No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
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[1]Because this appeal arises from a consolidated action, references to the District Court Case (D.C. Case) refers to the following consolidated cases:

- "*Osinek*" refers to the lead case, *United States, ex rel. Osinek v. Permanente Medical Group, et al.*, Case No. 3:13-cv-03891-EMC.
- "*Arefi*" refers to *United States, ex rel. Arefi, et al. v. Kaiser Foundation Health Plan, Inc., et al.,* Case No. 3:16-cv-01558-EMC.
- "*Stein*" refers to *United States, ex rel. Stein, et al. v. Kaiser Foundation Health Plan, Inc., et al.*, Case No. 3:16-cv-05337-EMC.
- "*Bryant*" refers to *United States, ex rel. Bryant, et al. v Kaiser Permanente, et al.*, Case No. 3:18-cv-01347-EMC.
- "*Bicocca*" refers to *United States, ex rel. Bicocca v. Permanente Medical Group, Inc., et al.*, Case No. 3:21-cv-03124-EMC.
- "*Taylor*" refers to *United States, ex rel. Taylor v. Kaiser Permanente, et al.*, Case No. 3:21-cv-03894-EMC.

Pursuant to Fed.R.Evid. 201, Appellants request the Court take judicial notice of the complaints, amended complaints, orders, judgment, and notices in the *Arefi, Bryant, Bicocca, Taylor*, and *Osinek* actions that are presented in Appellants' Excerpts of Record as they were considered by the District Court in connection with Appellees' Fed.R.Civ.P. 12(b)(1) motion to dismiss Appellants' action under the False Claims Act's first-to-file rule, 31 U.S.C. § 3730(b)(5).

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Dated: November 21, 2022

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No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

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United States of America, ex rel.,
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Defendants and Appellees.

On Appeal from the United States District Court
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APPELLANTS' EXCERPTS OF RECORD
VOLUME 1 of 9

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC, et al.,

Defendants.

Case No. 13-cv-03891-EMC

CONSOLIDATED MEMBER CASES

Case No. 16-cv-01558-EMC
Case No. 16-cv-05337-EMC
Case No. 18-cv-01347-EMC
Case No. 21-cv-03124-EMC
Case No. 21-cv-03894-EMC

JUDGMENT

On November 15, 2022, the Court issued its Order granting Defendants' request for entry of final judgment in the following cases:

- *United States ex rel. Arefi v. Kaiser Found. Health Plan, Inc.*, No. C-16-1558 EMC (N.D. Cal.).
- *United States ex rel. Stein v. Kaiser Found. Health Plan, Inc.*, No. C-16-5337 EMC (N.D. Cal.).
- *United States ex rel. Bicocca v. Permanente Med. Grp., Inc.*, No. C-21-3124 EMC (N.D. Cal.).

Pursuant to Federal Rule of Civil Procedure 58, the Court hereby **ENTERS** judgment in favor of Defendants and against the *Arefi*, *Stein*, and *Bicocca* plaintiffs but without prejudice to the United States. The Clerk of Court shall close the three cases identified above.

IT IS SO ORDERED.

Dated: November 15, 2022

EDWARD M. CHEN
United States District Judge

United States District Court
Northern District of California

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC, et al.,

Defendants.

Case No. 13-cv-03891-EMC

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Case No. 16-cv-01558-EMC
Case No. 16-cv-05337-EMC
Case No. 18-cv-01347-EMC
Case No. 21-cv-03124-EMC
Case No. 21-cv-03894-EMC

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION TO DISMISS

Docket No. 141

The above cases are all predicated on allegations that various Kaiser entities[1] submitted false claims for payment to the federal government as part of the Medicare Part C program, which is also called Medicare Advantage. *Osinek* was the first-filed case and was followed by five other cases: *Taylor*, *Arefi*, *Stein*, *Bryant*, and *Bicocca*.[2] The cases were consolidated in June 2021. *See Osinek*, Docket No. 61 (order). In July 2021, the United States filed a notice that it was

[1] The Kaiser entities are, generally speaking, various Health Plans, Hospitals, and Medical Groups. These entities "publicly hold themselves out and do business collectively as an integrated healthcare provider called "Kaiser Permanente." U.S. Compl. ¶ 28.

[2] *Taylor* was initially filed in the District of Colorado in 2014; *Arefi* in the Central District of California in 2015; *Stein* in the Central District of California in 2016; *Bryant* in the Northern District of California in 2016; and *Bicocca* in the Eastern District of California in 2020.

intervening in part and declining to intervene in part.[3] *See Osinek*, Docket No. 64 (notice of election).

Currently pending before the Court is Defendants' motion to dismiss based on the first-to-file bar in the False Claims Act ("FCA"). The relevant FCA provision states as follows: "When a person brings an action under this subsection, no person other than the Government may intervene or *bring a related action based on the facts underlying the pending action*." 31 U.S.C. § 3730(b)(5) (emphasis added). The purpose of the first-to-file bar is twofold: (1) "to promote incentives for whistle-blowing insiders" and (2) "[to] prevent opportunistic successive plaintiffs." *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1187 (9th Cir. 2001). Defendants argue that, with limited exceptions, the claims presented by the cases that follow *Osinek* are barred. The *Arefi* plaintiffs have filed a statement of nonopposition with respect to the motion to dismiss their case. *See* Docket No. 143 (nonopposition). The plaintiffs in all other cases have opposed dismissal.

Having considered the parties' briefs, as well as the oral argument of counsel, the Court hereby **GRANTS** in part and **DENIES** in part Defendants' motion.

I. FACTUAL & PROCEDURAL BACKGROUND

A. United States' Complaint-in-Intervention

Although the United States' Complaint-in-Intervention is not at issue in the pending motion, the Court begins with this pleading as it provides a good overview of the Medicare background.

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[3] The notice stated as follows:

> Specifically, the United States intervenes on the allegations that defendants Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group, Inc.; and Colorado Permanente Medical Group, P.C.; submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda under Medicare Part C from the years 2009 until present. The United States declines to intervene on all other allegations.

Osinek, Docket No. 64 (notice).

"Medicare is a federally operated health insurance program." U.S. Compl. ¶ 52. It has four parts:

- Part A covers inpatient and institutional care.
- Part B covers outpatient care.
- Part C is the Medicare Advantage program at issue in this case.
- Part D covers prescription drugs.

See U.S. Compl. ¶ 52.

Parts A and B are "traditional" Medicare.

> [T]he Government reimburses healthcare providers using a fee-for-service system, in which providers submit claims to CMS [Centers for Medicare and Medicaid Services] for healthcare services actually rendered, such as a provider officer visit or hospital stay. CMS then pays the providers directly for each service based on payment rates predetermined by the Government.

U.S. Compl. ¶ 53.

A Medicare beneficiary can opt out of traditional Medicare and enroll instead in a Medicare Advantage plan managed by a Medicare Advantage Organization ("MAO"). *See* U.S. Compl. ¶ 54. "CMS reimburses [Medicare Advantage] plans differently than traditional Medicare." U.S. Compl. ¶ 58. Specifically, Medicare Advantage uses a "'capitation' payment system." *United States ex rel. Silingo v. Wellpoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under that system, "private health insurance organizations provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program – regardless of actual healthcare usage." *Id.* The fixed monthly fee for an enrollee is set as follows. First, there is a predetermined base payment for each enrollee in a Medicare Advantage plan. *See* U.S. Compl. ¶ 57. Second, the base payment is then adjusted "to account for (1) demographic factors such as age and gender (among others) and (2) health status. This is known as risk adjustment." U.S. Compl. ¶ 58.

Risk adjustment is accomplished by assigning each beneficiary a risk score, which "acts as a multiplier that is applied to the [Medicare Advantage] plan's base rate to determine the overall monthly payment for the beneficiary." U.S. Compl. ¶ 58. A beneficiary's risk score is determined through a model called the CMS Hierarchical Conditions Category ("CMS-HCC") model, which,

as indicated above, is based on the patient's demographic factors and health status. *See* U.S. Compl. ¶ 59. With respect to health status, the model relies on diagnosis codes from the International Classification of Diseases ("ICD"). *See* U.S. Compl. ¶ 60. "ICD diagnosis codes are alphanumeric codes used by healthcare providers, insurance companies, and public health agencies to represent medical conditions; every disease, injury, infection, and symptom has its own code." U.S. Compl. ¶ 62.

> The ICD diagnosis codes included in the CMS-HCC model are grouped into categories of clinically related medical diagnoses that comprise the HCCs (i.e., the categories). For example, various cancer diagnosis codes are grouped together (e.g., colorectal and bladder cancers). The CMS-HCC model organizes related conditions into hierarchies based on disease severity and expected cost. For example, various cancer HCCs are in the same hierarchy, with the HCC associated with metastatic cancer diagnosis codes as the most severe. If a patient is diagnosed with conditions (diagnosis codes) that correspond to more than one HCC in a hierarchy, only the most severe HCC is kept and any lower-ranking HCCs are dropped.

U.S. Compl. ¶ 63.

> Each HCC is assigned a coefficient. CMS calculates a beneficiary's risk score by adding the coefficients associated with each of the beneficiary's applicable demographic characteristics (such as age and gender) and the applicable HCCs, if any, that apply to the beneficiary. A risk score of 1.0 reflects the average expected Medicare-incurred expenses. A risk score of 0.75 reflects expected costs for a particular beneficiary that are 25% less than the estimated average costs for enrollees in the MA plan, and a risk score of 1.25 reflects expected costs that are 25% greater than the estimated average costs for enrollees in the MA plan.

U.S. Compl. ¶ 65.

The CMS-HCC model is prospective in the sense that it uses diagnoses made in a base year (the 'service year'), along with demographic information (such as age and gender, among others), to predict costs for Medicare benefits and adjust payments for the following year (the 'payment year')." U.S. Compl. ¶ 60.

"To combat the 'incentive for [Medicare Advantage] organizations to potentially over-report diagnoses,' Medicare regulations require risk adjustment data to be produced according to certain best practices." *Silingo*, 904 F.3d at 673. For example,

> the diagnosis codes that MA Organizations submit to CMS for risk-adjustment purposes must be:
>
> a. established by a qualified physician;
>
> b. based on a face-to-face medical visit between the patient and physician[4];
>
> c. documented in the medical record; and
>
> d. coded in compliance with the ICD [Official Guidelines for Coding and Reporting], including the limitation that the condition must have required or affected patient care, treatment, or management for the visit.[5]

U.S. Compl. ¶ 87 (emphasis added); *see also Silingo*, 904 F.3d at 673 (also noting best practices).

"[I]t is an express condition of payment that a Medicare Advantage organization 'certify (based on best knowledge, information, and belief) that the [risk adjustment] data it submits . . . are accurate, complete, and truthful.'" *Id.* (quoting 42 C.F.R. § 422.504(l)(2)).

B. Osinek Complaint

The Court turns next to the Osinek Complaint as it provides the baseline for the Court – *i.e.*, the Court will have to compare the Osinek Complaint with the complaints in the other cases to determine whether the cases are related. *See* 31 U.S.C. § 3730(b)(5) (providing that, "[w]hen a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action").[6]

The allegations below all come from Ms. Osinek's original complaint filed in 2013. (Ms.

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[4] For example,

> even if an MA organization knows that a patient was diagnosed in a prior year with a chronic condition that tends not to go away, the MA organization may not submit the diagnosis for payment for the current year unless the physician has a face-to-face visit with the patient in the current year and the chronic condition required or affected care, management, or treatment during that patient visit.

U.S. Compl. ¶ 85.

[5] "In other words, only those conditions that specifically mattered to the patient care, treatment, or management that the physician actually provided at the visit could be submitted to CMS for payment." U.S. Compl. ¶ 5.

[6] Similarly, later-filed complaints must be compared with all preceding complaints.

Osinek filed an amended complaint in 2021. For the reasons discussed below, it is Ms. Osinek's original complaint that matters for purposes of the pending motion.)

Ms. Osinek has sued "Kaiser Permanente," "a private provider of Medicare Advantage insurance under Medicare Part C." Osinek Compl. ¶ 2. Ms. Osinek describes "Kaiser Permanente" as follows:

> Kaiser Permanente is a California corporation with its principal place of business [in] Oakland, California 94612. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage Plans than any other organization in California. At all times relevant, Kaiser conducted business in California, including but not limited to providing healthcare services through Medicare Advantage plans and to the general public in California.

Osinek Compl. ¶ 6.

According to the complaint, starting around 2007, Kaiser Permanente began a "scheme to upcode diagnoses to ensure Medicare payments for reimbursable, high-value conditions." Osinek Compl. ¶ 2. Not surprisingly, Kaiser Permanente "focuses . . . on high value conditions" so that it "can maximize its reimbursement from Medicare." Osinek Compl. ¶ 25. High-value disease conditions included, *e.g.*, chronic kidney disease, congestive heart failure, depression, chronic respiratory failure, cachexia/protein calories malnutrition, severe obesity, and seizure. *See* Osinek Compl. ¶ 25.

Kaiser Permanente effectuated its upcoding scheme in various ways. For example:

- Data mining. Kaiser Permanente used "algorithms to identify [high-value] disease conditions for data mining." Osinek Compl. ¶ 25. "Kaiser identified the higher value HCCs and then determined the diagnoses its doctors would need to make to support the HCCs Kaiser wanted to submit for Medicare reimbursement." Osinek Compl. ¶ 25.
- Refreshing. Although not clearly described in the complaint, refreshing appears to be a process related to chronic conditions. *See* Osinek Compl. ¶ 37 (alleging that "Kaiser tracks and rewards physicians based on the percentage of chronic conditions they are able to capture and refresh"). As indicated above, Medicare

Advantage plans are compensated based on medical conditions diagnosed in the previous payment year. Therefore, if a patient has a chronic condition, then that condition must be rediagnosed each year – *i.e.*, refreshed. Presumably, Kaiser Permanente used refreshing "to increase its billings for high value . . . HCCs," Osinek Compl. ¶ 24, because a doctor would be told to include the chronic condition as a diagnosis for a visit even if that condition was not at issue in the patient visit.[7]

- Guidance and policies. Kaiser Permanente provided guidance or policies that supported upcoding. For example, "Kaiser told its physicians to diagnose chronic kidney disease instead of the lower value nephritis or nephropathy." Osinek Compl. ¶ 26. As another example, "when CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser tells its physicians to change coding practices to reflect new reimbursable codes. . . . In response to CMS's notification that HC 131 will be eliminated, Kaiser promptly sent materials to its staff to begin prompting physicians to code diagnoses for acute kidney injury instead of chronic kidney disease stage 1, 2, or 3, which will be included in the 2014 HCC list and reimbursable by Medicare." Osinek Compl. ¶ 27.
- Addenda. In theory, "[a]ll relevant documentation is entered into a medical record at the time of service," but CMS recognizes "there may be times that a provider will need to amend, correct, or enter documentation related to an encounter. CMS

[7] The United States' Complaint provides further context on refreshing. *See, e.g.*, U.S. Compl. ¶ 7 ("Kaiser also employed a related data-mining program called 'refresh,' where Kaiser would mine patient medical files to find old diagnoses that had not yet been diagnosed in the current service year. If a physician failed to address any of these old diagnoses at a patient visit, the physician would be provided a list of these 'missed opportunities' – i.e., opportunities for risk-adjustment payment – to create an addendum to retrospectively add these diagnoses to the medical record."); U.S. Compl. ¶ 151 ("Another category of Kaiser's data-mining efforts focused on capturing diagnoses that had been made in a prior year. Kaiser referred to this program as 'refresh' and to conditions that needed to be captured as 'unrefreshed diagnoses.' Kaiser created algorithms that mined patients' electronic medical records for any diagnoses that had been made in any setting during the past several (typically three) years. As detailed below, Kaiser meticulously monitored and tracked these diagnoses, and if a physician failed to re-diagnose these conditions at a patient visit, Kaiser would systematically pressure the physician to add the diagnoses via addenda, as it did with its other data-mining efforts.").

expects supplemental documentation to be occasional and that delayed or amended entries will be entered within a reasonable time frame. CMS will consider delayed or amended explanations for diagnoses so long as the explanations are for clarification and *not* for substantiating retroactive diagnoses." Osinek Compl. ¶ 20 (emphasis added). Kaiser Permanente had its doctors use addenda to retroactively diagnose – *e.g.*, long after a patient visit, for a condition for which the patient was not treated at the time of the face-to-face visit, based on tests run after the face-to-face visit, to change a diagnosis to a higher value and more complicated form of disease, without proper support/documentation, and/or using boilerplate language. *See, e.g.*, Osinek Compl. ¶¶ 28-32.

- Pressuring doctors. "Kaiser pressures its physicians to addend diagnoses and capture the high value HCCs" – *e.g.*, there is "an escalation process for physicians who do not agree with the data mining prompts"; "[p]hysicians will have to meet one-on-one with Data Quality Trainers if they refused to make diagnoses changes that are presented by data mining"; "physicians have personal report cards based on how they perform in certain areas [including response to refreshing and data mining prompts], which are tied to their compensation"; and there are "mandatory meetings called 'coding parties,' where physicians are gathered in a single room with computers and asked to review past progress notes for addenda related to revised medical diagnoses." Osinek Compl. ¶¶ 33-35.

II. LEGAL ISSUES

Before the Court compares *Osinek* and the later-filed cases, it first takes into consideration four legal issues related to the first-to-file bar, each of which will have an impact on the Court's comparison of the cases.

(1) Is the first-to-file bar jurisdictional in nature?

(2) In comparing the first-filed and later-filed actions, should a court look at the original complaints or any amended complaints instead (assuming amended complaints have been filed)?

(3) In comparing the first-filed and later-filed actions, must the facts in the actions be identical in order for a court to apply the first-to-file bar?

(4) In comparing the first-filed and later-filed actions, how should a court proceed where there are different defendants?

A. Jurisdiction

Although not all courts agree, the Ninth Circuit has expressly held that the first-to-file provision (§ 3730(b)(5)) is jurisdictional in nature. *See, e.g., United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir. 2015) (stating that "[w]e treat the first-to-file bar as jurisdictional"); *see also United States ex rel. Marshall v. Univ. of TN Med. Ctr. Home Care Servs., LLC*, No. 3:17-CV-96, 2021 U.S. Dist. LEXIS 159167, at *41 & n.4 (E.D. Tenn. Aug. 23, 2021) (noting that the Fourth, Fifth, Sixth, Ninth, and Tenth Circuits have held that § 3730(b)(5) is jurisdictional but that the D.C., First, Second, and Third Circuits have held that it is not; citing cases).

The Ninth Circuit's view of § 3730(b)(5) as jurisdictional is important because it impacts which complaints should be considered when a court compares the first-filed and later-filed actions. *See* Reply at 4 (making this same point). That issue is addressed below.

In their papers, the *Stein* plaintiffs argue that the first-to-file bar is not jurisdictional. In support, they rely on *Gonzalez v. Thaler*, 565 U.S. 134 (2012), where the Supreme Court stated as follows: "A rule is jurisdictional '[i]f the Legislature clearly states that a threshold limitation on a statute's scope shall count as jurisdictional.'" *Id.* at 141. The problem for the *Stein* plaintiffs is that, post-*Gonzalez*, the Ninth Circuit issued *Hartpence* which clearly held that the first-to-file bar is jurisdictional. *See Hartpence*, 792 F.3d at 1130. The *Stein* plaintiffs acknowledge *Hartpence* but contend that the decision should not be given any weight as it relied solely on *Lujan*, 243 F.3d at 1181, a pre-*Gonzalez* decision. The Court rejects the *Stein* Plaintiffs' attempt to avoid *Hartpence*. *Hartpence* is binding authority that is clearly on point and was issued post-*Gonzalez*. It is not up to this Court to decide whether *Hartpence* was wrongly decided because the Ninth Circuit did not explicitly address *Gonzalez*.

B. Original v. Amended Complaint

The next issue for the Court to consider is which complaints should be evaluated in determining whether the first-filed and later-filed actions are related: the original complaints or the amended complaints? All of the cases before the Court – including *Osinek* – have amended complaints except for *Arefi*. (As noted above, the *Arefi* plaintiffs do not oppose Defendants' motion to dismiss their suit.) Below is a timeline with respect to the filing of the complaints.

Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
8/22/2013 (original complaint)					
	10/22/2014 (original complaint)				
	11/3/2014 (FAC)				
		9/4/2015			
			5/16/2016 (original complaint)		
			11/3/2016 (FAC)		
				3/1/2018 (original complaint)	
					2/10/2020 (original complaint)
					10/9/2020 (FAC)
7/27/2021 – U.S. notice of election to intervene in part					
7/29/2021 – Court order granting U.S. request to unseal complaints					
10/7/2021 (FAC)					
10/25/2021 – U.S. complaint in intervention					
			11/12/2021 (SAC)		
	11/15/2021 (SAC)			11/15/2021 (FAC)	

A number of courts have held that a court should compare (1) the original complaint in the later-filed action with (2) whatever was the operative complaint in the first-filed action at the time the later-filed action was filed (which in this case would be the original complaint in *Osinek*). *See, e.g.*:

- *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1279 (10th Cir. 2004) (stating that "[w]e judge whether § 3730(b)(5) barred Grynberg's [later-filed] qui tam action by looking at the facts as they existed at the time the action was brought"; at the time the Grynberg suit was filed, "Precision's 1992 amended complaint [in the first-filed case] was pending in federal district court").
- *U.S. ex rel. Branch Consultants, L.L.C. v. Allstate Ins. Co.*, 782 F. Supp. 2d 248, 259 (E.D. La. 2011) (hereinafter "*Branch II*") (indicating that "the Court should look to the jurisdictional facts that existed at the time the action was filed, as opposed to facts that existed when the relator later filed an amended complaint").
- *United States ex rel. Cestra v. Cephalon, Inc.*, No. 14-01842, 2014 U.S. Dist. LEXIS 143745, at *7-8 (E.D. Pa. Oct. 9, 2014) (agreeing with *Grynberg* and *Branch*).
- *United States ex rel. Carter v. Halliburton*, No. 1:11cv602 (JCC/JFA), 144 F. Supp. 3d 869, 881 (E.D. Va. 2015) (noting, *inter alia*, that "[i]t is consistent with the jurisdictional limitation to apply the first-to-file bar at the time the initial complaint is filed, rather than when the complaint is amended").
- *United States ex rel. Marshall v. Univ. of TN Med. Ctr. Home Care Servs., LLC*, No. 3:17-CV-96, 2021 U.S. Dist. LEXIS 159167, at *24 (E.D. Tenn. Aug. 23, 2021) (also agreeing with *Grynberg* and *Branch*).

In the case at bar, Defendants advocate for this approach, and most of the plaintiffs agree – but not all. *See, e.g.*, Stein Opp'n at 3 n.2 (arguing that the Court should consider the SAC which was filed in November 2021); Bicocca Opp'n at 5 (arguing that the Court should consider the FAC which was filed in October 2020).

The district court in *Branch II* has provided the most extensive analysis as to why the above approach should be followed. *Branch II* was the later-filed action. The first-filed action was known as *Rigsby*. After Branch filed its original complaint in August 2006, it filed two different amended complaints. The court gave several reasons why – for purposes of § 3730(b)(5) – the original complaint in *Branch II* (and not any amended complaint) should be compared with

the complaint in *Rigsby*.

First, the text of § 3730(b)(5) supports this approach.

> The first-to-file bar [in § 3730(b)(5)] and the original source exception to the public disclosure bar [in § 3730(e)(4)] refer specifically to jurisdictional facts that must exist when an "action," not a complaint, is filed. Under 31 U.S.C. § 3730(b)(5), *a qui tam* plaintiff may not "bring a related action based on the facts underlying the pending action." As the Seventh Circuit has noted, "[*o*]*ne 'brings' an action by commencing suit*." *United States ex rel. Chovanec v. Apria Healthcare Group Inc.*, 606 F.3d 361, 362 (7th Cir. 2010). Further, in order to be an original source under 31 U.S.C. § 3730(e)(4)(B), a relator must provide the information on which the allegations are based to the government "before filing an action under this section which is based on the information." Both provisions appear to contemplate that certain requirements must be met at the time a qui tam action is filed. The use of the term "action" in both provisions indicates that the Court should look to the jurisdictional facts that existed at the time the action was filed, as opposed to facts that existed when the relator later filed an amended complaint.
>
> As the Third Circuit has noted, however the FCA is based on the model of a single-count complaint, and it sometimes uses the term "action" when it likely means "claim." *United States ex rel. Merena v. SmithKline Beecham Corp.*, 205 F.3d 97, 101-02 (3d Cir. 2000). For example, under § 3730(b)(2) and (4), the government may choose to "proceed with the action" or may "decline to take over the action," yet it is commonplace for the government to proceed with only certain claims and not with others. *Id.* at 102. But even if "action" can mean "claim" in some contexts, it is perfectly natural to read the first-to-file bar and the original source provision as imposing certain requirements that must be met at the time the suit begins.

Branch II, 782 F. Supp. 2d at 259-60 (emphasis added).

Second, general jurisdictional principles also support the approach.

> The notion that a court cannot proceed if it lacked jurisdiction at the time the original complaint was filed is consistent with the "time-of-filing rule," under which "the jurisdiction of the Court depends upon *the state of things at the time of the action brought*[.]" *Mollan v. Torrance*, 22 U.S. 537, 539 (1824) (diversity jurisdiction exists if the parties are diverse when the action was brought, even if diversity is not maintained throughout the litigation) . . . .

Id. at 260 (emphasis added).

Third, the Supreme Court's decision in *Rockwell International Corp. v. United States*, 549 U.S. 457 (2007), does not conflict with the above approach.

> While the ruling [in *Rockwell*] focused on the original source

> provision [rather than the first-to-file provision], it also made broader jurisdictional statements that are relevant to the FCA as a whole. In *Rockwell*, the relator brought a *qui tam* action relating to toxic waste disposal at a nuclear weapons plant. The Supreme Court held that the relator was not an original source of new allegations in the amended complaint just because he was an original source of the allegations in the original complaint. *Id.* at 473-74. The Court concluded that the relator, "at a minimum," must be an original source of the claims in the amended complaint. *Id.* at 473. But the Court did not suggest that the original complaint becomes irrelevant for jurisdictional purposes once an amended complaint is filed. To the contrary, the Court stated that its holding was consistent with "[t]he rule that subject-matter jurisdiction 'depends on the state of things at the time of the action brought.'" *Id.* (quoting *Mollan v. Torrance*, 22 U.S. 537, 539 (1824)). . . . [Cases cited in *Rockwell*] indicate that a court cannot proceed if it lacked jurisdiction at the time the initial complaint was filed.
>
> *Rockwell* goes on to state that jurisdiction is also defeated if a plaintiff amends the complaint to withdraw the allegations upon which the court's jurisdiction is based, "unless they are replaced by others that establish jurisdiction." . . . But *Rockwell* does not suggest that a plaintiff can establish jurisdiction by amendment when jurisdiction did not previously exist. Indeed, such a conclusion would be directly contrary to the Court's statement that "demonstration that the original allegations were false will defeat jurisdiction."

Id. at 261-62.

Finally, there are several practical/policy reasons to support the approach. For example,

> the pre-filing disclosure requirement of § 3730(e)(4)(B) could not function if a court could acquire jurisdiction over a *qui tam* complaint through amendment. If a court could gain jurisdiction over a *qui tam* action by amendment, then a relator could neglect to inform the government of the information upon which the allegations are based before filing his or her action. Instead, the relator could provide that information to the government at a later time, and then amend the complaint, even in a trivial fashion, to ensure jurisdiction. Such a procedure would make the statutory language requiring disclosure to the government "before filing an action" meaningless.

Id. at 263.

In addition,

> while the first-to-file bar of 31 U.S.C. § 3730(b)(5) encourages relators to quickly report fraud about which they become aware, problems arise when a relator files without yet having direct and independent knowledge of the information underlying the allegations. As discussed *infra*, the Fifth Circuit has held that even skeletal allegations can bar other actions under the first-to-file bar in at least some circumstances. *See United States ex rel. Branch*

> *Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 379 (5th Cir. 2009). It would be anomalous if a relator could secure a place in the jurisdictional queue with merely skeletal allegations, only to then file an amended complaint after actually becoming an original source, and thereby trump any meritorious, related actions that were filed in the meantime. *Cf. United States ex rel. Ortega v. Columbia Healthcare, Inc.*, 240 F. Supp.2d 8, 14 (D.D.C. 2003) (amended complaint could not "relate back" to the date the original complaint was filed in order to jump ahead in line). Such an approach would shut out deserving relators while rewarding those who bring actions without having direct and independent knowledge of their publicly disclosed allegations. A relator, under this scenario, could secure first-to-file status before actually conducting the investigation that uncovers direct and independent information about the fraud. Requiring jurisdiction at the time the original complaint was filed allows a court to dismiss such an attempt, regardless of later amendments.

Id. at 264.[8]

> Finally, the time-of-filing rule has the advantage of simplicity. The benefits of a clear-cut rule are apparent in this case, which involves multiple claims, complaints, and defendants, as well as other relators whose complaints have themselves been amended and involve multiple defendants. *See United States ex rel Rigsby v. State Farm Ins. Co.*, No. 06-433, 2006 U.S. Dist. LEXIS 98179 (S.D. Miss. 2006) (discussed *infra*); *United States ex rel Denenea v. Allstate Ins. Co.*, No. 07-2795, 2011 U.S. Dist. LEXIS 6419 (E.D. La.); *United States ex rel Sonnier v. Allstate Ins. Co.*, No. 09-1038 (M.D. La.). The Court's jurisdiction may expand or shrink as amendments are made to the complaint, but that jurisdiction must rest upon a solid foundation.

Id.

The analysis in *Branch II* is sound and persuasive. Furthermore, the analysis in *Branch II* does not conflict with Ninth Circuit law, including *Hartpence*. Admittedly, in *Hartpence*, the Ninth Circuit made the following comment in a footnote: "For purposes of determining jurisdiction, we look to the allegations in the amended complaints. *Rockwell Int'l Corp. v. United States*, 549 U.S. 457, 473-74 (2007)." *Hartpence*, 792 F.3d at 1125 n.2. But this footnote in *Hartpence* does not mean that, for purposes of the first-to-file bar, that a court should look to an amended pleading in a later-filed case.

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[8] Relatedly, if the rule were that an amended complaint in the later-filed action should be considered (and not the original), that would give the relator in the later-filed action an incentive to amend its complaint once the first-filed action becomes public – *i.e.*, so as to try to distinguish the later-filed action from the first-filed action.

First, *Hartpence* referred to two different FCA provisions, not only the first-to-file bar (in § 3730(b)(5)) but also the public disclosure bar (in § 3730(e)(4)). *Hartpence*'s reference to *Rockwell* in footnote 2 may well have related to the public disclosure bar, which would make sense since *Rockwell* was a public disclosure case and not a first-to-file case

Second, as the *Branch II* court pointed out, *Rockwell* (the case that *Hartpence* cited) acknowledged the "rule that subject-matter jurisdiction 'depends on the state of things at the time of the action brought.'" *Rockwell*, 549 U.S. at 473.

Third, *Rockwell*'s statement that "courts look to the amended complaint" must be evaluated in context. The *Rockwell* Court noted that, if "original allegations [related to jurisdiction] were false," then jurisdiction is defeated. *Id.* "So also will the withdrawal of those allegations unless they are replaced by others that establish jurisdiction. Thus, when a plaintiff files a complaint in federal court and then voluntarily amends the complaint, courts look to the amended complaint to determine jurisdiction." *Id.* at 473-74. As indicated by the above text, the *Rockwell* Court made the last statement in the context of a plaintiff *withdrawing* allegations that gave rise to jurisdiction and pleading new allegations.

Finally, courts have recognized the context in which the *Rockwell* statement above was made and thus taken note of the limits of *Rockwell*. For instance, the Fifth Circuit has stated:

> The [*Rockwell*] Court did not hold . . . that the original complaint is irrelevant to jurisdiction or that a relator need not establish jurisdiction from the moment he first files his action. Indeed, *Rockwell* did not speak to the question whether a relator can use an amended complaint to establish jurisdiction when the original complaint is lacking. Consequently, we fall back on the longstanding rule that the amendment process cannot "be used to create jurisdiction retroactively where it did not previously exist." If [the relator's] complaint did not establish jurisdiction, it should have been dismissed; his amendments cannot save it.

U.S. ex rel. Jamison v. McKesson Corp., 649 F.3d 322, 328 (5th Cir. 2011). Similarly, in *Strudley v. Santa Cruz County Bank*, 747 F. App'x 617 (9th Cir. 2019), the Ninth Circuit held that the plaintiffs could not amend as a matter of right to cure a jurisdictional defect in the original complaint. "In line with Supreme Court precedent, this Circuit has adhered to the time-of-filing rule, which provides that '[s]ubject matter jurisdiction must exist as of the time the action is

commenced.'" *Id.* at 618. The court went on to reject the plaintiffs' reliance on *Rockwell*.

> *Rockwell* stands for the proposition that a plaintiff may voluntarily amend its original complaint to *remove* federal jurisdiction (except when a case has been removed to federal court). Plaintiffs amended their complaint for the exact opposite purpose in this case [*i.e.*, in the attempt to create jurisdiction]. Therefore, the district court correctly looked to the original complaint in concluding that it lacked subject matter jurisdiction over this case.

Id.; *see also Black Hills Media, LLC v. Pioneer Corp.*, No. CV 13-05980 SJO (PJWx), 2014 U.S. Dist. LEXIS 132030, at *9 (C.D. Cal. Jan. 14, 2014) ("The court in *Rockwell* had jurisdiction over the original complaint when it was first filed, and the issue before the Supreme Court was whether the amended complaint *divested* the court of that existing jurisdiction. The Supreme Court determined that it did so. The opposite was true in [a Federal Circuit case], where the court had no jurisdiction over the original complaint, and the amended complaint would therefore grant the court jurisdiction that would not otherwise exist.") (emphasis added).

Accordingly, the Court shall compare the original complaint in *Osinek* (*i.e.*, the operative complaint in the first-filed action at the time the later-filed action was filed) with the original complaints in the later-filed actions.

C. "Identical Facts" Test v. "Material Facts" Test

Turning to the heart of the matter, the Court considers next what is the legal standard for determining whether a first-filed suit and a later-filed suit are related for purposes of § 3730(b)(5). Like other circuit courts, the Ninth Circuit has rejected the position that the first-filed and later-filed actions must be based on "identical facts" in order to be deemed related. Instead of an "identical facts" test, the Ninth Circuit applies a "material facts" test.

> Most of the few courts that have addressed § 3730(b)(5) have rejected an identical facts test. The cases' common principle is that "section 3730(b)(5) precludes a subsequent relator's claim that alleges the defendant engaged in the same type of wrongdoing as that claimed in a prior action even if the allegations cover a different time period or location within a company." *United States ex rel. Capella v. United Technologies Corp.*, 1999 U.S. Dist. LEXIS 10520, 1999 WL 464536, at *9 (D. Conn. June 3, 1999) (summarizing the tests used by other courts). The Third Circuit, the only appellate court to discuss and apply § 3730(b)(5), rejected an identical facts test. *See LaCorte*, 149 F.3d at 233-34. We find the Third Circuit's reasoning persuasive.

> Section 3730(b)(5)'s plain language refers to "related" not "identical" actions. Therefore, we need not review the legislative history. *See Hockings*, 129 F.3d at 1071. Even if the language were considered ambiguous, the single sentence from the legislative history does not compel a different result. Furthermore, an identical facts test would defeat the congressional objectives for the 1986 amendments: "adequate incentives for whistle-blowing insiders with genuinely valuable information and discouragement of opportunistic plaintiffs who have no significant information to contribute of their own." *United States ex rel. Springfield Terminal Ry. v. Quin*n, 304 U.S. App. D.C. 347, 14 F.3d 645, 649 (D.C. Cir. 1994). Limiting § 3730(b)(5) to only bar actions with identical facts would be contrary to the plain language and legislative intent: (1) using a narrow jurisdictional bar, such as an identical facts test, would decrease incentives to promptly bring qui tam actions; (2) multiple relators would expect a recovery for the same conduct, thereby decreasing the total amount each relator would potentially receive and incentives to bring the suit; and (3) a narrow identical facts bar would encourage piggyback claims, which would have no additional benefit for the government," since once the government knows the essential facts of a fraudulent scheme, it has enough information to discover related frauds." *LaCorte*, 149 F.3d at 234.
>
> Therefore, we hold that § 3730(b)(5) bars later-filed actions alleging the same material elements of fraud described in an earlier suit, regardless of whether the allegations incorporate somewhat different details.

Lujan, 243 F.3d at 1188-89; *see also United States ex rel. St. John LaCorte v. SmithKline Beecham Clinical Labs., Inc.*, 149 F.3d 227, 234 (3d Cir. 1998) (stating that, "once the government knows the essential facts of a fraudulent scheme, it has enough information to discover related frauds").

As a practical matter, the material facts test often has a court consider "whether the [later-filed] Complaint alleges a fraudulent scheme the government already would be equipped to investigate based on the [first-filed] Complaint." *United States ex rel. Batiste v. SLM Corp.*, 659 F.3d 1204, 1209 (D.C. Cir. 2011) (noting, for example, "[i]f the government investigated the facts alleged in [first-filed] complaint on a nationwide basis, it would discover continuing fraud in the New Jersey offices [which was the focus of the later-filed complaint"); *see also id.* at 1210 (stating that "[s]ection 3730(b) is designed to allow recovery when a *qui tam* relator puts the government on notice of potential fraud being worked against the government, but to bar copycat actions that provide no additional material information"); *Hartpence*, 792 F.3d at 1125, 1131-32 ("disagree[ing] that [the later-filed] action provided no additional benefit to the government"; the

plaintiff in the later-filed suit "provided information about a different form of fraud, and without that information the government might not have investigated beyond [defendant's] fraudulent coding practices").[9]

As a frame of reference, below is a brief discussion of some cases where the material facts test was not met and where the material facts test was met.

1. Material Facts Test Not Satisfied

In *Hartpence*, the Ninth Circuit held that the material facts test was not satisfied. The defendant in *Hartpence* was KCI, a company that manufactured medical devices that speeded the healing of wounds. One such device was a V.A.C. (vacuum assisted closure) device. *See id.* at 1124. "V.A.C. devices perform negative pressure wound therapy ('NPWT')," and Medicare has covered NPWT devices as durable medical equipment. *Id.*

In the first-filed suit, the plaintiff Hartpence alleged that KCI had engaged in fraudulent conduct by submitting claims to Medicare related to the V.A.C. devices. Specifically, Hartpence asserted that KCI had submitted claims with a certain billing code, which indicated compliance with certain requirements even though those requirements had not, in fact, been met in various ways. *See, e.g., id.* at 1125 (noting that "Hartpence alleges that KCI improperly submitted claims with the KX modifier [*i.e.*, billing code]: (1) when there was no wound improvement in the

[9] Dr. Taylor contends that this notice standard is no longer applicable after *Kellogg Brown & Root Servs. v. United States ex rel. Carter*, 575 U.S. 650 (2015). *See* Taylor Opp'n at 21-22 n.23. In support, he cites an opinion from a Washington district court, *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, No. 4:14-cv-5002-EFS, 2015 U.S. Dist. LEXIS 137979 (E.D. Wash. Oct. 1, 2015). There, the court stated: "The Supreme Court's ruling in *Brown* inherently limits this 'notice' analysis. Applying a broad 'notice' test does not serve the FCA's purpose of providing private parties the opportunity to pursue actions alleging fraud against the government *once the first-to-file bar lifts following the dismissal of the earlier action*." *Id.* at *22 (emphasis added).

As indicated by the language italicized above, *Savage* has no application here because the first-filed action – *Osinek* – has not been dismissed and therefore the first-to-file bar cannot have not been lifted. *See also Brown*, 575 U.S. at 662 (indicating that "an earlier suit bars a later suit while the earlier suit remains undecided but ceases to bar that suit once it is dismissed"; rejecting the argument that the first-filed action remains pending even after it has been dismissed).

