they "knowingly file[ed] a statement of claim containing any misrepresentation or any false, incomplete or misleading information [he] may be guilty of a criminal act punishable under law and may be subject to civil penalties."

32. The Defendants were aware of, or should have been aware of, the conditions for repayment under the Medicare, Medicaid, TRICARE and FEHBP Programs referred to in the preceding paragraphs.

33. Medicare Part B permits providers to use either of two Evaluation and Management Documentation Guidelines. These Guidelines are discussed in more detail *infra* at Paragraphs 33-35. CPT Codes are used to report E/M services. While providers must insure that the Guidelines' requirements for the individual CPT Codes are met when selecting the appropriate CPT Code, medical necessity for the service must also be met. According to Medicare, it is not medically necessary or appropriate to bill a higher level of E/M service when a lower level of service is all that is medically necessary. Documentation in the medical record must support the level of service chosen.

34. Medical Necessity of E/M services is generally expressed in two ways, by the frequency of services and the intensity of service -- which corresponds to the CPT level. The provider's documentation of E/M services reported to Medicare must demonstrate that both the frequency and the intensity of the E/M service were appropriate considering the nature of the patient's complaint and condition. Medicare's determination of medical necessity is separate from its determination that the E/M service was rendered as billed. Medicare judges the

provision of the service based on CPT E/M Code definitions and the CMS E/M Service Documentation Guidelines (1995 and 1997 versions).

35. The CPT Codes that govern E/M services are as follows: for new patients, 99201 to 99205; and for established patients, 99211-99215. Each level reflects an increased level of acuity of the patient's presenting complaint; the number of physical systems evaluated and managed during the encounter; the acuity and/or duration of the problems evaluated and managed; and the complexity of documented comorbidities that have clearly influenced the physician's work. The CPT Codes thus reflect an increasing level of complexity of "medical decision making."

36. CPT Code 99212 is defined as an office or other outpatient visit for the evaluation and management of an established patient which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; or straightforward medical decision making. Usually the presenting problems are self-limiting or minor. Physicians typically spend 10 minutes face-to-face with the patient and/or family. CPT Code 99213 is defined as an office or other outpatient visit for the evaluation and management of an established patient which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of

low complexity. Usually the presenting problems are self-limiting or minor. Physicians typically spend 15 minutes face-to-face with the patient and/or family.

37. CPT 99214 is defined as an office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; and medical decision making of moderate complexity. Counselling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient or family. See Current Procedural Terminology, Fourth Edition. An office visit qualifying for CPT Code 99215 is identical, except that it involves medical decision-making of high complexity and typically involves a forty minute patient visit.[1] Medicare makes clear that in order to bill the highest levels of visit codes, the visit must include a comprehensive history that includes a review of all of the systems and a review of a complete past family and social history, whether taken at that visit or a prior visit.

38. To bill for an E/M visit on the day a patient has chemotherapy, the patient must have a “significantly separately identifiable service,” otherwise the

[1]The 1995 Documentation Guidelines for E/M Services explain that history, examination and medical decision making and not time spent with the patients are generally "the key components in selecting the level of E/M services, unless the visit predominantly consists of counselling or coordination of care.”

E/M visit is included in reimbursement for the chemotherapy service. Medicare Claims Processing Manual, c. 12, secs. 30.6.F, 30.6.6. A different diagnosis is not required; however, documentation for that visit must reflect a "significant, separately identifiable E/M service that is above and beyond the usual pre-and post-operative work of the [chemotherapy]." *Id.* At 30.6.6.

B. Defendant's Improper Billing of Evaluation and Management Services to Federal Payors

39. Almost immediately after joining JBACC in September, 2011, Plaintiff-Relator Barker identified a long-standing practice of improper coding and billing Federal Healthcare Programs and Medicaid for office visits. The issues that the Relator identified included: (1) billing for E/M services (office visits) at levels that were not supported by the documentation in the medical record; and (2) billing for E/M services that were included within the reimbursement for the administration of chemotherapy and thus were not separately billable.

40. JBACC has five medical oncologists: Wilbur Bassett Jr., M.D., Peter Jiang, M.D., Wendy Mahone Johnson, M.D., Suresh Nukala, M.D., and Andrew Pippas, M.D. Dr. Pippas serves as the Medical Director of JBACC. Medical oncologists specialize in diagnosing and treating cancer using chemotherapy, hormonal therapy, biological therapy, and targeted therapy. They often are the main health care provider for someone who has cancer.

41. At JBACC, during the first three years that medical oncologists are employed, they are salaried employees, and their compensation does not depend upon the number of patients they see or the revenue they generate. After three years, their compensation changes to a Revenue Value Unit ("RVU"), based methodology. Medicare assigns each CPT Code an RVU, which when multiplied by the conversion factor (which converts the RVU to an actual dollar amount) and a geographical adjustment (which accounts for the geographic differences in the cost of practice across the country), creates the compensation level for a particular service. CMS pays the bulk of the physician fees, under Medicare Part B, through RVUs. Medicare Claims Processing Manual, c. 12, sec. 20.2.

42. The medical oncologists at JBACC are paid $90 per RVU, for each and every RVU they generate, according to the following chart:

CPT Code	RVU	Payment
99201	.45	$40.50
99202	.88	$79.20
99203	1.34	$120.60
99204	2.0	$180.0
99205	2.67	$240.30
99211	.17	$15.30
99212	.45	$40.50
99213	.67	$60.30
99214	1.10	$99.00
99215	1.77	$159.30

43. In addition to receiving compensation based upon the RVUs they generate after three years, medical oncologists are given responsibility to code their own work. Thus, there is a direct correlation between a medical oncologist's compensation and the billing code he or she chooses to seek reimbursement from third party payers.

44. After the patient visit, the physician circles the CPT Code to be billed for that visit on a pre-printed charge sheet or "Super Bill," and forwards that form to Sandra Pritchett, Regional Oncology's only Medical Oncology Coder. Ms. Pritchett enters that code into Athena, the software package that the JBACC uses to submit its claims for professional fees. At the time Ms. Pritchett enters the code, she does not have the medical record, so that she cannot determine whether the documentation in the medical record supports the billing charge.

45. After Ms. Pritchett enters the charge into the billing system, the information is transmitted to the TMC Physician's Revenue Cycle Management department at JBACC's affiliated hospital, TMC. Jeffrey Johnson is the Director of this Department. TMC actually submits the charge to Federal Healthcare Programs through its fiscal intermediaries, in the case of Medicare, through Cahaba Government Benefit Administrators, for payment by CMS. Hewlett Packard Enterprise Services serves as the fiscal intermediary for Medicaid and Humana Military Healthcare Services, Inc. For TRICARE. TMC does not review

these charges to ensure that the medical record supports the level of acuity claimed prior to passing them on to its fiscal intermediaries for submission to the federal or state governments.