Moreover, the Ninth Circuit's decision in *Hartpence* – which applied the notice standard above – was issued *after* the Supreme Court's decision in *Brown*. *Brown* was decided in May 2015, and *Hartpence* in July 2015.

previous month; (2) for the treatment of wounds for which V.A.C. therapy was neither reasonable nor necessary; (3) when the required wound measurement documentation was absent; [etc.]").

In the later-filed suit, the plaintiff Godecke also claimed that KCI had improperly used the same billing code – albeit for a different reason. *See id.* (taking note of allegation that "KCI violated the FCA by knowingly misusing the KX modifier in submitting claims for a full month of V.A.C. therapy, even when the therapy . . . had been stopped and restarted within the same month"). In addition, Godecke claimed that there was a FCA violation related to DWOs (detailed written orders). Suppliers of durable medical requirement were required to obtain DWOs from a patient's treating physician before dispensing the supplied for which they sought reimbursement from Medicare. *See id.* at 1125 n.4. According to Godecke, "KCI ignored the requirement to receive correct and completed [DWOs] before delivering supplies and beginning therapy." *Id.* at 1125.

The Ninth Circuit effectively acknowledged the similarity of the Hartpence and Godecke complaints in that both implicated improper use of the same billing code (even though there were different reasons why the billing code was not properly used). However,

> Godecke's second claim involves different underlying facts. Whereas Hartpence's claims all allege knowing misuse of the KX modifier [*i.e.*, billing code], Godecke's second claim is based on facts which show KCI's violation of a *different Medicare program requirement* – the requirement that a provider receive Detailed Written Orders for the V.A.C. device before beginning to treat patients with the device. . . . [T]he claims are based on different material facts. The rules governing use of KX modifiers and DWOs were disseminated at different times, in different publications, and are plainly treated as separate regulations under the program.
>
> We further disagree that Godecke's action provided no additional benefit to the government. Unaided by Godecke's complaint, the government may have never discovered that KCI, in addition allegedly to misusing the KX coding system, was allegedly submitting V.A.C. claims before receiving DWOs. The two alleged frauds are materially different: the KX fraud allegations are based on *government payment for devices which were used, but unnecessary for treatment*, while the DWOs fraud allegations are based on the *government paying for devices that were never used at all*. The alleged frauds, in short, exist completely independent of one another.

Id. at 1131 (emphasis added).

2. Material Facts Test Satisfied

In *United States ex rel. Hampton v. Columbia/Hca Healthcare Corp.*, 318 F.3d 214 (D.C. Cir. 2003), the D.C. Circuit concluded that the material facts test was satisfied. The plaintiff Hampton's suit was the later-filed suit. The first-filed suit was brought by Boston. According to Hampton, the defendant companies and several employees had improperly billed the government under the Medicare program for home health services – *e.g.*,

> the companies billed for services that were miscoded; already paid for; performed by others; never administered; or supposedly administered to Hampton's mother after she died in 1996. Hampton also claimed that [the companies] submitted bills for supplies and medications that were unnecessary or never received; and that they billed for services to patients who did not qualify under the Medicare guidelines, did not need treatment, or were not charged required copayments. The companies submitted false or inaccurate documentation to the government and, so she alleged, shredded documents in order to destroy evidence of the fraud.
>
> [The D.C. Circuit held that Hampton's case and Boston's case were related because] Boston's allegations were along very much the same lines. He asserted that HCA home health subsidiaries billed the government for services that did not meet the Medicare eligibility criteria, for undocumented services, and for services not medically necessary. He also alleged that they submitted false or inaccurate Medicare documentation and destroyed documents.

Id. at 219.

Likewise, in *Batiste*, the D.C. Circuit also found the first- and later-filed cases related. The plaintiff Batiste filed the later action. Zahara filed the earlier action. The court found that "[a] side-by-side comparison has persuaded us that, although the complaints allege somewhat different facts, Zahara's complaint suffices to put the U.S. government on notice of allegedly fraudulent forbearance practices at [Sallie Mae] and its subsidiaries, and Batiste's complaint alleges the same material elements of the same fraud." *Id.* at 1209. In particular,

> Zahara and Batiste broadly allege that the same fraudulent activities occurred at each of their offices, for the same reasons, and that similar SLM corporate policies promoted the fraudulent behavior. They both allege SLM fraudulently increased its profits and promoted its standing with the Department of Education by falsifying forbearances. And both allege that SLM's corporate culture promoted increasing the dispensation of forbearances through quotas and a team bonus system. Though Zahara focused on the fabrication of oral forbearance requests, and Batiste focused

> on the offering of forbearances to unqualified borrowers, the allegations of the first complaint give the government grounds to investigate all that is in the second.
>
> Under the . . . material facts test, these complaints allege essentially the same corporation-wide scheme. The Zahara Complaint would suffice to equip the government to investigate SLM's allegedly fraudulent forbearance practices nationwide. Batiste's additional details would not give rise to a different investigation or recovery.

Id. at 1209-10.

D. Different Defendants

Finally, the Court must consider whether it makes a difference in "material facts" when different defendants are sued in the first-filed and later-filed actions. In *Osinek*, the original complaint named only one defendant – Kaiser Permanente – which Ms. Osinek described as "a private provider of Medicare Advantage insurance under Medicare Part C." Osinek Compl. ¶ 2.

> Kaiser Permanente is a California corporation with its principal place of business [in] Oakland, California 94612. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage Plans than any other organization in California. At all times relevant, Kaiser conducted business in California, including but not limited to providing healthcare services through Medicare Advantage plans and to the general public in California.

Osinek Compl. ¶ 6. The later-filed actions named a variety of different Kaiser entities, including but not limited to Kaiser Permanente.

COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
Kaiser Permanente	Kaiser Permanente		Kaiser Permanente	Kaiser Permanente	
	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	
	Kaiser Foundation Health Plan of Colorado	Kaiser Foundation Health Plan of Colorado	Kaiser Foundation Health Plan of Colorado		

COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
	Kaiser Foundation Health Plan of Georgia	Kaiser Foundation Health Plan of Georgia, Inc.	Kaiser Foundation Health Plan of Georgia, Inc.		
	Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest		
		Kaiser Foundation Hospitals	Kaiser Foundation Hospitals	Kaiser Foundation Hospitals	
		Southern California Permanente Medical Group	Southern California Permanente Medical Group	Southern California Permanente Medical Group	Southern California Permanente Medical Group, Inc.
		The Permanente Medical Group	The Permanente Medical Group	The Permanente Medical Group	Permanente Medical Group, Inc.
		Colorado Permanente Medical Group, P.C.	Colorado Permanente Medical Group	Colorado Permanente Medical Group P.C.	
		The Southeast Permanente Medical Group	The Southeast Permanente Medical Group	Southeast Permanente Medical Group	
		Hawaii Permanente Medical Group	Hawaii Permanente Medical Group	Hawaii Permanente Medical Group	
		Northwest Permanente, P.C.	Northwest Permanente, P.C.		
			Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.		
			Kaiser Foundation Health Plan of Washington		

United States District Court
Northern District of California

COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
			Mid-Atlantic Permanente Medical Group	Mid-Atlantic Permanente Medical Group, PC	
			Group Health Permanente		
				The Permanente Federation, LLC	The Permanente Federation, LLC
				Northwest Permanente Physicians & Surgeons, P.C.	
				Washington Permanente Medical Group	

The Ninth Circuit has not expressly addressed the issue of different defendants, but other circuit courts have. Most have indicated that "adding a new defendant to the mix does not *necessarily* allow a later-filed action to evade the first-to-file bar." *Cho v. Surgery Partners, Inc.*, No. 20-14109, 2022 U.S. App. LEXIS 8774, at *15 (11th Cir. Apr. 1, 2022) (emphasis in original). This is particularly true where the new defendant(s) named in the later-filed action is a subsidiary or affiliate of the defendant(s) named in the first-filed action. *See Branch I*, 560 F.3d at 379 (noting that "allegations of fraud against a corporation may bar subsequent allegations of fraud against the corporation's subsidiaries").

That being said, the fact that the new defendant(s) in the later-filed action is a subsidiary or affiliate of the defendant(s) in the first-filed action does not automatically mean that the first-filed and later-filed actions are related either. Ultimately, resolution depends on how the first-filed action defines the scope of the misconduct. If there are, *e.g.*, allegations in the first-filed suit that there was a nationwide problem or a corporate-wide problem, then, most likely, the fact that new subsidiaries or affiliates are named in the later-filed action will not make that action unrelated for purposes of § 3730(b)(5). *Cf. Batiste*, 659 F.3d at 1210 (related complaints "essentially alleged

same corporate-wide scheme"). On the other hand, if the first-filed action focuses on a local problem, then, most likely, a broader-in-scope later-filed action will not be related, even if the new defendant(s) in the latter action is an affiliate of the defendant named in the earlier action. *Cf. United States ex rel. Chovanec v. Apria Healthcare Group, Inc.*, 606 F.3d 361, 364 (7th Cir. 2010) (stating that, "to understand whether the suits materially overlap we must know whether the initial suits alleged frauds by rogue personnel at scattered offices or instead alleged a scheme orchestrated by Apria's national management").

"Two cases from the D.C. Circuit, *Hampton* and *Heath*, serve as useful bookends for this analysis." *Cho*, 2022 U.S. App. LEXIS 8774, at *15. *Hampton* found the first- and later-filed actions at issue related; *Heath* found the first- and later-filed actions at issue unrelated.

1. *Hampton*

In *Hampton*, the plaintiff Hampton named the following defendants in her later-filed action: HCA; Clinical Arts (Georgia subsidiary of HCA); and several Clinical Arts employees. She alleged that the defendants "had improperly billed the government under the Medicare program for home health services." *Hampton*, 318 F.3d at 218. The court was asked to decide whether Hampton's action was barred by an earlier lawsuit, filed by Boston. The D.C. Circuit noted that

> Hampton thinks her complaint differs significantly from Boston's because it named different defendants. Boston sued only HCA. Hampton sued not only HCA but also HCA's subsidiary Clinical Arts and several Clinical Arts employees. As Hampton sees it, Boston's complaint cannot possibly have covered fraud by Clinical Arts and its employees because it (1) fails to name Clinical Arts or its employees as defendants and (2) specifically mentions fraud at HCA home health care subsidiaries in six states that do not include Georgia.

Id. The court, however, found that

> these are not differences in the material elements of the fraud. Boston was a senior manager in HCA's home care group. *He alleged a corporate-wide problem*, revealed through internal audits, in which HCA perpetrated fraud in providing home health care services *through numerous subsidiaries*. It is true that Boston's complaint mentioned instances of fraud at particular home health agencies in only six specific states, not including Georgia. But Boston's complaint described these as *"examples" and "samplings"* of "a huge number of illegal payments from Medicare . . . received

> by Columbia/HCA's 550 home health locations *in 37 states*." Given Boston's broad allegations based on his position as an HCA insider, Hampton's naming Clinical Arts – a specific HCA subsidiary – and naming individual employees of Clinical Arts were merely variations on the fraud Boston's complaint described.

Id. (emphasis added); *see also Batiste*, 659 F.3d at 1209 (acknowledging that plaintiff in first-filed suit "discusses activities at [a Sallie Mae] subsidiary office in Nevada, but [still] alleges a nationwide scheme attributable not only to the subsidiary, but also to [Sallie Mae]"; thus, "[i]f the government investigated the facts alleged in [that plaintiff's] complaint on a nationwide basis, it would discover continuing fraud in the New Jersey offices"); *Chovanec*, 606 F.3d at 364 (taking note of allegations that fraud was enabled by changes made to a computer system used in all of a company's offices; also taking note of allegations that national headquarters provided guidance that enabled fraud); *United States ex rel. Marion v. Heald Coll., LLC*, No. 5:12-cv-02067-PSG, 2015 U.S. Dist. LEXIS 97767, at *11 (N.D. Cal. July 24, 2015) (stating that "[a]llowing plaintiffs to escape the first-to-file bar by naming specific employees who carried out a previously-alleged corporate fraud contravenes the purpose of Section 3730(b)(5) – to prevent piggyback claims[;] [h]ere, the previously-filed complaints against Corinthian [Colleges] allege that fraudulent conduct extended far beyond individual campuses and pervaded the entire company").

2. *Heath*

In *United States ex rel. Todd Heath v. AT&T, Inc.*, 791 F.3d 112 (D.C. Cir. 2015), the plaintiff Heath filed the later-filed action against AT&T and nineteen of its subsidiaries. The lawsuit was related to a federal program known as the Universal Service Fund. *See id.* at 117. Under federal law, "every interstate telecommunications carrier must contribute a portion of its quarterly interstate and international telecommunications revenue to the . . . Fund." *Id.* at 116. One of the programs administered through the Fund is "E-Rate," which "entitles qualifying schools and libraries to receive Internet and telephone services at discounted rates." *Id.* at 116-17. According to Heath,

> AT&T orchestrated and implemented through its subsidiaries a corporate-wide scheme to have false claims submitted to the Universal Service Fund by depriving schools and libraries in the E-Rate program of the lowest corresponding price for services. Schools and libraries, unaware of those overcharges, then passed

> those inflated costs on to the federal government for reimbursement through the Universal Service Fund.

Id. at 117. Of particular note, Heath asserted that AT&T deliberately or recklessly chose not to train its employees in the lowest-corresponding-price requirement. *See id.* (taking note of allegation that AT&T was a recidivist violator of the E-Rate Program).

Heath had also filed an earlier lawsuit but only against Wisconsin Bell, which was a wholly owned subsidiary of AT&T. *See id.* at 118. In this suit, Heath asserted that "Wisconsin Bell charged some E-Rate eligible schools more than others, and that Wisconsin Bell generally failed to provide school districts with the benefit of the favorable pricing it offered to state departments, agencies, and universities." *Id.* Furthermore, "[w]hen informed of this pricing discrepancy, Wisconsin Bell's sales representatives 'regularly denied the existence of the agreements' between Wisconsin Bell and other Wisconsin agencies." *Id.*

One issue before the D.C. Circuit was whether Heath's first-filed suit was a bar to his later-filed action. The court held that the first-filed suit was not a bar because the

> two complaints target factually distinct types of frauds. The Wisconsin Bell Complaint alerted the federal government only to a limited scheme by Wisconsin Bell to defraud the E-Rate program within Wisconsin. That alleged fraud was accomplished, in part, through affirmative misrepresentations by Wisconsin Bell employees to schools and libraries within Wisconsin, in which those employees openly denied the existence of a state contract with a lower corresponding price.
>
> In contrast, the AT&T Nationwide Complaint alleges a different and more far-reaching scheme to defraud the federal government through service contracts entered into across the Nation, and then to cover up that fraud. Critically, the alleged fraud was accomplished not through affirmative misrepresentations about the lowest corresponding price, but through institutionalized disregard of the lowest-corresponding-price requirement altogether in AT&T's employee-training and billing procedures. According to the AT&T Nationwide Complaint, AT&T and its subsidiaries deliberately failed to enforce that lowest-price mandate by refusing to train or even tell employees about that limitation on charges, and by failing to incorporate that limitation into its billing practices.

Id. at 121.

The court continued:

> On its face, the Wisconsin Bell complaint discloses nothing more than the rogue actions of individuals within a single AT&T subsidiary and their specific, overt misrepresentations. Nothing in

> the complaint would have alerted the United States government to a nationwide scheme centered in AT&T's corporate headquarters of mischarging the E-Rate program and subsequently concealing those overpayments. Nor, given the affirmative misrepresentations at issue, would the Wisconsin Bell Complaint have pointed the federal government to AT&T's systematic refusal to institutionalize compliance by employees with the lowest-corresponding-price requirement.
>
> The fraud thus manifested itself in sufficiently distinct ways in the two cases that the material elements of the fraud differ. As the Seventh Circuit has recognized, "to understand whether the suits materially overlap we must know whether the initial suit[] alleged frauds by rogue personnel at scattered offices or instead alleged a scheme orchestrated by * * * national management." Because the Wisconsin Bell Complaint alleged only the former, it did not disclose the nationwide fraud grounded in institutionalized training and enforcement failures, and compounded by efforts at concealment, that is the focus of Heath's later complaint.

Id. at 121-22 (citation omitted). The D.C. Circuit distinguished, *inter alia*, *Hampton* because, there, "the first complaint alleged a broad fraudulent scheme orchestrated by a national or parent company, and the second complaint merely added additional facts or widened the circle of victims of the same fraudulent conduct." *Id.*

> Those cases stand for the simple proposition that the greater fraud often includes the lesser. The problem for AT&T is that the lesser fraud does not, without more, include the greater. The Wisconsin Bell Complaint did not allege that AT&T encouraged Wisconsin Bell's fraud or affirmative misrepresentations, or even knew anything about them. Nor did the Wisconsin Bell Complaint suggest that AT&T and its subsidiaries engaged in "uniform billing practices" across the United States. There simply is no hint in the Wisconsin Bell Complaint of a country-wide, institutionalized corporate practice of disregarding the lowest-price requirement or of a calculated refusal to educate or train employees.

Id. at 122-23.

The court acknowledged AT&T's point that the E-Rate program is a national program but, it pointed out, so too "is virtually every law policed by the *federal* False Claims Act." *Id.* at 123 (emphasis in original). The first-to-file bar could not be triggered "every time an initial complaint alleges that a subsidiary of a national company violated a national law" or "a broad swath of False Claims Act coverage" would be "erase[d]." *Id.* The court underscored that the purpose of the first-to-file bar was "to prevent copycat litigation, which tells the government nothing it does not already know" but, here, "Heath's complaints go after two materially distinct fraud schemes." *Id.*;

see also United States ex rel. Branch Consultants v. Allstate Ins. Co., 560 F.3d 371, 379 (5th Cir. 2009) (stating that the first-filed action "*Rigsby* does not allege a true industry-wide fraud or concerted action among a narrow group of participants[;] [r]ather, looking only at the facts pleaded . . . , *Rigsby* implicates, at most, four specific [write-your-own] insurers among the approximately ninety-five WYI insurers conducting business in the Louisiana and Mississippi areas during Hurricane Katrina," and, therefore, "*Rigsby* tells the government nothing about which of the ninety-one other WYO insurers . . . , if any, actually engaged in any fraud").

III. COMPARING RELATOR ACTIONS

Having reviewed the major legal issues, the Court may now turn to a comparison of the first-filed action, *Osinek*, with the various later-filed actions. The Court makes the comparisons in the order listed below because, *e.g.*, if there are material differences between *Osinek* and *Taylor*, that would effectively make *Taylor* the first-filed action for the new material facts. In other words, the remaining cases would then need to be compared to both *Osinek* and *Taylor*.

- Case No. C-21-3894 EMC *Taylor* (filed in the District of Colorado in 2014 and transferred to this District in 2021).
- Case No. C-16-1558 EMC *Arefi* (filed in the Central District of California in 2015 and transferred to this District in 2016).
- Case No. C-16-5337 EMC *Stein* (filed in the Central District of California in 2016 and transferred this District in 2016).
- Case No. C-18-1347 EMC *Bryant*.
- Case No. C-21-3124 EMC *Bicocca* (filed in the Eastern District of California in 2020 and transferred to this District in 2021).

A. *Osinek* and *Taylor*[10]

Dr. Taylor argues that his case is materially different from *Osinek* in two ways: (1) different defendants were sued in each case and (2) different frauds were implicated in each case.

[10] Dr. Taylor argues his FAC is the operative complaint for purposes of comparing his case to cases filed after his. *See* Taylor Opp'n at 6 n.4. But for purposes of comparing *Osinek* and *Taylor*, the Court compares the *Osinek* complaint to Dr. Taylor's original complaint. At the time Dr. Taylor brought his case, there was only the original complaint in *Osinek* on file.

1. Different Defendants

Ms. Osinek sued only one entity: Kaiser Permanente. In contrast, Dr. Taylor sued multiple Kaiser entities: Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; Kaiser Foundation Health Plan of Georgia; and Kaiser Foundation Health Plan of the Northwest.

Dr. Taylor argues that the difference in defendants is meaningful. Defendants argue to the contrary. They take the position that, by suing "Kaiser Permanente," Ms. Osinek implicitly sued a national defendant which therefore covered all regional or local subsidiaries or affiliates. Defendants further argue that allegations made in the Osinek Complaint show that Ms. Osinek was implicating a nationwide fraud. *See* Mot. at 20. The Court finds that the Osinek complaint does not allege a nationwide fraud.

As a starting point, the Court takes note that there does not appear to be any legal entity with the name "Kaiser Permanente." Rather, "Kaiser Permanente" seems to be a trade name used by various Kaiser entities. *See* Mot. at 1 (asserting that there are "various healthcare organizations operating under the Kaiser Permanente trade name"); *cf.* U.S. Compl. ¶ 28 (noting Kaiser's Health Plans, Permanente Medical Groups, and hospitals publicly hold themselves out and do business collectively as an integrated healthcare providers called 'Kaiser Permanente'"); Taylor Compl. ¶ 16 (alleging that "Kaiser Permanente is a non-profit care consortium" that "includes three main groups: (1) the Kaiser Foundation Health Plan, Inc. and its subsidiaries; (2) the Kaiser Foundation Hospitals and their subsidiaries; and (3) the Permanente Medical Groups"). Thus, the fact that Ms. Osinek (not to mention Dr. Taylor and others) sued "Kaiser Permanente" is not particularly telling one way or the other.

What is more significant are the allegations in Ms. Osinek's complaint – specifically, the geographic scope of the allegations. The complaint implicates California only. For example, Ms. Osinek describes "Kaiser Permanente" as follows:

> a California corporation with its principal place of business *[in] Oakland* . . . . Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage plans than any other organization *in California*. At all times relevant, Kaiser conducted business *in California*, including

> but not limited to providing healthcare services through Medicare Advantage plans and to the general public *in California*.

Osinek Compl. ¶ 6 (emphasis added).

One might argue that the above paragraph is California-centric because Ms. Osinek was simply trying to establish that jurisdiction in California is proper. However, nowhere in the complaint does Ms. Osinek allege that there is a problem outside of California. She does not mention any other state. She does not allege a "corporate-wide problem" as in *Hampton*, 318 F.3d at 218. She never even uses the term "nationwide" or "corporate-wide" or otherwise suggest a "'scheme orchestrated by . . . national management.'" *Heath*, 791 F.3d at 122 (quoting *Chovanec*, 606 F.3d at 364). Nor is it not clear that any practice identified by Ms. Osinek was necessarily nationwide or corporate-wide in nature – *e.g.*, there is no suggestion that data mining through the use of algorithms was implemented through a nationwide computer system.

Defendants contend that just because the Osinek Complaint gave California examples does not mean that the pleading is limited in scope to California. In principle, this is true. But there must be some indication in the pleading that the problem extends outside of California.[11] *Compare Hampton*, 318 F.3d at 218 ("It is true that Boston's complaint mentioned instances of fraud at particular home health agencies in only six specific states, not including Georgia. But Boston's complaint described these as 'examples' and 'samplings' of 'a huge number of illegal payments from Medicare . . . received by Columbia/HCA's 550 home health locations in 37 states.'"). Indeed, if the rule were to the contrary, then there would seem to be serious policy concerns. The mere fact that a defendant company is part of a larger network of affiliated companies would be enough to deem the government on notice of a nationwide or corporate-wide problem – which would then, under the first-to-file bar, cut off all other actions. But if the government declined to investigate on a nationwide or corporate-wide scale (*e.g.*, because of limited resources), and the first filer stayed within the limited scope of its complaint as pled, then no one else would be able to bring a FCA claim to address a potentially broader problem. This

[11] Notably, where the Osinek Complaint does at one point refer to different regions, both of the regions identified are still based in California. *See* Mot. at 20 (citing Osinek Compl. ¶ 37); Osinek Compl. ¶ 37 (alleging that "Kaiser positioned the Southern California Region against Northern California in competition for the highest risk scores and physician approval rates").

would run counter to the FCA which is meant to encourage the uncovering of fraud against the government. The first-to-file bar would not only "prevent copycat litigation," *Heath*, 791 F.3d at 123, but also a wide swath of litigation far broader than the first-filed suit. Here, *Taylor* is not simply an "opportunistic successive suit," *Lujan*, 243, F.3d at 1187; *Taylor* cannot be said to have "provided no additional benefit to the government." *Hartpence*, 792 F.3d at 1131.

Confronted with this obstacle, Defendants invoke the practical aspect of the material facts test, which asks whether "[t]he first-filed claim provides the government notice of the essential facts of an alleged fraud." *Lujan*, 243 F.3d at 1187. Defendants note that, a few months after the *Osinek* complaint was filed in 2013, the government issued four subpoenas to (1) the Kaiser Foundation Health Plan; (2) the Permanente Medical Group; (3) Southern California Permanente Medical Group; and (4) Kaiser Foundational Hospitals. The subpoenas covered not only the named entities but also *all subsidiaries and affiliates*.[12] *See* RJN, Exs. A-D (subpoenas). Thus, Defendants argue, the government implicitly understood that *Osinek* pointed to a nationwide or corporate-wide problem. Defendants add that, in 2017, the government sent a letter to Defendants seeking the production of documents from the Colorado regions specifically – and cited to the 2013 subpoenas in support of that request. *See* RJN, Ex. E.

Defendants' contention is not convincing for several reasons. First, Dr. Taylor raises a legitimate argument that only the complaints should be considered in determining whether the first-to-file bar applies – not evidence outside of the complaints. *Cf. In re Natural Gas Royalties ex rel. United States*, 562 F.3d 1023, 1031 (10th Cir. 2009) (stating that "[t]he first-to-file bar is designed to be quickly and easily determinable, simply requiring a side-by-side comparison of the complaints"); *Batiste*, 659 F.3d at 1209 (making a "side-by-side comparison" of the complaints in the first-filed and later-filed suits). Dr. Taylor has not been privy to all of the communications

[12] *See, e.g.*, RJN, Ex. A (Subpoena at 2) ("The term 'KAISER FOUNDATION HEALTH PLAN, INC.' refers to the person or entity with its primary offices located at One Kaiser Plaza, Oakland, California, and also includes all current and former: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, *subsidiaries*, regions, segments, branches, groups, *affiliates*, and divisions; and joint ventures of which it is a part.") (emphasis added).

between the United States and Defendants. It is entirely possible that some communications might support his position here rather than Defendants.[13] And if the Court were to permit Dr. Taylor to, in effect, conduct discovery into the government's communications – or more generally, into the government's understanding of the *Osinek* complaint – then there would effectively be a mini trial on a secondary matter that would only delay the process of moving forward with the case. The task before the Court at this juncture is to compare the complaints, not conduct a mini-trial based on facts.

Accordingly, the Court does not dismiss *Taylor* based on the first-to-file bar because *Taylor* is broader in scope than *Osinek* in terms of defendants. *See Heath*, 791 F.3d at 122 ("Those cases [such as *Hampton*] stand for the simple proposition that the greater fraud often includes the lesser. The problem for AT&T is that the lesser fraud does not, without more, include the greater.").

2. Different Frauds

The closer question is whether *Taylor* implicates different frauds than does *Osinek*.

As noted above, *Osinek* is about mining records to look for places to upcode, particularly for high-value conditions. Upcoding was ultimately improper because it was based on, *e.g.*, exaggerating a patient's condition, diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a condition for which the patient was not treated, diagnosing without the proper support/documentation, and the like.

Taylor is essentially the flip side. It asserts the theory that, as a result of regular internal audits, Kaiser knew there were high error rates in risk adjustment claims in certain areas but *failed* to take action to find the false claims retroactively – and thus improperly retained the

[13] Even if the Court were to consider the 2013 subpoenas issued by the government and its 2017 letter to Defendants, Defendants do not fare any better. Although the subpoenas did refer to subsidiaries and affiliates, that language is boilerplate in nature. And fact that the government only issued subpoenas to four specific Kaiser entities (all of which appear to be based in California) points to a more limited scope of inquiry. As for the letter, the fact that the government relied on the 2013 subpoenas to justify an inquiry into Colorado in 2017 largely seems a litigation tactic. Notably, by 2017, the *Taylor* complaint – which expressly implicated the Colorado region – had been filed. (The original complaint in *Taylor* was filed in October 2014.)

government's overpayment for those false claims (essentially, a reverse false claim theory).[14] *See, e.g.*, Taylor Compl. ¶¶ 81-82 (citing "[e]xamples of risk adjustment claims that the Kaiser audits have identified as routinely false" and alleging that, "despite its knowledge that the categories of risk adjustment claims . . . are false a significant percentage of the time, Kaiser routinely fails to take reasonable steps to identify which of these claims are false . . . and then to prevent their submission in the first place or to delete them after submission"). *Taylor* contrasts the lack of effort by the Kaiser entities to take action to address the errors with their zealous pursuit of reviewing records to find instances where diagnoses could be added (*i.e.*, upcoding). *See* Taylor Compl. ¶ 62 (alleging that Kaiser's "lack of diligence contrasts starkly with [its] considerable efforts and substantial commitment of resources to audit current and past claims to identify new diagnoses that it could use to submit additional risk adjustment claims and thereby increase the amount of the risk adjustment payments it receives from CMS.").

Dr. Taylor argues that the flip side makes his case materially different from *Osinek*. Specifically, he argues that his case, unlike *Osinek*, focuses on (1) Kaiser's failure to act even after audits revealed high error rates for certain HCCs or diagnoses; (2) Kaiser's failure to act even after audits revealed high error rates for diagnoses made by external providers; and (3) Kaiser's failure to act even after audits revealed high error rates for "True Positive" results associated with Kaiser's Natural Language Processing program. Each of these claimed differences is discussed below.

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[14] In their papers, Defendants suggest that Dr. Taylor does not have a viable claim here: "Taylor's allegations about error rates identified in audits of diagnosis-code data do not identify a unique fraud scheme. Rather they purport to show that Defendants had *knowledge* of the upcoding scheme that Osinek already alleged." Reply at 3 (emphasis added). Defendants likely make this argument because, in its complaint, the United States alleges that "Kaiser's internal audits put [it] on . . . notice of fraudulent diagnoses." U.S. Compl. at 68; *see also* U.S. Compl. ¶ 304 (alleging that "[a] variety of internal audits provided further notice that Kaiser's addenda and query practices were resulting in false claims to CMS").

Although Defendants fairly argue that the audits are relevant to Kaiser's knowledge, it is not clear why Dr. Taylor would not also have a viable claim based on the theory that Kaiser failed to take corrective action which resulted in its being able to keep government overpayments for false claims in violation of the FCA. *Cf. United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1173 (9th Cir. 2016) (indicating that plaintiff had a viable theory based on allegations that, in the face of audit error rates in excess of 20%, defendants conceived and directed retrospective reviews that were "designed to identify only favorable reporting errors").

a. High Error Rates for Certain HCCs or Diagnoses

Dr. Taylor first claims a violation of the FCA because Kaiser failed to act even after audits revealed high error rates in risk adjustment claims for certain HCCs or diagnoses. For example, Dr. Taylor alleges as follows with respect to cancer:

- "Every year, Kaiser's National Compliance Office ('NCO') conducts a nationwide 'Probe' audit to test the accuracy of risk adjustment claims submitted the prior year." Taylor Compl. ¶ 69.
- The Probe Audits "have consistently identified cancer (HCCs 7-10) as the most upcoded condition." Taylor Compl. ¶ 102.
- "The most significant and consistent error is that Kaiser providers submit diagnosis codes representing active, current treatment of cancer when, in fact, the patient's cancer is cured, in remission, or otherwise irrelevant to the services provided to the patient." Taylor Compl. ¶ 103. Notably, a diagnosis of "history of cancer" does not result in a risk adjustment. *See* Taylor Compl. ¶ 105.

Cancer is not the only HCC/diagnosis called out as problematic. Other conditions that have had high error rates include:

- Stroke. *See, e.g.*, Taylor Compl. ¶ 118 ("Kaiser knew stroke was commonly coded as an active event, when, in fact, the patient should have been classified as having a history of stroke.").
- Vascular disease. *See, e.g.*, Taylor Compl. ¶ 127 ("[S]ome claims erroneously claimed the patient had current vascular disease, when, in fact, they had only a history of the condition."); Taylor Compl. ¶ 129 ("[C]ertain claims were false because of a 'mismapping' problem with HealthConnect, Kaiser's EMR [electronic medical records]. HealthConnect . . . allows physicians to choose a descriptive diagnosis (as opposed to a specific ICD-9 code) when entering clinical information. HealthConnect then 'maps' this descriptive diagnosis to a specific ICD-9 diagnosis code, which is then inserted into the medical record documentation.").
- Chronic bronchitis. *See, e.g.*, Taylor Compl. ¶ 134 ("Kaiser's EMR [electronic

medical records] . . . pressured physicians to use the diagnosis for chronic bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk adjust)."); Taylor Compl. ¶ 132 ("The probe audits regularly found COPD [chronic obstructive pulmonary disease] claims erroneous based on lack of documentation in the record, or because the doctor failed to document the patient's condition with sufficient specificity to determine if the patient actually had COPD.").

- Malnutrition. *See, e.g.*, Taylor Compl. ¶ 140 ("In some cases, the condition was diagnosed as current when the patient actually only had a 'history of' the condition.").
- Renal insufficiency. *See, e.g.*, Taylor Compl. ¶ 152 ("Chronic kidney disease ('CKD') is a condition that is often miscoded . . . .").

As indicated by the above, Dr. Taylor takes issue with Kaiser for not reacting to the high error rates – *i.e.*, had Kaiser done so then it would have seen that the diagnoses (of high-value conditions) lacked documentation or proper support and/or that the diagnoses were irrelevant to the treatment provided to the patient. Although Dr. Taylor is correct that his claim here is about Kaiser ignoring an upcoding problem (as revealed by error rates) rather than actively creating upcoding, the Court does not see this flip side as creating a material difference with respect to *Osinek*. This is because both *Taylor* and *Osinek* are ultimately based on the same "underlying facts," *Hartpence*, 792 F.3d at 1131: that the high-level condition that was diagnosed did not have documentation or proper support and/or did not affect patient care.

The practical aspect of the material facts test underscores that *Taylor* and *Osinek* are related cases, at least with respect to the above. Here, the Court must ask whether the allegations in *Osinek* "[gave] the government grounds to investigate all that is in" the Taylor Complaint. *Batiste*, 659 F.3d at 1209; *see also id.* at 1209-10 (stating that the first-filed "[c]omplaint would suffice to equip the government to investigate SLM's allegedly fraudulent forbearance practices nationwide" and the "additional details" in the later-filed complaint "would not give rise to a different investigation or recovery"). Based on *Osinek*, the government was put on notice that high-value conditions often did not have proper support and were diagnosed even when a patient

was not treated for that condition at the time of service. Thus, in light of *Osinek*, the government had grounds to investigate all that is in the Taylor Complaint which points to the same basic problem. That, according to Dr. Taylor, the problem would have been revealed if Kaiser had taken action in response to the high error rates, is somewhat beside the point. The error rates here are not in themselves what is critical; rather, at bottom, Dr. Taylor's broader claim is that high-value conditions were diagnosed without following the practices required by Medicare regulations. This is fundamentally the same charge that Ms. Osinek makes.

b. High Error Rates for Diagnoses Made by External Providers

Dr. Taylor also claims that his complaint is different from the Osinek Complaint because he has alleged that Kaiser failed to act even after audits revealed high error rates with diagnoses submitted by external providers. (Dr. Taylor refers to this as "one-way look chart review" in his papers. *See, e.g.*, Taylor Opp'n at 7.) The relevant allegations in support of this theory are as follows:

- Several of Kaiser's regions, including Colorado, Hawaii, and, until recently, Georgia, "rely heavily on external providers (hospitals or other facilities who are not owned by Kaiser) to provide inpatient care to Kaiser's HMO members." Taylor Compl. ¶ 83.
- The external providers submit claims to Kaiser after they have provided services to Kaiser members, and Kaiser uses the external providers' diagnoses as the basis for the risk adjustment claims that Kaiser submits to CMS. *See* Taylor Compl. ¶ 84.
- Kaiser's audits "have identified significant error rates in risk adjustment claims [that] Kaiser submitted to CMS based on diagnoses provided by external providers." Taylor Compl. ¶ 86. For example, for the Colorado region, the error rates for external providers in some years was over 40% and 60%. *See* Taylor Compl. ¶ 88; *see also* Taylor Compl. ¶ 89 (adding that "[t]he error rates for certain large hospitals . . . are striking" – some more than 90%).
- "Despite knowing of the consistent errors in claims data from external providers, Kaiser Colorado [for example] does not conduct any routine targeted audits of

claims submitted by external providers. This is particularly egregious because the Colorado region does have a coder review each hospital stay at an external provider *to look for additional diagnoses* present in the chart but not coded by the treating physician." Taylor Compl. ¶ 98 (emphasis added).

Here, the Court agrees with Dr. Taylor that this specific aspect of his case is not related to *Osinek*. Problematic coding related to high-value conditions is different from problematic coding by external providers. Notably, there is no indication that the problematic coding by external providers was related to high-value conditions. Accordingly, this specific claim made by Dr. Taylor involves "different underlying facts." *Hartpence*, 792 F.3d at 1131. Furthermore, it cannot be said that the government would likely have found the particular problem with external providers based on its investigation into the kinds of internal upcoding practices identified in *Osinek*.

c. Natural Language Processing Software

Finally, Dr. Taylor claims that his complaint differs from the Osinek Complaint because he has made allegations about Kaiser's Natural Language Processing ("NLP") software. The main allegations made in the Taylor Complaint with respect to the NLP software are as follows.

- "Broadly speaking, [a] NLP program uses an algorithm to search EMRs [electronic medical records] to find words that, individually or in combination, indicate that a patient has certain diagnoses." Taylor Compl. ¶ 191.
- Kaiser developed its own NLP audit program "to try to find new diagnosis codes to submit." Taylor Compl. ¶ 191.
- "All face-to-face visits to a physician or hospital . . . are run through the NLP software to identify new diagnoses that might be appropriate to use for submission of additional risk adjustment claims. The results are grouped into four categories: (a) True Positive: [meaning] diagnoses . . . have been confirmed by two Kaiser coders; (b) More Information Needed: [meaning] diagnoses . . . may be present, but further analysis is required to confirm; (c) Problem List Only: [meaning] diagnoses . . . show up only on the member's problem list [section of the medical record] with

no documentation of treatment; and (d) False Positives or Found Elsewhere." Taylor Compl. ¶ 196.

- "Kaiser allows the various regions to decide how to use [the above] information." Taylor Compl. ¶ 197. For some regions, if a result is True Positive, then a claim is submitted to CMS for payment – without any further review. *See* Taylor Compl. ¶ 200. This is true even though audits have revealed that there is a high error rate for True Positives. *See* Taylor Compl. ¶¶ 198, 200.

As indicated by the above, Dr. Taylor is not focusing here on the fact that Kaiser uses the NLP program to mine records for instances where it can upcode. Had he done so, then his case would clearly be related to *Osinek*. Rather, Dr. Taylor's point is that there is a high error rate associated with the NLP program's True Positives, but Kaiser still submits claims based on True Positives without any further inquiry.

The Court finds that the nature of wrongdoing claimed by Dr. Taylor here involves different "material elements" from *Osinek*. *Lujan*, 243 F.3d at 1189. Dr. Taylor is charging Kaiser with exploiting True Positives; this is different from *Osinek* which is focused on the exploitation of high-value conditions. Similar to above, there is nothing that suggests True Positives appear with high-value conditions only, or even primarily. Thus, Dr. Taylor here has "'significant information to contribute of [his] own.'" *Id.* The Court also notes that, under the practical aspect of the material facts test, this part of *Taylor* should not be deemed related to *Osinek*. Based on *Osinek*, the government would likely have looked at the NLP program given that it was purportedly used to data mine; however, that would not lead the government to question the True Positive results yielded by the NLP program. Rather, as a facial matter, the more likely candidates for exploitation by Kaiser would be the categories of "More Information Needed" and "Problem List Only," not the True Positives.

d. Summary

The *Taylor* case is not dismissed in its entirety but only in part. *Taylor* differs materially from *Osinek* in three ways: (1) *Taylor* points to a nationwide or corporate-wide problem whereas *Osinek* is local or regional (*i.e.*, California-centric) in nature; (2) *Taylor* has identified a fraud

related to external providers rather than high-value conditions; and (3) *Taylor* asserts a problem with Kaiser failing to evaluate the True Positives results yielded by the NLP program.