46. Not only does Ms. Pritchett not have the medical record at hand to verify the accuracy of the charge before it is submitted through the Athena billing system to TMC for billing Federal Healthcare Programs, but as the Relator has discovered through his tenure at JBACC, that documentation may, in fact, not exist. At JBACC, there are no electronic medical records in which providers contemporaneously enter information about encounters; instead, physicians may complete their medical documentation by dictating their impressions of their encounters with patients into cassette records. Their notes are then transcribed and returned to the medical oncologists for their review and signature to be placed in the patient's chart.

47. Under this system, many patient records are not transcribed for up to six months after the patient visit – long after the claim form has been submitted for the patient encounter. There are no written policies for timely dictation of progress notes or record completion.

48. Relator Barker began working at JBACC in September 2011. On September 29, 2011, during his first week there, Karon Duderewicz, JBACC's Health Information Management ("HIM") manager, showed the Relator a

bookcase in Dr. Pippas' office filled with patient medical records that contained unsigned physician telephone and verbal orders for drugs and laboratory tests, missing dictation and patient encounter forms with "HNO" (hand note only) written on them. (HNO indicates that there will not be any additional dictation generated for that visit.) Upon review, many, if not most of these HNO encounter forms did not contain enough information to support the CPT charge indicated for that day's visit.

49. The Relator soon learned that these problems with medical records were wide-spread. This disarray with the missing dictation violates CMS policy that the CPT Codes appropriately reflect the "medical necessity" of the particular E/M visit, that the medical records support the particular CPT Code assigned to the visit, and that the documentation in the medical records be completed during the patient visit or as soon as practicable thereafter.

50. The Relator learned from Karon Duderwicz, the JBACC HIM Manager, that Dr. Pippas, JBACC's Medical Director, frequently instructs his transcriptionist to "roll my last note forward with the following changes." Thus, his documentation for office visits duplicates, at least in part, information from one visit to the next.

51. On October 4, 2011, just a little over a week after he joined JBACC, and in his first regularly scheduled meeting with his then-boss, Kevin Sass, Chief

Executive Officer for the Doctors Hospital, Relator told Mr. Sass about the issues he had uncovered with medical documentation of office visits. The Relator informed Mr. Sass that many of the medical oncologists' patient encounter forms did not support the E/M claims submitted on their behalf. Mr. Sass agreed and admitted that this was not the first time that he had heard of this issue.

52. Relator raised this issue again during his next meeting with Mr. Sass, on October 13, 2011. Relator told Mr. Sass during this visit that he had learned that Dr. Pippas generated a disproportionate number of CPT Code level 5 visits, which, combined with the large number of patients Dr. Pippas saw every day, might raise red flags for an audit by CMS and other insurers. The Relator learned about the disproportionate number of 99215 billings from Angie Finley, a Senior Systems Analyst in JBACC Corporate Finance, who send the Relator a monthly report that lists all of the E & M visits billed broken down by code, by practitioner. These reports are utilized by JBACC to determine each physician's monthly compensation.

53. On October 25, 2011, Bonnie Conrad, the Interim Patient Financial Services Associate Director at JBACC, informed Susan Norton, Director of Self Pay at JBACC, that there were "in excess of 200 charts in Dr. Pippas' office that have not had dictation done on that we have already charged and billed for." After first confirming that Ms. Conrad had "actually seen" the charts, Ms. Norton

forwarded the email to Roland Thacker, Senior Vice President and Chief Financial Officer, CRHS, Kevin Sass, Chief Executive Officer, the Doctor's Hospital and Patricia Alford, Senior Director, Patient Financial Services, CRHS, that same day.

54. More than a month later, on November 30, 2011, Ms. Norton informed Mr. Thacker, Mr. Sass, and Ms. Alford that there has been no "improvement in the area of dictation and chart completion," employees are voicing their concerns and the organization is "billing and collecting with incomplete patient records."

55. After receiving no response to her earlier emails, Ms. Norton again reported to Mr. Thacker on January 16, 2012 that "concerns [about medical documentation] are growing." She stated that the JBACC is "continuing to perform services without the appropriate documentation," and people were discussing "corporate compliance" and "whistle blower."

56. Throughout this time period, Relator Barker repeatedly informed Jeffrey Johnson, Director of Professional Fees, JBACC and Ms. Alford of numerous infractions of Medicare rules and regulations that JBACC committed on a regular basis; both admitted that they were aware of the situation, but took no action to refund overpayments to Medicare, Medicaid or other federal payors. Relator Barker also expressed his concerns to Dr. Pippas, the Medical Director for JBACC; urging Dr. Pippas to complete his dictation and suggested the need for an

outside consultant to review JBACC's billing processes. Dr. Pippas assured Relator Barker that all was well, there was no need for an outside consultant and that he would complete his missing dictation.

57. In addition to sounding the alarm about the improper billing practices at JBACC, Relator Barker attempted to ensure that current coders received proper training. He submitted requests for travel and training for two coders: one who needed to be recertified and another who needed to take a test to be certified. Both requests were denied without further explanation. In fact, since Relator Barker's arrival in September 2011, there has been no training specific to coding or billing at JBACC. Nor does JBACC receive Medicare or Medicaid billing publications. Compared to his previous employment in the industry, Relator Barker notes that this lack of training is unusual. The only compliance training that employees receive is during new employee orientation, with no refresher courses or updates provided.

58. On January 12, 2012, Mr. Thacker finally replied to Ms. Norton's email, indicating that Mr. Johnson had conducted a brief audit on the issues and stated that at a minimum "all professional (physician) billings should be suspended until documentation or chart is considered complete." For incomplete records that have already been billed, Mr. Thacker indicated that they "might use an outside

firm to audit and/or provide assistance with eliminating the backlog," but he was waiting for a specific recommendation.

59. Mr. Thacker minimized the issue as just "unsigned charts." Ms. Norton responded the next day to explain that the problem is two-fold; there are both missing signatures and "some charges are missing documentation to support the E & M level."

60. On January 17, 2012, Mr. Thacker stated that he had called Healthcare Management Resources, Inc. ("HMR"), an outside consultant, regarding compliance audits. HMR evaluates medical practices and provides advice on a number of issues such as billing and account receivable management, administrative services and operations performance. HMR began its review of JBACC compliance issues on May 1, 2012.

61. On February 9, 2012, Ms. Conrad sent a memo to Ms. Norton, Ms. Alford, Mr. Sass and the Relator, which included her "Recommendations for JBACC Revenue [Billing] Cycle Improvements." In it, she specifically cited two possible compliance issues: (1) the lack of follow up physician signatures on all telephone and verbal orders; and (2) the lack of appropriate "back-up documentation in the medical record to justify the E & M coding/charging/billing/payment." Ms. Conrad also recommended that the JBACC

provide compliance training to physicians and staff and provide "documentation" training to all physicians. To date, this training has not occurred.

62. On February 28, 2012, the JBACC was also made aware of improper billing to private insurers (in addition to the Relator's earlier notice of its improper billing to Medicare) when Ms. Pritchett informed Mr. Johnson, Director of Professional Fees, that a private insurer had asked for medical records to support Dr. Basset's billing for E/M office visits because "he almost always [chooses] a 99215 level." 99215 is the highest level for an office visit. In fact, Dr. Bassett virtually always chooses the 99215 level for his patients covered by both private insurers and Federal Healthcare Programs.

63. On March 8, 2012, on her second to last day at the JBACC, Ms. Conrad wrote to Charles Stark, the new CEO of CRHS, to express her compliance concerns. Ms. Conrad was the Interim Patient Financial Services Associate Director pending the search for a permanent candidate. In her letter to Mr. Stark, she explained that she had received no response at all to her February 9, 2012 recommendations; met with her supervisor, Ms. Alford, Senior Director, Patient Financial Services, CRHS, only once since her initial interview for the position; had her weekly meetings with Ms. Norton, Director of Self Pay at JBACC, discontinued after the first month; and was told "don't go there" by Ms. Norton whenever she mentioned compliance issues.

64. During her time as Interim Patient Financial Services Associate Director, Ms. Conrad also created a Medical Necessity Task Force to help resolve these compliance and documentation issues. Relator Barker served on this Task Force, along with Ms. Conrad and Ms. Duderwicz. While it has not officially disbanded, the Task Force has not met since Ms. Conrad's departure in March 2012.

C. Relator's Medical Record Review

65. Ninety seven medical records reflecting services rendered to federal or state health benefit program patients were reviewed by an expert retained by Relator's counsel. The expert, John Beattie, Chief Executive Officer and President of Trusent Solutions ("Trusent"), is a former supervisory auditor for HHS's Office of Inspector General. He has twenty five years of experience in health care and the audit and investigation of various government programs. Mr. Beattie and other Trusent staff reviewed the medical records to determine whether the services rendered were medically necessary and whether the level of E/M services billed was appropriate under both the 1995 and 1997 Document Guidelines.

66. Trusent's review of the medical records determined the following:

1995 Guidelines	1997 Guidelines	Summary of Findings
27	21	Number of office visits coded correctly
46	56	Number of office visits over coded
11	11	Number of office visits not supporting an E/M level of service

1	1	Number of consultations and not office visits
12	8	Number of office visits under coded
97	97	Total number of office visits

67. Under the 1995 Guidelines, 47% of office visits were over coded, while under the 1997 Guidelines, this percentage increases to 58%. These over coded visits break down as follows:

1995 Guidelines	1997 Guidelines	Over Coded Visit Detail
23	28	Number of visits over coded by one level
14	17	Number of visits over coded by two levels
9	11	Number of visits over coded by three levels
46	56	Total number of visits over coded

68. Thus, an eye popping 50% of the office visits that were over coded were over coded by two or more levels. Of these over coded office visits, 35 were over coded under both the 1995 and 1997 Guidelines, as detailed below:

Office visits over coded under both the 1995 and 1997 Guidelines	Summary of findings
15	Office visits over coded by one level
12	Office visits over coded by two levels
8	Office visits over coded by three levels
35	Total office visits over coded under both the 1995 and 1997 Guidelines

69. In comparison with JBACC's 47% and 58% of over coded office visits, CMS, through its Comprehensive Error Rate Testing ("CERT") Program,

determined that the error rate in 2010 for improper Medicare payments for E & M services was 10.5%. The CERT Program reviews a random sample of 160,000 claims per year, to determine if they were paid correctly. According to CMS, claims are deemed paid incorrectly if: (1) a provider fails to submit a requested record [to support its chosen CPT Code], (2) there is insufficient documentation regarding the claim, (3) there is a lack of medical necessity for the claim, (4) the claim was incorrectly coded, or (5) for some other reason, including duplicate payments or another type of billing error.

70. Examples of the over coding of Federal Healthcare Programs and Medicaid patients determined by Trusent's audit include:

- Patient DH. On October 12, 2011, patient DH visited Dr. Pippas at JBACC claiming he was dizzy and lightheaded. A detailed patient history was taken, along with a problem focused medical exam, which led to medical decision making of low complexity. Under both the 1995 and 1997 Guidelines, this visit warranted a CPT Code 99213, not the claim for CPT Code 99215 that was submitted;
- Patient ER: On April 4, 2011, patient ER visited Dr. Pippas at JBACC. A problem focused history was taken, along with a problem focused medical exam, resulting in medical decision making of low complexity. Under both the 1995 and 1997 Guidelines, this visit

warranted a CPT Code 99212 rather than the CPT Code 99215 that was submitted;

- Patient JH: On December 12, 2007, patient JH visited Dr. Pippas at JBACC claiming epigastric pain. A problem focused history was taken, along with a problem focused medical exam, followed by straightforward medical decision making. Under both the 1995 and 1997 Guidelines, this visit warranted a CPT Code 99212 rather than the CPT Code 99214 that was submitted;
- Patient ES: On August 25, 2010, patient ES visited Dr. Pippas at JBACC to discuss the results of an MRI on the patient's brain. An expanded problem focused history was taken, along with a problem focused medical exam, followed by medical decision making of high complexity. Under both the 1995 and 1997 Guidelines, this visit warranted a CPT Code 99213 rather than the CPT Code 99215 that was submitted. Another visit by patient ES to Dr. Pippas also resulted in over coding. On January 19, 2011, patient ES visited the JBACC for an appointment relating to her breast cancer. With no record of a patient history, a problem focused medical exam and straightforward medical decision making, a claim was submitted under CPT Code 99215, rather than the CPT Code 99212 that the encounter warranted;

- Patient BB: On May 12, 2011, patient BB visited Dr. Pippas at JBACC. A problem focused history was taken, followed by a problem focused medical exam, resulting in straightforward medical decision making. Under both the 1995 and 1997 Guidelines, this visit warranted a CPT Code 99212 rather than the CPT Code 99214 that was submitted; and
- Patient MI: On September 23, 2010, patient MI visited Dr. Pippas at JBACC complaining of night sweats, chills and fever resulting. An expanded problem focused history was taken, followed by a comprehensive (1995 Guideline) or detailed (1997 Guideline) medical exam, which resulted in a straightforward medical decision making. Under both the 1995 and 1997 Guidelines, this visit warranted a CPT Code 99213 rather than the CPT Code 99215 that was submitted.