B. *Osinek* and *Arefi*

As noted above, the *Arefi* Plaintiffs do not oppose the motion to dismiss their complaint. Thus, the Court may move on to the next complaint filed after *Arefi*.

C. *Osinek* and *Stein*

As an initial matter, the Court takes note that the *Stein* plaintiffs contend that the Court should compare the complaint in *Osinek* with their operative SAC, which was filed in November 2021. *See* Opp'n at 3 n.2. The Court rejects that argument for the reasons discussed above.

Based on their original complaint, the *Stein* plaintiffs focus on two specific conditions: sepsis and malnutrition.[15] The main allegations are as follows.

- Sepsis. The criteria for diagnosing sepsis is not straightforward. *See, e.g.*, Stein Compl. ¶¶ 42-43, 49. In 2003, the ICD-9 diagnostic codes and ICD Guidelines were modified to, in essence, reflect that complexity. The Guidelines emphasize that "coders will likely have to query physicians when documenting Sepsis to trigger proper documentation that supports the Sepsis diagnosis due [to] the complex nature of those diseases." Stein Compl. ¶ 48. Defendants engaged in a scheme "to up-code and falsely diagnose MA enrollees with sepsis and/or severe sepsis, i.e., sepsis with acute organ failure[] (collectively referred to as 'Sepsis')[,] when Sepsis was not present." Stein Compl. ¶ 50. "[The] fraudulent scheme [involved] the identification and treatment of Sepsis for . . . MA enrollees that presented in the emergency room (ER) of [Kaiser] hospitals and was accomplished by (a) [Defendants] implementing unwritten policies that prohibited coders employed by [Defendants] from performing physician queries for Sepsis diagnoses as required by the ICD-9 Guidelines, (b) implementing unwritten policies

[15] The *Stein* plaintiffs also included in their original complaint allegations on Kaiser's practice of "refreshing." However, in their opposition, they have conceded that this conduct was sufficiently implicated in earlier-filed actions. *See* Stein Opp'n at 1 (stating that the *Stein* plaintiffs "do not oppose [the] first-to-file attack against [their] Refresh fraud claim").

requiring Kaiser's coders to code ICD-9 diagnosis codes for Sepsis based solely on the physician's instructions to code Sepsis instead of relying on the supporting clinical findings documented in the medical record, (c) using an improper Sepsis diagnostic standard that overstated the frequency of Sepsis diagnoses, (d) aggressively diagnosing Sepsis as part of a strategy to lower the reported Sepsis mortality rates at [Kaiser] hospitals throughout California, and (e) [Defendants], as an express condition of receiving capitation payments from CMS, routinely and annually falsely certifying that such ICD-9 diagnosis codes for Sepsis were accurate, complete, and truthful . . . ." Stein Compl. ¶ 50.

- Malnutrition. Defendants "participated in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA enrollees." Stein Compl. ¶ 70. The scheme "was conducted at all [Kaiser] Hospitals throughout California and involved the diagnoses and coding of malnutrition and severe malnutrition based upon assessment performed by dieticians . . . . The . . . dietician used a rubber stamp on the MA enrollee's medical record indicating that in his/her opinion the MA enrollee suffered from malnutrition or severe malnutrition. [The] physicians then countersigned the stamp in the MA enrollees' medical record. Based solely on the presence of the physician's countersignature . . . , Kaiser's coders recorded the ICD-9 diagnosis codes for malnutrition or severe malnutrition . . . ." Stein Compl. ¶ 70. There was no face-to-face encounter nor were there clinical findings in support, as required by federal regulations. *See* Stein Compl. ¶ 71.

These claims overlap with *Osinek*. *Osinek* asserts that upcoding was improper because it was based on exploiting high-value conditions – *e.g.*, exaggerating a patient's condition, diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a condition for which the patient was not treated, diagnosing without the necessary support/documentation, and the like. *Stein* implicates the same kind of conduct; essentially, *Stein* involves lesser-included conduct by virtue of the fact that it focuses on two conditions (sepsis and

malnutrition) specifically. Notably, *Osinek*, like *Stein*, expressly identified malnutrition as one of the high-value conditions that was being exploited.[16] *See* Osinek Compl. ¶ 25. The fact that *Osinek* did not also expressly identify sepsis as a high-value condition (as *Stein* did) is not dispositive since it is but one example of the alleged upcoding. *Cf. Hampton*, 318 F.3d at 219 (concluding actions were related because both alleged that bills were submitted for ineligible and undocumented Medicare services and for services not medically necessary).

The *Stein* plaintiffs suggest that their case is still materially different because the frauds implicated in their complaint were committed when "patients . . . were admitted to a KFH hospital or in the case of Sepsis, treated as a hospital outpatient through the emergency room." Opp'n at 12-13. But nothing about *Osinek* excepts a hospital setting from the alleged upcoding.

The only place where *Stein* is materially different from *Osinek* is with respect to the scope of the alleged misconduct. *Stein* suggests – by virtue of the Kaiser entities sued – that the alleged misconduct goes beyond California. While this does make *Stein* different from *Osinek* (the latter being California-centric in scope), *Stein* runs into a problem still because *Taylor*, the next case filed after *Osinek*, implicates a nationwide or corporate-wide problem and is broad enough to encompass the basic kind of upcoding practices alleged in *Stein*.

The Court therefore dismisses the *Stein* case based on the first-to-file bar – in its entirety. The *Stein* plaintiffs have asked for leave to amend but that is a futile request since the Court's evaluation is limited to the original Stein Complaint.

D. *Osinek* and *Bryant*

As a preliminary matter, the Court takes note that Defendants do not seek to dismiss *Bryant* in its entirety. It recognizes that *Bryant* has retaliation claims (based on the FCA and on

[16] The Stein FAC (filed in May 2016, *i.e.*, a few months after the original Stein Complaint) did add in a new condition – i.e., aortic atherosclerosis ("AA"). *See* Stein FAC ¶ 83 (noting that AA "is a chronic condition that results in the build up of arterial plaque or fatty deposits in the patient's aorta"). According to the Stein Plaintiffs, "Kaiser's coders coded . . . MA patients with an AA diagnosis based solely upon the physician's notation of AA in the medical record, without the medical record reflecting that the patient was treated for his/her AA condition." Stein FAC ¶ 84. Even if the Court were to consider this new condition identified in the Stein FAC (as well as the Stein SAC), there would still be overlap with the *Osinek* complaint. The nature of the conduct is similar such that AA is a condition that the government likely would have investigated given *Osinek*'s description of Kaiser exploiting high-value conditions.

other federal and state law) which are not subject to the first-to-file bar. *See* Mot at 1 n.3 ("This Motion seeks dismissal of the Later-Filed Complaints . . . in their entirety except for the retaliation causes of action in the operative *Bryant* complaint (Counts 5 through 8) and the California False Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4) . . . .").[17]

According to the *Bryant* plaintiffs, their case is materially different from *Osinek* in that,

> unlike the *Osinek* complaint, the *Bryant*/*Hernandez* Complaint exposes Kaiser's upcoding fraud: (i) relating to a specific high-value diagnosis code, mechanical ventilator dependence status, that first came to light after Osinek filed her suit[[18]]; (ii) not just on the Medicare Advantage program, but on a different government program (the Affordable Care Act) run by a different government agency entirely (the Department of Health and Human Services); and (iii) within Kaiser's insurance and physician-practice behemoths in all regions, not just one region, and also within Kaiser's massive hospital operation across Kaiser's regions, which was not even part of the *Osinek* suit.

Bryant Opp'n at 2.

For (iii), as noted above, it does not matter that the hospital setting was not expressly implicated in *Osinek*. Nothing in *Osinek* suggests that it excludes the hospital setting. The *Bryant* plaintiffs fairly argue that *Osinek* is California-centric; however, as noted above, *Taylor* – the case next in line after *Osinek* – put the government on notice of a nationwide or corporate-wide problem related to the upcoding of high-value conditions.

As for (i), *see* Bryant Compl. ¶¶ 85-86 (alleging that "a patient is vent dependent only if the patient relies on the ventilation to live on a long-term basis and not for the short-term acute phase of a condition" but Defendants fail to comply with that guidance) (emphasis omitted), the *Bryant* plaintiffs are basically making the same kind of argument that the *Stein* plaintiffs did. *See* Bryant Opp'n at 15 ("Given the sheer number of diagnosis codes, it would be impossible for the government to identify fraudulent over-documenting and upcoding in particular diagnoses without

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[17] At one point, the *Bryant* plaintiffs also had California FCA claims but they dropped those claims in their FAC.

[18] In their complaint, the *Bryant* plaintiffs explicitly identified additional high-value HCCs or diagnoses but implicitly recognize that these conditions have already been expressly named by plaintiffs in earlier-filed actions. *See, e.g.*, Bryant Compl. ¶¶ 56, 107, 136, 144, 146-49 (referring to aortic atherosclerosis, sepsis, malnutrition, acute renal failure, acute kidney injury, and respiratory failure, arrythmia for members with pacemakers, major depression, and acute stroke).

being pointed in the right direction."). But as with *Stein*, this is lesser-included conduct and sufficiently similar to the conduct put at issue in *Osinek* – *i.e.*, Defendants were exploiting high-value conditions by failing to provide support/documentation for the upcoding. *Cf. Hampton*, 318 F.3d at 219 (concluding actions were related because both alleged that bills were submitted for ineligible and undocumented Medicare services and for services not medically necessary). The fact that the practice allegedly was not discovered until after *Osinek* was filed does not mean that *Bryant* cannot be a related case. That Defendants may have allegedly expanded their misconduct to other high-value conditions does not negate the government being put on notice of the fraudulent scheme in the first instance as a result of *Osinek*.

This leaves the *Bryant* plaintiffs with (ii). Here, the *Bryant* plaintiffs correctly point out that their original complaint contains multiple allegations about payments Defendants receive under the Affordable Care Act (and not just Medicare Advantage). For example, the *Bryant* plaintiffs allege as follows:

- "The United States contributes to premiums that individuals pay to private health insurance companies such as Kaiser under the Affordable Care Act. *See* Bryant Compl. ¶ 7; *see also* Bryant Compl. ¶ 52 (alleging that the government contributes through tax credits).
- "The Affordable Care Act sets up a program of risk adjustment in individual and group markets to lessen or eliminate the influence of risk selection on the premiums that plans charge. In the risk adjustment model utilized under the AA, which is named the HHS-Hierarchical Condition Categories ('HHS-HCC') risk adjustment model, HHS [*i.e.*, the Department of Health and Human Services] utilizes criteria and methods similar to those utilized under the Medicare Advantage Program, and adapts Medicare Advantage HCCs for use in the HHS-HCC model." Bryant Compl. ¶ 51; *see also* Bryant Compl. ¶ 7.
- Thus, "as under the Medicare Advantage Program, the ACA risk adjustment model creates powerful incentives for private health insurance companies like Kaiser to over-report diagnosis codes in order to exaggerate the expected healthcare costs for

their enrollees; the more codes that are reported, the higher premiums the companies are permitted to charge, and the higher contributions will be made to such premiums by the United States." Bryant Compl. ¶ 7.

- "Defendants overdocument and upcode risk adjustment claims relevant to individuals covered by the ACA in the same manner and pursuant to the same schemes as relevant to the Medicare Advantage program . . . ." Bryant Compl. ¶ 11(b).
- The *Bryant* plaintiffs "seek . . . to recover damages and civil penalties arising from the false or fraudulent records, statements and/or claims that the Defendants made or caused to be made in connection with false and/or fraudulent claims for Medicare Advantage risk adjustment payments [and] Affordable Care Act insurance premiums . . . ." Bryant Compl. ¶ 18.

In response, Defendants point out that the actual causes of action asserted by the *Bryant* plaintiffs at the end of their complaint refer to risk adjustment payments under Medicare only. *See, e.g.*, Bryant Compl. ¶¶ 209-10, 214-15, 220, 224-26. Nowhere do the causes of action refer to risk adjustment payments under the Affordable Care Act. Although Defendants are correct, the *Bryant* plaintiffs fairly point out that each cause of action does incorporate all paragraphs previously pled. Accordingly, although the *Bryant* plaintiffs could have drafted a better and clearer pleading, they have not pled themselves out of FCA claims based on the Affordable Care Act as Defendants contend.

At the hearing, Defendants argued that, even if the *Bryant* plaintiffs have claims predicated on the Affordable Care Act, they are nonetheless still barred by the first-to-file provision because the government would have been put on notice of that alleged fraudulent scheme by virtue of *Osinek*. The Court does not agree. The Affordable Care Act is an entirely different scheme, not run by CMS specifically, and covering a broad range of individuals outside of the reach of Medicare. The ACA claims thus state causes of action entirely different and distinct from the Medicare Advantage claims. The government was put on notice of a problem with the Medicare Advantage program only. That the Affordable Care Act also uses risk adjustment does not mean

that the government's investigation of Medicare Advantage would naturally lead to an investigation of the Affordable Care Act.

Accordingly, the Court dismisses *Bryant* but only in part. The claims that survive are the retaliation claims, as well as the claims based on the Affordable Care Act.

E. *Osinek* and *Bicocca*

Defendants do not seek to dismiss the entirety of *Bicocca*. Specifically, they recognize that Dr. Bicocca has claims pursuant to the California FCA that are not subject to the first-to-file bar. *See* Mot. at 1 n.3 ("This Motion seeks dismissal of the Later-Filed Complaints . . . in their entirety except . . . the California False Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4) . . . .").

Second, the Court takes note that Dr. Bicocca admits his original complaint (filed in February 2020) is barred by the first-to-file provision. He argues, however, that his FAC (filed in October 2020) adds a theory that is not in *Osinek*. *See* Bicocca Opp'n at 2. Because, as discussed above, it is Dr. Bicocca's original complaint that must be compared to the Osinek Complaint, he is out of luck.

However, even if the Court were to consider the FAC, Dr. Bicocca's contention that his case is materially different from *Osinek* is without merit. He states:

> Relator Bicocca's Amended Complaint describes "two sources" of diagnoses that Kaiser requires physicians to add. *Bicocca* Dkt. 16 ¶ 108. One of these sources is addenda that Kaiser gives physicians *after* a patient visit, which include additional diagnoses for the physician to *retroactively* add to the patient's chart. *Id.* at ¶¶ 106, 110. The other is a list of the patient's past diagnoses, which Kaiser gives to physicians *before* the physician meets with the patient, with the intention that the physician will re-diagnose each of the specific diagnoses *during* the visit ("upfront list"). *Id.* at ¶ 109.

Bicocca Opp'n at 2 (emphasis in original); *see also* Bicocca FAC ¶ 109 ("The first source [for diagnoses that physicians are required to add onto Medicare] are diagnoses that these patients had already, confirmed in previous years by other physicians. While, as a matter of first impression, this does not seem to be a violation of regulations, since the patients have already had the diagnoses confirmed by others, having physicians re-confirm these diagnoses without spending sufficient time on it and without having any expertise on these diagnoses is still a violation of

Medicare's regulations on confirming diagnoses for the purpose of risk adjustment."). The problem for Dr. Bicocca is that the latter is essentially refreshing, which has already been put at issue in *Osinek*.

Accordingly, the Court grants the motion to dismiss Dr. Bicocca's claims, and the only claims that survive are those based on the California FCA which Defendants have not contested for purposes of the first-to-file bar.

IV. CONCLUSION

For the foregoing reasons, the Court grants in part and denies in part Defendants' motion to dismiss based on the first-to-file bar. Specifically:

- *Arefi* and *Stein* are dismissed in their entirety.
- *Taylor* is dismissed except to the extent that it pleads (1) a nationwide or corporate-wide fraud; (2) a fraud based on improper coding by external providers; and (3) a fraud based on True Positive results from the NLP program.
- *Bryant* is dismissed except to the extent that it pleads (1) retaliation claims and (2) claims based on fraud in the Affordable Care Act program.
- *Bicocca* is dismissed except to the extent that it pleads claims based on the California FCA.

This order disposes of Docket No. 141.

IT IS SO ORDERED.

Dated: May 5, 2022

EDWARD M. CHEN
United States District Judge

United States District Court
Northern District of California

No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
VOLUME 2 of 9

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TAB 1

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

Before The Honorable Edward M. Chen, Judge

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,	)	
Plaintiffs,	)	
VS.	)	**NO. C 13-03891 EMC**
KAISER PERMANENTE, et al.,	)	
Defendants.	)	

San Francisco, California
Thursday, April 21, 2022

TRANSCRIPT OF REMOTE ZOOM VIDEO CONFERENCE PROCEEDINGS

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Thursday - April 21, 2022 **1:31 p.m.**

P R O C E E D I N G S

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THE CLERK: These proceedings are being recorded by this court. Any other recording of this proceeding, either by audio, video, including screenshot or other copying of the hearing, is strictly prohibited.

This court is now in session. The Honorable Edward M. Chen presiding.

The Court is calling the case Osinek, et al. versus Kaiser Permanente, Case Number 13-3891.

Counsel, please state your appearances for the record, beginning with the plaintiffs.

MR. HANAGAMI: William Hanagami for plaintiffs and relators Stein and Bone.

THE COURT: All right. Thank you, Mr. Hanagami.

MR. VOLDMAN: Max Voldman for plaintiff/relator James Taylor.

THE COURT: All right. Thank you, Mr. Voldman.

MR. LEWIS: Roger Lewis for plaintiff/relators Bryant and Hernandez.

THE COURT: All right. Thank you, Mr. Lewis.

MS. ZEMAN: Amy Zeman on behalf of relator Osinek.

THE COURT: All right. Thank you, Ms. Zeman.

MS. QUINN: Janel Quinn on behalf of plaintiff/relator

Michael Bicocca.

THE COURT: All right. Thank you, Ms. Quinn.

Does that cover all the relators? Anybody else?

All right. Then for the defense.

MR. BLALACK: Good afternoon, Your Honor. Lee Blalack on behalf of the defendants, and I have one colleague, my partner David Leviss here.

Dave?

MR. LEVISS: Good afternoon, Your Honor. David Leviss also on behalf of the defendants.

THE COURT: All right. Thank you.

Is the Government attending?

MR. DYAL: Yes. This is Gary Dyal on behalf of the Department of Justice.

THE COURT: All right. Thank you, Mr. Dyal.

I thought I saw a hand raised. Was there another hand raised? Someone else want to be admitted? Abram Zinberg?

We can't hear you, Mr. Choe.

MR. ZINBERG: Okay.

THE COURT: Is that Mr. Zinberg?

MR. ZINBERG: I'm trying. There we go.

THE COURT: All right. Do you want to make your appearance, Mr. Zinberg?

MR. ZINBERG: Yes. Abram Zinberg on behalf of relators Stein and Bone.

THE COURT: Okay. And, Mr. Choe?

Well, we cannot hear you, unfortunately.

MR. CHOE: Apologies, Your Honor. Can you hear me now?

THE COURT: Yeah, we can hear you now.

MR. CHOE: Yes. Shiwon Choe on behalf of the United States.

THE COURT: All right. Thank you.

All right. We're here to examine the defendants' motion to dismiss based on the first-to-file bar of the FCA, which bars related actions, quote/unquote, based on facts underlying the pending action.

And so as I understand it, the exercise requires us to examine the first-filed complaint, which is the Osinek case, against subsequent complaints. But the subsequent actions are also measured against the preceding actions. So if, for instance, I find that Osinek and Taylor are not so related that some aspects of Taylor survive, the next series of cases, including Stein, Bryant, and Bicocca, are subject to "first to file" based on any preceding case.

It seems to me there's an obvious logic to that because the whole idea is we don't want multiple cases on the same subject. So, sort of, the later you are in the chain, the more of a challenge it is because you've got a bigger base to try to measure up against in order to escape.

But the first order of business, I think, is to look at

the first two filed cases. And Taylor's is the first filed, at least in Colorado, and then being transferred here.

And so the first sort of legal question is: Do we look at the original complaint of the later filed or the amended complaint? And although there's some division in the cases, for reasons that have been stated by, I think, the majority rule, it seems to me that you look at the original complaint because, generally, that's how you measure jurisdiction as it existed when the action was filed. And there are a number of policy reasons supporting that as well. And so I am going to proceed by looking at the original complaints of the subsequent filers.

I think the bigger question is: How do we measure the similarity, the related action, the relatedness? Do we use the identical-facts test or the material-facts test? And if it's the material-facts test, how do you apply -- what does that really mean?

I think it's clear in this circuit that the Court does not apply -- the Ninth Circuit does not apply the identical-facts case; it applies the material-facts case. And it seems, though, that what the Courts have suggested is that you look to -- one aspect of applying the material-facts case is whether, quote, the first-filed claim provides the Government notice of the essential facts of an alleged fraud.

The D.C. circuit in the ***Ex Rel. Batiste*** case adopted a

similar approach. And *Hartpence* also talked about sort of the likelihood of the Government, being ultimately the party in interest here, having enough notice such that its notice of first case would have led to its decision, investigation into other claims.

So it seems to me that's the yardstick. I'll stop right there and see if others have any comment upon that theoretical framework, if anybody disagrees with that.

MR. BLALACK: Your Honor, this is Lee Blalack for the defendants. My partner David Leviss will be handling the argument today for the defendants; so I'll direct your question to him.

I think our answer is, we generally agree with that framework, but he can share our position.

THE COURT: All right. Mr. Leviss?

MR. LEVISS: In fact, we do, Your Honor, generally agree with the framework.

There was one, I guess, scope point that I wanted to clarify at the outset because the case law also makes clear that "first to file" is measured by a pending complaint at the time a later-filed complaint is filed. So even in the case of the Arefi complaint, which has not contested our motion and will be dismissed, Arefi could still have preclusive first-to-file effect on the later-filed complaints because it was pending at the time they were filed.

THE COURT: Right, right. And that's consistent with my view, is you look at all pending cases at the time it was filed. Unfortunately, if you're at the back of the line, you've got two, three, four, five hurdles to jump over, not just one, which, logically, I think that's the point of this.

In the end, I don't know if that's going to make much difference because, as we'll talk, we'll see what ground is covered by the first two, maybe three.

MR. LEVISS: Okay. Thank you, Your Honor.

THE COURT: Well, let's talk about the -- oh, Ms. Quinn, you had a -- you were going to --

MS. QUINN: Well, Your Honor, and I don't know if now is appropriate; or if we're kind of just going to go down the line, then I can certainly wait my turn.

But in terms of the framework that you've laid out on behalf of relator Bicocca, I think that we do take issue with looking at the original complaint, and we believe that would be the appropriate amended or pending complaint at the time that would be the operative pleading to look at.

I'm happy to discuss that more now, or like I said, if we're going down the line, we can address it later as well.

THE COURT: Well, let me ask you. Let me make sure I understand your point.

I agree that if the earlier complaints had been amended by the time the one you're comparing to is filed, you look at

whatever was existing at that time.

When I said you look at the original complaint, I'm saying the subsequent action, the second action or third -- whatever it is -- the subsequent action by which you're measuring the preceding actions, you would look at the complaint in that action and not further amendments to the subsequent actions as the comparator, as the comparison.

MS. QUINN: Correct, Your Honor. And I would respectfully disagree with that.

For example, in Bicocca's case, we filed an amended complaint and, shortly thereaf- -- or we filed our original complaint and, shortly thereafter, filed an amended complaint.

In the intervening, I believe, six or eight months between the original complaint and the amended complaint, you know, there was no challenge to the complaint based on "first to file"; there was no intervening complaint or amended complaint by any of the other relators. And so we believe that, essentially, because those two filings -- right? -- even if, for example, we had simply filed six months later with our first amended complaint as the original pleading, that would stand on its own for purposes of a comparison of pleadings for "first to file."

THE COURT: All right. Well, I understand there are two views on this question, and I think I noted that, and there's some authority for each.

I do think that the *Branch II* case, which had a very extensive analysis and looked at the policy reasons, I find persuasive in analyzing not only the *Rockwell* decision, but some of the policy advantages of, for instance, having a clear-cut rule that's clear at the outset and, two, avoiding the anomaly of a relator who secures a place in line by filing skeletal allegations and then kind of -- and then being able to amend the complaint later on to sort of enhance its position and then getting the benefit of that.

I understand there's sort of two views of that, and your view is not without some support. But ultimately, I've got to decide one way or the other on this, and it seems to me that it's appropriate to look at the original complaint.

MS. QUINN: Understood. Thank you, Your Honor.

THE COURT: I understand this is one of those issues where reasonable people could differ. Reasonable courts have differed, I think.

Well, let's talk about the actual facts here. So we have a situation, comparing the first two, where there are some differences: first, the difference in named defendants and the sort of resulting geographic scope or at least related geographic scope.

It seems to me that the Osinek case is really centered on California. It seems very California centered. And although -- there's no implication -- although it names, kind

of identifies the practice generally, such as the use of the algorithms to mine advantageous coding, et cetera, it appears to me that there was no indication of a nationwide issue, whereas the Taylor case does expressly. And so I'd like to get comments on that.

There does seem to be a difference in scope in terms of the -- at least the regional aspect. And so one could argue that they are different in that regard and that the Taylor case should arguably survive, at least to the extent it involves regions other than California that was identified in the Osinek case.

MR. LEVISS: Your Honor, may I address those points?

THE COURT: Yes.

MR. LEVISS: Okay. So for starters, I would note that, as we noted in our briefs, that Osinek names Kaiser Permanente, a national brand that encompasses an integrated healthcare consortium, including the provider groups, hospitals, and plans in all of the regions where the Kaiser affiliated defendants provide their healthcare model. That's who Osinek sued.

Many of the later-filed complaints also identified Kaiser Permanente as a national entity. So there seems to be agreement among several of the relators that invoking Kaiser Permanente gives the allegations nation- -- national scope.

While it's not surprising that Ms. Osinek's allegations

are focused on California, where she was an employee and had the most familiarity, there's nothing in the complaint that suggests that she is alleging that these practices were somehow specific or limited to the California regions.

And, again, as Your Honor has noted, the primary test in "first to file" is whether the allegations in the first complaint gave the Department of Justice sufficient information that it could investigate broadly enough to uncover allegations elsewhere. Whether different practices or different regions or different members of the same corporate family, the case law is clear that the question is whether the relator has given DOJ enough information to go on. And here, that's demonstrably the case.

On the face of it, the Court can reach that conclusion; but because we also have the examples of the Government's several subpoenas that were issued when only the Osinek complaint was pending that we've asked the Court to take judicial notice of, it, in fact, addresses clearly that DOJ viewed these allegations as justifying an investigation of broader scope, both geographically and entities.

And lastly, I would point Your Honor to some of the cases that we've cited in our brief. *Batiste v. Sallie Mae*, *Hamilton v. Columbia HCA, Branch Consultants* all addressed second-in-time relators whose complaints expanded geographic focus but were found wanting under the first-to-file bar.

THE COURT: All right. Well, let me get the defense response to two points.

One is, the defendant, as described, although it's not a -- I guess it's more of a brand than anything, but it is not confined -- Kaiser Permanente is not confined to California.

And then on the notice point, as I adopted the kind of notice to the defendant, a yardstick for measuring relatedness, I guess the argument here is, the proof is in the pudding because the investigation that was triggered did exceed or go beyond just the state of California.

What's the response to that?

MR. VOLDMAN: May I speak to that point, Your Honor?

THE COURT: Yes. Yes.

MR. VOLDMAN: So a few points.

First, the standard that Kaiser is setting out asked the Department of Justice that every time a large brand that operates in multiple regions that runs large lines of business, the Department of Justice is functionally obligated to investigate their entire dealings with the Government program an FCA complaint deals with or risk chilling future whistleblower actions.

Here, that means Kaiser had plans in seven states covering nearly 3 million beneficiaries as of this year.

The subpoenas that the defendants point to aren't particularly instructive. First, they only provide a single

view of the investigation. And as all litigants know, investigations mold based on pushback and based on what the Government ends up focusing on.

But Attachment E to their RJM motion is particularly instructive for showing that Colorado is a different region, and Taylor brought different allegations, because it is issued after Taylor is filed and that is the only one specific to a region outside of California.

It's true that the initial subpoenas say things like "all regions" and boilerplate language that's included in HHS subpoenas; but after Taylor is filed, there is a subpoena specific to Colorado; and the United States ends up intervening against defendants in Colorado and not against defendants in the five other states Kaiser operates MA plans in.

Finally, it's not just the geographic difference. The difference in corporate functioning in different regions matters here. Because Kaiser didn't operate hospitals in the Denver area, the claim we're pursuing based on chart review was able to happen. There, Kaiser contracted with hospitals that had high error rates of diagnostic coding, and then reviewed those charts only for additional codes that benefited Kaiser financially. When it discovered codes that were erroneous and should have been deleted, thus costing Kaiser money, it did not delete those.

The *Branch* case, for example, is significantly different

because it is about a hurricane that struck houses in both Mississippi and Louisiana. There's no business difference with how insurance companies operated on one side of the state line or the other that anyone in that case points out.

Here, there's different schemes brought on by the different regions.

THE COURT: Well, all right. And I understand this is the high error rate with the true positives. I want to put that aside for a moment, the nature of the claims. I just want to ask you about the geographic scope.

When I look at the original -- well, the complaint, the original complaint in Osinek, it does identify Kaiser Permanente as a California corporation, although it does say it's one of the largest Medicare Advantage organizations in the country; but it does say -- it talks about Kaiser conducting business in California, providing healthcare services to the general public in California, and there's nothing in there that suggests a national scope.

But then, if we're using the notice-to-the-Government kind of yardstick, and if the allegations here are, given the upcoding and the use of algorithms and all that stuff, why wouldn't that have been enough -- whether it did or didn't is not actually necessarily the question -- but why wouldn't that be enough to give -- I don't know if you call it constructive notice, inquiry notice, whatever the analogy is -- the kind of

notice to the Government of potential facts that would have uncovered a nationwide problem? Why isn't that notice, sort of, standard satisfied here?

MR. VOLDMAN: Sure. So it's true that both cases are about fraud in the Medicare Advantage program; and obviously, upcoding is alleged in both cases; but that is only a product of upcoding being the basic unit of the way Medicare Advantage plans are paid. It is the same thing as saying overcharging on the contract.

Here, the Osinek complaint alleges a data-mining scheme that led to addenda in California. It makes no allegations about any of the other regions. And the other regions, like Colorado, specifically had different schemes that would not have necessarily made sense in California and did not happen in California.

That notice isn't enough for the Government to investigate those specific schemes, besides the fact that both are about Medicare Advantage.

The *Hartpence* case, like, clearly allows related, but distinct, frauds to go forward, and this is an example of that.

THE COURT: Well, what about the geographic? I understand your focus is a different kind of fraud. Before we get there, I'm asking: Why not notice of a geographic -- beyond geographic issue, beyond the borders of California?

MR. VOLDMAN: There are no allegations in the Osinek

complaint about any events happening with beneficiaries or physicians outside of California. We feel it's unreasonable for the Department of Justice to launch a nationwide investigation that affects lots of states, lots of Medicare beneficiaries, based on every time a False Claims Act complaint was filed.

And finding for the defendants here would likely lead to a chilling effect on whistleblowers, where if any defendant family was sued about any government program, it would necessarily block anything else about overcharging that government program by that defendant family.

MR. LEVISS: I share Mr. Voldman's view that it's unreasonable for the Department of Justice to investigate broadly, but the reality is they did so here.

THE COURT: Well, and I think the question is not what they did or didn't, because there may be a situation where they didn't but they had enough notice, and you might be arguing the opposite. I'd be curious whether the Government has any view on this particular question.

MR. CHOE: Your Honor, I think it's right in terms of what the Government did or didn't is not the issue here.

And in terms of the investigation, we were investigating California and Colorado. So we did not investigate every region of Kaiser.

And -- but I think Your Honor is exactly right, that what

the Government did or didn't is not the relevant question here.

THE COURT: Right. Do you have any views on the more theoretical construct? It's almost a form of, like, constructive notice. I mean, I'll use that as an analogy here.

It's not actually what the Government did in response, but should this be deemed enough notice such that it would bar a California-centered complaint, which alleges a practice which could be generalized, would then serve to bar all other regional complaints under the FCA? Does the Government have any view on that question?

MR. CHOE: I think, Your Honor, to the extent that if you're asking -- setting aside the specific allegations here in Osinek versus Taylor, we're not taking a position on the --

THE COURT: Yes.

MR. CHOE: -- specific motions before Your Honor.

But with respect to whether a complaint that alleges misconduct in California necessarily triggers the Government's notice or obligation to investigate the company nationwide, we would not take that position, no.

THE COURT: Yeah. Well, thank you.

Let me ask the defendants. I mean, there's something to this idea that any time anybody brings any FCA action in one state and seeks to confine its complaint to that state; but if it happens to be a regional organization, a national organization, which many are, especially if you look at

subsidiaries and affiliates and this sort of thing, that would have the effect -- if the first action only sought a California action, it would effectively bar all other actions in 49 other states. That seems troubling from an FCA point of view.

MR. LEVISS: I guess, Your Honor, we're not taking the position that in any hypothetical situation, allegations about a nationwide corporation's practices in one state would bar their practices in every state.

We are taking the position that in this complaint against a national consortium that has operations in seven regions, that the broad sweep of the allegations in Osinek's complaint that allege a broad upcoding scheme to knowingly submit false diagnosis codes to CMS for purposes of improperly increasing reimbursement under the Medicare Advantage risk adjustment program, it's the breadth of those allegations that potentially apply to Kaiser Permanente and Kaiser-affiliated defendants' practices in the other regions.

So just to be clear, we're not suggesting a broad rule that this would be the case in every case; but we're saying in the context of this complaint, it fits more squarely within the case law where adding geographic scope in a subsequent complaint was insufficient.

In Re Natural Gas, the first-to-file bar didn't apply to new corporate defendants that had no relationship to the existing defendants; but a corporate sub in a different

geographic region brought in by a second-filed complaint, those allegations were barred.

THE COURT: Well, that would suggest, even though you say you're not seeking that in this case, an overarching rule that once you bring in one region and, actually, against a corporation, to the extent that corporation has subs, affiliates in other parts of the country, it's hard to distinguish. As long as you allege kind of a systemic practice, which often it is, hard to avoid the nationwide bar consequence, it seems to me.

MR. LEVISS: Well, that may be a consequence of the -- of the results of a case like this, but it's not inconsistent with Congress's intent in adding the first-to-file rule. They wanted relators to bring their allegations to the Government as soon as possible so that DOJ could investigate as broadly as it determined was reasonable under the circumstances.

THE COURT: But it raises the stakes because if the Government decides it does not have the resources or the priorities -- because there's a lot of stuff going on with the Government -- if they decide not to do a nationwide investigation, that has the effect of barring all other actions. Nobody else can step in. It really puts pressure on the Government to say: Well, if we don't do it, everybody else is barred.

MR. LEVISS: Well, it does bar subsequent relators from

coming in afterwards. When the Government has already intervened, in part, in here and is proceeding with its own case, another relator could not then step in to bring new allegations. That wouldn't stop the Government from adding allegations to its own complaint if it deemed them appropriate.

THE COURT: All right. Let me ask you about the difference in the actual fraud claim here, that Taylor is a bit of sort of the flip side, in a sense, as I understand it.

It all involves upcoding. It all involves natural language processing software. I understand that. But the actual wrong here, as I understand it in Taylor, is ignoring the high error rates for certain diagnoses as opposed to sort of affirmatively mining things and doing other things to upcharge and upcode.

What's your response to that? It's a different kind of fraud. It's a different aspect. You could argue it's somewhat related, but it seems different.

MR. LEVISS: Well, I would take issue with the conclusion that it's a different kind of fraud but, rather, that it's a different argument for satisfying the False Claims Act element of knowledge, for example. Ultimately, the fraud that Taylor is alleging boils down to the fraud that Osinek is alleging: that the Kaiser defendants upcoded their diagnoses; that they submitted diagnosis codes to CMS that were unsupported for purposes of increasing risk adjustment compensation.

They point -- Taylor points to audits that they allege should have put the defendants on notice that certain diagnoses were unsupported. But that's no different from an argument, again, alleged in Osinek, that unsupported diagnoses are being submitted to CMS.

Any surviving complaint will need to establish knowledge under the False Claims Act. I don't see how Taylor has alleged a separate theory of False Claims Act liability resulting from these audits that's distinct from the underlying arguments that unsupported diagnosis codes were submitted.

THE COURT: All right. Mr. Voldman, your response?

MR. VOLDMAN: Sure.

So you're correct, Your Honor, in both the chart review and the natural language processing claims. We're not questioning what additional diagnoses Kaiser made through its audits and submitted to the Medicare Advantage program for additional premiums. We're questioning what was in there before.

One-way chart review theory has been recognized by this district in a case against Sutter and by the Central District in a case against United Health. Both those hinge on a plan being put on notice that its providers, in the case of Taylor's complaint specifically, in the chart review claims, external hospital systems were poorly coding diagnosis codes. Kaiser did an audit of those and added and fixed diagnosis coding when

it benefited it and decided not to fix diagnosis coding when it would have cost them money, in violation of the reverse False Claims Act.

So they are distinct buckets. We're not saying that anything Kaiser added through these audits is the problem. We're saying that the things that Kaiser failed to delete through these audits is the problem.

THE COURT: But it does involve intent, I mean, the same deliberate kind of conduct. It was a conscious conduct not to delete.

MR. VOLDMAN: Correct. Both the Osinek -- as Mr. Leviss pointed out, both the Osinek and the Taylor complaints would require a scienter pleading.

But the scheme at issue is quite different and, also, would not have made sense in California, where Kaiser operated its own hospitals and the incentives were aligned between providers, groups, and plan.

Here, we believe that Kaiser did this one-way chart review because the incentives weren't aligned. Hospitals were generally paid on a fee-for-service schedule, meaning for the services they did; while the plan was paid on a schedule based on the health of their beneficiaries. So that's why they did the review, and that's why the review wasn't done in California.

THE COURT: All right. Let me ask the Government, was --

as I understand it, the Taylor theory of fraud or that aspect of fraud -- sort of the non-fixing of the erroneous diagnostic codes when it benefited Kaiser; fixing it when it didn't benefit -- or maybe I have it reversed, but you know what I mean -- is that in the Government's case?

MR. CHOE: No, that is not part of the Government's complaint-in-intervention, no, Your Honor.

THE COURT: All right. Well, certainly, to the extent that there are high diagnosis -- high rates of errors for external providers, that adds yet another layer of distinction, it seems to me. I guess it still comes back to whether Kaiser could have fixed it; right? But the source of the error there is the external providers.

Is that my understanding, Mr. Voldman?

MR. VOLDMAN: Yes, that's right. And that Kaiser was on notice of their error rates and failed to fix it.

MR. LEVISS: But ultimately, Your Honor, what makes the codes unsupported is they're different. Taylor's argument is that the codes were unsupported. And when the audits were conducted, they allege that Kaiser then learned -- or had knowledge that they were unsupported and should have acted on them.

The ultimate alleged False Claims Act scheme is submitting unsupported diagnosis codes, which, again --

THE COURT: Well, that's like saying it's fraud. I mean,

anything to do with overcharge and not supported is covered, no matter how the methodology is. That seems kind of a broad sweep, Mr. Leviss.

MR. LEVISS: Well --

THE COURT: I --

MR. LEVISS: I'm sorry, Your Honor.

THE COURT: Yeah. Go ahead.

MR. LEVISS: It's not the same as saying any kind of overcharging. In fact, there are lots of different business practices within the Medicare Advantage program. These complaints all concern the identification of diagnosis codes and submission of diagnosis codes for risk adjustment purposes, and they all allege the upcoding, the submission of unsupported diagnosis codes.

So we don't agree with the characterization that upcoding is the same as saying there's fraud. In this instance, all six complaints are alleging the same material fraudulent -- allegedly fraudulent scheme involving submitting unsupported, improper diagnosis codes to increase risk adjustment income.

THE COURT: All right. Let me just turn briefly to the Stein complaint. To the extent that the focus there is on two specific conditions, sepsis and malnutrition, how is that -- I understand that there's a different focus; but seems like the same general mechanism is sort of the same there. Why does Stein -- why would Stein not being deemed sufficiently related

for the "first to file"?

MR. ZINBERG: Thank you, Your Honor.

First, I want to take a second and address the previous statement. I think your analysis regarding the defendants' position is correct. Saying that submitting increased risk adjustment codes is different than saying fraud simply doesn't hold any water, not in the Medicare Advantage situation, because the risk adjustment codes are the basis of all of the payments that come later. So any fraud involving Medicare Advantage at some point is going to have to, by necessity, have an upcoding or an invalid code submitted to CMS.

Now, what I referred to as our unintervened claims are quite distinct from the Refresh program. As you know, our complaint also had what's colloquially known as the "refresh fraud"; and we conceded that the prior-filed complaints put the Government on sufficient notice where we were not challenging "first to file" on the refresh frauds.

But with respect to the sepsis claim, for example, it's a completely different type of fraud. One, it didn't involve any data mining. It didn't involve any addendums. It doesn't involve the coders making leading queries and instructing physicians what codes to insert. In fact, it's the opposite. The coders -- this fraud takes place on two levels, which is also distinct from the allegations of the prior complaint. One is on the ground, in the hospital, the way that the physicians

are diagnosing, making the sepsis diagnosis; and the second is the way the coders are being instructed to code it.

Here, the coders are being instructed not to query sepsis, even though the coding guidelines instruct them that they have to query for sepsis to properly document the medical record and rule out some instances where the sepsis should not be coded.

They are also -- the coders are also instructed to code sepsis whenever the term "sepsis" is used, regardless of the quality of the documentation in the medical record. And, again, those are against the coding guidelines of the ICG9 and the AHIMA ethical coding guidelines.

So it is not a fraud that would be investigated and reached by investigating the allegations of the refresh fraud of the complaint of Osinek and her allegations and the Arefi and Taylor complaints, which all deal with some aspect of what I refer to as the refresh frauds, whether regionally or nationally.

Now, our clients are in Southern California, and they had a lot of detailed information about Southern California and Northern California and believed that these frauds were picked up and used nationally.

Now, the malnutrition is similarly --

THE COURT: Let me stop you on the sepsis for a moment there.

MR. ZINBERG: Sure.

THE COURT: Isn't there an allegation that there's some direction or some incentive for doctors, physicians, to indicate sepsis?

MR. ZINBERG: Sepsis is a very high risk adjustment factor. So if a medical group was interested in committing fraud, using the higher risk adjustment factors is going to be the most productive way to do it. So in that regard, there is an incentive.

There was also a mention of sepsis in the Arefi complaint, where he had some sort of statistical analysis saying he believes that the Kaiser Hospitals have sepsis coded too frequently, but he didn't really explain how that came about.

Our complaint addressed how at least a significant portion of that came about because of the quite different coding practices that were adopted with regard to hospital inpatient sepsis cases.

So we think that this is completely unrelated to the refresh fraud and not something that would logically fall under its purview.

THE COURT: Let me just stop you on that and get the defense perspective on why this is not related or why this is related.

MR. LEVISS: Thank you, Your Honor.

Well, for starters, I'd like to address Mr. Zinberg's threshold statement that risk adjustment codes are the basis

for all payments in Medicare Advantage. It's just demonstrably untrue. Plans are paid on other bases besides risk adjustment. That's not the question you asked, but I can't let that go unaddressed.

THE COURT: All right. But I'd like you to address the sepsis. I'm kind --

MR. LEVISS: Yes.

THE COURT: -- of beyond that now.

Thank you.

MR. LEVISS: Okay. Thank you, Your Honor.

So the allegations about sepsis upcoding ultimately boil down to a similar diagnosis scheme as alleged in Osinek. Osinek lists various examples of diagnoses that she alleges are identified through the allegedly improper practices. She doesn't say that her list of diagnoses is exclusive, and it certainly would be sufficient to put the Government on notice to explore other diagnoses practices -- other diagnoses that are addressed through the same practices.

THE COURT: What's the most similar aspect of the scheme in Osinek that you think brings it close to the sepsis allegation here? Which seems a little different in that the direction is, as I understand it, for the coders to just accept it without any kind of query.

MR. LEVISS: Well, Osinek's alleges that the -- that Kaiser Permanente pressured physicians to diagnose risk

adjusting conditions, that it had guidance and policies that were targeting high-value conditions for risk adjustment purposes. I think that fairly captures Stein's sepsis allegations within its ambit.

THE COURT: Okay. I don't know if Stein specifically indicates there's an express directive or guidance to sort of upcode, upcharge, or find sepsis when it's questionable whether it's there.

MR. ZINBERG: We do not, Your Honor.

What we alleged was a scheme where sepsis was intentionally overcoded to ensure that no sepsis codes were missed as a matter of safety.

As a matter of safety, patient safety, Kaiser adopted sepsis protocols that would knowingly overdiagnose sepsis cases, but then failed to identify and readjust the cases that were not, in fact, sepsis; that were due to a much simpler ailment like a urinary tract infection or some other mild condition rather than the life-threatening condition of sepsis with organ dysfunction.

And we identified very specifically that the fraud dealt with patients that were being held in observation in the emergency room and not admitted to the hospital at all and discharged after a short stay of one to two days or admitted to the hospital, but not the ICU, and, likewise, discharged very soon afterwards.

THE COURT: All right. But you've indicated that there were Kaiser protocols that were --

MR. ZINBERG: Sepsis protocols.

THE COURT: -- sepsis protocols that aggressively diagnosed and perhaps overly diagnosed sepsis in the first instance.

And its the failure to correct afterwards -- the combination of that plus the failure to request afterwards that resulted in the upcharges; correct?

MR. ZINBERG: Yes, which is not at all the allegations in the Osinek complaint, which is a data-mining coding scheme to identify every missed code after the fact.

THE COURT: Well, that wasn't the only allegation.

MR. ZINBERG: And so --

THE COURT: That wasn't the only allegation. The other allegation is pressuring doctors to --

MR. ZINBERG: And --

THE COURT: -- stand diagnoses and capture high HCCs, and sepsis is one of those.

MR. ZINBERG: Yes, but as part of their Refresh program. All of that was under the ambit of their Refresh program --

THE COURT: Well, all right. But --

MR. ZINBERG: -- where --

THE COURT: The more you finely cut that, the more difficult it is against the notice standard, it seems to me.

Again, it doesn't have to be exactly the same; it's got to be within the ballpark enough to give notice.

Let me ask the Government again. Are the sepsis and malnutrition upcoding practices alleged in the Stein case part of the Government's case?

MR. CHOE: No, Your Honor, that's not part of the Government's complaint-in-intervention.

THE COURT: Okay.

MR. LEVISS: Your Honor, can I just make one point addressing the significance of whether these allegations are in the Government's complaint or not?

THE COURT: Yeah.

MR. LEVISS: We're not arguing in this motion that the later-filed allegations would be outside the complaint. We're arguing that the later-filed relators are not the appropriate plaintiffs to bring those allegations. The allegations all fall within Osinek's complaint. So the fact that they're not part of the intervention complaint isn't ultimately material to the first-to-file analysis.

THE COURT: All right. Let me just briefly touch on Bryant. I understand that there are --

MR. ZINBERG: Your Honor, you want to discuss the other --

THE COURT: I have your brief, and I've got to move on, because there's a lot here. So, thank you.

MR. ZINBERG: Thank you, Your Honor.

THE COURT: On Bryant, I'm a little confused because there's some reference to the Affordable Care Act, but the causes of action are based solely on Medicare, not on the Affordable Care Act. Do I have that correct?

MR. LEWIS: No, Your Honor. The causes of action incorporate all of the prior allegations in the complaint, which include a number of paragraphs devoted to the Affordable Care Act, the specific allegations, including that there was fraud on the Affordable Care Act program. And all of those allegations are swept into those claims.

It is true that the claims have a specific reference to Medicare Advantage. They do not have a specific reference to Affordable Care Act. But that is a difference without a distinction, in our view.

THE COURT: Why is that a difference without -- why isn't that rather important?

MR. LEWIS: Well, Your Honor, in incorporating all the prior allegations in the complaint, including paragraph 7 through 9 of our introduction to the schemes that were alleged in the complaint, we allege quite clearly that the Affordable Care Act was a program that was defrauded, in addition to the Medicare Advantage program.

THE COURT: Where in the -- if I were to look at the -- I'm looking at your complaint. Where do I find a cause of action that's based on Affordable Care Act?

MR. LEWIS: Well, Your Honor, Counts One through Four all allege that the schemes that are alleged throughout the remainder of the complaint give rise to causes of action under the False Claims Act, and we intended to incorporate the schemes that we alleged above in the bulk of the complaint that included both Medicare Advantage and Affordable Care Act.

THE COURT: So the incorporation paragraph, for instance, at page -- at paragraph 208?

MR. LEWIS: Yes.

THE COURT: Is that what you're relying on?

MR. LEWIS: Yes, paragraph 208; similar, paragraph 213 in the second claim for relief; paragraph 218 in the third claim; paragraph 223 in the fourth claim.

THE COURT: All right. What's the defense response on that particular question?

MR. LEVISS: Well, we agree with the observation that Bryant has not actually alleged a cause of action specifically stemming from defrauding the Affordable Care Act.

To the extent that Your Honor is persuaded that the paragraphs cited there do allege a cause of action, it's clear from the complaint itself that Bryant alleges that the upcoding of ACA risk adjustment claims occurred in the same manner and pursuant to the same scheme as the alleged MA upcoding scheme. They're alleging the same specific activities and scheme that is itself barred by Osinek's first-filed Medicare Advantage

scheme. So we would say that Osinek alerted DOJ to upcoding of risk adjustment diagnosis data. If it happened in the same manner, then it certainly should cover these derivative allegations, to the extent that the Bryant complaint links the Affordable Care Act to these --

THE COURT: So it's still covered by the FCA first-to-file bar?

MR. LEVISS: Correct.

MR. LEWIS: May I respond, Your Honor?

THE COURT: Yeah, briefly.

MR. LEWIS: Thank you.

You don't see Affordable Care Act anywhere in the Osinek complaint. You don't see it anywhere in the other complaints, both before or after the Bryant and Hernandez complaint, and there's a reason.

Ms. Bryant and Mr. Hernandez were senior folks. And Ms. Bryant, in the national office of Kaiser, she saw a big picture, a much bigger picture than the other relators. She saw that this fraud was not limited to Medicare Advantage. She saw that it extended to an entirely different program run by the Health and Human Services, not by CMS, and she brought it to the Government's attention.

And, you know, if Kaiser wants to live by the subpoenas that it issued and wants to make a big issue on judicial notice about those subpoenas, those subpoenas don't mention the

Affordable Care Act either. The Government wasn't on notice until the Bryant and --

THE COURT: How do you deal with -- the bar itself says it reaches a related action based on the facts underlying the pending action. That suggests that you look at the operative facts and not necessarily whether that violates, you know, one government program versus another. If it's the same facts, why doesn't that come within the reach of the first -- even if it's framed as a different violation, a different program, isn't it the same facts?

MR. LEWIS: It's not actually, Your Honor. The facts are that the Osinek complaint and the others alerted the Government to Medicare fraud. Medicare beneficiaries are, of course, older folks that are beneficiaries of the Medicare program, including Medicare Advantage.

Nothing would have alerted the Government to look at recipients of Affordable Care Act insurance, including newborn infants that were defrauded in the vent dependents scheme, among others.

THE COURT: But isn't the conduct -- isn't the wrongful conduct the same? You may say that the clientele may be a little different from program to program, but wouldn't the same upcharging, data mining, all that stuff, the incentivization, isn't that all the same?

MR. LEWIS: You know, Your Honor, if they attempted to

defraud the Government in two different ways using similar methods, I suppose you could say -- you could say it's similar frauds, but they're not. They're two different frauds committed on two different programs of the United States Government. And the fact that they use similar methods, for convenience or otherwise, shouldn't rule the day, in our view.

THE COURT: All right. What's the response to that?

MR. LEVISS: The alleged fraud is and derives from the same alleged fraudulent scheme. Mr. Lewis concedes that his client identified the fraud, this fraud. And the allegations in the complaint, spare as they are, that refer to the Affordable Care Act suggest that the same practices, the same manner of this scheme applied to risk adjustment. It fits squarely within the first-to-file bar because they're not alleging a different -- materially different fraudulent scheme that would put the Government on notice of something distinct.

THE COURT: All right. Let me just conclude if I have any questions here on the Bicocca case.

Claims pursuant to the California FCA are not subject to the federal FCA first-to-file bar. Is that agreed? Is that a principle that we agree on?

MR. LEVISS: It is, Your Honor, although I believe those allegations have been withdrawn.

THE COURT: Oh. Is that correct?

MS. QUINN: Yes. I agree with Mr. Leviss, Your Honor.

THE COURT: All right. So what's left then?

MS. QUINN: Well, Your Honor, given the Court's position on the operative complaint to be reviewing, unfortunately, I don't think much.

THE COURT: All right. Well, I appreciate your frankness on that.

All right. Well, there's a couple -- obviously, there's some pretty major issues here. I want to take a second look at it. This argument has been helpful. It's clarified some things. And we didn't get to address every single issue, but I think we addressed the major ones. And I'm going to take a second look at the authorities, and I'll take the matter under submission.

Thank you. Thank you for your help.

ALL: Thank you, Your Honor.

(Proceedings adjourned at 2:28 p.m.)

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CERTIFICATE OF REPORTER

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

DATE: Monday, May 30, 2022

Ana Dub, CSR No. 7445, RDR, RMR, CRR, CCRR, CRG, CCG
Official United States Reporter

TAB 2

OFFICE OF THE CLERK
UNITED STATES DISTRICT COURT
Northern District of California

CIVIL MINUTES

Date: April 21, 2022 **Time:** 1:30-2:26 56 Minutes **Judge:** EDWARD M. CHEN

Case No.: 13-cv-03891-EMC **Case Name:** Osinek v. Kaiser Permanente

Attorneys for Plaintiffs: Amy Zeman, Max Voldman, Janel Quinn, Roger Lewis, Abram Zimberg, William Hanagami, Gary Dyal and Shiwon Choe
Attorneys for Defendant: David Leviss and Lee Blalack

Deputy Clerk: Vicky Ayala **Court Reporter:** Ana Dub

PROCEEDINGS

Motion to Dismiss - held

SUMMARY

Parties stated appearances.

Matter taken under submission.

TAB 3

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:13-cv-03891-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: April 14, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: April 14, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: April 14, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: April 14, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiffs, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: April 14, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiffs, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:21-cv-03894-EMC **REPLY IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: April 14, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

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I. INTRODUCTION

Defendants'[1] Motion warned that permitting the Later-Filed Complaints to proceed based on the same fraudulent scheme alleged by Ronda Osinek in her 2013 complaint would complicate the litigation, confuse the issues, and waste resources—all pitfalls that the FCA's first-to-file bar is designed to prevent. The multiple Oppositions confirm that this warning was well founded. The Opposing Relators[2] have filed over 70 pages in response to the Motion, Oppositions that contradict one another, confuse the law, and misstate the facts alleged in *Osinek* and the other *qui tam* complaints. The Opposing Relators cannot even agree with one another on foundational questions such as whether the first-to-file bar is jurisdictional, which it is, and whether the original complaints control the Court's analysis, which they do.

The best that can be said about the Opposing Relators' varied and inconsistent Oppositions is that they have significantly narrowed the focus of their complaints, including the disputed questions that the Court must decide here. Indeed, they make several key concessions at the outset:

- The *Arefi* Relators concede that the first-to-file bar requires dismissal of their entire complaint, having filed a non-opposition to the Motion.
- The *Stein* Relators concede that the first-to-file bar requires dismissal of their FCA claims based on allegations about "refresh" practices, which were asserted against Defendants across the country.
- And Bicocca concedes that the first-to-file bar requires dismissal of his entire original complaint, which alleged that Defendants improperly pressured specialist healthcare providers to diagnose chronic medical conditions.[3]

---

[1] Defined terms and acronyms have the same meaning as in Defendants' Motion, unless otherwise specified. Because the various complaints do not name all of the same defendants, "Defendants" or "Kaiser" refers to the defendants named in the complaint(s) referenced in the relevant portion of the Motion and this Reply, unless otherwise indicated. Although Kaiser Permanente is not a legal entity, Dkt. No. 141 ("Mot.") n.1, "Defendants" and "Kaiser" include Kaiser Permanente where named in the complaint at issue.

[2] The "Opposing Relators" are Taylor, the *Stein* Relators, the *Bryant* Relators, and Bicocca. The *Arefi* Relators filed a non-opposition to the Motion. Dkt. No. 143.

[3] Bicocca voluntarily dismissed his claims under the California False Claims Act. *See* Dkt. No. 159. Accordingly, even assuming his amended complaint is the relevant pleading, only his

Attempting to save the remainder of their complaints from dismissal, the Opposing Relators propose a myopic reading of Osinek's complaint, contending that it concerns only "addenda" practices in the state of California, whereas their complaints extend beyond addenda, California, or both. The Opposing Relators ignore, however, that Osinek's first-filed complaint named "Kaiser Permanente"—a trade name that describes the national collaboration among the various Defendant health plans, hospitals, and medical groups—and never limits its allegations to addenda practices. Given the broad scheme that it alleges, *Osinek* clearly put the United States on notice of a purported nationwide scheme to defraud the Medicare Advantage program that went beyond addenda practices and that implicated Medicare Advantage diagnosis-coding practices generally. And this conclusion is not speculation because, shortly after Osinek filed her complaint, the United States issued to various Defendants wide-ranging subpoenas that encompassed virtually every diagnosis-coding practice imaginable.

Unable to limit *Osinek*'s subject matter to addenda or its geographic reach to California, the Opposing Relators contend that their complaints nonetheless identify fraud schemes that the *Osinek* complaint does not. Their own allegations belie that assertion. The most the Opposing Relators can muster are inconsequential variations on the essential facts that Osinek already alleged. The factual distinctions to which they point in their Oppositions would render meaningless the intent of the first-to-file bar. Every relator in every *qui tam* action can point to some factual distinctions, but the first-to-file bar requires more—it requires material and consequential distinctions sufficient to raise distinct fraud schemes to proceed to litigation.

Taylor contends that his allegations about natural language processing, "one-way chart review," and audit results constitute distinct fraud schemes that survive the first-to-file bar. But Osinek's complaint encompasses each of these allegations. Taylor's allegations about Defendants' natural language processing program closely resemble Osinek's allegations about data mining—both concern the use of algorithms to search for additional medical conditions to report to CMS, which Taylor and Osinek allege occurred without a proper focus on data quality

---

FCA claims remain, and as discussed in the Motion and *infra* at 27–31, the first-to-file bar requires dismissal of those claims as well.

and auditing. Similarly, Taylor's one-paragraph allegation about chart review simply says that Defendants hired coders to review medical records in search of additional diagnoses to report to CMS, which echoes Osinek's allegations that Defendants used data mining to identify missed diagnosis-coding opportunities. And Taylor's allegations about error rates identified in audits of diagnosis-code data do not identify a unique fraud scheme. Rather, they purport to show that Defendants had knowledge of the upcoding scheme that Osinek already alleged.

The *Stein* Relators contend that they have alleged unique fraud schemes about the way Defendants "upcoded" diagnoses of sepsis, malnutrition, and aortic atherosclerosis. But Osinek alleges an upcoding scheme and does not purport to limit it to specific medical conditions. She alleges that Kaiser Permanente submitted diagnosis codes to CMS for complex medical conditions without support, allegations which necessarily encompass the condition-specific fraud that the *Stein* Relators allege. Similar allegations in the initial *Arefi* and *Taylor* complaints—both of which preceded *Stein*—provide additional reasons to dismiss *Stein* under the first-to-file bar.

The *Bryant* Relators focus their Opposition on three fraud allegations that they contend distinguish their complaint from *Osinek*: diagnosis coding in the hospital setting, improper diagnosis coding of vent dependence, and fraud on the risk-adjustment program established by the Affordable Care Act ("ACA"). But Osinek's complaint was sufficient to put DOJ on notice of hospital-related claims, given that Osinek alleged a nationwide scheme across Kaiser-affiliated entities. The *Bryant* Relators' allegations about improper coding of vent dependence again are merely factual variations on the upcoding scheme that Osinek alleged, which describes how Kaiser Permanente instructed healthcare providers to diagnose medical conditions in ways that contravened diagnosis-coding guidelines. And the *Bryant* Relators' ACA arguments are without merit because their causes of action do not even refer to a fraud based on violations of the ACA.

Bicocca concedes that the first-to-file bar requires dismissal of his original complaint, but then argues that a single allegation from his amended complaint somehow survives dismissal. Because the first-to-file analysis centers on a comparison of original complaints, and Bicocca concedes that *Osinek* bars his original complaint, the Court should summarily dismiss his FCA claims. In any event, his amended complaint does not allege any unique fraud in comparison to

Osinek and cannot save his *qui tam* action. The single allegation that Bicocca highlights—that Defendants used "upfront diagnoses lists to re-diagnose" members—is substantively the same as Osinek's allegations that Kaiser Permanente refreshed Medicare Advantage members' medical conditions each year.

The Opposing Relators insist that they are not "opportunists" copying earlier allegations, since they did not know about *Osinek* or each other's complaints until the Court unsealed the complaints in 2021. Indeed, the *Bryant* Relators urge the Court not to "punish" them for failing to know about Osinek's prior allegations. But this argument is misdirection. The first-to-file bar is neither a punishment nor reward, and the Opposing Relators' lack of knowledge is neither unique nor relevant to the first-to-file analysis. The Opposing Relators ignore that a key purpose of the first-to-file bar is to create a virtuous race to the courthouse so that whistleblowers will bring their claims of fraud to the United States as soon as possible, and to prohibit duplicative suits that do nothing to assist DOJ in its investigation of fraud allegations. Allowing five *qui tam* actions to go forward on the same allegations of fraud would do nothing to advance this statutory goal and would permit future whistleblowers to delay bringing fraud claims without consequence. The knowledge or lack of knowledge of later relators is simply irrelevant to the statute's language and purpose. The Court should grant the Motion and dismiss all of the FCA fraud claims in the Later-Filed Complaints under the first-to-file bar.

II. ARGUMENT

A. The First-to-File Bar Is Jurisdictional and the Court's Analysis Must Focus on the Original Complaints.

As Defendants explained in the Motion, the first-to-file bar is jurisdictional, and the Court must compare original complaints for purposes of the first-to-file analysis. Mot. at 17–18. Even among themselves, the Opposing Relators cannot agree on either foundational point.

The Ninth Circuit has stated unequivocally that the first-to-file bar is jurisdictional. It did so two decades ago in *Lujan* and again fourteen years later, sitting en banc in *Hartpence*. *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1186–87 (9th Cir. 2001) (explaining that 31 U.S.C. § 3730(b)(5) is a "jurisdictional bar"); *see also United States ex rel. Hartpence v.*

Kinetic Concepts, Inc., 792 F.3d 1121, 1130 (9th Cir. 2015) (en banc) ("We treat the first-to-file bar as jurisdictional."). Because the first-to-file bar implicates the Court's subject-matter jurisdiction, Defendants brought the Motion under Federal Rule of Civil Procedure 12(b)(1) rather than Rule 12(b)(6).

Only the *Stein* Relators contest that the bar is jurisdictional, and they offer no persuasive reason to deviate from Ninth Circuit precedent. Dkt. No. 157 ("*Stein* Opp'n") at 9–10. They point to the Supreme Court's statement in *Gonzalez v. Thaler* that a rule is jurisdictional if the legislature "clearly states that a threshold limitation on a statute's scope shall count as jurisdictional," *see* 565 U.S. 134, 141 (2012), arguing that the first-to-file bar does not use such clear language. *Stein* Opp'n at 9. But *Thaler*, a habeas decision, does not address the first-to-file bar. Nor does *Thaler* state that a statute must use the word "jurisdiction" to be jurisdictional. The first-to-file bar clearly states that "no person other than the Government" can bring an FCA action related to a pending action—stripping non-governmental litigants of the ability to bring, and thus courts of the ability to hear, any such related case. 31 U.S.C. § 3730(b)(5). While at least one other circuit has concluded that the bar is not jurisdictional,[4] such decisions are not binding on this Court; *Lujan* and *Hartpence* are binding precedent. This Court must follow the Ninth Circuit's en banc decision—which, in any event, postdates *Thaler*—and evaluate the Motion under Rule 12(b)(1).[5] *See United States ex rel. Doe v. Janssen Pharm. N.V.*, 2018 WL 5276291, at *2 (C.D. Cal. Apr. 19, 2018) (noting that "some courts have questioned" whether the first-to-file bar is jurisdictional, but following "Ninth Circuit guidance" and dismissing a complaint barred by § 3730(b)(5) under Rule 12(b)(1)).

While none of the other Opposing Relators contests that § 3730(b)(5) is jurisdictional, they cannot agree on which complaints the Court should compare when conducting the first-to-file analysis. The *Bryant* Relators do not contest that the Court should compare original

[4] *See, e.g.*, *United States ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 121 (D.C. Cir. 2015).

[5] The Fourth, Fifth, and Tenth Circuits also have concluded that the first-to-file bar is jurisdictional. *See United States ex rel. Carter v. Halliburton*, 866 F.3d 199, 203 (4th Cir. 2017); *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 376–77 (5th Cir. 2009); *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1278 (10th Cir. 2004).

complaints. But the *Stein* Relators and Bicocca ask the Court to focus on their most recent amended complaints.[6] *Stein* Opp'n at 10; Dkt. No. 154 ("*Bicocca* Opp'n") at 5–6. And without any authority, Taylor takes the inexplicable position that the Court should evaluate his first amended complaint—not his original or even his operative second amended complaint.[7] Dkt. No. 156 ("*Taylor* Opp'n") at 6 n.4.

The Relators' original complaints govern the analysis. This conclusion accords with the bar's jurisdictional nature, its plain text, and common sense. As the Motion explained, subject-matter jurisdiction must exist at the time the action was commenced. *Strudley v. Santa Cruz Cnty. Bank*, 747 F. App'x 617, 618 (9th Cir. 2019) ("This Circuit has adhered to the time-of-filing rule, which provides that '[s]ubject matter jurisdiction must exist as of the time the action is commenced.'" (quoting *Morongo Band of Mission Indians v. Cal. State Bd. of Equalization*, 858 F.2d 1376, 1380 (9th Cir. 1988))). "[F]ederal jurisdiction cannot be created by amendment if it did not exist at the outset" of an action. *Sepehry-Fard v. Countrywide Home Loans. Inc.*, 2014 WL 2707738, at *3 (N.D. Cal. June 13, 2004); *see also United States ex rel. Branch Consultants, L.L.C. v. Allstate Ins. Co.*, 782 F. Supp. 2d 248, 261 (E.D. La. 2011) ("[A] court cannot proceed if it lacked jurisdiction at the time the initial complaint was filed.").

The *Stein* Relators point to a footnote in *Hartpence* stating that the court would look to amended complaints to determine jurisdiction there, but that was merely dictum in the opinion's factual background section and the statement is distinguishable in two respects. *Stein* Opp'n at 10; *Hartpence*, 792 F.3d at 1125 n.2. First, in making that statement, the Ninth Circuit relied exclusively on the Supreme Court's opinion in *Rockwell*, which evaluated a different FCA provision that also was at issue in *Hartpence*, but is not at issue here. *See Hartpence*, 792 F.3d at 1125 n.2 (citing *Rockwell Int'l Corp. v. United States*, 549 U.S. 457, 473–74 (2007), which discusses the FCA's public-disclosure bar in 31 U.S.C. § 3730(e)(4)). Second, *Rockwell*

[6] Bicocca's amended complaint is substantively similar to his original complaint, so the first-to-file analysis would not change in any event for the *Bicocca* action.

[7] Like Bicocca's amended complaint, Taylor's first amended complaint is similar to his original complaint with minor factual variations.

concerned when a plaintiff can "amend himself or herself ***out of jurisdiction*** by withdrawing allegations that appeared in the original complaint." *See Branch*, 782 F. Supp. 2d at 261 (emphasis added); *see also Rockwell*, 549 U.S. at 468 ("[T]he issue is whether . . . a clear and explicit *withdrawal* of jurisdiction withdraws jurisdiction." (emphasis in original)). But *Rockwell* "does not suggest that a plaintiff can establish jurisdiction by amendment when jurisdiction did not previously exist." *Branch*, 782 F. Supp. 2d at 261–62. That is why courts continue to conclude that the first-to-file analysis requires an evaluation of original complaints. *Id.*; *United States ex rel. Carter v. Halliburton*, 144 F. Supp. 3d 869, 882 (E.D. Va. 2015); *United States ex rel. Moore v. Pennrose Props., LLC*, 2015 WL 1358034, at *15 (S.D. Ohio Mar. 24, 2015).

The plain text of § 3730(b)(5) confirms this view. *See Carter*, 144 F. Supp. 3d at 880. The statute bars a person from "***bring[ing] a related action*** based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5) (emphasis added). As the U.S. District Court for the Eastern District of Virginia found in analyzing this same issue, a plaintiff "does not 'bring an action' by amending a complaint, 'one brings an action by commencing suit.'" *Carter*, 144 F. Supp. 3d at 880 (quoting *United States ex rel. Chovanec v. Apria Healthcare Grp., Inc.*, 606 F.3d 361, 362 (7th Cir. 2010)).[8] Accordingly, the Court must follow the text of § 3730(b)(5) and compare the Opposing Relators' original complaints to Osinek's original complaint.

Focusing the first-to-file analysis on original complaints also makes good sense. It has "the advantage of simplicity," a virtue that is "apparent in this case, which involves multiple claims, complaints, and defendants, as well as other relators whose complaints have themselves been amended and involve multiple defendants." *Branch*, 782 F. Supp. 2d at 264. If the rule were otherwise, the first-filed complaint could constantly change based on relator amendments, and § 3730(b)(5) could be thwarted any time a relator amended a complaint. *See Carter*, 144 F.

[8] *See also Moore*, 2015 WL 1358034, at *14 ("[T]he language of the first-to-file bar does suggest that Congress intended to isolate the determination of subject matter jurisdiction to the time of filing of a complaint."); *United States ex rel. Shea v. Verizon Commc'ns, Inc.*, 160 F. Supp. 3d 16, 29 (D.D.C. 2015) ("[T]he language of § 3730(b)(5) itself . . . requires the Court to look to the moment when Plaintiff filed his initial Complaint . . . . What offends the first-to-file bar is the bringing of the action (*i.e.*, filing an initial complaint), not the failing to amend a complaint or litigating the case.").

Supp. 3d at 882 ("allowing a relator to avoid the first-to-file bar by amending would interfere with the efficient operation of *qui tam* suits"). While the Court's "jurisdiction may expand or shrink as amendments are made to the complaint," "that jurisdiction must rest upon a solid foundation. That foundation is the Court's jurisdiction over the original complaint. Without it, the case cannot proceed." *Branch*, 782 F. Supp. 2d at 264.

B. Osinek Alleges an Enterprise-Wide Upcoding Scheme Implicating Defendants' Risk-Adjustment Diagnosis-Coding Practices Across the Nation.

Even if the first-to-file bar were not jurisdictional, and even if the Court compares amended complaints, the bar still requires dismissal here: the Opposing Relators' amended complaints allege fraudulent schemes that are fully encompassed by *Osinek*. To avoid dismissal under § 3730(b)(5), some Relators have mischaracterized *Osinek* as a relatively narrow complaint, contending that it concerns only Defendants' addenda-related business practices in California. *Taylor* Opp'n at 5–6, 11; *Stein* Opp'n at 12; Dkt. No. 155 ("*Bryant* Opp'n") at 6–7. But Osinek's broad allegations belie that description. In fact, her allegations, concessions by other Relators, and DOJ's investigation all confirm that her complaint put DOJ on notice of a broad upcoding scheme that was not limited to addenda practices in California.

1. Osinek alleges an upcoding scheme that extends beyond addenda.

Osinek's complaint is not limited to an alleged fraud relating to the use of addenda. Rather, as detailed in the Motion, she broadly alleges that Kaiser Permanente (which she also calls simply "Kaiser") "upcode[d] diagnoses to ensure Medicare payments for reimbursable, high-value [medical] conditions." Dkt. No. 1 ¶ 2.

The *Taylor*, *Stein*, and *Bryant* Oppositions point to allegations about addenda in Osinek's complaint to argue that she focuses solely on addenda. *Taylor* Opp'n at 5–6, 11; *Stein* Opp'n at 12; *Bryant* Opp'n at 6–7. But their Oppositions gloss over Osinek's other allegations that do not mention addenda at all. In faulting Kaiser Permanente's data-mining program, for example, Osinek contends that Kaiser Permanente "identified the higher value HCCs and then determined the diagnoses its [healthcare providers] would need to make to support the HCCs Kaiser wanted to submit for Medicare reimbursement." Dkt. No. 1 ¶ 25. Again without mentioning addenda,

she emphasizes that the "focus on refreshing and data mining for missed opportunities is that [healthcare providers] take into consideration HCCs and the Medicare payment system when coding and recording . . . encounters." *Id.* ¶ 26. *Osinek* makes clear that a healthcare provider can "refresh" a medical condition directly through a visit with a member. *See id.* ¶ 38 (citing a document discussing how refresh efforts involved "Seeing Patients" for appointments). Similarly, Osinek's complaint criticizes Kaiser Permanente for advising healthcare providers "to change coding practices to reflect new reimbursable codes," and does not allege that providers used such codes only in addenda. *Id.* ¶ 27; *see also id.* ¶ 36 (stating generally that "Kaiser also pressures [providers] to diagnose Medicare [members] through incentive programs"). Osinek's allegations about incentives to healthcare providers "to capture and refresh" medical conditions also are not limited to addenda. *See id.* ¶ 37. And her summary allegation, after describing various business practices, specifically ties Kaiser Permanente's purported FCA violations to "data mining prompts" and does not mention addenda. *Id.* ¶ 42.

Bicocca's Opposition confirms the breadth of the allegations in *Osinek*. In conceding that his original complaint is barred by *Osinek*, *see Bicocca* Opp'n at 2, Bicocca effectively corroborates Defendants' view that Osinek's complaint did, in fact, put the United States on notice of an alleged fraud that extended to an array of Defendants' purported upcoding practices. Bicocca does not allege an upcoding scheme focused solely on addenda; his original complaint does not even mention "addenda," and his amended complaint mentions "addenda" only once. *See Bicocca* Dkt. No. 16 ¶ 106. Bicocca's allegations instead focus on how Defendants allegedly "pressur[ed]" specialists to diagnose medical conditions that the specialists "may not have the expertise to address." *Id.* ¶ 105; *see also id.* ¶¶ 111–15, 125; Mot. at 13–14. Even though his original complaint does not reference addenda, Bicocca acknowledges that "the claims alleged in his original Complaint are barred by Osinek's original Complaint based on the first-to-file rule." *Bicocca* Opp'n at 2.

Further, the United States' subpoenas to Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, and Southern California Permanente Medical Group—issued just months after Osinek filed her complaint—requested documents

beyond those related to addenda practices. The United States sought virtually any document or communication concerning "the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage [members]." Dkt. No. 142 ("RJN"), Exs. A–D at 14.[9] These broad requests confirm that Osinek put the United States on notice of a purported upcoding scheme related to practices well beyond addenda.

2. Osinek alleges a nationwide scheme that extends beyond California.

Osinek's complaint also describes an alleged upcoding scheme that extends beyond California. As noted in the Motion, the only defendant Osinek names in her original complaint is "Kaiser Permanente." *See* Dkt. No. 1 ¶ 6. Kaiser Permanente is the trade name used to describe all Kaiser-affiliated entities across the nation, including health plans, hospitals, and medical groups, underscoring the national scope of her allegations. *See id*. The Opposing Relators recognize that "Kaiser Permanente" refers to a national enterprise. Taylor alleges that Kaiser Permanente refers to a group of health plans, hospitals, and medical groups that operate nationally. *Taylor* Dkt. 1 ¶¶ 16–17. The *Bryant* Relators allege that Kaiser Permanente "is a healthcare consortium that operates one of the nation's largest health plans . . . and provides medical services" through regional affiliates across the country. *Bryant* Dkt. 1 ¶ 25. Similarly, the *Stein* Relators assert that "Kaiser Permanente" describes a "national integrated health care delivery system." *Stein* Opp'n at 1. As such, they allege a fraud scheme against multiple Kaiser Permanente entities operating across the country, including in California, Colorado, Georgia, Hawaii, and Washington. *See Stein* Dkt. No. 1 ¶¶ 5–24, 80. And they concede that *Osinek* entirely bars their FCA claim based on alleged refresh practices. *Stein* Opp'n at 1 ("Relators do

[9] Of the Opposing Relators, only Taylor objects to Defendants' request that the Court judicially notice the subpoena-related documents. *Taylor* Opp'n at 23–25. Yet he does not cite a single case holding that the type of materials submitted by Defendants are not judicially noticeable or that requests for judicial notice are prohibited on a Rule 12(b)(1) motion under the first-to-file bar. *Id.* He cites only cases where courts have rejected requests for evidentiary hearings. *Id.* But Defendants have not requested an evidentiary hearing. They have submitted materials that are not subject to reasonable dispute. Courts, including this one, routinely consider such unobjectionable materials when deciding pleadings motions. *See, e.g.*, *Wen v. Greenpoint Mortg. Funding, Inc.*, 2021 WL 5449048, at *1 n.1 (N.D. Cal. Nov. 22, 2021) (Chen, J.).

not oppose the Kaiser Defendants' first-to-file attack against Relator's [*sic*] Refresh fraud claim.").

Taylor and the *Bryant* Relators nonetheless argue that Osinek's complaint alleges a California-specific fraud, because Osinek focuses on "examples" and "events" in California. *Taylor* Opp'n at 19–20; *see also Bryant* Opp'n at 6–7. But in doing so, they ignore her repeated allegations about Kaiser Permanente's general practices: "***Kaiser*** defrauded the United States," "***Kaiser's*** upcoding scheme" violates the FCA, "***Kaiser*** focuses its data mining on high value conditions," "***Kaiser*** tells [healthcare providers] to change diagnoses," "***Kaiser*** also addended and submitted diagnostic codes for complex conditions without proper support," "***Kaiser*** tracks and rewards [providers] based on the percentage of chronic conditions they capture and refresh," "***Kaiser*** ties funding allocations to a facility's refresh and data mining rates," and so on. Dkt. No. 1 ¶¶ 2, 3, 25–27, 30–33, 37, 39 (emphases added). Osinek supports these enterprise-wide allegations with examples from her own personal experience in California, but that does not mean her complaint is limited to an alleged fraud perpetrated only in California. Taylor and the *Bryant* Relators cannot seriously contend otherwise—their own complaints focus heavily on alleged events and practices in the geographic regions where they worked, yet also purport to allege a fraud spanning multiple regions.

A similar fact pattern arose in *United States ex rel. Batiste v. SLM Corp.*, a case that based dismissal of a later-filed *qui tam* action on a broadly framed first-filed action. 659 F.3d 1204 (D.C. Cir. 2011). There, the first relator's suit "discussed activities" at a parent company's "subsidiary office," but also "name[d] the parent company . . . as the lead defendant." *Id.* at 1209. Despite the first relator's focus on "activities at [the] subsidiary office," § 3730(b)(5) barred a subsequent relator's suit that "focuse[d] on activities at [a different] office[.]" *Id.* In finding the first-to-file bar applied, the D.C. Circuit emphasized that the first complaint "would suffice to equip the government to investigate [defendant's] allegedly fraudulent forbearance practices nationwide." *Id.*; *see also United States ex rel. Hampton v. Columbia/HCA Healthcare Corp.*, 318 F.3d 214, 219 (D.C. Cir. 2003) (holding that first complaint's "broad allegations" of "corporate-wide" fraud barred similar fraud allegations in later complaint under § 3730(b)(5),

even though later complaint focused on fraud at a subsidiary operating in a state not mentioned in the first complaint). Similarly here, Osinek alleges an enterprise-wide upcoding scheme, but does not allege details about how that scheme functioned in every single geographic region in which Defendants operate. As in *Batiste* and *Hampton*, here Osinek's broad allegations require dismissal of similar allegations of fraud in specific regions. *See id.*

Because Osinek alleges a nationwide fraud, the Court also should reject Taylor's argument that Osinek's complaint does not allege a fraud scheme in Colorado. *See Taylor* Opp'n at 19–20. Although Taylor now asserts that different CMS contracts govern Defendants located in California and Colorado, neither his complaint nor Osinek's first-filed complaint says anything about these contracts and their differences; those complaints govern the first-to-file analysis, not assertions by counsel in motion papers. Regardless, the argument is irrelevant given that Osinek's complaint put DOJ on notice that Defendants purportedly used the same methods to allegedly defraud the United States in both California and Colorado. Contrary to Taylor's assertion, *id.* at 20, this is not a case like *Savage*, where one relator alleged a fraud scheme about one contractor and another relator alleged a similar fraud scheme about a completely different contractor. *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, 2015 WL 5794357, at *8–9 (E.D. Wash. Oct. 1, 2015). Osinek's broad allegations put DOJ on notice of the ***same*** alleged fraud scheme perpetrated by the ***same*** entities at issue in both her complaint and the Later-Filed Complaints. That the Defendants in the various regions may have had different contracts with CMS is entirely immaterial under the first-to-file analysis. *See United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 378 (5th Cir. 2009).