71. In addition, Trusent determined that 11 of the 97 office visits did not support an E/M level of service at all because the office visit was inherent to the chemotherapy session and did not support a separately identifiable E/M service. Examples of these visits which were billed to federal health care programs or Medicaid include:

- Patient ER: On May 23, 2011, patient ER went to JBACC for chemotherapy. A claim with CPT Code 99213 was submitted, but the

documentation for this office visit does not support a separately identifiable E/M service. Instead, the patient history, medical exam and medical decision making were all inherent to the patient's chemo session;

- Patient ER: On June 27, 2011 and September 6, 2011, patient ER went to JBACC for chemotherapy. Claims with CPT Code 99214 were submitted for each visit, but the documentation for these office visits does not support separately identifiable E/M services. Instead, the patient history, medical exam and medical decision making were all inherent to the patient's chemo session;
- Patient JP: On May 16, 2011 and June 13, 2011, patient JP went to JBACC for chemotherapy. Claims with CPT Code 99215 were submitted for each visit, but the documentation for these office visits does not support separately identifiable E/M services. Instead, the patient history, medical exam and medical decision making were all inherent to the patient's chemo session;
- Patient JB: On November 14 and 21, 2011, patient JB went to JBACC for chemotherapy. Claims with CPT Code 99213 and 99214 were submitted for each visit, but the documentation for these office visits does not support separately identifiable E/M services. Instead,

the patient history, medical exam and medical decision making were all inherent to the patient's chemo session; and

- Patient JS: On December 28, 2011, patient ER went to JBACC for chemotherapy. A claim with CPT Code 99215 was submitted, but the documentation for this office visit does not support a separately identifiable E/M service. Instead, the patient history, medical exam and medical decision making were all inherent to the patient's chemo session.

72. In sum, the JBACC's RVU-based compensation methodology, coupled with its complete lack of oversight over medical oncologist's coding practices, has allowed it to systematically overbill Medicare and other federally funded health benefit programs for years, reaping potentially millions of dollars in unearned fees.

D. Defendant's 2012 Internal Audit of E & M Billing Practices

73. As noted above, in ¶ 58, in or about February 2012, the Defendants hired an independent consultant, Health Management Resources ("HMR") Audit Guard, to review E & M coding for all outpatient clinics including JBACC. The results of that audit were provided to the Defendant on or about July 13, 2012. That audit confirmed the concerns expressed by Mr. Barker to his colleagues at

JBACC that medical record documentation and coding were seriously deficient. (See ¶¶46-55, *supra*) and corroborated the results of the Trusent audit.

74. The HMR audit included a review of 40 charts. The results for Dr. Bassett showed that he over-coded E & M visits 63% of the time, a figure that significantly exceeds the non-compliance rate determined by Trusent. The audit conducted by the Defendant determined that Dr. Bassett never under-coded his E & M visits. An audit showing that E & M visits are over-coded 63% of the time accompanied by a finding that E & M visits are never under-coded is consistent with fraud and not with errors/mistakes made in good faith. The review of Dr. Bassett's patient records included patients who are beneficiaries of federal health benefit programs including Medicare and Medicaid.

75. The HMR audit concluded, based upon the review of 40 charts, that Dr. Pippas had an error rate of 68%, that is, 68% of the time he up-coded his E & M visits to a higher level. The auditors found that none of Dr. Pippas E & M visits were under-coded. A finding that 68% of charts are up-coded and no charts are under-coded is consistent with fraud and inconsistent with a finding of good faith errors or mistakes. The review of Dr. Pippas' patient records included patients who are beneficiaries of federal health benefit programs including Medicare and Medicaid. Dr. Currie, another medical oncologist had a 40% error rate (with 5 charts under-coded).

76. The Defendant's audit also uncovered excessive coding error rates in other disciplines besides medical oncology. For example, Dr. Villegas, an OB/GYN, was found to have an up-coding rate of 50% based upon a review of 40 charts. None of his E & M charges were found to be under-coded. Dr. Hardy, another OB/GYN, had a 45% error rate; no charts were found to be under-coded. Dr. Samuel, an internal medicine physician, had a 61% up-coding error rate; 2 of the 40 charts were found to be under-coded. Other physicians with striking error rates include Dr. Hill, maternal fetal medicine, 54% error rate (1 chart under-coded); Dr. Naqvi, 38% error rate (1 chart under-coded); Dr. Johnson, 37% error rate (2 charts under-coded); and Dr. Nwaobi, an OB/GYN, 39% error rate (5 charts under-coded). The audits not only showed which patients' claims had been incorrectly coded but also reflected the amount that should be refunded to insurers, including the amount that should be refunded to federal health benefits programs. The audit results could also easily be extrapolated to calculate an overall overpayment amount that should be refunded to insurers, including federal health benefit programs. Extrapolation from a sample is a commonly accepted routine practice to determine an overall overpayment. As of the date of this Amended Complaint no money has been refunded by CRHS to federal health benefit programs despite the fact that CRHS knows that money is owed because of the up-coding described herein.

77. After the audit, the Defendant provided further training to the JBACC physicians, including Drs. Bassett and Pippas. For a time, charts that auditors determined had been coded at too high a level (up-coded) were returned to Dr. Pippas for review, with a notation that indicated how the documentation failed to meet the CMS coding requirements set forth above. Instead of adjusting his selected code downward, Dr. Pippas instead modified the existing medical record to justify the higher charges, for example, adding additional "reviews of systems" that were not initially included in the original documentation in order to justify a higher level E & M charge. This practice ended in or about October, 2012 when Dr. Pippas was finally told that he would be unable to change the medical records to conform to the higher billing code he had selected.

78. Dr. Pippas was aware that the change in coding practice (to appropriately reflect the service actually rendered rather than the inflated code he assigned) would directly affect his compensation. Instead of receiving a payment for the up-coded 99215s of $159.30, Dr. Pippas would receive $40.50 (for a 99212) or a $60.30 (for a 99213). Dr. Pippas vociferously objected to this reduced compensation and sought a guarantee from JBACC management that his compensation would remain at the same level for at least six months after the coding changes were implemented. Dr. Pippas also enlisted the advocacy on his behalf of JBACC's major donor, Dan Amos, CEO of AFLAC, who had played a

role in hiring Dr. Pippas to become Medical Director of JBACC. Dr. Pippas told Amos that his compensation was being curtailed by coding changes. Amos responded by telling Charles A. Stark (CEO of CRHS) that if the hospital continued to curtail the amount Dr. Pippas could earn by correcting the bills submitted to insurers he (Amos) would withhold his contribution to JBACC's planned building expansion project.

79. Not only did up-coding E & M services cause federal health benefit programs to pay more than they would have for doctor's visits based strictly on the compensation set by Medicare for each E & M level (Medicare pays roughly $60 more for a 99215 than a 99213), but because CRHS also charges Medicare a "facility fee" (which it is permitted to do because it is operated as a hospital outpatient department, POS22). The facility fee is determined by CRHS' billing department in a way that links it is directly to the charge to Medicare for the E & M code. If a doctor codes a visit as a 99215, then Medicare is automatically (through CRHS' Athena pro fee billing software) charged an equivalent amount for a technical fee, causing Medicare to reimburse the technical fee at an inflated rate as well as the E & M charge. The professional fee is billed on a HFCA 1500 to Part B of Medicare and the facility fee is billed on a UB04 to Part A of Medicare.

80. As of no later than August 10, 2012, the Defendants knew that Medicare and other federal health benefit programs had overpaid for the E & M

services provided to federal health program beneficiaries. Defendants also knew that they were legally obligated to refund any overpayments made by Medicare and other federal health benefit programs. In conversations with senior executives with financial oversight employed by the defendants, including Jeffrey Johnson, JBACC Chief Financial Officer and Renee Archer, CRHS Compliance Officer, Mr. Barker was told that the Defendants intended to repay the overpayments identified by the HMR audit, if at all, only in small increments that would not raise any concerns with Medicare or other federal health benefit programs. Mr. Barker was informed that any amounts repaid would not begin to capture the true amounts owed, for fear of drawing the attention of federal payors, resulting in an audit. As of the date of this Complaint no repayments of overpayments identified by HMR have been made.

V. Defendant's Improper Billing of Incident To Services

A. Reimbursement Requirements for Incident to Services

81. CMS regulations require as a condition of payment that mid-level providers such as Nurse Practitioners be credentialed with Medicare and obtain their own provider number in order to bill their services to Medicare.

82. CMS regulations require, as a condition of payment, that providers services that are provided jointly by a mid-level practitioner and a physician to an inpatient may only be billed as "incident to" a physician's service if: (1) the

physician's documentation clearly indicates his or her face-to-face involvement; (2) the physician and NPP personally document the portion of the E & M they each performed; (3) the documentation clearly supports the combined service level billed; and (4) both providers are both enrolled as Medicare providers.

B. Facts Relating to Defendant's Improper Billing for Incident to Services

83. As early as January 10, 2007, the Defendants were informed by Gates, Moore & Company, who conducted an audit of the Defendants' billing practices, that "mid-level providers [at JBACC] are not credentialed with payors and are being billed "incident to" the physicians [which is] not acceptable to Medicare and Medicaid since this site is classified as a hospital based out-patient clinic". The auditors warned the Defendant to "credential your PAs and Nurse Practitioners with Medicare and Medicaid and begin billing their services under their own provider numbers".

84. The January 10, 2007 audit also noted that "Dr. Rodriguez's charges are being filed under Dr. Pippas' provider number. There are no circumstances under which a physician's charges can be billed 'incident to' another physician except under a locum/tenens arrangement which this situation does not qualify for. Therefore we recommend that you discontinue billing Doctor Rodriguez's charges under Doctor Pippas and begin billing his services under his own provider number immediately."

85. The January 10, 2007 audit recommended with respect to mid-level providers that a "comprehensive review be undertaken and that Medicare and/or Medicaid is refunded for any collections that may not meet their billing guidelines for mid-level providers…." As for Dr. Rodriquez, the audit stated that "as the claims filed using Doctor Pippas' provider number for Doctor Rodriguez's services were not appropriate, CRHS may need to review and refund to Medicare and/or Medicaid any collections obtained in this matter."

86. Despite the warnings contained in the 2007 audit, as of 2013, six years later, the Defendants still were not in compliance with the CMS regulations regarding mid-level practitioner credentialing with Medicare and appropriate documentation of a split/shared visit. On or about February 13, 2013 Renee Archer, CRHS Ethics and Compliance Officer learned from Karen Nelson, a JBACC Nurse Practitioner , that she was not credentialed with Medicare and did not have her own Medicare provider number. Ms. Archer also learned that Dr. Pippas, did not, as required by Medicare, personally document the services he performed. On February 13, 2013, Jeffrey Johnson, Chief Financial Officer for JBACC, warned Dr. Pippas in an email that "It has been brought to my attention that you are using a mid-level provider (Karen Nelson) in the hospital to round on your inpatients. There are certain criteria that must be met to comply with CMS guidelines in order to bill under your provider number. In reviewing your

December 2012 and January 2013 hospital charges there were submissions that don't meet the criteria described below and therefore have not been billed. The primary issue is that Karen Nelson isn't enrolled in Medicare. When coding your hospital visits we can only consider the work you performed and documented on that day. I have instructed Tammy Barnwell to contact Karen and start the credentialing process. We will review your submitted hospital charges on an individual basis and submit all allowable visits."

VI. Defendants' Violations of Stark and the Anti-Kickback Statute

A. The Anti-Kickback Statute

87. The federal Anti-Kickback Statute ("AKS") prohibits the payment, in any form, whether direct or indirect, made in part or in whole to induce or reward the referral or generation of federal health care business. The AKS prohibits the offer or payment of "anything of value" in return for referrals. A "thing of value" is defined broadly to include payment in cash or kind. The AKS extends equally to the solicitation or acceptance of payments and to offers to pay and to actual payments for referrals. Under the AKS both criminal and civil penalties apply, including civil monetary penalties, and the sanction of exclusion from federal health benefit programs. The AKS was enacted because of Congressional concerns that payments made in return for referrals would lead to overutilization,

affect medical judgment, and restrict competition, ultimately resulting in poor quality of care being delivered to patients.

88. In addition to prohibiting payments designed to induce referrals, the AKS prohibits the entity receiving a prohibited referral from presenting or causing to be presented to Medicare any claim for referrals that are induced by kickbacks. In 2010 the AKS was amended to provide that a claim that includes items or services resulting from kickback violations are deemed "false" under the FCA. 42 U.S.C. § 1320a-7b(g).

89. The AKS has statutory and regulatory "Safe Harbors" that identify specific arrangements that do not violate the statute if all terms of the Safe Harbors are observed by the parties. For example, the "personal services" Safe Harbor permits compensation arrangements between non-employee physicians and hospitals if: (1) there is a written agreement between the parties that is signed by the physician and the institution; (2) the term of the agreement is at least one year; (3) the agreement covers all of the services to be provided by the physician and sets forth his or her duties with specificity; (4) the aggregate compensation paid to the consultant over the term of the agreement is set in advance, is consistent with Fair Market Value in an arms-length transaction, and is not determined by the volume or value of any referrals or business otherwise generated between the physician and the hospital. 42 C.F.R. § 1001.952(d).

90. The AKS Safe Harbors also address space and equipment rental. To comply with this Safe Harbor, the parties must (1) enter into a written lease, (2) that has a term of at least one year; and (3) sets a fair market value payment for the space or equipment that is set in advance and is not determined by the value of referrals. In particular the Safe Harbor requires that, for leases of office space, that "[t]he aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purposes of the rental." Fair Market Value as defined as "the value of the rental property for general commercial purposes."

B. The Stark Statute

91. The Stark Statute prohibits a physician from referring Medicare patients for certain "designated health services" (DHS) to an entity with which he has a "financial relationship", unless an exception applies. 42 U.S.C. § 1395nn(a)(1)(A). The purpose of the statute is to reduce excess costs incurred by the Medicare program due to overutilization of services, anti-competitive behavior, and the corruption of medical judgment caused by physicians' financial self-interests.

92. The Stark Statute defines DHS to include inpatient and outpatient hospital services. Id. § 1395nn(h)(6). Radiation oncology is a Stark DHS. While the professional services involved in delivering radiation therapy are not

considered “referrals” under Stark if personally performed by the referring physician, the technical portion (i.e. the portion billed to Medicare for the facility or equipment used) is a DHS “referral” under Stark. The statute broadly defines “financial relationship” to include physician compensation arrangements, as well as ownership and investment interests. *Id*. 1395nn(a)(2). The Stark Statute applies to both direct and indirect financial relationships. 42 C.F.R. § 411.354.