Even if Osinek had not intended to allege a fraud scheme outside California, she named a nationwide defendant and identified practices that could apply to regions outside California without explicitly cabining them to California—her complaint was thus sufficient to give DOJ notice to investigate her allegations nationwide. *See United States ex rel. Heineman-Guta v. Guidant Corp.*, 718 F.3d 28, 35 (1st Cir. 2013) (holding that the first-to-file bar applies where "the first-filed complaint contains enough material information (the essential facts) about the potential fraud, the government has sufficient notice to launch its investigation"). "Once the

government is put on notice of its potential fraud claim, the purpose behind allowing *qui tam* litigation is satisfied." *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1279 (10th Cir. 2004). Allowing the Later-Filed Complaints to survive the first-to-file bar simply because they focus on geographic locations not explicitly addressed in *Osinek* would subvert this purpose and "allow an infinite number of copycat *qui tam* actions to proceed." *Branch*, 560 F.3d at 379.

DOJ's investigation also shows that Osinek's complaint actually put DOJ on notice of an alleged enterprise-wide fraud scheme. The United States' subpoenas stated no geographic limits and applied to all subsidiaries and affiliates of the subpoenaed parties. RJN, Exs. A–D at 2. Taylor argues that this language about subsidiaries and affiliates is irrelevant boilerplate. *Taylor* Opp'n at 25. But that is belied by the course of DOJ's investigation, which extended into the Colorado region based on the ***original*** subpoenas. *See* RJN, Ex. E. Indeed, when DOJ began investigating the Colorado region, it made clear that it was just "prioritiz[ing] [Defendants'] production under the [United States'] subpoena issued [on] December 4, 2013." *Id.* at 1. DOJ thus explained that it was ***not*** indicating "a limitation of the production requests as specified" in the United States' subpoenas. *Id.* And in that same correspondence, DOJ requested documents from "all regions." *Id.* at 1, 7–8.

3. Osinek alleges a broad upcoding scheme implicating Defendants' Medicare Advantage risk-adjustment coding and documentation practices.

Under controlling precedent, Osinek's broad upcoding scheme frames the analysis here. *See Lujan*, 243 F.3d at 1189. She alleges an enterprise-wide scheme by "Kaiser Permanente" to report diagnosis codes to CMS for Medicare Advantage members that Kaiser Permanente allegedly knew did not comply with CMS coding and documentation requirements and that these diagnosis codes resulted in overpayments from the Medicare Advantage program. Dkt. No. 1 ¶¶ 2–3. And she contends that Kaiser Permanente utilized several business practices to effectuate the upcoding scheme. *See* Mot. at 5–8; Dkt. No. 141-1 ("Mot. App'x") at 1–9.

Taylor and the *Bryant* Relators insist that such a scheme is too broad to govern the analysis. *Taylor* Opp'n at 2; *see also Bryant* Opp'n at 1. Taylor, for example, asserts that Defendants' interpretation of the first-to-file bar would require dismissal of any *qui tam*

complaint that makes any allegations whatsoever about Defendants' Medicare Advantage business practices. *Taylor* Opp'n at 1–2, 9. He argues that such a result would be untenable given the large size of Defendants' Medicare Advantage business. *Id.* at 1–2.

These exaggerated fears are nothing but an objection to the legal test required by the first-to-file bar. That test asks whether the first-filed complaint put DOJ on notice of the essential facts of a fraudulent scheme that also appear in a later-filed complaint. *See Lujan*, 243 F.3d at 1189. That Osinek alleged a broad upcoding scheme, rather than a narrow and discrete fraud, is precisely the reason to apply the first-to-file bar, not a defect in the legal test. Taylor and the Bryant Relators also lose sight of the targeted business practices actually at issue in Osinek. Osinek's allegations do not implicate all of Defendants' business practices. To the contrary, all of the complaints focus on a specific part of Defendants' Medicare business operations—practices relating to the diagnosing and reporting of medical conditions to CMS for purposes of Medicare Advantage risk adjustment. Indeed, the Relators' complaints are so similar that the Court consolidated them without opposition from a single Relator.

While the scope of potential theories of FCA liability left for future relators is not relevant to the first-to-file analysis, Defendants never have argued that all future relators will be barred from bringing FCA claims based on a unique fraudulent scheme involving distinct business practices, nor do the arguments in the Motion imply such a result. As with any other first-filed *qui tam* complaint, *Osinek* bars later-in-time *qui tam* actions based on the same fraudulent scheme that she alleges, such as the FCA claims asserted by Taylor and the other Opposing Relators.

C. The Opposing Relators Do Not Allege Unique Fraud Schemes.

Unable to cabin *Osinek*'s broad allegations to addenda practices or California, the Opposing Relators latch onto factual nuances in their complaints that do not meaningfully distinguish their fraud claims from the fraud alleged in *Osinek*. As the case law makes clear, their quibbles over negligible variations of the same essential scheme are insufficient to avoid dismissal under § 3730(b)(5).

1. *Taylor*

Taylor's Opposition argues that his complaint asserts three fraud schemes not present in

Osinek that relate to (1) natural language processing, (2) chart review, and (3) audits. This argument fails because all three alleged schemes are subsumed within Osinek's allegations of a scheme to upcode the diagnoses of Medicare Advantage members. Taylor contends that certain Defendants employed natural language processing and chart review practices to identify in medical records previously unreported medical conditions for Medicare Advantage members that could then be reported to CMS for increased risk-adjusted payments. *Taylor* Dkt. No. 1 ¶¶ 191–201. Taylor also alleges that certain Defendants conducted audits of risk-adjustment data that put them on notice of medical conditions that had been upcoded and previously submitted to CMS for payment. *Id.* ¶¶ 154–61, 164, 169, 174–80. Taylor's allegations about all three business practices merely describe variations on the upcoding scheme that Osinek first identified. In any case, Osinek made specific factual allegations in her complaint that put DOJ on notice of each purportedly distinct scheme.

Natural Language Processing. Taylor argues that he alleges a unique fraud scheme based on the use of an algorithm-powered program called natural language processing ("NLP"). *Taylor* Opp'n at 18. He contends that "the NLP program uses an algorithm to search [medical records] to find words that, individually or in combination, indicate that a [member] has certain diagnoses." *Taylor* Dkt. No. 1 ¶ 191. Taylor asserts that certain Defendants used NLP to identify "new diagnoses that might be appropriate to use for the submission of additional risk adjustment claims," that those Defendants did not properly audit the diagnoses identified, and that, as a result, those Defendants submitted diagnosis codes to CMS that should not have been submitted. *Id.* ¶¶ 196–201.

But these allegations do not reflect a unique fraud scheme—as the Motion explains, Osinek's complaint describes a nearly identical "data mining" program that she contends also caused the submission of false claims to CMS. She alleges that Kaiser Permanente used "algorithms to identify . . . [medical] conditions for data mining." *See* Dkt. No. 1 ¶¶ 24–25. And she emphasizes that data mining reflected a shift away from "data quality and auditing [healthcare provider] coding." *Compare* Dkt. No. 1 ¶¶ 2, 24–25, *with Taylor* Dkt. No. 1 ¶ 191. Both Osinek's data-mining allegations and Taylor's NLP allegations concern the alleged used of

algorithms to search medical records for medical conditions without a proper focus on auditing for accuracy. The only appreciable difference is the name used to describe the practice by each Relator.

Taylor's Opposition fails to address any of these similarities. He instead falsely asserts that Defendants' entire argument is that both practices "involved some use of technology." *Taylor* Opp'n at 18. That oversimplification is contradicted by the allegations themselves. *See* Mot. at 19 ("Both [complaints] describe alleged 'data mining' algorithms used to identify medical conditions in medical records for upcoding."); Mot. App'x at 2. The two practices do not just involve "some use of technology"; they involve using algorithm-based technology ***in the same manner and for the same purpose***. As alleged in the complaints, both NLP and data mining rely on algorithms to search medical records for new medical conditions to report to CMS without a proper focus on data quality and auditing. They also both contend that the purpose of conducting these medical record reviews was to obtain additional and unwarranted risk-adjustment payments from the Medicare Advantage program. With notice from Osinek's data-mining allegations, DOJ had sufficient grounds to investigate similar programs across Defendants' operations, even if those programs had different names or varied in minor respects. And DOJ did investigate these programs. Again, the United States' subpoenas targeted virtually any document or communication about "the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage [members]." RJN, Exs. A–D at 14.

Chart Review. Taylor's Opposition also asserts that his complaint brings a distinct fraud claim based on a "one-way chart review" practice. *Taylor* Opp'n at 14–16. But Taylor alleges no such theory of fraud in his initial complaint or first amended complaint, which he argues is operative for the first-to-file analysis.[10] He asserts that his first amended complaint contains

[10] Taylor's original complaint is the operative complaint for purposes of the first-to-file analysis. *See supra* at 5–8. Because Taylor's Opposition relies on his first amended complaint, Defendants similarly cite the first amended complaint for this allegation, but all relevant allegations are identical in both the original and first amended complaints. *Compare Taylor* Dkt. No. 1 ¶ 98, *with Taylor* Dkt. No. 4 ¶ 91. As a result, for purposes of resolving this dispute over Taylor's

fourteen paragraphs describing "one-way chart review"; in reality, it contains a single allegation that alludes to a review of medical charts. *See id.* at 14–15 (citing *Taylor* Dkt. No. 4 ¶¶ 78–91). One paragraph offers the following observation related to chart review:

> Kaiser Colorado does not conduct any routine targeted audits of claims submitted by external providers. This is particularly egregious because the Colorado region does have a coder review each hospital stay at an external provider to look for additional diagnoses present in the chart but not coded by the treating [healthcare provider]. The coders do not attempt to validate the codes submitted by the hospital. These are simply passed through to CMS for payment.

Taylor Dkt. No. 4 ¶ 91 (emphasis in original). Nowhere in this paragraph—or anywhere else in his complaint—does Taylor allege that this review resulted in the submission of false or fraudulent claims to CMS.[11]

Even if this single allegation could be read to support an independent fraud scheme based on chart-review practices, all the paragraph does is identify an alleged practice that presumably resulted in the submission of false diagnosis codes to CMS based on a review of medical records. Not only is that just a variation on the upcoding scheme that Osinek alleged in 2013, but it is strikingly similar to the specific data-mining program that Osinek first described in her complaint. As Taylor explains, the chart-review program described in his complaint entailed a review of medical records "to search for additional diagnosis codes to submit to CMS." *Taylor* Opp'n at 7. Osinek similarly alleged that Kaiser Permanente "used a variety of algorithms to identify . . . disease conditions" that were then added to the medical records and ultimately submitted to CMS. Dkt. No. 1 ¶¶ 24–25. Like the chart-review practice described by Taylor, the purpose of the data-mining program alleged by Osinek was to "capture 'missed opportunities,' . . . to ensure that all possible Medicare billing opportunities are captured." *Compare id.* ¶ 24, *with* Taylor Dkt. No. 1 ¶ 98 (alleging that the purpose of the coder review is to "look for additional diagnoses present in

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chart-review allegations, it is unnecessary for the Court to decide which of the two complaints governs the analysis.

[11] The crux of the paragraph is not even about chart review—it is about audits of risk-adjustment data submitted by so-called "external providers" who are not controlled by Defendants. The mention of chart review is clearly an aside, only intended to highlight an alleged lack of targeted external-provider audits.

the chart but not coded"). That the chart-review program alleged by Taylor is a manual review and the data-mining program alleged by Osinek relies on algorithms is exactly the type of trivial detail that is insufficient to defeat dismissal under § 3730(b)(5). *See Branch*, 560 F.3d at 378.

Taylor argues that his chart-review allegation should survive because it alleges "that [healthcare] providers initially generated these false codes and Kaiser failed to delete them, a violation of the 'reverse' false claims provision" of the FCA. *Taylor* Opp'n at 15. But this point matters not a whit to the first-to-file analysis. Whether he is alleging a reverse false claim or a presentment claim under the FCA is irrelevant here, where the essential facts in Taylor's chart-review allegation mirror Osinek's data-mining allegations. DOJ needed no more than Osinek's initial allegations to investigate this purported chart-review scheme. *See* RJN, Exs. A–D at 16 (requesting documents "regarding the systems . . . used to determine, document, assign, ***review***, ***analyze***, ***report***, data mine, addend, update, or refresh the diagnosis or diagnosis codes or HCCs for Medicare Advantage [members]" (emphases added)).

Taylor also argues that "the differences in the Kaiser regional affiliates mean that the chart review scheme [he] alleges would not have even been possible in California" because there are "no external providers" in California. *Taylor* Opp'n at 15. But Taylor's own allegations contradict this argument—he explicitly alleges that Defendants' Northern and Southern California regions review diagnoses submitted by external providers. *Taylor* Dkt. No. 1 ¶ 94. And again, Osinek's allegations are not limited to California. *See supra* at 10–13. Osinek's allegations about data mining and searching for "missed opportunities" also do not exclude any type of healthcare providers.

Contrary to Taylor's Opposition, *Hartpence* does not change the analysis. There, the first-filed *qui tam* complaint alleged that a medical-device manufacturer violated the FCA by using a specific code (the "KX modifier") to certify that a treatment with its devices was medically necessary when it was not, rendering claims for reimbursement for that treatment false. 792 F.3d at 1130. The second-filed *qui tam* alleged that the manufacturer had failed to satisfy a distinct payment requirement that the manufacturer receive a "correct and completed Detailed Written Order" for treatment before delivering devices and beginning therapy. *Id.* at 1125. The relators'

theories of fraud focused on different representations: one *qui tam* action alleged a scheme to fabricate medical-necessity certifications, while the other *qui tam* action described false claims about a separate program requirement for therapy. The court concluded that because the theories of fraud differed, the first-to-file bar did not require dismissal of the second complaint. *Id.* Here, there is no such dichotomy. Both Taylor and Osinek allege that Defendants searched the medical records of Medicare Advantage members, identified medical conditions based on that search that had not previously been reported to CMS, and then submitted new diagnosis codes to CMS to increase their payments from the Medicare Advantage program. Their theory of how and why the fraud occurred is essentially the same, even if they allege some inconsequential differences in the medical-record reviews.[12]

Audits. Finally, Taylor's allegations about diagnosis-coding errors identified in audits of medical records for Medicare Advantage members do not describe a separate fraud scheme from the one Osinek first alleged. Instead, as Taylor himself explains, these audits allegedly "put Kaiser ***on notice*** that it has submitted and continues to submit" false claims to CMS. *Taylor* Dkt. No. 1 ¶ 71 (emphasis added); *Taylor* Opp'n at 16. In other words, these allegations purport to show that certain Defendants had sufficient knowledge under the FCA of the fraudulent upcoding scheme—the same fraudulent scheme that Osinek already alleged.

Knowledge is a legal element of an FCA claim that a plaintiff must establish, not a separate fraudulent scheme. *See United States ex rel. Ruhe v. Masimo Corp.*, 977 F. Supp. 2d 981, 991 (C.D. Cal. 2013); *United States ex rel. Hopper v. Anton*, 91 F.3d 1261, 1266 (9th Cir.

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[12] Taylor's reliance on *Barrett* and *Millennium Laboratories* fails for similar reasons. In *Barrett*, the court rejected a motion to dismiss under § 3730(b)(5) where the first-filed complaint alleged a kickback scheme while the second-filed complaint alleged a price-inflation scheme: two distinct theories of FCA liability with different "material facts" and different alleged "damages." *See United States ex rel. Barrett v. Allergan, Inc.*, 2019 WL 4675756, at *3 (C.D. Cal. Sept. 24, 2019). In *Millennium Laboratories*, the court held that the first-to-file bar did not apply where the relators focused on "different mechanisms" of fraud—the first centered on the faulty design of diagnosis-testing kits, while the second alleged improper medical orders of unneeded diagnosis tests. *See United States v. Millennium Lab'ys, Inc.*, 923 F.3d 240, 254 (1st Cir. 2019). Here, the alleged fraud schemes are the same—an improper review of medical records for the purpose of identifying previously unreported medical conditions to submit to CMS for increased reimbursement from the Medicare Advantage program.

1996). Taylor's reliance on *Lakeshore* acknowledges as much. *Taylor* Opp'n at 16–17. In that case, the relator alleged that audits "revealed that some physicians were 'upcoding,'" and the court concluded that "[t]hese allegations plausibly suggest[] that defendant acted with reckless disregard for the truth." *United States v. Lakeshore Med. Clinic, Ltd.*, 2013 WL 1307013, at *3 (E.D. Wis. Mar. 28, 2013). The audit allegations in *Lakeshore* established the defendant's knowledge of the fraudulent upcoding scheme; the audits were not separate acts of upcoding themselves.

Taylor nonetheless argues that his audit allegations constitute a separate fraudulent scheme because the audits revealed "specific reasons" that Osinek does not explicitly discuss, such as problems with certain diagnosis codes not mentioned in Osinek's complaint. *Taylor* Opp'n at 17. But these "specific reasons" merely add factual color to the upcoding scheme that Osinek described in her complaint; they do not provide a basis to circumvent the first-to-file bar. *See Lujan*, 243 F.3d at 1185. In any event, the *Osinek* complaint actually put DOJ on notice of potential issues with audits because the United States' subpoenas—issued ***before*** Taylor filed his complaint—requested documents related to Defendants' "internal and external review or audits," as well as "compliance or monitoring activities related to . . . diagnoses or diagnosis codes or HCCs for Medicare Advantage [members]." *See* RJN, Exs. A–D at 14.

In short, Taylor has not shown that his complaint alleges a distinct fraud scheme. Taylor invites the Court to put his complaint and Osinek's complaint side-by-side, claiming that such a comparison will reveal stark differences between the two. *See Taylor* Opp'n at 11. Defendants welcome that suggestion. Indeed, Defendants provided such a side-by-side comparison for the Court in support of their Motion, appending a chart that compares all of the relevant allegations in the complaints. *See* Mot. App'x. And that chart corroborates that Taylor—and the other Opposing Relators—do no more than allege immaterial variations on the same upcoding scheme that Osinek alleges, requiring dismissal under the first-to-file bar.

2. *Stein*

The *Stein* Relators concede that § 3730(b)(5) requires dismissal of their fraud claim based on alleged "refresh" practices, *Stein* Opp'n at 1, and thus the only disputes that remain concern

their allegations about sepsis, malnutrition, and aortic atherosclerosis ("AA"). The *Stein* Relators argue that *Osinek* does not encompass these alleged frauds because her complaint is limited to allegations about "utilizing computer programs," addenda, and outpatient diagnosis coding, whereas their allegations do not relate to addenda practices and extend to hospital coding. *Stein* Opp'n at 3–7. But, as explained *supra* at 8–13, this is an overly narrow reading of *Osinek*, which alleges an enterprise-wide fraud that involves multiple business practices and implicates Defendants' diagnosis-coding practices across all Kaiser-affiliated entities—including hospitals.

Sepsis. The thrust of the *Stein* Relators' sepsis allegations is that certain Defendants inappropriately coded sepsis without proper clinical findings, often in the hospital setting, and then reported those diagnosis codes to CMS to support increased risk-adjustment payments from the Medicare Advantage program. *See Stein* Opp'n at 3–4; *Stein* Dkt. No. 1 ¶ 50. For her part, Osinek generally alleges that "Kaiser Permanente"—which would include the Kaiser-affiliated hospitals at issue in *Stein*—submitted diagnosis codes to CMS for complex medical conditions without proper support and for the purpose of increasing their risk-adjustment payments from the Medicare Advantage program. Dkt. No. 1 ¶¶ 26, 31. Osinek, like the *Stein* Relators, also alleges that Defendants used internal guidance and policies to encourage diagnosis coding of medical conditions that should not have been coded. *Compare* Dkt. No. 1 ¶¶ 26–31, *with Stein* Dkt. No. 1 ¶ 50; *see also* Mot. App'x at 8.

Osinek's upcoding allegations were sufficient to put DOJ on the trail of the sepsis-specific scheme alleged in *Stein*. Although Osinek does not reference sepsis, her complaint does not purport to list every medical condition implicated by the alleged fraud. Instead, Osinek provides examples—indeed, she introduces them with the phrase "for example"—to illustrate the alleged enterprise-wide scheme. *See, e.g.*, Dkt. No. 1 ¶¶ 26–27, 30. The United States' subpoenas confirm that the United States understood Osinek's allegations to implicate practices extending beyond the specific medical conditions referenced explicitly in her complaint, as the United States requested documents about Defendants' internal diagnostic standards for ***all*** medical conditions of Medicare Advantage members, which necessarily includes sepsis, as well as malnutrition and AA. *See* RJN, Exs. A–D at 14.

The *Stein* Relators are not only second-in-time to Osinek, but also to Taylor and the *Arefi* Relators. *Stein* Opp'n at 7–9. The *Arefi* Relators' upcoding allegations thus provide a separate basis to dismiss the *Stein* Relators' sepsis allegations.[13] Both *Arefi* and *Stein* allege that certain Defendants engaged in an upcoding scheme. *Arefi* Dkt. No. 1 ¶ 42; *Stein* Dkt. No. 1 ¶ 50; Mot. App'x at 1. Both allege that those Defendants used incorrect diagnostic criteria and standards. *Arefi* Dkt. No. 1 ¶ 2 (allegedly using "diagnostic criteria that find no support in medical literature or accepted standards of medical or coding practice"); *Stein* Dkt. No. 1 ¶¶ 57–60 (allegedly adopting incorrect sepsis criteria). And both raise concerns about sepsis diagnoses in particular. *Stein* Dkt. No. 1 ¶¶ 50–69; *Arefi* Dkt. No. 1 ¶ 81 (alleging a 132 percent increase in the diagnosis rate of septicemia and sepsis in certain Medicare Advantage members between 2008 and 2013).

Malnutrition. The *Stein* Relators' malnutrition allegations provide yet another example of the general upcoding scheme alleged by Osinek, and § 3730(b)(5) requires dismissal on that basis. *See Stein* Dkt. No. 1 ¶ 70 (alleging that certain Defendants "participated in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA [members] in order to increase the risk adjustment scores for the MA [members] so diagnosed"). Osinek even cites two types of malnutrition conditions—cachexia and protein calorie malnutrition—to illustrate the alleged upcoding scheme in her complaint. Dkt. No. 1 ¶¶ 25, 37, 39, 41.

The *Taylor* and *Arefi* complaints also include allegations about malnutrition, providing further reason to bar *Stein*'s malnutrition allegations. Like the *Stein* Relators, Taylor identifies malnutrition as a medical condition that certain Defendants upcoded. *Taylor* Dkt. No. 1 ¶¶ 139–41. He alleges that "false claim[s] resulted from Kaiser coders and/or computer systems adding a

[13] Because *Arefi* was pending when *Stein* was filed, the *Arefi* Relators' notice of non-opposition to the Motion does not change this analysis. *See United States ex rel. Shea v. Cellco P'ship*, 863 F.3d 923, 930 (D.C. Cir. 2017) (holding that a later-filed *qui tam* was "incurably flawed from the moment [the relator] filed it" because the earlier-filed *qui tam* was "pending" at the time of the filing); *Lujan*, 243 F.3d at 1188 (finding that subsequently dismissed *qui tam* "should still be considered a 'pending' action for purposes of § 3730(b)(5)" because it had not yet been dismissed when the second *qui tam* was filed, and reasoning that dismissal of the later-filed action still alerted the government to the essential facts of the fraudulent scheme).

malnutrition diagnosis where the treating [healthcare providers] had not." *Id.* ¶ 141. Taylor explains that a coder, who is not an appropriate provider type, should not determine that a Medicare Advantage member has a medical condition because that determination can be made only by the healthcare provider or other appropriate provider type. *Id.* The *Stein* Relators' malnutrition allegations similarly assert that certain Defendants purportedly submitted malnutrition diagnosis codes to CMS that were not supported by a diagnosis from an appropriate provider type. *Stein* Dkt. No. 1 ¶ 71. The *Arefi* Relators likewise raise concerns about the diagnosis coding for malnutrition and allege that Defendants' upcoding scheme resulted in the submission to CMS of inappropriate diagnoses of protein calorie malnutrition. *Arefi* Dkt. No. 1 ¶ 81. While *Osinek* is independently sufficient to require dismissal of the *Stein* Relators' malnutrition allegations, the *Taylor* and *Arefi* complaints make clear that DOJ had abundant notice of such a scheme well before *Stein* was filed.

Aortic Atherosclerosis. The *Stein* Relators' AA allegations appear only in their amended complaints. Because the first-to-file analysis centers on a comparison of initial complaints, *see supra* at 5–8, the *Stein* Relators cannot rely on their amendments to manufacture jurisdiction where none existed in the first place. *Sepehry-Fard*, 2014 WL 2707738, at *3. The AA allegations therefore have no relevance to the Court's first-to-file analysis.

Even if the AA allegations were alleged in the initial *Stein* complaint, however, they would not save the complaint from dismissal. The *Stein* Relators' allegations that certain Defendants submitted AA diagnosis codes to CMS whenever AA was observed in an x-ray or listed in a medical record are no more than a factual nuance encompassed by Osinek's broad allegation that Defendants submitted diagnosis codes for complex medical conditions without proper support. *Compare* Dkt. No. 1 ¶¶ 26, 31, *with* Dkt. No. 116 ¶¶ 84–91. Additionally, the *Stein* Relators' allegation that AA was inappropriately coded based on test results mirrors Osinek's allegation that Defendants instructed their healthcare providers to review previous test results to support their diagnoses. *Compare* Dkt. No. 1 ¶ 29, *with* Dkt. No. 116 ¶ 86; *Stein* Opp'n at 6. The *Arefi* Relators likewise faulted certain Defendants for coding based on old test results and for using clinical standards that were "not based on generally accepted standards of medical

or coding practice." *Arefi* Dkt. No. 1 ¶¶ 45–46 (alleging that documentation specialists would review medical records, "including diagnostic test results, going as far back as fifteen years for clinical signs and symptoms to support additional HCCs in the current year").

The Court also should reject the *Stein* Relators' request for leave to amend. *See Stein* Opp'n at 14. Since the first-to-file bar is jurisdictional and states that "no person other than the Government" may bring an FCA action related to a pending action, 31 U.S.C. § 3730(b)(5), the *Stein* Relators cannot cure the jurisdictional deficiency through amendment.

3. *Bryant*

The *Bryant* Relators focus their Opposition on only three aspects of their complaint: (1) diagnosis coding in the hospital setting, (2) diagnosis coding of vent dependence, and (3) fraud on the risk-adjustment program established by the ACA. *Bryant* Opp'n at 2, 8–9, 12–13.[14] Having failed to identify any other allegations they contend should survive the first-to-file bar, the *Bryant* Relators effectively concede that *Osinek* bars the remainder of their allegations. Yet the three categories of allegations to which the *Bryant* Relators now cling are no more than variations on the same upcoding scheme first alleged by Osinek.

Hospital Coding. The *Bryant* Relators argue that Osinek's complaint did not encompass their allegations of fraud in the hospital setting. *Id.* at 9, 12. But this technical distinction does not save the *Bryant* complaint. That Osinek did not name "Kaiser Foundation Hospitals" as a defendant does not narrow the scope of her allegations to upcoding practices within Defendant medical groups. Again, by naming "Kaiser Permanente," Osinek alleged an enterprise-wide scheme across Defendants' affiliated entities, including the hospital division. *See supra* at 10–13. That the United States issued subpoenas directed to Kaiser Foundation Hospitals in 2013—***nearly five years before*** the *Bryant* Relators filed their complaint—shows the breadth of Osinek's allegations and DOJ's actual notice that they extended to hospital practices. RJN, Ex. D.

[14] As noted *supra* at 11, the *Bryant* Relators also argue that their complaint is "unique in its national scope." *Bryant* Opp'n at 9; *see also id.* at 2, 6–7, 18. But this argument fails because Osinek alleged an enterprise-wide scheme implicating Defendants' risk-adjustment diagnosis-coding practices across the nation. *See supra* at 10–13. Moreover, other complaints filed earlier than the *Bryant* complaint name Defendant entities outside the California region.

Even if Osinek's complaint had not been so broad as to encompass diagnosis coding in the hospital setting, the *Bryant* Relators still would not be the first to allege a hospital-related fraudulent scheme. The *Arefi* complaint, filed in 2015—nearly three years before *Bryant*—named Kaiser Foundation Hospitals as a defendant. *Arefi* Dkt. No. 1 ¶¶ 16–17. And the *Stein* Relators, who both worked at Defendant hospitals and who filed their original complaint in 2016, also named Kaiser Foundation Hospitals as a defendant. *Stein* Dkt. No. 1 ¶ 5. The sepsis and malnutrition allegations at the core of the *Stein* complaint all concern hospital-related diagnosis coding. *Stein* Dkt. No. 1 ¶¶ 50–79; *see also Stein* Opp'n at 3–5. Thus, by the time the *Bryant* Relators filed their complaint, the United States was on notice of an alleged hospital-related upcoding scheme not just through *Osinek*, but through *Arefi* and *Stein* as well.

Vent-Dependence Status. The *Bryant* Relators' allegations about diagnosis coding of vent dependence are merely factual variations on the broader upcoding scheme first alleged by Osinek, particularly her allegations that Kaiser Permanente instructed healthcare providers to diagnose medical conditions in ways that did not comport with diagnosis-coding guidelines. *See, e.g.*, Dkt. No. 1 ¶¶ 26–31. Even the *Bryant* Relators' Opposition describes their vent-dependence allegations as part of this same alleged "scheme[] to fraudulently overbill" and "systemic[ally] over-document[] and upcod[e]" specific high-value diagnoses. *Bryant* Opp'n at 11–12.

It makes no difference under § 3730(b)(5) that Osinek did not mention the specific diagnosis of mechanical vent-dependence status or its associated HCC. What matters for the first-to-file analysis is that Osinek first alleged the business practices and motives behind Defendants' purported scheme to target diagnoses improperly for increased risk-adjustment payments from the Medicare Advantage program. *Compare* Dkt. No. 1 ¶ 29 (alleging that Kaiser Permanente "tells" healthcare providers to make diagnoses in a way that is inappropriate under "guidelines" and "best practices"), *with Bryant* Dkt. No. 1 ¶ 87 (alleging that certain Defendants issued "directives" to healthcare providers that "contravene" guidance on the diagnosis coding of vent dependence issued by the American Hospital Association's Coding Clinic). The *Bryant* Relators' vent-dependence allegations "simply add[] factual details" about the same upcoding scheme alleged in *Osinek* and therefore do not survive the first-to-file bar. *Branch*, 560 F.3d at

378; *see also United States ex rel. Marion v. Heald Coll., LLC*, 2015 WL 4512843, at *3 (N.D. Cal. July 24, 2015). Indeed, the *Bryant* Relators' silence about other medical conditions specified in their complaint but not referenced in *Osinek* implicitly concedes that merely adding a new diagnosis to the list referenced in *Osinek* is not enough to allege a new and different fraudulent scheme under § 3730(b)(5).

The *Bryant* Relators further argue that their vent-dependence allegations are unique because they allege the medical condition was diagnosed "contemporaneously *during* hospital inpatient stays, not through an 'addendum' process." *Bryant* Opp'n at 12 (emphasis in original). But as noted *supra* at 8–13, Osinek's complaint encompasses diagnosis coding in the hospital setting and extends beyond addenda practices.

Citing no authority, the *Bryant* Relators also argue that their vent-dependence allegations cannot be barred because they relate to alleged conduct that postdated Osinek's complaint. *Bryant* Opp'n at 12. But the first-to-file bar applies to allegations that postdate the filing of the first-filed complaint where the first-filed complaint alleges an ongoing fraud, as is the case here. *See Chovanec*, 606 F.3d at 364–65 ("The [earlier-filed] complaints couldn't allege that any of [the alleged fraud] was certain to continue past their filing dates (1998 and 1999), but neither did either complaint allege that it had stopped. Fraud . . . in 2002 thus is within the scope of a national, continuing, scheme alleged in 1998 and 1999."). This argument also runs headlong into the very purpose of the first-to-file bar, which Congress added to the FCA to prevent repetitive claims once DOJ is on notice of the "essential facts" of the alleged fraud. *Lujan*, 243 F.3d at 1186–87. Because the *Osinek* complaint alleged the "essential facts" giving rise to the purported vent-dependence scheme—that Kaiser Permanente, for example, "tells its [healthcare providers] to change coding practices" and "to change diagnoses to upcode to higher value and more complicated forms of diseases," Dkt. No. 1 ¶¶ 27, 30—her allegations gave DOJ notice of the practices leading to the purported vent-dependence scheme later alleged in the *Bryant* complaint. *See Lujan*, 243 F.3d at 1188 (noting that § 3730(b)(5) "precludes a subsequent relator's claim that alleges the defendant engaged in the same ***type*** of wrongdoing as that claimed in a prior action" (emphasis added)). That the United States requested through its subpoenas in 2013 documents

encompassing Defendants' internal diagnostic standards for all medical conditions demonstrates that *Osinek* gave DOJ the information it needed to investigate Defendants' diagnosis-coding standards for medical conditions like vent dependence, whether or not the *Osinek* complaint explicitly referenced them. *See* RJN, Ex. A at 14, 16.

Affordable Care Act. Finally, the *Bryant* Relators try to distinguish their complaint from *Osinek* by arguing that they allege a separate fraudulent scheme under the ACA. *Bryant* Opp'n at 2, 8, 12, 14. But this contention is baseless on the face of their complaint. The *Bryant* Relators' FCA causes of action (Counts 1 through 4) do not even reference the ACA, citing only the Medicare program. *See Bryant* Dkt. 1 ¶¶ 208–28. For example, they allege that Defendants violated 31 U.S.C. § 3729(a)(l)(A) when they "knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the ***Medicare Program***." *Id.* ¶ 209 (emphasis added). Of the 270 paragraphs in the *Bryant* complaint, only nine reference the ACA, *id.* ¶¶ 7–9, 11, 51–54, 180, and of those nine only two generally describe risk-adjustment under the statute, *id.* ¶¶ 51–52—the others make just a passing reference to the ACA, lumping it in with allegations about the Medicare Advantage program. It is evident from the face of the *Bryant* complaint that it does not bring a distinct FCA claim involving the ACA at all.[15]

4. *Bicocca*

Bicocca concedes that all of the FCA claims alleged "in his original Complaint ***are barred by Osinek's original Complaint based on the first-to-file rule***." *Bicocca* Opp'n at 2 (emphasis added). Because the relevant complaint is Bicocca's original complaint, that concession ends the analysis under § 3730(b)(5), and the Court should dismiss Bicocca's FCA claims against Defendants. *See supra* at 5–7.

Even if the Court were to consider Bicocca's amended complaint, dismissal is still warranted. Bicocca readily admits the striking similarities between his amended complaint and Osinek's complaint: "Both complaints allege a fraud scheme involving inaccurate and

[15] Nor can the *Bryant* Relators' Opposition add new allegations to save the complaint from dismissal.

manipulated [member] diagnoses to obtain increased reimbursements from the government," and both complaints "are centered around, essentially, the same group of defendants over the same general period of time." *Bicocca* Opp'n at 7–8. In short, both complaints allege the same fraudulent scheme and motive, and both involve the same defendants as well as geographic and temporal scope.

In the face of these similarities, Bicocca concedes that many of the allegations in his amended complaint are also barred. *Bicocca* Opp'n at 6 ("To the extent that some of Bicocca's allegations overlap with the same essential elements of the fraud scheme Osinek alleges — specifically the addenda claims — Bicocca does not dispute that these allegations are barred by the first-to-file rule."). In his Opposition, Bicocca frames his amended complaint as alleging "'two sources' of diagnoses that Kaiser requires [healthcare providers] to add." *Id.* at 2. He admits that his allegations about the first "source"—the use of addenda to diagnose chronic medical conditions after a member visit—were first alleged by Osinek and are barred by § 3730(b)(5). *See id.* at 2, 6, 11. Thus, the only allegations that Bicocca contends were not first alleged by Osinek are his allegations about the second "source"—"Kaiser's use of upfront diagnoses lists to re-diagnose [members]." *Id.* at 6.

But Bicocca's "re-diagnose" allegations are not new; they merely repackage Osinek's allegations about Defendants' "refresh" practices. *See* Dkt. No. 1 ¶¶ 24, 33–34 (describing the alleged refresh scheme). According to Bicocca, the "re-diagnose" scheme centered on Defendants' practice of giving healthcare providers "a list of the [member's] past diagnoses" "*before* the [provider] meets with the [member], with the intention that the [provider] will re-diagnose each of the specific diagnoses *during* the visit ('upfront list')." *Bicocca* Opp'n at 2 (emphasis in original). The purpose of the alleged scheme was to ensure that chronic medical conditions among these Defendants' members were diagnosed each year in an effort to "improperly increase[] [Defendants'] capitation rate," and the scheme purportedly was carried out "through data mining, by a computer search of [member medical] records looking for key words." *Bicocca* Dkt. No. 16 ¶¶ 87, 110. This alleged fraud is no different than the "refresh" scheme first described by Osinek. *See, e.g.*, Dkt. No. 1 ¶ 33 (describing "data mined and refreshed

diagnoses"), ¶ 34 (describing healthcare providers' responses "to refreshing and datamining prompts"), ¶ 37 (alleging that Kaiser Permanente "tracks and rewards [healthcare providers] based on the percentage of chronic conditions they are able to capture and refresh"), ¶¶ 39–40 (discussing refresh goals for chronic medical conditions). Thus, "refresh" in *Osinek* and "re-diagnose" in *Bicocca* refer to the exact same concept: ensuring that a member's chronic medical conditions are added to the medical record each year, including through the use of data mining and prompts to identify conditions for healthcare providers to consider at the time of the member encounter.

Bicocca's argument that *Osinek* encompassed the first source of purportedly false diagnoses he alleged (*i.e.*, the addenda scheme) but not the second source (*i.e.*, the "re-diagnose" scheme) asks the Court to ignore the scope of *Osinek*'s refresh allegations. Osinek's complaint alleges that the "refresh" scheme was not limited to diagnoses added to the medical record via addenda, and that Kaiser Permanente encouraged healthcare providers to diagnose certain medical conditions during the member's visit, including through the use of data mining and prompts. *See id.* ¶¶ 24, 26, 33–34. This distinction between refreshed and addended diagnoses makes intuitive sense: for any chronic medical condition, a healthcare provider might diagnose the condition ***at the time*** of the member encounter (*i.e.*, refresh or "re-diagnose" the condition) or ***after*** the encounter (*i.e.*, in an addendum). Because *Osinek* described both scenarios, Bicocca's allegations are barred by § 3730(b)(5).