93. In addition to prohibiting certain physician referrals, the Stark Statute prohibits an entity receiving a referral from a person or entity with which it has a financial relationship from presenting or causing to be presented to Medicare any claim for DHS provided as a result of that referral. 42 U.S.C. § 1395nn(a)(1)(B). The statute prohibits a physician or other person from presenting or causing to be presented a claim for DHS that the physician knows or should know is for an item or service that is not payable under the statute. *Id.* § 1395nn(g)(3).

94. As with the AKS, Stark is subject to "Safe Harbor" exceptions that identify specific arrangements that will not violate the statute as long as all terms of the exceptions are observed. For example, under Stark, a compensation arrangement between a physician and a hospital is exempt if: (1) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement; (2) the arrangement covers all the services to be provided by the

physician; (3) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangements; (4) the term of the arrangement is at least one year; and (5) compensation under the arrangement is set in advance, does not exceed fair market value and does not take into account the volume or value of any referrals.

95. The Stark Safe Harbors include one for space and equipment rental. To comply with this Safe Harbor, the parties must (1) enter into a written lease, (2) that has a term of at least one year; and (3) sets a fair market value payment for the space or equipment that is set in advance and is not determined by the value of referrals. In particular the Safe Harbor requires that, for leases of office space, that "[t]he aggregate space rented does not exceed that which is reasonably necessary to accomplish the commercially reasonable business purposes of the rental." Fair Market Value as defined as "the value of the rental property for general commercial purposes."

96. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program, to pay for the costs of certain healthcare services furnished to eligible individuals over the age of 65. See 42 U.S.C. §§ 1395-1395hhh. Part A of the Medicare Program authorizes payment for covered institutional care, including hospital, skilled nursing facility and home health care. See 42 U.S.C. §§ 1395c-1395i-4. Part B of the Medicare Program authorizes

payment for, among other things, outpatient hospital services. 42 U.S.C. §§ 1395k(a), 1395l(t).

97. In order to participate in Medicare, hospitals must enter into provider agreements with HHS under which HHS reimburses them for providing covered services to eligible Medicare beneficiaries. Medicare generally pays a provider for inpatient and outpatient hospital services under one of the prospective payment systems applicable to such services. The prospective payment amounts reflect the costs of treating individual patients, including certain operating and administrative expenses.

98. The Provider Agreement that the Defendants entered into with Medicare and Medicaid states, as relevant here:

> "I agree to abide by the Medicare laws, regulations and program instructions that apply [to me]....I understand that payment of a claim by Medicare is *conditioned upon* the claim and the underlying transaction complying with such laws, regulations and program instructions (including but not limited to, the Federal Anti-Kickback Statute and the Stark Law) and on the provider's compliance with all applicable conditions of participation" See Form CMS-855A (emphasis added).

99. Upon discharge of Medicare beneficiaries from a hospital, the hospital submits claims for reimbursement for items and services delivered to those beneficiaries during their hospital stays. 42 C.F.R. § 412.116. At all times relevant to this Complaint, the Defendants submit patient-specific claims on a Form UB-92.

100. Hospitals must submit a Form CMS-2552, more commonly known as the hospital cost report, to CMS annually. Cost reports are the final claim that a provider submits for items and services rendered to Medicare beneficiaries. 42 C.F.R. § 412.52.

101. During the relevant time period, final Medicare payment for hospital services was determined in part by the claims submitted during the course of the fiscal year by the provider for particular patient discharges as listed on UB-92s and later captured on the Medicare cost report.

102. Under the rules applicable at all times relevant to this Complaint, Medicare, through its fiscal intermediaries, had the right to audit the hospital cost reports and financial representations made by the Defendants to ensure their accuracy and to preserve the integrity of the Medicare Trust Funds. This right includes the right to make retroactive adjustments to hospital cost reports previously submitted by a provider if any overpayments have been made.

103. The Defendants were, at all times relevant to this Complaint, required to submit an annual hospital cost report to Medicare. Every hospital cost report contains a "Certification" that must be signed by the chief administrator of the provider or a responsible designee of the administrator.

104. At all times relevant to this Complaint, the hospital cost report certification page included the following notice:

> Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil, and administrative action, fines and/or imprisonment may result.

105. At all times relevant to this Complaint, the responsible provider official was required to certify, in pertinent part:

> to the best of my knowledge and belief, it [the hospital cost report] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.
> I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

106. Thus, the provider was required to certify that the filed hospitals cost report is (1) truthful, i.e., that the cost information contained in the report is true and accurate; (2) correct, i.e., that the provider is entitled to reimbursement for the reported costs in accordance with applicable instructions; (3) complete, i.e., that the hospital cost report is based upon all information known to the provider; and (4) that the services provided in the cost report were billed in compliance with applicable laws, including the Anti-Kickback Statute and the Stark Statute.

107. A hospital is required to disclose all known errors and omissions in its claims for Medicare reimbursement (including its cost reports). 42 U.S.C. § 1320a-7b(a)(3) specifically creates a duty to disclose known errors in cost reports:

Whoever...having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment...conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized...shall in the case of such a ...concealment or failure...be guilty of a felony.

108. The Defendants submitted cost reports, with the signed certification quoted above, at all times material to this Complaint. By violating the Anti-Kickback Statute and the Stark Statute in the manner described below, Defendants knowingly caused the certification quoted above to be falsely submitted.

C. The Defendants' Violation of the Stark Law and the AKS

109. Since at least March 1, 2011, the Defendants have had a remuneration relationship with Radiation Oncology of Columbus ("ROC"), an independent professional corporation that provides radiation oncology therapeutic services at CRHS. ROC includes or included Drs. Doug, Ciuba, John Cabelka and Woodrow McWilliams. That remuneration relationship includes (1) an agreement that ROC appoint a physician to serve as Medical Director of JBACC's Department of Radiation Oncology in return for the payment of $50,000.00 per year, with no defined number of hours and no hourly rate; (2) an agreement that ROC will have an exclusive arrangement to provide radiation oncology services at CRHS for

which ROC physicians will be compensated at a rate of $200 per hour up to 120 hours per year; (3) an agreement that CRHS provides ROC free office space and staff, an arrangement that is not reduced to writing as required by Stark and the AKS Safe Harbors; (4) an agreement that CRHS hire a consulting company, American Medical Accounting & Consulting ("AMAC") to conduct a professional and technical survey to review coding, billing and documentation at ROC, for which CHRS has agreed to pay $13,000. That survey is currently set for August 12, 2013.

110. The remuneration that CRHS provides to ROC violates Stark and the AKS because, *inter alia*, the agreements are not reduced to writing, do not require payment of fair market value, are not commercially reasonable and are designed to induce or reward referrals from ROC to CRHS. CRHS entered into these arrangements knowing that they violated Stark and the AKS. CRHS provided compliance training to its employees that specifically links violations of Stark and the AKS to liability under the FCA. A recent training session, which was attended by the Relator, was held on October 30, 2012, and all executive level employees of CRHS, specifically addressed financial relationships prohibited by the Stark Law and the AKS, and discussed the interaction between those statutes and the False Claims Act.

111. On May 9, 2013, Chuck Stark (CEO of CRHS) sent an email to all CRHS Directors and Managers acknowledging the jury verdict in the *Toumey* case in Virginia, holding the defendant hospital liable for violating Stark. Mr. Stark wrote "[w]e at Columbus Regional use outside firms to establish fair market value rates for all financial transactions involving physicians and others in a position to influence referrals, adding that "[w]hen you don't…you find yourself in a lawsuit like the one described in the link below."

112. CHRS's agreement with ROC provides that ROC will bill payors for the professional component of radiation therapy and that CHRS will separately bill payors for the technical component. The technical component bills are submitted by CHRS directly to Cahaba, the Medicare contractor for Georgia and to Humana Military Healthcare Services, Inc. for TRICARE, to Hewlett Packard for Medicaid and to Blue Cross/Blue Shield for Federal Employees Health Benefit Program through the process described in ¶¶ 22-24 *supra*. More than fifty percent of the Defendants' patient population are beneficiaries of federal health insurance programs which means that at least fifty percent of the time the technical component referral fee is billed by CRHS to a federal payor in violation of Stark.

D. Allegations Relating to Defendant's Purchase of Tidwell Cancer Treatment Center

113. Columbus Radiation Oncology Associates d/b/a/ the Tidwell Cancer Treatment Center (TCTC) was an independent radiation therapy center

located at 2121 Warm Springs Road, Columbus, Georgia. TCTC was founded and run by Thomas J. ("Jack") Tidwell, M.D., a radiation oncologist. TCTC treats a variety of cancers with radiation therapy, including, but not limited to breast, prostate and lung cancer.

114. In or about July, 2010, Defendant CRHS acquired TCTC for a purchase price of approximately $10.5 million. As recounted to the Relator when he joined JBACC, Defendants viewed its purchase of TCTC as a defensive move, designed to prevent acquisition of TCTC by a competitor. The purchase was not made to fill a need by CRHS for radiation therapy treatment facilities, as CRHS has, at JBACC, sufficient, state of the art radiation therapy equipment. In fact, during the relevant time period , CRHS had determined that it had excess radiation therapy capacity.

115. When CRHS purchased TCTC in or about July 2010, it did so through a wholly owned subsidiary, Columbus Radiation Oncology Treatment Center, LLC ("CROTC"). CRHS paid $10.5 million for TCTC and booked $9 million of that as "good will" on its balance sheet over the objections of its accountants. According to Kevin Sass, CEO of the Doctors Hospital, CRHS created CROTC in order to insulate itself from any liability for the operation of TCTC, but CRHS treated CROTC as nothing more than a shell. In fact, in August 2012, when TCTC/CROTC had to indicate to TCTC/CROTC's landlord, St.

Francis Hospital, whether TCTC/CROTC planned to exercise its option to renew the lease, the response came from CRHS over Dan Elder's (Senior Vice President for CRHS) signature. In an email dated August 9, 2012 to, among others, Charles A. Stark, CRHS's CEO, discussing the lease option, Elder recounts that "[t]he previous letter regarding exercise of the option to renew was sent out under my signature and on *created* letterhead for Columbus Regional Oncology Treatment Center, LLC…I'm comfortable in sending the letter and we might as well *be straightforward and send it on CRHS letterhead*."(Emphasis added)

116. CRHS and CROTC agreed that after CROTC purchased TCTC, Dr. Tidwell would continue to administer TCTC's affairs on a day to day basis and continue to practice radiation oncology there. Dr. Tidwell did not become an employee of CRHS, although all other administrative and non-physician staff for TCTC became CRHS employees. CRHS/CROTC did not attempt to recruit a new practitioner to take over Dr. Tidwell's practice. The two entities –TCTC and CRHS/CROTC—agreed that TCTC would submit bills, including bills to Medicare, Medicaid and other federal health benefit payors, for both the professional component of radiation therapy treatments and for the technical component. For a partial list of patients, with CPT codes and dates of services billed under to federal payors under this arrangement, see ¶ 120, *infra*. Payments from insurers were deposited to TCTC's bank account, transferred to CROTC's

bank account by a CRHS employee Malone Moore and then transferred from CROTC's bank account to CRHS's bank account. When TCTC was disbanded upon the retirement of Dr. Tidwell in December 2012, CROTC, TCTC/CROA's assets were transferred to the Medical Center's financial accounts.

117. In order to comply with the AKS, purchase of a professional practice by a hospital must fall within the Sale of Practice Safe Harbor. That Safe Harbor requires that the purchasing entity, in this case CRHS, must meet all of the following four conditions: (i) the sale must be completed in less than three years; (ii) the practitioner who is selling his practice must not be in a professional position to make or influence referrals to or generate business for the purchasing entity; (iii) the Medicare or Medicaid practice being acquired must be located in a Health Professional Shortage Area ("HPSA") for the practitioner's specialty area; and (iv) the purchasing entity must, at the time of the purchase, diligently and in good faith engage in commercially reasonable recruitment activities that may reasonably be expected to result in the recruitment of a new practitioner to take over the acquired practice within a one year period, and complies with the physician recruitment Safe Harbor.

118. In order to comply with Stark, purchase of a physician practice by a hospital (or any other entity or person) must meet the requirements of the "isolated transaction" exception. That exception requires that the one-time sale of

a practice may be exempted from Stark if the amount of the remuneration is (i) reasonable and determined through arm's length negotiations; (ii) is not determined in a manner that takes into account the volume or value of referrals by the referring physician; and (iii) the remuneration is provided pursuant to an agreement that would be commercially reasonable even if no referrals were made to the purchaser.

119. The Defendant's purchase of TCTC did not meet any of the requirements of the AKS Sale of Practice Safe Harbor. First, from July, 2010 until December, 2012 (after the sale was finalized to CRHS) Dr. Tidwell continued to be employed at TCTC/CROTC and was in a position to make or influence referrals to generate business to the Defendants. Second, CRHS at no time made diligent and good faith efforts to recruit a new practitioner to take over the practice. In fact, as noted, from July 2010 until 2012 when he retired, Dr. Tidwell continued to work at, and run, TCTC/CROTC. When he retired from practice in December 2012, the practice (TCTC/CROTC) was disbanded and the equipment was mothballed. Finally, Muscogee County, in which CRHS is located, is not HPSA for radiation therapy, Dr. Tidwell's specialty area.