Bicocca nevertheless argues that his "re-diagnose" allegations are unique because of additional details he alleges in his complaint, allegations that "hard copy" lists were "provided to [healthcare providers] for their daily Medicare [members] that include[d] 'the [member's] chronic conditions that [Defendants] wanted the [provider] to check off in the EMR.'" *Bicocca* Opp'n at 3 (quoting *Bicocca* Dkt. No. 16 ¶ 94). But these "hard copy" lists, which were called "MDP reports," *see Bicocca* Dkt. No. 16 ¶¶ 94–97, were first alleged by Osinek using the exact same terminology. *See* Dkt. No. 1 ¶ 33 (screenshot of an internal document advising Defendant The Permanente Medical Group to "[i]mplement process for printing MDPs for same day appointments"). Further, the methods that Bicocca alleges certain Defendants used to ensure that

chronic medical conditions were "re-diagnosed"—such as tracking healthcare provider performance, pressuring providers to comply, "turning chronic condition management into a performance metric" as "a means to increased salary, bonuses, and potentially other benefits," and the "use of dot phrases"—also were first alleged by Osinek. *Compare Bicocca* Dkt. No. 16 ¶¶ 127–45, *with* Dkt. No. 1 ¶¶ 28, 32–37.

Bicocca makes much of the fact that he alleged two "underlying issues" with the refresh or "re-diagnose" scheme—(1) healthcare providers did not always have sufficient time to properly confirm and diagnose chronic medical conditions suggested by the MDP reports, *see Bicocca* Dkt. No. 16 ¶¶ 114–17; and (2) healthcare providers did not always have adequate expertise or specialization to diagnose the suggested chronic conditions, *see id.* ¶¶ 118–23. But neither of these allegations save his complaint from dismissal. These allegations are "merely variations" on the refresh scheme first alleged by Osinek and do not describe a materially different fraud. *Hampton*, 318 F.3d at 218. Indeed, the *Stein* Relators' concession that their refresh allegations are barred by Osinek's complaint shows the breadth and scope of the refresh scheme first alleged by Osinek. *See Stein* Opp'n at 1 ("Relators do not oppose the Kaiser Defendants' first-to-file attack against Relator's [*sic*] Refresh fraud claim."). There is simply no basis to find that Bicocca's allegations about the same purported scheme survive in light of the *Osinek* and *Stein* complaints.

Bicocca's case citations do not compel a different result. In *Hartpence*, as described *supra* at 18–19, the first-to-file bar did not preclude the second relator's claims premised on violations of the detailed written order requirement because those claims were based on different material facts than those alleged by the first relator. 792 F.3d at 1131. Here, in contrast, Bicocca's alleged "re-diagnose" scheme is the same as Osinek's alleged refresh scheme. Both schemes are based on the same material facts, the same alleged motive, and do not allege a separate fraud.

United States ex rel. Heath v. AT & T, Inc. is distinguishable for the same reason. 791 F.3d 112 (D.C. Cir. 2015). There, the first-filed complaint alleged a fraudulent scheme against the federal Education Rate program in Wisconsin based on the "affirmative misrepresentations"

of Wisconsin Bell employees who allegedly lied about the existence of a state contract with a lower price. *Id.* at 121. The second-filed complaint, by contrast, was against Wisconsin Bell's parent company, AT&T, and alleged a "more far-reaching scheme" that purportedly occurred across the country based on AT&T's institutionalized and corporate-wide training and billing procedures. *Id.* Here, Osinek's complaint reflects a "more far-reaching scheme," whereas Bicocca's complaint alleges just a variant of the upcoding scheme that Osinek already alleged.

United States ex rel. Chin v. CVS Pharmacy, Inc. is also readily distinguishable because the two complaints concerned a similar fraudulent scheme but involved different, independent defendants. 2017 WL 4174416 (C.D. Cal. Aug. 15, 2017). There, the court found that the first-to-file bar did not apply because the first-filed complaint named Walgreens as a defendant, whereas the second-filed complaint named CVS. *Id.* at *4–5. Although both complaints alleged similar facts—that the pharmacies provided gift cards and coupons in exchange for customers transferring their prescriptions—nothing in the first-filed complaint suggested that CVS provided gift cards to federal healthcare plan beneficiaries or alleged any facts suggesting an industry-wide fraudulent scheme. *Id.* at *4. Here, Osinek's complaint alleged a broad, enterprise-wide scheme by "Kaiser Permanente," and Bicocca does not even argue that his amended complaint could somehow survive dismissal simply because he named specific Kaiser-affiliated entities as defendants.

Finally, the court's decision in *Savage* turned on the fact that the first-filed and second-filed *qui tam* actions each named different prime contractors as defendants, and the different defendants were operating under different Department of Energy contracts and performing different remediation work. 2015 WL 5794357, at *8–9. As a result, proving the claims in both *qui tam* actions would have required materially different evidence. *Id.* at *9. Here, Bicocca's allegations and Osinek's allegations implicate the same Defendants, and proof of Bicocca's "re-diagnose" scheme would require the same evidence as proof of Osinek's refresh scheme.

D. The Motion Is "Ripe."

The Court should reject any suggestion from the Opposing Relators that the Motion is not yet "ripe" given the early stage of the litigation. *See Bryant* Opp'n at 19. The *Bryant* Relators

argue that, because DOJ has intervened on addenda-related allegations, and there has not been a final judgment or settlement as to DOJ's intervention complaint, deciding first-to-file issues now would be "premature." *Id.* Notably, the *Bryant* Relators have not cited a single authority stating that first-to-file issues should be left for resolution until after final judgment or settlement where DOJ has intervened.[16] And the *Bryant* Relators' argument would turn logic on its head—requiring this Court to decide a threshold jurisdictional question at the ***end*** of a case—without providing any meaningful standard to distinguish this case from countless others that have decided, without controversy, first-to-file questions on a motion to dismiss.

A rule allowing relators to keep their *qui tam* cases pending until a final resolution even if the first-to-file bar requires dismissal makes no sense. In addition to a lack of grounding in statutory text or case law, it contravenes the policies of the first-to-file bar. Delay would not help DOJ police fraud or mitigate the burden of litigating duplicative allegations. The outset of the case is precisely the right time to make first-to-file determinations, especially where, as here, there are several *qui tam* cases at issue and their dismissal can simplify the case for other parties and the Court. The *Arefi* Relators apparently realized this fact, filing a non-opposition to the Motion that will result in the dismissal of their complaint in its entirety. And the Court has a duty to resolve this matter now given that its subject-matter jurisdiction is at issue. *See Corral v. Select Portfolio Servicing, Inc.*, 878 F.3d 770, 773 (9th Cir. 2017) ("[T]he court has an 'independent obligation to determine whether subject-matter jurisdiction exists, even in the absence of a challenge from any party.'" (quoting *Arbaugh v. Y&H Corp.*, 546 U.S. 500, 514 (2006))). Accordingly, the Court should decide the Motion on its merits now before further progression in the litigation.

III. CONCLUSION

The Opposing Relators' concessions already have narrowed this case—requiring dismissal of *Arefi* and *Bicocca* in their entirety as well as the refresh allegations in *Stein*. Unable to limit

[16] The case that the *Bryant* Relators cite stands for the uncontroversial proposition that the DOJ's intervention complaint "necessarily incorporate[s] the material elements of fraud from the earliest-filed complaints containing those elements." *Bryant* Opp'n at 19 (quoting *United States v. Berkeley Heartlab Inc.*, 225 F. Supp. 3d 487, 495 (D.S.C. 2016)).

Osinek to addenda practices or California, Taylor and the *Bryant* Relators also effectively concede that all but a select number of allegations in their complaints should be dismissed. But the Court should not stop there. Osinek alleged a broad upcoding scheme targeting Defendants' Medicare Advantage diagnosis-coding practices that not only could have ***but did*** put DOJ on notice of a purported nationwide fraud scheme. The Oppositions merely point to allegations that do not explicitly appear in *Osinek*, but are nonetheless encompassed by Osinek's upcoding allegations. That is not sufficient to avoid dismissal under the first-to-file bar. The Court should grant the Motion and dismiss the *Taylor*, *Arefi*, and *Stein* complaints in their entirety, as well as Counts 1 and 2 of the operative *Bicocca* complaint and Counts 1 through 4 of the operative *Bryant* complaint.

Dated: March 17, 2022

Respectfully submitted,

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION; ~~[PROPOSED]~~ ORDER

Courtroom: 5, 17th Floor
Judge: Hon. Edward M. Chen

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION; ~~[PROPOSED]~~ ORDER** Courtroom: 5, 17th Floor Judge: Hon. Edward M. Chen

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, INC., et al, Defendants.	Case No. 3:18-cv-01347-EMC **STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION; ~~[PROPOSED]~~ ORDER** Courtroom: 5, 17th Floor Judge: Hon. Edward M. Chen

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiffs, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION; ~~[PROPOSED]~~ ORDER** Courtroom: 5, 17th Floor Judge: Hon. Edward M. Chen

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, INC., et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION; ~~[PROPOSED]~~ ORDER

Courtroom: 5, 17th Floor
Judge: Hon. Edward M. Chen

Pursuant to Civil Local Rule 7-12, Defendants Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and The Permanente Federation, LLC (collectively, "Defendants"); and Relators James Taylor, M.D., Marcia Stein, Rodolfo Bone, Gloryanne Bryant, Victoria Hernandez, and Michael Bicocca, M.D. (collectively, "Relators") hereby stipulate and request as follows:

1. On January 18, 2022, Defendants filed a motion to dismiss the *Taylor*, *Arefi*, *Stein*, *Bryant*, and *Bicocca* complaints on the grounds that the complaints are wholly or partially barred by the False Claims Act's first-to-file bar, 31 U.S.C. § 3730(b)(5) (the "Motion"). Dkt. No. 141.

2. On January 24, 2022, the relators in the *Arefi* action filed a non-opposition to the Motion. Dkt. No. 143.

3. On February 15, 2022, Relators filed four oppositions, one for each remaining action subject to the Motion. Dkt. Nos. 154-57. Together, the oppositions total approximately 70 pages.

4. Defendants are entitled to file a reply brief in response to each of the four opposition briefs. Under the Court's Civil Local Rules, a reply brief may not exceed 15 pages. Civil L.R. 7-4. Accordingly, Defendants would be entitled to 60 total pages on reply if they filed a reply brief in response to each opposition brief.

5. Defendants believe that it would be more efficient to file a single reply brief that addresses all of the arguments in opposition to the Motion rather than four separate reply briefs. Although Defendants are entitled to 60 pages on reply if they file four briefs, Defendants request that the Court permit them to file a single reply brief that does not exceed 50 pages. Defendants hope to be able to brief their collective reply arguments in a brief that is fewer than 50 pages.

6. Counsel for Defendants and Relators have conferred about Defendants' request, and Relators do not oppose the request.

IT IS SO STIPULATED.

Dated: February 24, 2022

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*

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ATTESTATION

Pursuant to Local Rule 5-1(i)(3), I hereby attest that the other signatories listed, on whose behalf this filing is submitted, concur in the filing's content and have authorized the filing.

DATED: February 24, 2022

/s/ *K. Lee Blalack, II*
K. LEE BLALACK, II

~~[PROPOSED]~~ ORDER

Pursuant to stipulation and with good cause shown, Defendants are permitted to file a single reply brief in support of their Motion to Dismiss Pursuant to False Claims Act's First-to-File Bar (Dkt. No. 141) that shall not exceed 50 pages.

PURSUANT TO STIPULATION, IT IS SO ORDERED.

DATED: February 28, 2022

HONORABLE EDWARD M. CHEN
UNITED STATES DISTRICT JUDGE

TAB 5

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, Defendant.	CASE NO. 3:13-cv-03891-EMC PLAINTIFFS AND RELATORS MARCIA STEIN AND RODOLFO BONE'S OPPOSITION TO MOTION TO DISMISS COMPLAINT
UNITED STATES OF AMERICA, *ex rel.* MARCIA STEIN and RODOLFO BONE, Plaintiffs, vs. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	c/w CASE NO. 3:16-cv-05337-EMC PLAINTIFFS AND RELATORS MARCIA STEIN AND RODOLFO BONE'S OPPOSITION TO MOTION TO DISMISS COMPLAINT DATE: March 31, 2022 TIME: 1:30 p.m. JUDGE: Edward M. Chen CRTRM: 5, 17th Floor

COME NOW, Plaintiffs and Relators Marcia Stein and Rodolfo Bone, and submit the following Memorandum of Points and Authorities in opposition to the Kaiser Defendants' Motion to Dismiss Relators' Complaint.

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION AND SUMMARY OF ARGUMENT.

Relators Marcia Stein and Rodolfo Bone's (collectively, "Relators") Sepsis, Malnutrition, and Aortic Atherosclerosis fraud claims are factually different from the fraud claims made in the previously filed *Osinek, Taylor,* and *Arefi* complaints, and Defendants' first-to-file attack against these claims should be denied. Relators do not oppose the Kaiser Defendants' first-to-file attack against Relator's Refresh fraud claim.

II. SUMMARY OF FACTS.

A. THE PARTIES.

1. The Kaiser Defendants.

Kaiser Permanente (KP) is the commonly used name for the national integrated health care delivery system comprised of the defendant non-profit health plans, the exclusively contracted defendant for-profit medical groups, and the exclusively contracted defendant non-profit hospitals. The original KP health plan, Kaiser Foundation Health Plan (KFHP) serves all of California and has a Medicare Advantage (MA) contract with the Government's Centers for Medicare and Medicaid Services (CMS) to provide managed care health services to MA enrollees. KFHP and Kaiser Foundation Hospitals (KFH) are California corporations, while the defendant medical groups are separate regional entities in various states. ¶¶1, 8-15, *Stein* Complaint (*Stein* Dkt. #1). KFHP and KFH, through an exclusive contractual relationship, operates as one the nation's largest integrated health care delivery system focused on providing managed health care services to HMO beneficiaries and to seniors through the federal Medicare Advantage (MA) health care program. ¶17, *Stein* Complaint (*Stein* Dkt. #1).

California, due to its size and the large number of managed care members and MA enrollees, is divided into two regions: the Northern California region, which consists of all counties north of Ventura and Kern Counties, served by 21 KFH hospitals and The Kaiser Permanente Medical Group (TPMG); and the Southern California region served by 13 KFH

hospitals and the Southern California Permanente Medical Group (SCPMG). Outside of California, there are six KP affiliate health plans, each with a separate MA contract to service MA enrollees within that state(s) along with regional for-profit exclusively contracted medical groups. ¶¶5-17, *Stein* Complaint (*Stein* Dkt. #1).

2. Relators Marcia Stein and Rodolfo Bone.

Relator Marcia Stein (Stein) is an American Health Information Management Association (AHIMA) Registered Health Information Administrator (RHIA) and was employed by both the SCPMG and KFH. At SCPMG, Stein worked in Panorama City, California as the clinic records administrator and worked at KFH's Panorama City, California hospital as the Director of KFH's Health Information Management (HIM) from about October 1987 until about May 2011. Health Information Managers are professionals with expertise in managing health information systems, and processing, analyzing and reporting information vital to the operations of hospitals, medical groups, medical clinics and health plans. Typically, Health Information Managers are also responsible for training physicians, health care professionals and coders on utilizing the available health information systems, electronic health records (EHR) and correct coding and documentation practices. ¶¶25-26, *Stein* Complaint (*Stein* Dkt. #1).

Between 2010 and 2016, Rodolfo Bone (Bone) worked part-time at KFH Hospital-South Bay, in Harbor City, California, as a per diem coder. At the beginning of 2016, his position was moved to KFH's Southern California corporate offices in Pasadena, California where he continued as a per diem coder reporting to KFH's Regional Revenue Cycle Department. ¶¶27, *Stein* Complaint (*Stein* Dkt. #1).

3. Plaintiff United States.

Plaintiff United States (Government), funded the Medicare program, administered by the Centers for Medicare and Medicaid Services (CMS), which provides payment of healthcare services for, among others, Americans 65 years of age and older. Medicare provides an option, Medicare Advantage (MA), in which eligible Medicare beneficiaries can enroll with a health plan or managed care organization (collectively, "MAO") contracted with

CMS for a capitated rate paid by CMS that generally provides at least those services provided to standard fee-for-service (FFS) Medicare beneficiaries. ¶¶28, *Stein* Complaint (*Stein* Dkt. #1).

B. THE KAISER DEFENDANTS' FRAUDULENT SCHEMES ALLEGED IN THE *STEIN* ACTION.

The *Stein* action is based upon four factually separate risk adjustment fraud schemes in which the Kaiser Defendants utilized different schemes to submit false hierarchical chronic condition (HCC) diagnosis codes[1] to CMS, thus increasing the risk-adjusted capitated payments paid by the Government.[2]

1. Sepsis Fraud.

Most patients diagnosed with sepsis are treated in the hospital's intensive care facility (ICU). The average length of stay for patients with sepsis is 9 days and those with sepsis as a secondary diagnosis 15 days. ¶38, *Stein* Complaint (*Stein* Dkt. #1); ¶39, *Stein* SAC (*Osinek* Dkt. #116).

The Kaiser Defendants' coders (Kaiser's coders) prepared, and caused to be submitted to CMS, Sepsis diagnoses whenever the emergency room physician noted sepsis or sepsis with acute organ failure in the medical record, regardless of whether sufficient clinical findings were documented in the medical record to support such Sepsis diagnosis or there were other documented clinical findings that would likely rule out a Sepsis diagnosis. Further, the Kaiser Defendants intentionally prohibited Kaiser's coders from querying the emergency room

[1]HCC diagnosis codes serve to increase capitated payments paid by CMS.

[2]In the Ninth Circuit, application of the first-to-file bar looks to the allegations of the pending *Stein* amended complaint. *United States ex rel. Hartpence v. Kinetic Concepts, Inc.,* 792 F.3d 1121, 1125, fn. 2 (9th Cir. 2015). Although the original *Stein* Complaint alleges three (3) risk adjustment fraud schemes (Sepsis, Malnutrition, and Refresh frauds), ¶¶ 50-103, *Stein* Complaint (*Stein* Dkt. #1), the *Stein* First Amended Complaint (*Stein* FAC) added a fourth risk adjustment fraud scheme (Aortic Atherosclerosis fraud), ¶¶51-114, *Stein* FAC (*Stein* Dkt. #27). The pending *Stein* Second Amended Complaint (SAC) includes these four (4) risk adjustment fraud schemes, and limited the Sepsis scheme's scope of claims. ¶¶51-116, *Stein* SAC (*Osinek* Dkt. #116). As discussed in Section III(A) below, Relators contend that a first-to-file analysis looks at Relators' pending amended complaint.

physicians in order to clarify the clinical findings documented so that the medical record supports, or ruled out, the Sepsis diagnoses as required by the ICD-9 and AHIMA Guidelines. ¶¶50-54, *Stein* Complaint (*Stein* Dkt. #1); ¶¶51-57, 71, *Stein* SAC (*Osinek* Dkt. #116). The submitted Sepsis diagnoses that are fraudulent and the subject of the *Stein* action are those that Kaiser knew the patients were not septic because either (a) blood tests ruled out Sepsis, and/or (b) the patient was not admitted to the hospital. ¶¶50-69, *Stein* Complaint (*Stein* Dkt. #1); ¶¶51-72, *Stein* SAC (*Osinek* Dkt. #116).

2. Malnutrition Fraud.

Kaiser's malnutrition fraud scheme occurred from at least 2006 until mid-2014, and is the result of KFH's dieticians improperly making malnutrition diagnoses instead of the MA enrollee's KP physician. Upon admission to a KFH hospital, MA enrollees received, among other things, an assessment from a dietician. If in the KFH dietician's opinion, the MA enrollee was suffering from malnutrition, the dietician stamped the word "malnutrition" in the MA enrollee's medical record for the KP physician to countersign. The KP physician would countersign the dietician's stamp and Kaiser's coders then coded malnutrition diagnosis as indicated by the dietician's stamp. ¶¶70-73, *Stein* Complaint (*Stein* Dkt. #1); ¶¶73-76, *Stein* SAC (*Osinek* Dkt. #116).

Kaiser's procedure for diagnosing and documenting malnutrition is fraudulent for several reasons. First, dieticians are excluded from the list of acceptable types of medical providers that can make clinical diagnoses of MA enrollees. (Medicare Managed Care Manual Ch. 7 §120.1.1, Table 19.) ¶72, *Stein* Complaint (*Stein* Dkt. #1); ¶75, *Stein* SAC (*Osinek* Dkt. #116). Therefore, the KP physician noting concurrence with the KFH dietician's assessment of malnutrition, by countersigning the dietician's stamp, is not a valid physician diagnosis recorded in the medical record. Rather, the KP physician must personally make a diagnosis of malnutrition in the medical record and must document supporting clinical findings, or identify properly documented clinical findings, in the medical record. ¶¶71-73, *Stein* Complaint (*Stein* Dkt. #1); ¶¶74-76, *Stein* SAC (*Osinek* Dkt. #116).

Pursuant to the ICD-9 Guidelines and CMS regulations, KP physicians have to record

the malnutrition diagnosis in the medical record and document, or identify the clinical findings that support the diagnosis, in the medical record so that Kaiser's coders can legitimately code the malnutrition diagnosis as risk adjustment data (RAD) for submission to CMS. ¶¶74-75, *Stein* Complaint (*Stein* Dkt. #1); ¶¶77-78, *Stein* SAC (*Osinek* Dkt. #116). Since dieticians are prohibited from making clinical diagnoses for MA enrollees, countersigning the KFH's dietician's stamp cannot satisfy the physician's diagnostic and documentation requirements. Likewise, KP physicians cannot simply rely on the malnutrition assessment performed by the KFH dieticians for making a malnutrition diagnosis because the KFH dietician's assessment cannot be used as RAD. ¶¶71-72, *Stein* Complaint (*Stein* Dkt. #1); ¶¶74-75, *Stein* SAC (*Osinek* Dkt. #116).

On December 13, 2013, KFH disseminated instructions prohibiting the continued practice of allowing physicians to countersign a dietician's stamp as a method of diagnosing and documenting malnutrition. The instruction states, among other things, "It is not appropriate to have physicians counter-sign the dieticians stamp as a means of establishing the diagnosis by the physician." (Citing, CMS 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Resource Guide.) KHF and KFHP's new policy required the treating physician to document the appropriate clinical findings in the MA enrollees' medical records to support malnutrition diagnoses. ¶¶76-74, *Stein* Complaint (*Stein* Dkt. #1), ¶¶79-80, *Stein* SAC (*Osinek* Dkt. #116).

Accordingly, such malnutrition HCC diagnoses using the dieticians' stamp submitted to CMS resulted in excessive capitated payments paid by CMS. ¶¶77-78, *Stein* Complaint (*Stein* Dkt. #1); ¶¶80-82, *Stein* SAC (*Osinek* Dkt. #116).

3. Aortic Atherosclerosis Fraud.

During and between 2007 until about April 4, 2016, KFH and the Kaiser Health Plans instructed their hospital coders to code the ICD-9 and later ICD-10 diagnosis code associated with Aortic Atherosclerosis (AA) any time the physician noted the presence of AA or listed AA in the patient's medical record. This instruction was applied to MA and FFS Medicare patients admitted to Kaiser inpatient facilities in, among other states, California. Pursuant to

these instructions, Kaiser's coders coded KFH's MA and FFS Medicare patients with an AA diagnosis based simply upon the physician's notation of AA in the medical record, without the medical record reflecting that the patient was treated for his/her AA condition. ¶¶84-85, *Stein* FAC (*Stein* Dkt. #27); ¶¶85-86, *Stein* SAC (*Osinek* Dkt. #116). Such coding and documentation of AA was not in compliance with the ICD-9 and the later ICD-10 Coding and Documentation Guidelines, which require the patient to have received treatment for a chronic condition, such as AA, in order to validly code the ICD-9 or ICD-10 diagnosis code for such chronic condition, and prohibits coding based upon an abnormal test result, such as from an x-ray. ¶¶85-87, 89, *Stein* FAC (*Stein* Dkt. #27); ¶¶86-88, 90, *Stein* SAC (*Osinek* Dkt. #116). The bare notation of AA in the medical record or noting the presence of AA without documentation of the medical services provided to treat the AA condition or notations explaining the clinical significance of the AA diagnosis is insufficient documentation to support the submission of an AA diagnosis code to CMS. ¶¶85, 89, *Stein* FAC (*Stein* Dkt. #27); ¶¶86, 90, *Stein* SAC (*Osinek* Dkt. #116). Such AA diagnoses submitted to CMS resulted in excessive capitated payments paid by CMS. ¶¶85, 89-90, 155, *Stein* FAC (*Stein* Dkt. #27); ¶¶86, 90-91, 158, *Stein* SAC (*Osinek* Dkt. #116). Kaiser knew that its AA coding for hospital in-patients was incorrect and in 2016 issued instructions to KFH hospitals to code AA in compliance with ICD-9 and ICD-10 coding guidelines, meaning that KFH hospitals' AA in-patients would no longer be automatically coded based upon the findings noted on the radiological reports, but required clinical documentation regarding the treatment of AA in the enrollee's hospital record by a treating physician. ¶¶86-89, Stein FAC (*Stein* Dkt.#27), ¶¶87-89, *Stein* SAC (*Osinek* Dkt. #116). The Kaiser Health Plans made no attempt to determine the amount of the overpayments it received from CMS resulting from the submission of falsely diagnosed and improperly documented AA diagnoses and failed to notify CMS of the receipt of overpayments nor attempt to refund the same as required by 42 C.F.R §422.326. ¶90, *Stein* FAC (*Stein* Dkt.#27); ¶91, *Stein* SAC (*Osenik* Dkt. #116).

4. Refresh Fraud.

Kaiser's coders reviewed the last closed payment year's medical records to confirm the

existence of the past hit-list HCC diagnoses in each MA patient's prior year's portion of the medical record that were missing from their current year's diagnoses. Kaiser's coders then sent written leading queries to the MA enrollees' attending physicians with a list of the missing HCC diagnoses. The leading queries instructed the physicians to "refresh" (i.e., add) the missing HCC diagnoses to a particular MA enrollee's medical record. Kaiser's coders then met with the physicians to ensure that the hit-list HCC diagnoses were "refreshed." Most TPMG and SCPMG physicians readily complied with Kaiser's coders' requests and added the hit-list HCC diagnoses identified in the Kaiser's coders' leading queries without question. ¶¶ 83-84, *Stein* Complaint (*Stein* Dkt. #1); ¶¶94-95, *Stein* SAC (*Osinek* Dkt. #116).

All RAD that KP's MAOs submit to CMS must be the result of a face-to-face physician encounter and must be supported by a medical record documented in accordance with ICD-9 Guidelines. ¶¶32, 85, *Stein* Complaint (*Stein* Dkt. #1); ¶¶32, 98, *Stein* SAC (*Osinek* Dkt. #116). The "refreshed" HCC diagnoses were invalid as RAD for submission to CMS because they were not the result of face-to-face encounters, as such diagnoses were made long after the patient's encounters with Kaiser physicians. ¶¶ 87-88, 91-92 *Stein* Complaint (*Stein* Dkt. #1); ¶¶100-101, 104-105, *Stein* SAC (*Osinek* Dkt. #116). Such "refreshed" diagnoses submitted to CMS resulted in excessive capitated payments paid by CMS. ¶¶83, 139-140, *Stein* Complaint (*Stein* Dkt. #1); ¶¶165, 170-171, *Stein* SAC (*Osinek* Dkt. #116).

C. THE PREVIOUSLY FILED ACTIONS.

The previously filed actions (*Osinek, Taylor,* and *Arefi*) allege risk adjustment fraud schemes factually different from those alleged in the *Stein* action.

1. The *Osinek* Complaint.

The *Osinek* Complaint alleges that Kaiser Permanente Health Plan increased its risk adjusted capitated payments by utilizing computer programs to identify HCC diagnoses that were missing from their MA patients' current year's diagnoses, and instructing Kaiser physicians to amend their patient files to reflect such identified HCC diagnoses long after the patient encounters. *Osinek* Complaint, ¶¶24-42 (Dkt. #1). The resulting HCC diagnoses

submitted to CMS were not the result of a face-to-face encounters in violation of Medicare rules and regulations. *Id.* at ¶18.

2. The *Taylor* Complaint.

The *Taylor* Complaint alleges that Kaiser (a) continued to submit HCC diagnoses to CMS (and failed to withdraw previously submitted HCC diagnosis codes from CMS) that Kaiser's internal audits found were not supported by properly documented medical records for the following diagnoses: cancer, arrhythmia, stroke, vascular disease, ulcers, vertebral fractures, chronic bronchitis, myocardial infarction, renal failure, depression and diabetes, *Taylor* Complaint, ¶¶69-82, 101-185 (*Taylor* Dkt. #1), (b) conducted probe audits and knowingly submitted false claims from external (i.e., non-Kaiser) providers, *Id.* at ¶¶83-100, (c) "refreshed" patients' HCC diagnoses by identifying patients' prior years' HCC diagnoses that were missing from their MA patients' current year's diagnoses, and instructed Kaiser physicians to amend their patient files to reflect such identified HCC diagnoses long after the patient encounters, despite knowing any such added diagnoses were incorrect, *Id.* at ¶¶186-190, (d) utilized a defective Natural Language Processing Audit Program to submit false HCC diagnosis codes, *Id.* at ¶¶191-201, and (e) (e) knowingly submitted false diagnoses for various cancers that were incorrectly coded as active conditions instead of a "history of" diagnoses, *Taylor* Complaint, ¶79 (*Taylor* Dkt. #1); ¶¶99-100, *Taylor* FAC (*Taylor* Dkt. #4).

3. The *Arefi* Complaint.

The *Arefi* Complaint alleges that Kaiser (a) used its Convergent Medical Terminology to manipulate Kaiser physicians into upcoding the severity of patients' illnesses, *Arefi* Complaint, ¶¶43-44 (*Arefi* Dkt. #1), (b) used its coding department to "data mine" patients' prior years' HCC diagnoses that were missing from their MA patients' current year's diagnoses, and instructing Kaiser physicians to amend their patient files to reflect such identified HCC diagnoses long after the patient encounters, *Id.* at ¶45, (c) data mined electronic medical records to have Kaiser's coders identify and submit queries to physicians to add HCC diagnoses based on the patient's prior years' diagnoses or medication, or diagnostic test results, *Id.* at ¶46, (d) had its coding department send leading and coercive

leading queries to physicians to change their medical record entries, *Id.* at ¶47, (e) encouraged its physicians to have patients get annual check-ups to obtain additional HCC diagnoses, *Id.* at ¶48, and (d) entered into contracts with the Los Angeles Fire Department to transport Kaiser enrollees to the nearest Kaiser hospital, and pressured non-Kaiser hospitals to prematurely send Kaiser enrollees to a Kaiser hospital. *Id.* at ¶78. Arefi alleges that these fraudulent practices significantly increased Kaiser's risk-adjusted capitated payments from CMS. *Id.* at ¶¶79-87.

III. LEGAL ARGUMENT.

A. THE FIRST-TO-FILE BAR IS NOT JURISDICTIONAL, AND SHOULD BE RULED UPON USING A RULE 12(b)(6) STANDARD.

In *Gonzalez v. Thaler*, 565 U.S. 134, 132 S.Ct. 641, 181 L.Ed.2d 619 (2012), the Supreme Court declared, "A rule is jurisdictional '[i]f the Legislature clearly states that a threshold limitation on a statute's scope shall count as jurisdictional.'" *Id.* at 141. Relators are cognizant that in *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 112, 1123, fn.1 (9th Cir 2015), the Ninth Circuit stated, "We treat the first-to-file bar as jurisdictional." *Id.* at 1130. However, *Hartpence* simply cites *United States ex rel. Lujan v. Hughes Aircraft Co.,* 143 F.3d 1181, 1186-1187 (9th Cir. 2001) as its authority, and *Lujan's* determination that the first-to-file bar is jurisdictional does not address *Thaler's* requirement that a rule, such as the first-to-file rule, is jurisdictional "if the Legislature clearly states that a threshold limitation on a statute's scope shall count as jurisdictional." *Lujan,* 143 F.3d 1186-87. *See, United States ex rel. Savage v. CH2M Hill Plateau Remediation Co*., 2015 WL 5794357 at *5 (E.D.Wash. Oct. 1, 2015).

Because the first-to-file rule, 31 U.S.C. § 3730(b)(5), does not in anyway speak in terms of jurisdiction nor does any part of the statute in its current form, Relators urge the Court to hold that first-to-file rule is not jurisdictional. *Thaler*, 565 U.S. at 141; *Savage,* 2015 WL 5794357 at *4-5 (citing cases applying the jurisdictional test). As a result, the first-to-file issue should be analyzed under Rule 12(b)(6) for failure to state of claim rather than Rule

12(b)(1) for lack of standing. *Savage,* 2015 WL 5794357 at *4 (citing *Maya v. Centex Corp.,* 658 F.3d 1060, 1067 (9th Cir.2011) [recognizing that the lack of Article III standing requires dismissal for lack of subject matter jurisdiction under Rule 12(b)(1) while the lack of statutory standing requires dismissal for failure to state a claim under Rule 12(b)(6)]. Most courts that have examined this issue agree. *See*, *United States v. Kiewit Pac. Co.*, 2013 WL 5770514 at *5 (N.D.Cal. Oct. 24, 2013) (collecting cases discussing the Court's jurisdiction following the 2010 amendment to 31 U.S.C. § 3730(e)(4)(A).)

The Supreme Court held,

> "For purposes of ruling on a motion to dismiss for want of standing, both the trial and reviewing courts must accept as true all material allegations of the complaint, and must construe the complaint in favor of the complaining party. At the same time, it is within the trial court's power to allow or to require the plaintiff to supply, by amendment to the complaint or by affidavits, further particularized allegations of fact deemed supportive of plaintiff's standing. If, after this opportunity, the plaintiff's standing does not adequately appear from all materials of record, the complaint must be dismissed." *Warth v. Seldin,* 422 U.S. 490, 501–02, 95 S.Ct. 2197, 2206–07, 45 L.Ed. 2d 343 (1975) (internal citations omitted.)

Hartpence held that the pending amended complaint should be used in a first-to-file analysis, which is consistent with the foregoing. *Hartpence*, 792 F.3d at 1125, fn. 2.

Accordingly, Relators contend that the instant motion to dismiss should be governed by Rule 12(b)(6), under which, among other things, "the court must construe the complaint in the light most favorable to the plaintiff, taking all her allegations as true and drawing all reasonable inferences from the complaint in her favor, *Doe v. United States*, 419 F.3d 1058, 1062 (9th Cir. 2005) (internal citation omitted).

B. THE FIRST-TO-FILE BAR DOES NOT BAR FACTUALLY DIFFERENT RISK ADJUSTMENT FRAUD SCHEMES.

The Kaiser Defendants seeks to eliminate all post-*Osenik* complaints because they allege that defendants upcoded diagnosis codes for their MA members and such improper practices caused CMS to pay excessive capitated payments to defendants. Moving Papers at

2:17-20. Yet, Ninth Circuit decisions reflect that different types of factually different risk adjustment fraud schemes involve submitting false diagnosis codes to CMS or failing to withdraw from CMS diagnosis codes known to be false, such as (a) conducting retrospective medical chart reviews that are designed to only identify and report to CMS new diagnosis codes, but not previously reported diagnosis codes that were unsupported by the chart reviews, *United States, ex rel. Swoben v. United Healthcare Ins. Co.,* 848 F.3d 1161, 1175 (9th Cir. 2016), (b) submitting diagnosis codes based on inappropriate and unsecured electronic medical records that were improperly modified by coders, *United States, ex rel. Silingo v. Wellpoint, Inc.,* 904 F.3d 667, 674 (9th Cir. 2018), (c) submitting diagnosis code based on nurse practitioners and physician assistants that were not legally authorized to make such diagnoses, *Id.* at 674, (d) submitting diagnosis codes based on fabricated complex diagnoses that the medical examiners could not have possibly confirmed during an in-home assessment, *Id.* at 674-5, (e) submitting diagnosis codes based upon prior year's diagnoses and medical histories, *Id.* at 675, (f) submitting diagnoses that were not the result of face-to-face medical encounters, *Id.* at 675, and (g) and (g) claims that relate to violations of different Medicare program requirements *Hartpence*, 792 F.3d at 1130.

Relators allege three (3) fraud schemes that are factually different from those alleged in the prior *Osinek, Taylor,* and *Arefi* complaints. A qui tam complaint based on different facts that a prior qui tam complaint is not barred by the first-to-file rule. *Hartpence,* 792 F.3d at 1131 [Although both qui tam complaints were against the same defendants, arose out of the same time period, involved defendants' billing practices for the same therapy device, alleged incorrect use of the same KX billing code, and shared nearly 100 identical paragraphs, the two complaints were factually different because the first filed complaint alleged defendants knowingly misused the KX modifier billing code for devices that were used but unnecessary for treatment, whereas the second complaint alleged that the defendants knowingly misused the KX modifier billing code for devices that were not used at all.].

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C. THE *OSINEK* COMPLAINT DOES NOT BAR THE *STEIN* ACTION'S SEPSIS, MALNUTRITION, AND AORTIC ATHEROSCLEROSIS FRAUD CLAIMS.

The *Osinek* Complaint, which is based on defendants' "refresh" scheme, is factually unrelated to, the *Stein* action's Sepsis, Malnutrition, and AA claims. The Sepsis, Malnutrition, and AA claims do not involve Kaiser's use of patients' prior year's diagnoses to append their medical charts without a face-to-face medical encounter.

D. THE *TAYLOR* COMPLAINT DOES NOT BAR THE *STEIN* ACTION'S SEPSIS, MALNUTRITION, AND AORTIC ATHEROSCLEROSIS FRAUD CLAIMS.

The *Taylor* Complaint does not bar the Relators' Sepsis, Malnutrition, and AA fraud claims because they are factually different from Taylor's alleged frauds that Kaiser (a) continued to submit HCC diagnoses to CMS (and failed to withdraw previously submitted HCC diagnosis codes from CMS) that Kaiser's internal audits found were not supported by properly documented medical records for cancer, arrhythmia, stroke, vascular disease, ulcers, vertebral fractures, chronic bronchitis, myocardial infarction, renal failure, depression and diabetes, *Taylor* Complaint, ¶¶69-82, 101-185 (*Taylor* Dkt. #1), (b) submitted false claims from external (i.e., non-Kaiser) providers, *Id.* at ¶¶83-100, (c) "refreshed" patients' HCC diagnoses by identifying patients' prior years' HCC diagnoses that were missing from their MA patients' current year's diagnoses, and instructing Kaiser physicians to amend their patient files to reflect such identified HCC diagnoses long after the patient encounters, *Id.* at ¶¶186-190, or (d) utilized a defective Natural Language Processing Audit Program to submit false HCC diagnosis codes, *Id.* at ¶¶191-201.

In contrast, Relators' Sepsis, Malnutrition, and AA fraud claims all involve Southern California Permanent Medical Group's ("SCPMG") and other Permanente medical groups' MA enrollees and Medicare patients that were admitted to a KFH hospital or in the case of Sepsis, treated as a hospital outpatient through the emergency room. The false and improper

coding occurred contemporaneously with the MA enrollees' and Medicare patients' hospital encounter and were carried out by KFH coders. The frauds do not directly involve Kaiser Health Plan personnel nor rely on data mining, HCC refreshing, probe audits, leading queries, physician manipulation via NLP or CMT mis-mapping, nor other tactics that required medical records to be improperly subsequently amended.

E. THE *AREFI* COMPLAINT DOES NOT BAR THE *STEIN* ACTION'S SEPSIS, MALNUTRITION, AND AORTIC ATHEROSCLEROSIS FRAUD CLAIMS.

The *Arefi* Complaint does not bar the Sepsis, Malnutrition, and AA claims because they are factually different from Arefi's fraud claims. Arefi alleges that Kaiser (a) used its Convergent Medical Terminology to manipulate Kaiser physicians into upcoding the severity of patients' illnesses, *Arefi* Complaint, ¶¶43-44 (*Arefi* Dkt. #1), (b) used its coding department to "data mine" patients' prior years' HCC diagnoses that were missing from their MA patients' current year's diagnoses, and instructing Kaiser physicians to amend their patient files to reflect such identified HCC diagnoses long after the patient encounters, *Id.* at ¶45, (c) data mined electronic medical records to have Kaiser's coders identify and submit queries to physicians to add HCC diagnoses based on the patient's prior years' diagnoses or medication, or diagnostic test results, *Id.* at ¶46, (d) had its coding department send leading and coercive leading queries to physicians to change their medical record entries, *Id.* at ¶47, (e) encouraged its physicians to have patients get annual check-ups to obtain additional HCC diagnoses, *Id.* at ¶48, and (d) entered into contracts with the Los Angeles Fire Department to transport Kaiser enrollees to the nearest Kaiser hospital, and pressured non-Kaiser hospitals to prematurely send Kaiser enrollees to a Kaiser hospital. *Id.* at ¶78.

In contrast, Relators' Sepsis, Malnutrition, and AA fraud claims all involve Southern California Permanent Medical Group's ("SCPMG") and other Permanente medical groups' MA enrollees and Medicare patients that were admitted to a KFH hospital or in the case of Sepsis, treated as a hospital outpatient through the emergency room. The false and improper

coding occurred contemporaneously with the MA enrollees' and Medicare patients' hospital encounters and were carried out by KFH coders. The frauds do not directly involve Kaiser Health Plan personnel nor rely on data mining, HCC refreshing, probe audits, leading queries, physician manipulation via NLP or CMT mis-mapping , nor other tactics that required medical records to be improperly subsequently amended.

F. IN THE ALTERNATIVE, RELATORS SHOULD BE GRANTED LEAVE TO AMEND THEIR COMPLAINT.

Leave to amend a complaint "shall be freely given when justice so requires." Fed.R.Civ.P. 15(a). "The standard for granting leave to amend is generous." *Balistreri v. Pacifica Police Dept*., 901 F.2d 696, 701 (9th Cir. 1990). "The court considers five factors in assessing the propriety of leave to amend—bad faith, undue delay, prejudice to the opposing party, futility of amendment, and whether the plaintiff has previously amended the complaint." *United States v. Corinthian Colleges,* 655 F.3d 984, 995 (9th Cir. 2011).

Here, there is no evidence of bad faith, undue delay, prejudice to the opposing parties, nor futility of amendment. Although Relators filed their first and second amended complaints, they were filed to clarify or add allegations. Those amended complaints were NOT filed in response to pleading motions. Leave to amend should be denied only if the Court determines that "allegation(s) of other facts consistent with the challenged pleading could not possibly cure the deficiency." *Schreiber Distributing Co. v. Serv-Well Furniture Co.*, 806 F.2d 1393, 1401 (9th Cir. 1986). In the event the Court grants any portion of the motion to dismiss the Sepsis, Malnutrition or AA claims, Relators request leave to file a further amended complaint to correct any deficiency in the pending SAC.

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/ / /

IV. CONCLUSION.

Relators' Sepsis, Malnutrition, and Aortic Atherosclerosis fraud claims are factually different from the fraud claims made in the previously filed *Osinek, Taylor,* and *Arefi* complaints, and Defendants' first-to-file attack against these claims should be denied. Alternatively, Relators should be granted leave to amend.

Respectfully submitted,

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Dated: February 15, 2022

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, FOUNDATION HEALTH PLAN, INC., and THE PERMANENTE MEDICAL GROUP, INC., Defendants.	Consolidated Case No. 3:13-cv-03891 -EMC RELATOR TAYLOR'S OPPOSITION TO DEFENDANTS' MOTION TO DISMISS AND REQUEST FOR JUDICIAL NOTICE Noticed Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor
UNITED STATES OF AMERICA, *ex rel.* JAMES M. TAYLOR, M.D., Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HEALTH PLAN OF COLORADO, COLORADO PERMANENTE MEDICAL GROUP, P.C., THE PERMANENTE MEDICAL GROUP, INC., and SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, Defendants.	(Original N.D. Cal. Case No. 3:21-cv-03894-EMC) RELATOR TAYLOR'S OPPOSITION TO DEFENDANTS' MOTION TO DISMISS AND REQUEST FOR JUDICIAL NOTICE Noticed Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

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Kaiser faces a host of allegations of rampant fraud on the Medicare Advantage ("MA") program, through which the United States provides health insurance coverage to 28 million American seniors. In 2013, Ronda Osinek filed a complaint under the False Claims Act ("FCA") primarily alleging that Kaiser in California improperly and fraudulently used the retrospective amendment of medical records (called "addenda") to increase its payments from Medicare by claiming diagnosis codes that were never evaluated or considered at the time of the medical encounter.

In 2014, Dr. James Taylor, a Kaiser physician and Medical Director of Revenue Cycle in Colorado, filed a complaint that alerted the United States to that fraud's existence in Colorado and nationally, as well as at least three additional types of fraud not pleaded in Osinek's complaint. Taylor alleged, among other things, that Kaiser (1) engaged in a fraudulent one-way-look chart review program in Colorado, in which it willfully ignored false codes while mining medical records for additional revenue; (2) refused in Colorado and nationally to investigate or delete diagnosis codes it knew to have consistent, high rates of falsity; and (3) knowingly relied on natural language processing software that by design did not assess the validity of previously submitted diagnosis codes and caused the submission of false diagnosis codes. Over the next several years, multiple other whistleblowers brought other claims against Kaiser. The United States partially intervened in each of these six complaints.

In an attempt to dodge the majority of the claims they face, Defendants would have the Court craft a new first-to-file rule, contrary to the statute and Ninth Circuit precedent. This wide-sweeping rule would bar any False Claims Act action by a relator once any other whistleblower has made allegations regarding any aspect of Kaiser's Medicare Advantage business anywhere in the country. And that is a broad sweep indeed: as of January 2022, the various affiliated entities

that the layperson knows as Kaiser are the fifth largest insurer in the MA program, spanning seven insurance plans, based in seven different states across the country, and covering nearly 1.8 million beneficiaries.[1]

But the statutory bar is nowhere near so broad. It rightly prohibits repetitious complaints that plead the same material facts, while welcoming those that bring new information and frauds to light. Complaints like Dr. Taylor's, which plead distinct fraudulent schemes in different regions involving different affiliated entities under different contracts, are exactly those that the rule is designed to permit. They fit the rule's purpose of incentivizing relators to come forward with information about fraud on the government.

Defendants seek shelter under a rule designed to prevent parasitic lawsuits, but Taylor's complaint brought forward new regions and new fraud claims. Taylor's claims are only similar to Osinek's when Defendants generalize the allegations, describing the complaints at the most superficial level, as if all they alleged was a summary: that the various Defendants "upcoded diagnosis codes for Medicare Advantage members." Def. Mot. to Dismiss, ECF No. 141 (January 18, 2022) at 2.

But that conflates multiple distinct fraud schemes by describing those separate schemes in the most general terms, which simply reference the method of billing the program that Kaiser is allegedly defrauding. The core determinant of payment under the MA program is the health status of beneficiaries. A Medicare Advantage Organization ("MAO") that reports insuring sicker beneficiaries will receive higher payments from the Centers for Medicare and Medicaid

[1] In addition to Kaiser's insurance business, the conglomerate also operates a large number of medical providers, across multiple states, employing over 20,000 doctors and over 300,000 total employees.

Services ("CMS") than one reporting healthier beneficiaries. The beneficiaries' health status is determined by diagnosis codes that MAOs submit to CMS. These codes are subject to certain conditions and must be accurate, and their submission is the only means of securing increased payments from CMS.

In other words, due to the structure of the program, fraudulent diagnosis codes are the *only* means of overbilling the government. Nearly any case against Kaiser's MA program would fall within this description. Defendants' position, simply put, is that any allegation of a company defrauding the MA program blocks *all* other allegations of that or any related company defrauding the MA program.

Defendants' interpretation of the first-to-file bar is improperly broad. Under their interpretation of the bar, a hypothetical defense contractor would be able to block allegations of billing for work it never performed if an affiliate of that same defense contractor was already accused of billing for installing substandard materials, merely because both sets of allegations could be described as submitting false invoices to the government. That is simply not the law.

Instead, the law instructs that the bar applies only when subsequent complaints allege the same material elements of fraud. Here, Taylor's complaint alleges different fraud schemes, different geography, different contracts at issue, and different Defendants. Thus, Taylor's claims are distinct from Osinek's and are permissible under 31 U.S.C. § 3730(b)(5) and Ninth Circuit caselaw. Both the facts and the law support this conclusion.

FACTUAL BACKGROUND

I. The Medicare Advantage Program

Through the MA program, CMS allows private health insurers to set up managed care plans to cover Medicare beneficiaries. All told, CMS currently has over 900 contracts with different insurers.

CMS pays a monthly capitation rate for each beneficiary enrolled as a member of an MA plan, known as a "per-member, per-month" payment. This predetermined base payment varies for each MA Plan depending on various factors, primarily demographics (age and sex) and health status.

Individuals with multiple and/or serious health conditions account for more health care costs than healthier members. Accordingly, CMS pays a substantially higher capitation rate for members who have been recently treated for one or more serious, expensive diseases or conditions. *See* 42 U.S.C. § 1395w-23(a)(1)(C). These increased payments are known as "risk adjustment" payments. The only variable that determines a beneficiary's health status is the diagnosis codes an MAO submitted on that beneficiary's behalf. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2).

Because diagnosis coding is inherently linked to payment, MAOs are bound by regulation, contract, and CMS guidance to follow certain rules that dictate the conditions under which they may submit codes for risk adjustment purposes. These rules include requirements that the diagnosis code must be supported by the beneficiary's underlying medical record, must come from an acceptable provider type, must come from a face-to-face medical encounter,[2] and must

[2] Prior to March 2020 and the onset of the pandemic caused by the SARS-CoV-2 virus.

come from a visit in the relevant timeframe determining that payment, among other requirements.

A violation of any of these requirements can render a code false. The code might have been derived from a visit with an unacceptable provider type, been from the wrong year, or simply been fabricated—or, as the government's various FCA litigations show, many, many other alleged fraud schemes. Here, Kaiser is accused, by the United States, Relator Osinek, Relator Taylor, and others, of multiple types of fraudulent schemes to draw higher payments from CMS, each of which violates the FCA.

All of these varied schemes can be characterized as "upcoding." In the MA context, the term "upcoding" is akin to an allegation of "overbilling" in an FCA case involving a contract dispute. It simply means claiming more payment than is permissible.

II. Relator Osinek's Complaint

In 2013, Relator Osinek filed her original complaint against Kaiser Permanente ("KP"), which she identified as a California corporation that operated health plans and provided insurance coverage under the MA program to "the general public in California."[3] Osinek Compl. ¶ 6.

Osinek primarily alleged that KP exaggerated the disease state of its beneficiaries to garner higher payments from CMS by retrospectively amending medical records to provide support for diagnosis codes that were never evaluated or considered at the time of the medical encounter, a process Osinek refers to as "addenda." *Id.* at ¶¶ 28-32. Osinek provides a great

[3] Osinek has since amended her complaint to name Kaiser Permanente, Kaiser Foundation Health Plan, INC., and The Permanente Medical Group, INC. as Defendants.

amount of detail about the addenda process, describing KP's reaction to physicians refusing to agree to the amendment of medical records (¶¶ 33-34) and KP's practice of hosting "coding parties" at which physicians were gathered in a single room and asked to review, and approve, hundreds of addenda records (¶ 35).

Osinek also alleged that KP used data analytics to target certain conditions that it intended to exaggerate the severity of, such as coding various less serious kidney conditions as severe chronic kidney disease (*Id.* at ¶¶ 25-27), and that it was encouraging, monitoring, and paying physicians to recode certain chronic conditions year after year, which KP called "refresh" (¶¶ 36-40).

Nowhere in her complaint does Osinek mention Kaiser regions or contracts outside of California, nor does she mention any schemes outside of those involving addenda, the exaggeration of certain disease states, such as the severity of various kidney conditions, or the encouraging and incentivizing of physicians to refresh chronic conditions.

III. Relator Taylor's Complaint

Dr. James Taylor, a physician who had worked at Kaiser since 1995, filed his FCA complaint in 2014.[4] In addition to practicing medicine, Taylor also worked in a variety of Kaiser's business functions, including serving as the Medical Director of Revenue Cycle and as the Physician Director of Coding for the region. Taylor named Kaiser Permanente, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, Kaiser Foundation

[4] Dr. Taylor's original complaint was filed on October 22, 2014. He amended November 3, 2014, before any of the other Relators filed their initial complaints. Cites to the complaint below are to the First Amended Complaint, which is operative for purposes of comparison to later filed relators. Dr. Taylor filed a Second Amended Complaint on November 15, 2021. The Second Amended Complaint is now Dr. Taylor's operative complaint.

Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest as Defendants to his original complaint.[5]

In addition to pleading fraud in these additional regions, with separate contracts, Taylor alleged that the Kaiser entities exaggerated the disease state of their beneficiaries to garner higher payments from CMS by:

1. Conducting a one-way-look chart review program. Under this program, Kaiser Colorado reviewed all hospital records of its beneficiaries discharged from a certain chain of hospitals, then called Exempla. Kaiser Colorado did this to search for additional diagnosis codes to submit to CMS. However, despite knowledge that the original, hospital-submitted diagnosis codes were riddled with errors, Kaiser did not investigate or delete previously submitted codes that were hospital-generated and not substantiated by the Kaiser review, even though it had all the necessary information at its fingertips. Kaiser sought and retained payment for the additional codes that its reviews found and *all* hospital-submitted codes, including those the review revealed were false. Taylor FAC ¶¶ 78-91.
2. Refusing to investigate or delete diagnosis codes representing a number of conditions that Kaiser knew its providers coded with consistently high rates of falsity. These included cancer (¶¶ 95-109, ¶¶ 128-29), stroke (¶¶ 110-17), vertebral fracture (¶ 118), vascular disease (¶¶ 119-23), chronic bronchitis (¶¶ 124-27), history of heart attack

[5] Dr. Taylor's Second Amended Complaint names Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; Colorado Permanente Medical Group, P.C.; The Permanente Medical Group, INC.; and Southern California Permanente Medical Group as Defendants.

(¶¶ 130-31), malnutrition (¶¶ 132-34), ulcers (¶¶ 135-37), sick sinus syndrome (¶¶ 138-43), and renal insufficiency (¶¶ 144-46). Dr. Taylor alleges that the diagnosis codes were false for a variety of reasons, including but not limited to coding resolved cancer as active (¶ 98), coding history of stroke as acute stroke (¶ 111), coding a history of heart attacks from test results and not from face-to-face encounters (¶ 131), and coding an arrythmia condition once it has been resolved by a pacemaker (¶ 140). Taylor's complaint also describes several remedial steps that he suggested to improve the accuracy of the diagnosis codes Kaiser submitted to CMS, including a filter to pause the submission of certain high-risk codes for an additional level of review (¶¶ 92, 155-61), a software feature, referenced in the complaint as a pop-up, that queried, in real time, whether a physician was sure about the current state of a disease (¶¶ 103-04), and the hiring of an external consultant to review charts for accuracy for certain hospital-generated diagnosis codes (¶ 109).

3. Using a natural language processing ("NLP") software that failed to determine the validity of previously submitted diagnosis codes and also caused the submission of false diagnosis codes that did not follow CMS rules. This resulted in the submission of false codes due to the software design and implementation limitations, a fact Kaiser was acutely aware of. *Id.* at ¶¶ 184-94.

On July 29, 2021, the United States filed its Notice of Election to Intervene in Taylor's claims alleging that Kaiser "submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda . . . ." United States' Notice of Election to Intervene in Part and to Decline to Intervene in Part at 1, ECF No. 65 (July 29, 2021).

It declined to intervene in the remainder of Taylor's claims, including those just enumerated, on which Taylor is proceeding alone. *Id.*

ARGUMENT

Taylor and Osinek bring different claims, about different schemes, regarding different regions of the country, pursuant to different contracts between CMS and Kaiser entities. Under Ninth Circuit precedent and the proper reading of the first-to-file rule, Osinek's complaint does not bar Taylor's claims. Taylor is first-filed as to the intervened and non-intervened claims set out in his complaint, and his and Osinek's claims should both proceed.[6]

Although both complaints allege Kaiser defrauded CMS through the MA program, that is a generality so broad as to be meaningless for the first-to-file analysis.[7] Defendants' broad interpretation of the first-to-file bar would prevent *any* later claim against any Defendant or its affiliates. Such a reading is contrary to the statute and caselaw—and nonsensical. Osinek's complaint would not have put the government on the trail of the frauds alleged in Taylor's complaint, unless one imagines that the government should review *all* types of behavior at any defendant or its affiliate under *all* contracts, as soon as any of them is sued under the FCA. No entity doing business with the government would want that, including Defendants, who would undoubtedly resist any effort by the government to investigate every aspect of their coding

[6] Taylor's complaint thus necessarily blocks any subsequent relators who brought claims with the same material elements of fraud as those for which Taylor is first-filed. The motion before the Court, however, raises only the first-to-file implications of Osinek's complaint.

[7] Whether the broad commonalities supported consolidation of the cases is a different question.

practices at any affiliate. Defendants' overly broad reading of the statute would serve no purpose other than insulating them from legitimate claims of fraud.

I. The First-to-File Bar Only Blocks Cases Alleging the Same Material Elements of Fraud

The first-to-file bar is rooted in statutory language that dictates that "[w]hen a person brings a [qui tam action], no person . . . may . . . bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). The bar has dual purposes: to "promote incentives for whistle-blowing insiders" by encouraging prompt filing and to "prevent opportunistic successive plaintiffs" by barring their complaints. *United States ex rel. Hartpence v. Kinetic Concepts, Inc*., 792 F.3d 1121, 1130 (9th Cir. 2015) (citation omitted). Critically, the bar allows for "related but distinct fraud claims" to proceed, because that "encourages broader investigation and increases the total potential for recovery"—both for whistleblowers generally and for the government. *Id*. at 1131; *see also United States ex rel. Barrett v. Allergan, Inc.*, No. SACV 18-203 JVS, 2019 WL 4675756, at *4 (C.D. Cal. Sept. 24, 2019).

To determine whether an action is barred, the Ninth Circuit, like most Circuits to consider the issue,[8] considers whether the later-filed complaint pleads the same "material elements of

[8] Nearly all circuits use a similar approach, although sometimes by a different name. *United States v. Millenium Lab'ys, Inc.*, 923 F.3d 240, 253 n.16 (1st Cir. 2019) (noting that the First Circuit's same "essential facts" test was not meaningfully different from "material facts" test); *United States ex rel. Wood v. Allergan, Inc*., No. 10-CV-5645, 2017 WL 1843288 (S.D.N.Y. 2017) (finding cases related under essential facts test); *United States ex rel. LaCorte v. SmithKline Beecham Clinical Lab'ys, Inc.*, 149 F.3d 227, 232-33 (3d Cir. 1998) (applying the same test); *United States ex rel. Carter v. Halliburton Co*., 710 F.3d 171 (4th Cir. 2013) (joining sister circuits in adopting the "material elements test"); *Walburn v. Lockheed Martin Corp.*, 431 F.3d 966, 971 (6th Cir. 2005) (applying the same "essential facts" test); *United States ex rel. Chovanec v. Apria Healthcare Grp. Inc*., 606 F.3d 361, 363-64 (7th Cir. 2010) (applying the same material facts or essential facts tests means those on which the original relator is entitled to

fraud" as the earlier one. *United States ex rel. Lujan v. Hughes Aircraft Co*., 243 F.3d 1181, 1189 (9th Cir. 2001). As the Tenth Circuit, which uses the same approach, has explained, the analysis is "designed to be quickly and easily determinable, simply requiring a side-by-side comparison of the complaints." *In re Nat. Gas Royalties*, 566 F.3d at 964. No dive into evidence is required.

Here, such a comparison makes clear that Dr. Taylor's complaint is not barred. Osinek's complaint is primarily about the retrospective, fraudulent amendment of medical records in California. Dr. Taylor's, by contrast, pleads a different scope of fraud (Colorado and nationally, rather than only California), different types of fraud (fraudulent chart review, a known failure to delete codes, and fraudulent use of NLP software), and different material facts.

Precedent is clear, given the differences between these two cases, including the investigation and evidence required to prove them, that the first-to-file bar does not apply. Defendants know this, so they resort to a radically broad interpretation of the bar that would effectively prevent any subsequent claims against the same defendant or affiliates. Such a reading finds no support in the law.

In *Hartpence,* the Ninth Circuit permitted two cases brought against the same medical device producer that involved billing the Medicare program for the same device during the same time period. *Hartpence*, 792 F.3d at 1131. The first-filed action alleged billing for use of the device when it was medically unnecessary; the second, billing for the device when it was never used at all. The Ninth Circuit, reversing the district court's decision, determined that both cases

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compensation if the suit prevails); *In re Nat. Gas Royalties Qui Tam Litig. (CO2 Appeals)*, 566 F.3d 956 (10th Cir. 2009) (same).

should proceed. Comparing them side-by-side, it found that, despite the similarities, the alleged frauds "exist completely independent of one another." *Id.*

That difference sufficed to permit the claims in the later case even though, applying Defendants' logic here, both cases could be described as involving impermissible billing for the same medical device.[9] Fitting within the same category of fraud is not enough to trigger the bar; they must have the same material elements of fraud.[10] Indeed, as one District Court neatly summarized it, *Hartpence* found that the bar permitted the later case "even though the complaints named the same defendants, arose out of the same time period, involved the billing practice for the same therapy code, and were drafted by the same counsel . . . ." *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, No. 4:14-cv-5002-EFS, 2015 WL 5794357 (E.D. Wash. Oct. 1, 2015).

The *Hartpence* court also explained that permitting the latter case was consistent with both goals of the first-to-file bar. Allowing it increases incentives for relators because "allowing claims for related but distinct fraud claims encourages broader investigation and increases the total potential for recovery." 792 F.3d at 1131. At the same time, opportunistic plaintiffs would not be encouraged because the second-filed relator brought information about a "different form of fraud." *Id.* at 1131-32.

Likewise, in *Barrett*, the Central District compared cases that both alleged violations of the Anti-Kickback Statute by the same pharmaceutical company for providing physicians with

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[9] The second relator did not contest the district court's decision that her claim relating to medically unnecessary use was barred. *Id.* at 1130.

[10] Although Defendants make much of the Ninth Circuit's rejection of the "identical facts" test in *Hartpence*, Taylor's claims easily survive the "same material elements" test the Circuit adopted instead. *See Hartpence*, 792 F.3d at 1130; Mot. at 16.

free samples of Botox. *Barrett,* 2019 WL 4675756, at *3. The first-filed complaint alleged a kickback scheme, and the second-filed complaint alleged a similar kickback scheme and a price inflation scheme. Despite the similarities, the court allowed the second-filed complaint to proceed because the first-filed complaint's "allegations are significantly narrower than those made by [second-filed relator]." *Id.* at *4. They alleged both different schemes and different material facts, which the Court noted would result in different damages. *Id.* Thus, both could proceed.

As *Hartpence* and *Barrett* show, the specifics of the alleged frauds matter. Separate FCA complaints do not bar another under 31 U.S.C. § 3730(b)(5) simply because they involve the same defendant and the same government program. Defendants suggest that "all six complaints allege essentially the same wrongdoing: that Defendants knowingly upcoded diagnosis codes for Medicare Advantage members . . . ." Mot. at 2.[11] They might as well say that they are barred because they are False Claims Act cases against affiliated companies engaged in the same business. That is not sufficient to trigger the first-to-file bar, which requires a look at the four-corners of the complaints. Such a review here demonstrates that Taylor's complaint should go forward.

[11] *See also United States ex rel. Galmines v. Novartis Pharms. Corp.*, No. 06-3213, 2013 WL 2649704, at *10 (E.D. Pa. June 13, 2013), on reconsideration in part, 2013 WL 5924962 (E.D. Pa. Nov. 5, 2013) (bar did not apply in cases both alleging that Novartis engaged in off-label promotion for the same drug but for different off-label purposes); *Millenium Lab'ys*, 923 F.3d at 253-54 (two complaints against clinical lab for excessive confirmatory testing alleged "different frauds with different mechanisms").

II. Taylor and Osinek Have Brought Different Claims

Taylor alleges three distinct fraud schemes that are not pleaded in the Osinek complaint.[12] Each of these schemes pleads different material elements of fraud against different Kaiser entities,[13] and Taylor's complaint should proceed on each one.[14]

A. Kaiser Colorado's One-Way Chart Review Fraud Scheme

First, Taylor uniquely alleges that Kaiser Colorado conducted a one-way chart review program, under which Kaiser Colorado reviewed each medical chart of one of its beneficiaries discharged from a particular chain of hospitals.[15] Kaiser Colorado did this to search for additional diagnosis codes to submit to CMS on its beneficiaries' behalf and collect additional money from CMS. At the same time, despite knowledge that these hospitals were consistently inaccurate in their coding, Kaiser Colorado did not compare the results of its review with the hospitals' coding, which it had already submitted to CMS. Nor did it review discrepancies between its chart review and the original cording or delete any codes that it found to be false from CMS databases. Instead, Kaiser improperly retained payments based on false information.

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[12] Contrary to Defendants' assumption (Mot. at 20), Taylor does not rely on his Second Amended Complaint for purposes of this comparison. The distinct fraud claims identified here are all present in his original and First Amended Complaint, the latter of which is operative for this analysis.

[13] At the time Taylor filed his case, Osinek had only named "Kaiser Permanente" as a Defendant. In his complaint, Taylor named Kaiser Permanente, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest.

[14] The first-to-file analysis is a claim-by-claim analysis, and the Court must review each independent fraud claim as a separate question. *See, e.g, Hartpence,* where two of three claims in the second case were allowed to proceed. 792 F.3d at 1130.

[15] Kaiser, which operated no hospitals in Colorado, relied on the services of external hospitals to treat its beneficiaries.

Taylor FAC ¶¶ 78-91. This is a recognized theory of liability under the FCA, and similar, one-way-look chart review programs are the subject of several other FCA litigations and settlements. *See United States ex rel. Poehling v. UnitedHealth Group, Inc.*, No. CV 16-08697-MWF, 2018 WL 1363487 (C.D. Cal. 2018) (denying defendant's Motion to Dismiss against similar allegations); *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010 (N.D. Cal. 2020) (same; subsequently settled).

Osinek alleges no similar scheme. She does not make any allegations about chart review, let alone a one-way-look yielding fraudulent coding. That difference means Taylor's claims survive. *Hartpence*, 792 F.3d at 1131-32; *Barrett*, 2019 WL 4675756; *see also Millenium Lab'ys*, 923 F.3d at 253-54 (second complaint alleged clinical laboratory engaged in "different frauds with different mechanisms" because referenced "custom profiles" and "standing orders" which first complaint did not)]. Critically, the differences in the Kaiser regional affiliates mean that the chart review scheme Taylor alleges would not even have been possible in California, where Osinek alleges her frauds. There, Kaiser operates its own hospitals, and it has no external providers as it does in Colorado.

Defendants' motion addresses this scheme only superficially, by inaccurately quipping that it represents a "low-tech version of Osinek's data mining allegations." Mot. at 20. That is incorrect. Kaiser Colorado's chart review program involved no data mining at all. It involved the manual review of all the charts from certain hospitals. Additionally, the allegation claims that providers initially generated these false codes and Kaiser failed to delete them, a violation of the "reverse" false claims provision, 31 U.S.C. § 3729(a)(1)(G), because Kaiser improperly retained

the inflated premiums paid by CMS.[16] Osinek's data mining allegations are about the plan targeting certain diagnosis codes for improper submittal to CMS, and the Osinek complaint does not even plead a violation of 31 U.S.C. § 3729(a)(1)(G).

In brief, like the second-filed complaints in *Hartpence* and *Barrett,* Taylor alleges a unique mechanism of fraud based on different material facts.

B. Kaiser's Failure to Delete Unsupported Diagnoses Following Audits

Second, Taylor alleges a far-reaching scheme where Kaiser, in Colorado and nationally, despite knowing of large, systemic numbers of false claims in its submissions to CMS, did nothing to remedy those issues and continued to act in reckless disregard of the data it submitted to CMS.

Each year, Kaiser conducted audits of its submitted diagnosis codes for each region, including Colorado. These audits, known as "probe" audits, showed errors in the data Kaiser was submitting to CMS. These audits were prompted by Kaiser regions trying to prepare for potential Risk Adjustment Data Validation ("RADV") audits, which are periodically conducted by CMS to check the accuracy of a sample of an MAO's diagnosis code submissions. Taylor FAC ¶¶ 69-77. Certain disease categories showed consistent and very high error rates, as noted above. These audits put Kaiser on notice that they were submitting thousands of unsupported codes to the MA program. It was Defendants' duty to investigate and delete the codes that were unsupported. Defendants declined to do so, in violation of the FCA. *See e.g., United States v. Lakeshore Med.*

[16] Taylor, in his Second Amended Complaint, also alleges that this practice is a violation of 31 U.S.C. § 3729(a)(1)(A) due to certifications an MAO must sign when submitting diagnosis codes to CMS but that clarification does not appear in his initial complaint which is at issue for the purposes of the first-to-file analysis.

Clin., LTD., No. 11-CV-00892, 2013 WL 1307013, at *3 (E.D. Wis. Mar. 28, 2013) (denying a Motion to Dismiss where a "defendant ignored audits disclosing a high rate of upcoding" because that "plausibly suggests that defendant acted with reckless disregard for the truth and submitted some false claims.").

Like chart review, the Osinek complaint makes no mention of probe audits, RADV preparedness, error rates, or many of the conditions Taylor pinpoints as problematic. Nor does Osinek mention the specific reasons diagnosis codes were false that were discussed by Taylor, such as coding resolved cancer as active cancer (Taylor FAC ¶ 98), coding history of stroke as acute stroke (¶ 111), coding a history of heart attacks from non face-to-face encounters (¶ 131), and coding an arrythmia condition once it has been resolved by a pacemaker (¶ 140). In fact, the Osinek complaint only references auditing once, merely alleging that Kaiser moved away from auditing and onto other priorities, such as data mining and refresh. Osinek Compl. ¶ 24. Despite Osinek herself drawing this distinction between data mining and auditing, Kaiser now tries to obscure that difference, seemingly using the terms auditing and data mining interchangeably in its motion. *See* Mot. at 9.

That semantic game obfuscates the real differences between the alleged schemes. Osinek alleges an identification of opportunities for upcoding and then doing so. Taylor alleges that Kaiser was put on notice of false diagnosis codes, which were false for a variety of reasons and affected the coding of a variety of conditions, and then it did nothing to explore or resolve that problem, continuing to submit false codes to pad its bottom line.[17] These are different frauds.

[17] Osinek's allegations form the basis of only a "direct" false claims theory. In addition to "direct" false claims, Taylor also alleges that Defendants violated the "reverse" provision of the False Claims Act, 31 U.S.C. § 3729(a)(1)(G), because Kaiser learned information about certain

C. Kaiser's Fraudulent Use of NLP Software

Finally, Taylor alleges a scheme of using natural language processing to submit false diagnosis codes to CMS. Taylor FAC ¶¶ 184-94. Taylor alleges that Kaiser built software that both failed to determine the validity of previously submitted diagnosis codes and that it directly caused the submission of false diagnosis codes to CMS, submitting codes that did not follow CMS rules.

Osinek makes no such claim. Kaiser argues that, because both data mining and natural language processing involved some use of technology, Osinek's complaint should somehow block Taylor's on this point. Mot. at 9. That is nonsense: all administration of healthcare in the 21st century involves the use of technology.[18] Would Defendants have argued in the 20th century that the use of paper and pencil rendered fraud schemes identical?

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diagnosis codes being false after those diagnoses had already been submitted to CMS, and Kaiser failed to delete them.

[18] Defendants claim to put forward their own supposed side-by-side analysis of the complaints in Appendix A to their motion, but they focus on similarities in language, not the required analysis of the facts or schemes. First, Defendants focus on the allegation of upcoding, but as discussed above, the schemes do not overlap in the facts material to the resulting upcoding. Appdx. A at 1. Second, Taylor's acknowledgement that the company did data mine does not block any of his claims. Appdx. A at 2. Even Taylor's allegations about the natural language processing scheme, which is distinct from Osinek's data mining scheme, does not allege the submission of false diagnosis codes from data mining, as Osinek does. Third, the sections of the Taylor FAC quoted on Appdx. A at 3 do not reveal any claim blocked by Osinek's addenda allegations. Those quoted portions concern Taylor's allegations about the submission of diagnosis codes from improper visit types, not the retroactive amendment of medical records. Finally, the fact that both complaints allege the company "pressured" providers to upcode is not instructive to a first-to-file analysis. Appdx. A at 6. Pressuring employees to defraud the government in different ways, in different regions, and under different contracts, is not a meaningful area of overlap.

Like the second-filed case permitted in *Hartpence*, Taylor's complaint sets out fraud schemes that "involve[] different underlying facts." 792 F.3d at 1131. "[W]ithout that information" from Taylor's complaint, "the government might not have investigated" the frauds it spelled out. *Id.* at 1132. That is sufficient to find that each of these claims in Taylor's complaint should move forward, with no further analysis required.[19]

III. Taylor and Osinek Allege Fraud in Different Regions, on Different Contracts, and by Different Defendants

In addition to pleading different schemes, Taylor pleads MA fraud in different regions, and under different contracts than does Osinek. Although Taylor alleges certain specifics about Kaiser's two California regions (Taylor FAC ¶¶ 75, 87, 174, 178), the bulk of his complaint focuses on Colorado, where Taylor worked. By contrast, Osinek's complaint alleges no schemes in Kaiser's Colorado region, does not name the Kaiser entities operating in Colorado as Defendants, and does not even mention the word "Colorado."

Defendants argue that Osinek's complaint alleged, or at least put the government on notice, of a nationwide scheme. That is neither true nor supported by law or facts. First, Osinek does not allege a scheme spanning the various affiliated entities around the country that wear the Kaiser name. Despite only naming "Kaiser Permanente" as a Defendant, Osinek goes on to discuss only the California MA plan, cites only examples of California beneficiaries and physicians, and describes only events in California. Defendants point out that Osinek cites

[19] Defendants argue for dismissal because they assert that the later complaints are "related to the same fraudulent scheme alleged." Mot. at 2. The test is not "related," as the discussion here demonstrates, and in any event the claims are not related. These three schemes alleged by Taylor are independent of Osinek's allegations. They can and did exist regardless of whether Kaiser entities in California were using a fraudulent addenda process.

examples from both Northern and Southern California, two separate Kaiser regions. But notably both of these regions have the same contract with CMS[20] and neither overlaps with Colorado, which is under its own contract. These contract and geographic differences are an additional reason the complaints should not be found to allege the same material elements of a fraud against the government. *See Savage*, 2015 WL 5794357, at *8 (finding that where two complaints involved different prime contractors under different contracts, second case was not barred); *United States ex rel. Heath v. AT&T, Inc.*, 791 F.3d 112, 121 (D.C. Cir. 2015) (second complaint alleged a "factually distinct type[] of fraud[]" covering a wider geographic scope, notwithstanding that both complaints addressed whether AT&T (or a subsidiary) engaged in pricing misrepresentation); *United States v. Sanford-Brown, Ltd*., 27 F. Supp. 3d 940, 948 (E.D. Wis. 2014) (second complaint not barred where involved geographically different campuses of different subsidiaries within defendant's corporate structure). Even if they were in the same region, the distinct nature of the fraud described above would mean that most of Taylor's claims survive.[21]

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[20] Kaiser has seven contracts with CMS, one for each state in which the company operates an MA plan. Kaiser's contract for its California plan is numbered H0542 and is between CMS and an entity called "Kaiser Foundation Health Plan, Inc." The Colorado plan contract is numbered H0630 and is between CMS and an entity called "Kaiser Foundation Health Plan of Colorado."

[21] The cases cited by Defendants do not support dismissal of any parts of the Taylor case. *United States ex rel. Batiste v. SLM Corp.*, 659 F.3d 1204 (D.C. Cir. 2011) involved two cases alleging the exact same type of fraud: falsifying forbearances on the same Department of Education contract, just in different offices. Even if the Court were to adopt the idea that geographic difference alone is insufficient, that would not bar Taylor's claims. Here, unlike in *Batiste,* the types of fraud, and the government contracts in question, are distinct between the complaints. *Batiste* based its ruling on the fact that the later-filed complaint's "additional details would not give rise to a different investigation or recovery." *Id.* at 1210. In contrast, Taylor's complaint clued the government into a new region, key evidence, and new types of fraud: not just fraudulent use of addenda, but deliberately turning a blind eye to known instances of false

Finally, Osinek's case did not suffice to put the government on notice of the fraud allegations Taylor brought forward.[22] It is simply implausible, and not the case here, that every time a *qui tam* plaintiff files a complaint, the government is on notice and obliged to investigate all of that defendant's dealings with the government, as well as those of the defendant's corporate relatives. In this case, Defendants together treat and insure nearly two million MA beneficiaries. For the government to discover all the disparate frauds pleaded by relators here simply from Osinek's complaint, which focuses on the improper use of addenda, it would have had to engage in a comprehensive review of all Kaiser affiliates' practices around the country, potentially reviewing every aspect of the coding of tens of millions of medical charts spanning more than a decade. That is not how FCA investigations work, and every defense counsel worth their hourly rate works diligently to constrain the focus of the government's investigation at every turn. Thus a single complaint like Osinek's cannot be considered meaningful notice of different fraud schemes, such as those alleged by Taylor and discussed above.[23]

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coding. Both the regions and additional fraud claims add new sets of damages beyond what Osinek alleged.

The case of *United States ex rel. Hampton v. Columbia/HCA Healthcare Corp.*, 318 F.3d 214 (D.C. Cir. 2013) is equally inapposite. That case involved a first-filed complaint where a senior manager "alleged a corporate-wide problem, revealed through internal audits" about fraud in home health services, mentioning 37 states. That tracks the Taylor complaint much closer than it does the Osinek complaint. In *Hampton,* the second-filed complaint added no detail and alleged an identical scheme, which is not the case here.

[22] As the First Circuit has pointed out under its similar standard "[m]ere notice—particularly of a different fraud than the government chose to pursue—is not enough. . . . '[W]e must ask not merely whether the first-filed complaint provides some evidence from which an astute government official could arguably have been put on notice, but also whether the first complaint contained all the essential facts of the fraud it alleges.'" *Millenium Lab'ys*, 923 F.3d at 254.

[23] The District Court in *Savage* cast doubt on the validity of this theory about "notice of the need to investigate" in light of the Supreme Court's decision in *Kellogg Brown & Root*

Defendants do not set a limiting principle of what notice would mean. If a defense contractor is sued under the FCA alleging inflating invoices on a contract to build tanks, the government is not on notice of fraud on different contracts. If a pharmaceutical company is sued under the FCA alleging kickbacks with regard to a single drug, the government is not on notice of a price inflation scheme the company might also be performing. Courts have agreed. *Hartpence*, 792 F.3d at 1130 (second-filed suit not barred despite both cases alleging a medical device manufacturer misbilled the government in two ways when billing for the same device); *Barrett*, 2019 WL 4675756, at *4 (second-filed suit not barred despite both cases alleging different kickback schemes involving free Botox samples); *Savage*, 2015 WL 5794357, at *8 ("[E]ven though *Savage I* may have notified the U.S. government of the need to ensure that all prime contractors at Hanford were correctly claiming their . . . credits . . . the Court finds *Savage I* and *Savage II* are not based on the same material elements of fraud."); *United States ex rel. Chin v. CVS Pharmacy Inc.*, No. CV-09-1293 PSG, 2017 WL 4174416, at *5 (C.D. Cal. Aug. 15, 2017) (concluding that the government was not put on notice of a kickback scheme involving gift cards despite an earlier filed complaint mentioning it). Osinek's complaint did not put the government on notice of the claims brought by Taylor, including the expansion of her addenda claims to new regions.[24]

Servs., Inc. v. U.S. ex rel. Carter, 575 U.S. 650 (2015), which found that earlier filed suits that had been dismissed were no longer "pending" and thus do not serve as a bar to later suits. The District Court reasoned that this ruling "inherently limits" the analysis because a "broad 'notice' test does not serve the FCA's purpose of providing private parties the opportunity to pursue actions alleging fraud against the government once the first-to-file bar lifts following the dismissal of the earlier action." 2015 WL 5794357, at *8.

[24] It is notable that the United States did not intervene only in Osinek's complaint, or only against the California-based Defendants Osinek described, despite pursuing only the addenda theory.