120. The Defendant's purchase of TCTC did not meet the Stark Law isolated transaction because the purchase of TCTC by CRHS for $10.5 million was not at fair market value and the purchase was otherwise not commercially

reasonable. First, the purchase of TCTC was not commercially reasonable because the purchase was designed not to meet a commercially reasonable need (such as additional capacity or needed new equipment) but to insure that no competitors to JBACC/CRHS entered the market for radiation oncology therapy services. Second, the purchase price did not reflect fair market value, but reflected the price CRHS believed it would have to pay to keep competitors out of the market for TCTC. In fact, as the Defendants determined in December 2012 after Dr. Tidwell retired, the equipment they purchased was essentially worthless. The purpose of CRHS' purchase of TCTC was to secure referrals from TCTC to CRHS instead of to its competitors. If any one purpose of a remuneration relationship is to secure referrals, the AKS and Stark Law have been violated.

121. The CRHS purchase was not commercially reasonable for the further reason that CRHS paid well in excess of fair market value for aging, out-dated equipment. A "Tidwell Cancer Treatment Center Radiation Oncology Equipment and Configuration" prepared in January 2, 2013 by Wyndioto Chisela, PhD., the Chief Medical Physicist for CRHS notes that "the radiation therapy equipment and configuration at TCTC" was, as of September 21, 2012, "not capable of supporting radiation treatment of cancer patients to meet minimum acceptable standards of care." The report noted that the equipment ranged in age from 15 to 30 years of age in some cases, lacked "record and verify" functions,

suffered from recurring malfunctions, had not been continuously maintained, and were, in some cases, so old that the manufacturers could not guarantee spare parts and would not provide service contracts because some of the equipment had reached the "end of life many years ago." The $10.5 million that CRHS paid for the TCTC was not commercially reasonable in light of the condition and capabilities of the equipment. That purchase price was designed to secure a stream of referrals and to prevent those referrals from going to competitors of CRHS. In fact, CRHS booked nine million dollars ($9 million) as "good will" on its books resulting from this purchase.

122. The report and a review of the patients' medical records raise concerns about whether the billings from TCTC/CROTC to federal health benefit programs for IMRT were false or fraudulent. The equipment at TCTC/ROTC is not capable of delivering IMRT to the standard of care, making delivery of IMRT not reasonable or medically necessary. Alternatively, IMRT was not delivered at all, making the billings for IMRT to federal health benefit programs factually false.

123. Examples (among dozens in the Relator's possession) of billings to federal health benefits programs for radiation therapy that was performed after TCTC was acquired by CRHS and that was not "reasonable and medically necessary", not rendered as described in bills submitted by CRHS/TCTC to federal health benefit payors, or in violation of the AKS/Stark include:

a. Patient R.S.	DOS	Paid
(Medicare, Medicaid)		
CPT77418	10/29/12	$360.94
CPT77418	10/30/12	$360.94
CPT77418	10/31/12	$360.94
CPT77418	11/01/12	$360.94
CPT77418	11/05/12	$360.94
CPT77418	11/06/12	$360.94
CPT77418	11/07/12	$360.94
CPT77418	11/08/12	$360.94

b. Patient M.H	DOS	Paid
(Medicare, BlueCross/BlueSheild, FEP)		
CPT77418	10/22/12	$341.86
CPT77418	10/23/12	$341.86
CPT77418	10/25/12	$341.86
CPT77418	10/29/12	$341.86
CPT77418	10/30/12	$341.86
CPT77418	10/31/12	$341.86
CPT77418	11/01/12	$341.86

c. Patient L.J.	DOS	Paid
(Medicare, Tricare)		
CPT77418	10/18/12	$341.86
CPT77418	10/22/12	$341.86
CPT77418	10/24/12	$341.86
CPT77418	10/25/12	$341.86

COUNT I
FALSE CLAIMS ACT VIOLATIONS
31 U.S.C. § 3729(a)(1)(A) (2009)
(Presenting or Causing Presentment of a False Claim)

124. Relator realleges and incorporates by reference the allegations contained in the foregoing paragraphs of this Complaint.

125. By virtue of the acts described above, Defendant knowingly presented or caused to be presented, false or fraudulent claims to the United States Government for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(a).

COUNT II
FALSE CLAIMS ACT VIOLATIONS
31 U.S.C. § 3729(a)(1)(B)
(Knowingly Presenting a False or Fraudulent Record)

124. Relator realleges and incorporates by reference the allegations contained in the foregoing paragraphs of this Complaint.

125. By virtue of the acts described above, Defendant knowingly made, used, or caused to be made or used false records and statements, to get the false or fraudulent claims paid or approved by the Government in violation of 31 U.S.C. § 3729(a)(1)(b), presented or caused to be presented, false or fraudulent claims to the United States Government for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(b).

COUNT III
FALSE CLAIMS ACT, 31 U.S.C. § 3729(a)(1)(G)
(False Record to Avoid an Obligation to Refund)

126. Relator realleges and incorporates by reference the allegations contained in the foregoing paragraphs of this Complaint.

127. Defendants knowingly caused to be made or used false records or false statements to conceal, avoid, or decrease an obligation to pay or transmit money or property to the United States and knowingly concealed and improperly avoided or decreased an obligation to pay or transmit money or property to the Government.

128. By virtue of the false records or false statements caused to be made by Defendants, the United States suffered damages and therefore is entitled to treble damages under the False Claims Act, to be determined at trial, plus civil penalties of $5,500 to $11,000 for each violation.

COUNT IV
GEORGIA FALSE CLAIMS ACT
GEORGIA CODE § 49-4- 168.1

129. Relator realleges and incorporates by reference the allegations contained in the foregoing paragraphs of this Complaint.

130. By virtue of the acts described above, Defendant knowingly made or caused to be made a false statement or misrepresentation for use in determining rights to a benefit or payment under the Georgia Medicaid Program. GEORGIA CODE. § 49-4-168.1.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff United States of America demands that judgment be entered in its favor and against the Defendants as follows:

A. On Count I (Presenting or Causing Presentment of False Claims), judgment against the Defendants for treble damages as further established at trial plus a penalty of $11,000 per false claim as established at trial;

B. On Count II (Knowingly Presenting A False Or Fraudulent Record), judgment against the Defendants for treble damages as further established at trial plus a penalty of $11,000 per false claim as established at trial;

C. On Count III (False Record to Avoid an Obligation to Refund), judgment against the Defendants for treble damages as further established at trial plus a penalty of $11,000 per false claim as established at trial.

WHEREFORE, Plaintiff the State of Georgia demands that judgment be entered in its favor and against the Defendants as follows:

C. On Count IV(Knowingly Making a False Statement in Connection with Determining Right to Payment), judgment against the Defendants for treble damages as further established at trial plus a penalty of $10,000 per false claim as established at trial.

PRAYER FOR A JURY TRIAL

The United States of America and Relator prays a jury trial in this action.

Respectfully submitted,

By: /s/ Jamie M. Bennett
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Attorneys for Relator Richard Barker

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a copy of the foregoing was served by First Class U.S. mail, this 10th day of May, 2013, to:

Hon. Eric Holder
Attorney General of the United States
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530-001

Michael J. Moore
United States Attorney for the Middle District of Georgia
300 Mulberry Street, Suite 400
Macon, Georgia 31201

/s/ Jamie M. Bennett
Jamie M. Bennett