Even were the Court to disregard the differences in geography, defendants, and contracts, which it should not, Taylor's three unique claims enumerated above nonetheless may move forward because they are distinct theories of fraud.

IV. Defendants' Request for Judicial Notice Should Be Denied, and Their Cherry-Picked Documents Would Not Change the Outcome

Defendants attempt to put a one-sided view of the government's investigation before the Court with an improper use of judicial notice, but that ploy should fail, because it is unwarranted and unsupported. Even if the Court were to take notice of the requested documents, they would not change the outcome of its first-to-file analysis.

Defendants proffer a selection of documents from the government's investigation to try to create a misleading view of the response to Osinek's complaint. Judicial notice of these documents is inappropriate and unnecessary for an evaluation of the first-to-file bar. A first-to-file analysis is "designed to be quickly and easily determinable, simply requiring a side-by-side comparison of the complaints." *In re Nat. Gas Royalties*, 566 F.3d at 964. Thus, it would be inappropriate for the Court to go beyond the pleadings to make the first-to-file determination. *LaCorte*, 149 F.3d at 235 n.6 ("Because we may decide whether the later complaints allege the same material elements as claims in the original lawsuits simply by comparing the original and later complaints, further factual development is unnecessary."); *see also United States ex rel. Ferrara v. Novo Nordisk, Inc.*, No. CV 11-1596 (RBW), 2019 WL 4305503, at *11 (D.D.C. Sept. 11, 2019); *United States ex rel. Ortega v. Columbia Healthcare, Inc.*, 240 F. Supp. 2d 8, 15 (D.D.C. 2003) (rejecting an evidentiary hearing on the ground that "[t]he only evidence needed to determine if a complaint is barred by § 3730's first-to-file rule is the complaints themselves"). The Court should therefore deny the judicial notice request as irrelevant to the issue before it. *See, e.g., Franklin v. City of San Leandro*, No. 17-cv-00789-HSG, 2017 WL 5665656, at *4 n.2

(N.D. Cal. Nov. 27, 2017) (denying as moot defendants' request for judicial notice where the court "did not rely on the documents in question to reach its disposition").

The documents Defendants seek to add to the record also offer only a partial view of the investigation, making them unsuitable for judicial notice under these circumstances—or if notice is taken, they should be accorded no weight. Judicial notice is only proper for facts "not subject to reasonable dispute . . . ." Fed. R. Evid. 201(b); *United States ex rel. Hong v. Newport Sensors Inc.*, 728 Fed. Appx. 660 (9th Cir. 2018).

The existence of the letters may not be under dispute, but their context is, and Relators do not have full access to the investigative back-and-forth between the United States and Defendants. It is plainly not appropriate on a Motion to Dismiss to permit discovery or introduce the comprehensive factual evidence about the focus, depth, breadth, and evolution of the government's investigation that would be required to give a full view of how the United States' investigation unfolded. Nor, again, is it necessary to the first-to-file determination, which looks only to the complaints.

Even if the Court were to take notice of the documents in isolation, they would not change the outcome. If the government initially sought broad discovery of Kaiser entities, that is standard practice, as is defendants' typical response: To insist on narrowing the investigation to what is really in the government's crosshairs.

Even on their own terms, Defendants' arguments about the subpoenas fail, as an examination of them reveals: The HHS OIG subpoenas target the allegations in Osinek's complaint but not those in Taylor's, not referencing NLP, Chart Review, or Probe Audits, while specifically mentioning data mining and the refresh of diagnosis codes. The focus on Kaiser's hospital network also strongly implies an investigation into business practices outside of

Colorado, a region in which Kaiser owned or operated no hospitals. Def. Req. for Judicial Notice, ECF No. 142 (January 18, 2022) (RJN), Exs. A–D at 6-10. Defendants' only connection between the Taylor case and the RJN exhibits are the fact that the subpoenas mention all "affiliates" and "subsidiaries" of the named entities and the fact that a 2017 letter from the Department of Justice clarified that the 2013 subpoenas applied to Kaiser's Colorado region. Mot. at 20. The boilerplate references to "affiliates" and "subsidiaries" in an OIG subpoena that names four Kaiser entities in California that the Osinek allegations focus on does nothing to show that the government was aware of any of Taylor's specific allegations. It is merely standard language in a cover letter.

Kaiser's argument about the 2017 letter, RJN Ex. E, fails as well. This letter was sent three years into the Taylor investigation and was clearly triggered by Taylor's complaint. The fact that certain of the documents would have been responsive to the 2013 subpoenas, had those subpoenas focused on Colorado, does not demonstrate overlapping claims between Osinek and Taylor. This is merely a shifting of focus of the government's investigation, as is common when the government is investigating disparate fraud schemes brought forward by multiple relators.

CONCLUSION

Because the Taylor and Osinek complaints allege different fraud schemes, regarding different government contracts, in different regions, by different Defendants, the first-to-file bar under 31 U.S.C. § 3730(b)(5) does not apply to Taylor's claims.

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Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, *et al.*, Defendants.	Case No. 3:13-cv-03891-EMC (Consolidated) Hearing Date: March 31, 2022 Time: 1:30 p.m. Judge Hon. Edward M. Chen Courtroom: 5, 17th Floor

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UNITED STATES OF AMERICA and STATE OF CALIFORNIA, *ex rel.* GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, *et al.*, Defendants.	Case No. 3:18-cv-01347-EMC **RELATORS BRYANT AND HERNANDEZ'S RESPONSE IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT FIRST-TO-FILE BAR**

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I. INTRODUCTION

Kaiser's Motion to Dismiss (ECF No. 141, the "Motion") seeks to flip the False Claims Act's first-to-file doctrine on its head. Kaiser would have this Court believe that the consolidated FCA cases before it are an extraordinary example of "parasitic" or "opportunistic" relators in competition for a single FCA award. But that is clearly not this case. On the contrary, it is the scope and extent of Kaiser's avarice that is extraordinary here. Not one, but a dozen different relators, in six different cases, came forward under seal, unknown to one another and their respective filing statuses, in aid of the government, to expose Kaiser's disparate, fraudulent activities. With the government partially intervening in just a portion of these consolidated cases, and several of the "later-filed" relators pursuing declined, unique portions of their claims, applying the first-to-file bar to narrow the claims against Kaiser would work a stark injustice, favoring the wrongdoer (Kaiser) over relators and the government on whose behalf they are suing.

Under Kaiser's improper formulation, the first-to-file bar precludes all later-filed FCA complaints here once the earliest complaint (*Osinek*) asserted upcoding fraud in Kaiser's massive Medicare Advantage plans. That is not how the bar operates. There is no basis to apply the first-to-file doctrine where relators' claims are, at least in part, materially different from an earlier FCA complaint, bringing to the government unique allegations of fraud that were not inevitably discovered after the earlier disclosure.

As applied here, the billions that Kaiser receives each year in Medicare Advantage dollars are comprised of millions of individual patient diagnoses and their related codes. Diagnoses and coding are the basic currencies of Medicare Advantage; over-diagnosing and upcoding are thus the basic currencies of Medicare Advantage fraud. To say that one relator blowing the whistle on Medicare Advantage over-diagnosing and upcoding by Kaiser based on specific diagnoses and codes, in specific Kaiser regions, during a discrete time period, operates as a bar to any other relator coming forward with different upcoding, in different diagnoses, in different regions and timeframes, carries the FCA's first-to-file doctrine well beyond its legal limit.

The first-to-file bar is particularly inapplicable to the 2018 complaint filed by relators Gloryanne Bryant and Victoria Hernandez (the "*Bryant/Hernandez* Complaint," Case No. 3:18-cv-

01347-EMC, ECF No. 1). These relators, senior leaders in Kaiser's national and regional coding and audit departments respectively, brought to the government unique information and never-before-asserted fraud claims based on events and evidence that the purported first-to-file relator (*Osinek*) did not and could not have known about when she filed her complaint, and which were not inevitably discovered based on her (or anyone else's) earlier, substantially narrower, and materially different allegations. Specifically, unlike the *Osinek* complaint, the *Bryant/Hernandez* Complaint exposes Kaiser's upcoding fraud: (i) relating to a specific high-value diagnosis code, mechanical ventilator dependence status, that first came to light *after* Osinek filed her suit; (ii) not just on the Medicare Advantage program, but on a different government program (the Affordable Care Act) run by a different government agency entirely (the Department of Health and Human Services); and (iii) within Kaiser's insurance and physician-practice behemoths in all regions, not just one region, and also within Kaiser's massive hospital operation across Kaiser's regions, which was not even part of the *Osinek* suit.

One relator identifying one or more fraudulent straws in an enormous stack of hay (*e.g.*, Kaiser's massive Medicare Advantage plans) does not inevitably lead to the government's discovery that fraud will be found elsewhere in the stack, or where to look for it. Here, it took Relators Bryant and Hernandez to expose different Kaiser frauds, and different material elements of other frauds, that would not have been discovered otherwise, including fraud on a different haystack entirely (the Affordable Care Act). Kaiser's motion to dismiss should be denied as to Bryant and Hernandez.

II. BACKGROUND

A. Government Programs' Payments Are Premised on Diagnosis Codes

1. Medicare Advantage Program

Millions of elderly and disabled individuals throughout the United States receive their Medicare benefits through the Medicare Advantage Program (also referred to as "Medicare Part C"). *Bryant/Hernandez* Complaint ("Compl.") ¶ 1. A central, distinguishing feature of the Medicare Advantage Program is the provision of Medicare benefits by private healthcare insurance organizations. *See* 42 U.S.C. §§ 1395w-21 to 1395w-28. Medicare beneficiaries enroll in managed healthcare insurance plans called Medicare Advantage Plans ("MA Plans") that are owned and

operated by these private organizations, called Medicare Advantage Organizations ("MA Organizations" or "MAOs"). Compl. ¶ 1. *See also* 42 C.F.R. § 422.2.

The government pays each MA Organization a fixed monthly payment for each Medicare beneficiary enrolled in its plans. Compl. ¶ 2. *See also* 42 U.S.C. § 1395w-23; 42 C.F.R. §§ 422.250 - 422.330 (Subparts F and G). The government adjusts these payments for various risk factors that affect expected healthcare expenditures, including the health status of each enrollee. Compl. ¶ 2. The adjustments are intended to ensure that MA Organizations are paid more for those enrollees expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower costs. *Id.*

To obtain payments based on adjustments for health status, MA Organizations submit diagnosis codes to the government for the beneficiaries in their MA Plans. *Id.* ¶ 3. These diagnosis codes are from the beneficiaries' medical encounters (*e.g.*, office and hospital visits). *Id.* Using these diagnosis codes, the government calculates a risk score for each beneficiary. *Id.* The beneficiary's risk score is then used to calculate monthly payments to the MA Organization for that beneficiary for the following year. *Id. See also* 42 U.S.C. § 1395w-23(a)(1)(G); 42 C.F.R. § 422.308(e). In general, the more numerous the conditions diagnosed, and the more severe the conditions, the higher the risk score for a beneficiary and the greater the risk-adjusted payments made to the MA Organization for that beneficiary. Compl. ¶ 3.

Thus, the Centers for Medicare & Medicaid Services' ("CMS's") health-based risk adjustment model — known as the Hierarchical Conditions Category ("HCC") model — takes into account diagnoses from inpatient hospital stays, emergency and outpatient surgery encounters, and physician office or clinic visits. Compl. ¶ 41. *See also* 42 U.S.C. § 1395w-23; 42 C.F.R. § 422.208(c). The HCC model is prospective, meaning that it relies on diagnoses for certain medical conditions documented in the medical record and assigned to beneficiaries by their physicians in a one-calendar-year timeframe to set the payment for each beneficiary for the following year. Compl. ¶ 42. The medical conditions included in the model are grouped into HCCs, which are categories of clinically related medical diagnoses. *Id. See also* 42 C.F.R. § 422.2. Related groups of diagnoses are

ranked on the basis of disease severity or burden, and the cost associated with their treatment. Compl. ¶ 42.

Risk adjustment claims are true, and the resulting risk adjustment payments are valid, only to the extent that the diagnosis codes submitted by the MA Organizations are valid. Compl. ¶ 49. The diagnoses must be coded according to the *International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting* ("ICD-9- CM" & "ICD-10-CM") and documented with sufficient clinical specificity. *Id. See also* 42 C.F.R. § 310(d)(1); 45 C.F.R. § 162.1002. CMS publishes each year the many thousands of ICD diagnoses that map to HCCs for purposes of Medicare Advantage risk adjustment. *See, e.g.,* https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Risk-Adjustors-Items/Risk2013 (listing ICD to HCC mapping for 2013, the year the *Osinek* complaint was filed).

This payment model creates powerful incentives for MA Organizations to over-document and over-report diagnosis codes in order to exaggerate the expected healthcare costs for their enrollees. Compl. ¶ 4. In order to combat these incentives and protect the government from making erroneous payments to MA Organizations, the government requires that submitted diagnoses be supported and validated by the beneficiaries' medical records. *Id.* It is a well-established requirement that all diagnosis codes submitted to the Medicare Program for risk adjustment payments must be unambiguously supported by clinical documentation included in the beneficiaries' medical records. *Id.* In addition, each MA Organization must expressly certify in "Risk Adjustment Attestations," submitted to CMS, that the diagnosis codes it has provided are accurate and truthful. *Id.* ¶ 5; 42 C.F.R. § 422.504(1)(2). Each MA Organization must also "[a]dopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with [the government's] program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." Compl. ¶ 5; 42 C.F.R. § 422.503(b)(4)(vi).

2. Affordable Care Act

The United States also contributes to premiums paid by individuals to private health insurance companies, including Kaiser's private health plans, under the Affordable Care Act (sometimes referred to as the "ACA"). Compl. ¶ 7. The Affordable Care Act authorizes the

Department of Health and Human Services (HHS) to utilize criteria and methods similar to those utilized under the Medicare Advantage program to implement risk adjustment, and requires similar attestations/certifications from health insurance companies as to the accuracy and documentation of their risk adjustment data. *Id. See also*, *e.g.*, 42 U.S.C. §§ 18021 to 18024; 45 C.F.R. §§ 153.610 - 153.630. The HHS risk adjustment methodology developed by and on behalf of the CMS is based on the premise that premiums should reflect the differences in plan benefits, quality, and efficiency, and not the health status of the enrolled population. Compl. ¶ 7. Accordingly, as under the Medicare Advantage program, the more risk-adjusted diagnosis codes that are reported, the higher premiums the companies are permitted to charge, and the higher contributions will be made to such premiums by the United States. *Id.* When premiums are artificially high due to documentation and coding fraud, both enrollees and the United States are harmed by the overcharges. *Id.* ¶ 52.

B. Kaiser's Health-Care Consortium – A Three-Legged Stool

Kaiser Permanente is a massive healthcare consortium that operates: (1) one of the nation's largest health plans, serving over 11 million members; (2) among the nation's largest physician and physician-service organizations; and (3) one of the nation's largest hospital chains. Compl. ¶ 25. *See also* Motion at 1 n.1; United States Complaint in Intervention (Case No. 3:13-cv-03891 EMC, ECF No. 110, "U.S. Compl.") ¶ 19. On the public insurance side, Kaiser's Medicare Advantage plans serve well over 1 million members in seven different states, and generate approximately 30% of Kaiser's overall profits. Compl. ¶ 26; U.S. Compl. ¶ 100. On the physician practice side, Kaiser employs doctors and other medical professionals and provides direct medical services through its Permanente Medical Groups, a for-profit set of regional affiliates that includes The Permanente Medical Group ("TPMG") in Northern California, Southern California Permanente Medical Group ("SCPMG") in Southern California, and five other regional areas including Hawaii, the Pacific Northwest, Colorado, Georgia, and the Mid-Atlantic States. Compl. ¶ 25; U.S. Compl. ¶ 23. On the hospital side, Kaiser owns and operates acute care hospitals in four regions (Northern California, Southern California, Northwest and Hawaii), and provides care in other settings through its non-profit Kaiser Foundation Hospitals ("KFH"). Compl. ¶ 25.

The three-legged stool of the Kaiser Permanente companies – health plans, medical groups, and hospitals – reported revenue of $64.6 billion in 2016. Compl. ¶ 27; U.S. Compl. ¶ 19.

C. *Osinek* Complaint (2013)

On August 22, 2013, Kaiser employee Rhonda Osinek filed a complaint under seal against Defendant "Kaiser Permanente" under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, Case No. 3:13-cv-03891, ECF No. 1 ("*Osinek* Compl."). Osinek was employed by Kaiser's physician group in Northern California (TPMG) in its Encounter Information Operations ("EIO") department as a "Data Quality Trainer" and "Audit Manager" at the time of her complaint. *Osinek* Compl. ¶¶ 5, 23. In that capacity, she trained TPMG physicians on coding guidelines and practices out of TPMG's San Rafael, California facility. *Id.*

Osinek alleged that, beginning in 2007, the EIO department in Kaiser's TPMG region began "data mining" and "diagnosis chasing" to improperly increase billings in the TPMG region for certain "high value" HCCs in the Medicare Advantage program. *Osinek* Compl. ¶ 24. *Osinek* alleged that the EIO department used algorithms to identify 18 specific disease conditions for its data mining strategy, including chronic kidney disease and several diabetes-related conditions. *Id.* ¶ 25. *Osinek's* allegations focused on TPMG EIO's efforts to "amend" or "addend" patient files after physician office visits to "capture" these specific diagnoses retroactively for Medicare Advantage patients even though they "were not addressed at the time of an encounter." *Id.* ¶ 28. *Osinek* alleged that TPMG and EIO used boilerplate prompts, coding parties, and other incentives to "pressure[] providers into approving retroactive diagnoses." *Id.* ¶¶ 28-39. According to *Osinek*, the focus on data mining and high value HCCs resulted in over $50 million in CMS Medicare Advantage payments to Kaiser's Northern California (TPMG) region in 2009. *Id.* ¶ 41 (listing each specific condition and associated reimbursement). On October 7, 2021, Osinek filed an Amended Complaint naming TPMG and the Kaiser Foundation Health Plan, Inc. as defendants, but otherwise leaving her allegations unchanged. *See* Case No. 3:13-cv-03891, ECF No. 87.

Osinek has never asserted fraud in either her original or amended complaints by Kaiser-owned hospitals (or sued the Kaiser entity that owns and operates those hospitals), or asserted claims about any of Kaiser's eight regions other than the Northern California region (or sued the Kaiser

entities in those other regions). The specific diagnoses that she alleges were being upcoded as of the filing of her Complaint in 2013 are specifically enumerated in her pleadings, and do not include the diagnosis of mechanical ventilation dependence. The *Osinek* Complaint is limited to allegations of fraud on CMS under the Medicare Advantage program; it does not assert any allegations of fraud on HHS under the Affordable Care Act.

D. *Taylor* Complaint (2014), *Arefi* Complaint (2015) and *Stein* Complaint (2016)

While the *Osinek* Complaint remained sealed, several other relators, unbeknownst to one another and to Osinek, filed new complaints against various Kaiser entities arising out of fraud on the Medicaid Advantage program. The 2014 *Taylor* Complaint filed in Colorado detailed a Medicare Advantage scheme by Kaiser largely in Kaiser's Colorado region, including coding errors caused by external providers (*e.g.*, non-Kaiser hospitals), and the upcoding of certain specific conditions (*e.g.*, cancer, stroke, and vascular disease) from 2004 to the 2014 filing of the Complaint. *Taylor*, Case No. 3:21-cv-03894-EMC, ECF No. 1.

The 2015 *Arefi* Complaint filed in the Central District of California alleged that Kaiser used an electronic "workflow tool" and improper physician querying to "data mine" for diagnoses mapped to high-value Medicare Advantage HCCs, leading to the upcoding of certain specific conditions (*e.g.*, angina pectoris, cachexia, and chronic kidney disease) between 2009 and 2013. *Arefi*, Case No. 3:16-cv-1558-EMC, ECF No. 1.

The 2016 *Stein* Complaint filed in the Central District of California focused on the upcoding of two specific Medicare Advantage diagnoses, sepsis and malnutrition (an Amended Complaint later added aortic atherosclerosis), and the use of improper physician queries and medical record reviews designed to "refresh" or add diagnoses unsupported by the medical records from 2006 to the 2016 filing of the Complaint. *Stein*, Case No. 3:16-cv-05337, ECF Nos. 1, 27.

E. *Bryant/Hernandez* Complaint – Unique Claims on Different Diagnoses Against Additional Kaiser Defendants Defrauding a Different Government Program During a Later Time Period

On March 1, 2018, while the *Osinek*, *Taylor*, *Arefi* and *Stein* Complaints remained under seal, Relators Bryant and Hernandez, through their counsel, filed their complaint under seal against numerous Kaiser entities, only some of which had been implicated in the *Osinek* Complaint. Given

that each of the complaints were filed under seal and remained sealed to the public when Bryant and Hernandez filed their complaint, none of the other complaints were known or available to Ms. Bryant, Ms. Hernandez or their counsel at the time of filing, and the other relators were unaware of the *Bryant/Hernandez* Complaint when that complaint was also filed under seal.

Gloryanne Bryant is a national leader, speaker, and educator in coding, clinical documentation improvement, and physician querying, and holds numerous coding and clinical documentation credentials. Compl. ¶ 22. From 2009 until her retirement in late 2017, Ms. Bryant held senior leadership positions within Kaiser, including, from 2013 until her retirement, as National Director for Coding Quality, Education, Systems and Support within Kaiser's national office. *Id.* Victoria Hernandez also carries decades of coding experience and 20 years at Kaiser in various leadership positions, including as Regional Director for Kaiser's Northern California hospitals and, separately, for TPMG; she also holds numerous coding and clinical documentation credentials. *Id.* ¶ 23.

The *Bryant/Hernandez* Complaint contained similar allegations to the *Osinek* Complaint (and the others) in some respects, but also included claims and allegations that were and are entirely unique. The *Bryant/Hernandez* Complaint, for example, is the first and only one to allege that Kaiser is committing fraud on the government through HHS-HCC risk adjustment manipulation under the Affordable Care Act, a fraud on an entirely different government agency (HHS) and statutory scheme (the ACA) than the Medicare Advantage agency (CMS) and program. *Id.* ¶¶ 51-52.[1]

The *Bryant/Hernandez* Complaint is the first and only one to allege that mechanical vent dependence, just one of the dozens of diagnoses that maps to just one of the HCCs (HCC 82) under both the Medicare Advantage and ACA models, was systematically over-diagnosed and over-coded by Kaiser. *Id.* ¶¶ 83-106. Kaiser physicians and hospitals were directed to diagnose the condition even for short-term, acute use of ventilation on patients, exactly contrary to applicable and direct

[1] The *Bryant/Hernandez* Complaint also asserted fraud on the State of California's Medi-Cal program, an additional distinguishing feature from the *Osinek* Complaint and the others. In their Amended Complaint, however, the *Bryant/Hernandez* Relators have dropped their allegations and claims implicating Medi-Cal.

coding guidelines. *Id*. ¶¶ 84-85, 87-88. Notably, the vent dependence fraud did not even come to light until late 2013, after the *Osinek* Complaint had already been filed. *Id.* ¶¶ 89-101. And when Ms. Bryant and Ms. Hernandez did discover it, they did so initially in the context of a patient population (newborns) receiving care under the Affordable Care Act, before later discovering that Kaiser was also improperly documenting and coding the vent dependence status diagnosis for Medicare Advantage patients. *Id.*

The vent dependence allegations in the *Bryant/Hernandez* Complaint also distinguish it from the *Osinek* Complaint in another critical way. The *Osinek* Complaint focuses on fraud in upcoding diagnoses after physician office visits through the use of addenda, naming only the regional Kaiser physician group, TPMG, and the Kaiser Health Plan that benefitted from TPMG's upcoding as defendants. In contrast, the vent dependence section of the *Bryant/Hernandez* Complaint, among others, focuses on *in-hospital* over-diagnosing and upcoding, not office visits, thus implicating an entirely different leg of Kaiser's three-legged consortium, Kaiser Foundation Hospitals, which is not even named in the *Osinek* Complaint. The *Bryant/Hernandez* Complaint is also unique in its national scope. While the *Osinek* Complaint focuses on Kaiser's Northern California region, Bryant and Hernandez gathered data from *all* Kaiser regions on, *inter alia*, improper vent dependence diagnosing and coding; allege that the improper "capture" of this code was discussed at regional reporting group meetings attended by representatives from every Kaiser region; and detail how they raised the issue with the independent, official clearing house for coding guidance (the American Hospital Association's Coding Clinic), which confirmed that Kaiser's approach to coding vent dependence was erroneous. *Id.* ¶¶ 86-91, 101, 104.

On November 15, 2021, the *Bryant/Hernandez* Relators filed their Amended Complaint, which narrowed their original Complaint somewhat, but left intact their unique claims and allegations under the ACA and relating to vent dependence status documentation and coding. Case No. 3:13-cv-03891-EMC, ECF No. 117.

F. Consolidation and the United States' Complaint-in-Intervention (2021)

On June 25, 2021, this Court granted the United States' unopposed motion to consolidate the various complaints,[2] finding that they "involve common questions of fact and law" relating to fraud alleged on the Medicare Advantage Program. Case No. 3:13-cv-03891 EMC, ECF No. 61. On July 27, 2021, the United States filed its notice of election to intervene in each of the actions in part and to decline in part:

> [T]he United States intervenes on the allegations that defendants Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group, Inc.; and Colorado Permanente Medical Group, P.C.; submitted or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added ***via addenda*** under Medicare Part C from the years 2009 until present. The United States declines to intervene on all other allegations.

Case No. 3:13-cv-03891 EMC, ECF No. 65 (emphasis added).

On October 25, 2021, the United States filed its Complaint-in-Intervention in all of the consolidated cases, including the *Bryant/Hernandez* case. Case No. 3:13-cv-03891 EMC, ECF No. 110. Consistent with its intervention election, the United States' claims are brought against the Kaiser Health Plan and several regional physician groups, including TPMG, based on fraud on the Medicare Advantage program through Kaiser's "systematically altering patient medical records to add diagnoses that either did not exist or were unrelated to the patient's visit with the Kaiser physician." *Id.* ¶ 1. The United States' Complaint does not name Kaiser Foundation Hospitals as a defendant; includes no allegations premised on vent dependence over-diagnosing and upcoding; and does not include assertions of fraud on the government under the Affordable Care Act. Those claims are only being pursued by Bryant and Hernandez on behalf of the government on a non-intervened basis.

III. ARGUMENT

After a relator files an FCA lawsuit, no subsequent relator may "bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). The aim of the first-to-file rule

[2] After the *Bryant/Hernandez* Complaint was filed, relator Bicocca filed a sixth case against various Kaiser entities. *See* Bicocca, Case No. 3:21-cv-03124 EMC, ECF No. 1.

is to "promote incentives for whistle-blowing insiders and prevent opportunistic successive plaintiffs." *United States ex rel. Hartpence v. Kinetic Concepts, Inc*., 792 F.3d 1121, 1130 (9th Cir. 2015) (quotation omitted). Importantly, "allowing claims for related but distinct fraud claims encourages broader investigation and increases the total potential for recovery." *Id*. at 1131. The first-to-file focus is on whether the two lawsuits contain "different material facts;" if they do, the first-to-file bar does not apply. *Id*. at 1132.

Against this backdrop, Kaiser's Motion fails with respect to the *Bryant/Hernandez* Complaint. Kaiser argues that the first-to-file bar applies "because the business practices and motives alleged to target these conditions are the same" in the *Bryant/Hernandez* Complaint and in the *Osinek* Complaint. Motion at 23. Kaiser avers that the allegations in the *Bryant/Hernandez* Complaint are "just factual variations" from the allegations in the *Osinek* Complaint. *Id*. But Kaiser's attempt to minimize the differences between the *Bryant/Hernandez* and *Osinek* complaints falls well short. Bryant and Hernandez based their complaint on their own first-hand knowledge and observations of fraud pervasive at Kaiser across all of Kaiser's regions. Most importantly for the purposes of the Motion, they allege "different material facts": they were the first relators to describe, in great detail, how Kaiser schemed to fraudulently overbill for the specific diagnosis of vent dependence status; they were the first relators to detail how Kaiser's fraud schemes defrauded both CMS' Medicare Advantage program and HHS' Affordable Care Act program; and they were the first relators, given their senior positions within the organization and aggressive-but-futile attempts to report up the chain to Kaiser's national leadership, to witness and detail all three prongs of the Kaiser empire – (1) the health plan network, (2) the hospital network, and (3) the doctor network – participating in Kaiser's massive frauds, throughout Kaiser's entire geographic footprint.

As Bryant and Hernandez were the first relators to allege these "different material facts," their complaint is not barred by the first-to-file rule. Far from being "opportunistic," Bryant and Hernandez filed their complaint with no knowledge that anyone else had already done so. Kaiser's motion, if granted, would improperly weaponize the first-to-file doctrine, stripping away unique relator claims being pursued on a declined basis that Kaiser should be required to defend; and

prematurely adjudicating first-to-file status on consolidated claims in which the United States has intervened. Kaiser's first-to-file motion should be denied in full.

A. The First-to-File Bar Does Not Apply To the *Bryant/Hernandez* Complaint, Which Alleges Different Material Facts Regarding Kaiser's Schemes

Bryant and Hernandez go well beyond the "material facts" of the upcoding scheme alleged in *Osinek*. *Osinek* alleges that Kaiser directed the scheme at specific conditions to defraud Medicare through its practice of reviewing patient encounters in physician offices and changing diagnoses in patient chart and billing information by way of adding "addenda" to visit notes well after the patient encounter to capture "missed opportunities." *Osinek* Compl. ¶¶ 23-25. *Osinek* does not allege that the upcoding scheme went beyond the identified conditions, that it happened contemporaneously with the patient's visit, or that there was a separate scheme under the ACA; instead, it alleges there were specific "disease conditions for data mining" that would support the specific "higher value HCCs" identified by Kaiser in after-the-fact chart reviews as targets for over-documenting and upcoding for Medicare Advantage reimbursements. *Id*.

Bryant and Hernandez, on the other hand, allege systemic over-documenting and upcoding of the specific diagnosis of mechanical ventilation dependence status (HCC 82). Am. Compl. ¶¶ 80-103. Vent dependence diagnoses were largely made contemporaneously *during* hospital inpatient stays, not through an "addendum" process as part of a chart review as alleged in *Osinek*. Osinek did not and could not know about the vent dependence fraud since it did not even come to light until late 2013, after the *Osinek* Complaint had already been filed. Patients receiving vent dependence diagnoses were generally hospital patients, not the patients at Kaiser's provider network as alleged in *Osinek*. Bryant and Hernandez also allege that Kaiser schemed to over-charge individuals covered by the ACA, not just the Medicare Advantage program that was the sole focus of *Osinek*. *See, e.g.*, Am. Compl. ¶¶ 10, 49-51. *Osinek* never mentions vent dependence status diagnosing or coding, HCC 82, or anything related to this condition. *See, e.g.*, *Osinek* Compl. ¶¶ 25-26. That complaint never makes any allegations about the ACA. It says nothing about hospital outpatients or inpatients. Simply put, it makes no allegations that would lead to an investigation into Kaiser's wrongdoing on these issues brought to light by Bryant and Hernandez at all. Far from being "opportunistic

successive plaintiffs," the *Bryant/Hernandez* Complaint's unique allegations related to vent dependence and the ACA "encourage[] broader investigation and increase[] the total potential for recovery," all the while reinforcing the FCA's goal of "promot[ing] incentives for whistle-blowing insiders." *See Hartpence*, 792 F.3d at 1130-31.

As binding Ninth Circuit precedent dictates, the *Bryant/Hernandez* Complaint does not allege mere "factual variations" on the over-documenting and upcoding scheme, so the first-to-file bar does not apply. *See Hartpence*, 792 F.3d at 1121. In *Hartpence,* defendant Kinetic Concepts Inc. ("KCI") submitted false claims to Medicare related to one of its medical devices, and two different relators filed FCA lawsuits. Both complaints "arose out of the same time period, involved KCI's billing practices for the same therapy device, alleged incorrect use of the same billing codes (the KX modifier), shared '100 nearly identical paragraphs,' and were drafted by the same counsel." *Id.* at 1131. In addition to KCI's fraud related to the KX modifier billing code, the later-filed complaint also alleged that KCI committed fraud related to its failure to obtain "Detailed Written Orders" ("DWOs") before delivering the device in question. The district court ruled that the first-to-file rule barred the second complaint because it alleged "slightly different variations of false [Medicare] billing" schemes for the same device as the first complaint. *Id*. The Ninth Circuit reversed, finding that "[t]he rules governing use of KX modifiers and DWOs were disseminated at different times, in different publications, and are plainly treated as separate regulations under the program." *Id*.

Similarly, *Osinek* alleges upcoding related to different conditions and HCC codes than does the *Bryant/Hernandez* Complaint. The distinct HCC codes are subject to their own criteria and regulations, and are as similar to each other as the KX modifier is to the DWO scheme in *Hartpence*. Further, in *Hartpence,* the second complaint's allegations of the DWO fraud provided key benefits to the government, as without them, "the government may have never discovered" the second scheme. *Id*. The Ninth Circuit found that dismissal of the second complaint was antithetical to the purpose of the first-to-file bar, because the second relator "provided information about a different form of fraud," without which the government may have never investigated beyond the KX modifier fraud, and never discovered the DWO fraud. *Id*. at 1131-32. The same is true here: without Bryant and Hernandez's allegations of vent dependence over-documenting and upcoding, the government

would not inevitably search for and discover what would otherwise be a unique needle in the haystack of HCC codes that Kaiser exploits; it would not have cause to investigate wrongdoing under the ACA; and it would not have been led to investigate fraud at Kaiser's hospitals.

United States ex rel. Barrett v. Allergan, Inc., No. SACV 18-203 JVS(KESx), 2019 WL 4675756 (C.D. Cal. Sept. 24, 2019), is also instructive. In that case, the court held that the first-to-file bar did not apply, even though both relators alleged fraud pertaining to the same drug. The first complaint alleged that Allergan engaged in a kickback scheme when it improperly induced physicians to prescribe and promote Botox with free goods and services. *Id.* at *3. The later complaint also alleged that Allergan improperly gave physicians free goods and services as part of an illegal kickback scheme, but also that this scheme resulted in Allergan fraudulently "elevating the price of Botox reported and paid by the Government" by manipulating the "Average Sales Price" ("ASP") that Allergan reports and that the government uses to calculate its payment. *Id*. at *1. The court concluded that even though both complaints centered on Botox, the "fraudulent schemes" and "material facts underlying the allegations" were different, and thus the first-to-file bar did not apply. *Id*. at *4. The second complaint's allegations of ASP fraud were broader than the first complaint's, and would lead to different damages, *id*., just like the *Bryant/Hernandez* Complaint's over-documenting, upcoding and ACA allegations go beyond what *Osinek* alleges, and would lead to different and additional damages. Notably, the first-to-file bar did not apply in *Barrett* even though the first complaint also had "allegations of fraudulent ASP reporting," since the first complaint's treatment of the ASP issue was narrower. *Id*. Thus, even if the allegations in *Osinek* are construed to touch on issues relevant to vent dependence, its allegations are indisputably narrower than what *Bryant/Hernandez* alleges.

Further, in *United States ex rel. Galmines v. Novartis Pharms. Corp.*, No. 06-3213, 2013 WL 2649704 (E.D. Pa. June 13, 2013), *on reconsideration in part*, 2013 WL 5924962 (E.D. Pa. Nov. 5, 2013), two relators alleged that Novartis engaged in fraudulent off-label marketing of the drug Elidel. The first relator alleged that Novartis improperly marketed Elidel for treatment of psoriasis and seborrhea; the second alleged that Novartis improperly marketed it for treatment of atopic dermatitis and for use in infants. Even though the two complaints alleged marketing schemes

pertaining to the same drug, the court held that the first-to-file bar did not bar the second relator's off-label marketing allegations, as "[n]o reasonable reading" of the first complaint would have informed the government of the need to investigate further potential off-label marketing abuses. *Id.* at *10. Novartis' marketing of Elidel is akin to Kaiser's overall over-documenting and upcoding schemes. Just as the first-to-file bar did not apply to distinct manifestations of Novartis' marketing scheme, it does not apply to distinct manifestations of Kaiser's upcoding schemes or to allegations of fraud on an entirely different government agency and program (HHS and the ACA), involving a different arm of Kaiser (the hospital division), and covering all of Kaiser's regions.

Kaiser's reliance on *United States ex rel. Marion v. Heald Coll., LLC*, No. 5:12-cv-02067, 2015 WL 4512843 (N.D. Cal. July 24, 2015) is misplaced, as *Marion* does not relate to relators alleging distinct forms of fraud. *See* Motion at 16-17. *Marion* was a case about fraud in the for-profit education industry. Earlier-filed lawsuits alleged that the defendants engaged in "attendance fraud" schemes, whereby attendance figures were inflated resulting in higher payments to the schools. Marion argued that her complaint alleged an "enrollment fraud" scheme, focusing on "phantom students" enrolled without consent or confirmation that they met eligibility requirements. The court found the two schemes "sufficiently related" to trigger the first-to-file bar because any government investigation into attendance fraud "would inevitably uncover" enrollment fraud: "The government's investigation into discrepancies between actual and electronic attendance records therefore would identify any student fraudulently enrolled in the manner Marion alleges. Her allegations therefore contribute little—if anything—to the government's investigation." *Id.* at *3.

In contrast, the government's investigation into Kaiser's fraud related to the upcoded diagnoses identified in *Osinek* would not have "inevitably uncovered" upcoding in unidentified diagnoses, particularly given the maze of diagnoses that map to risk-adjusted HCCs in the Medicare Advantage program. Given the sheer number of diagnosis codes, it would be impossible for the government to identify fraudulent over-documenting and upcoding in particular diagnoses without being pointed in the right direction. *Osinek* never pointed the government to vent dependence over-documentation and upcoding; she did not point to in-hospital coding at all; and the particular scheme

that she did identify, the use of addenda to populate diagnoses after physician office visits, is not implicated in the vent dependence scheme identified by Bryant and Hernandez.

Kaiser also cites *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371 (5th Cir. 2009). Motion at 16. That case dealt with fraud by insurers in the aftermath of Hurricane Katrina. *Branch*, 560 F.3d at 374. The federal government backs a flood insurance program for private insurers, and pays benefits for damages caused by floods. *Id*. Normally, the insurer is required to submit certain proof to the federal government that the loss is indeed caused by flood waters, as opposed to other damage such as wind. *Id*. After Hurricane Katrina, the government relaxed its documentation requirements in order to expedite payments to affected insureds. *Id*. The first-to-file relator, Rigsby, alleged that four insurance companies exploited the weakened reporting requirements to fraudulently classify damage as flood damage (and thus covered in part by the federal government) instead of wind damage (which would have to be covered solely by the insurers' funds). *Id*. at 374-75. The later-to-file relator, Branch, alleged the same fraudulent scheme conducted by 14 insurance companies, including two of the four that *Rigsby* named.

As to the twelve defendants named in *Branch* but not named in *Rigsby*, the court held that the first-to-file bar did *not* apply. *Id*. at 379-80. As to the two common defendants, the court held the first-to-file bar applied, as the only additional allegations that Branch included were 57 specific examples of the fraud in action, finding these were mere "factual details" of the same fraud scheme. *Id*. at 375, 378. In sharp contrast, the *Bryant/Hernandez* Complaint alleges additional schemes than the one identified in *Osinek*, involving vent dependence status documentation and coding, the Affordable Care Act, and a completely different arm of Kaiser, its hospital network. *Branch* is inapposite.

B. The First-to-File Bar Does Not Apply To the *Bryant/Hernandez* Complaint As It Alleges Different Material Facts Regarding the Kaiser Entities Involved in the Frauds

The fact that the *Bryant/Hernandez* Complaint alleges fraud by Kaiser's hospital division – an entity not named in *Osinek* – is an independent reason why the complaint escapes the first-to-file bar. So too is the fact that the *Bryant/Hernandez* Complaint's allegations implicate the entire Kaiser organization in all its breadth; not just a single region's physician group and health plans like *Osinek*.

Bryant and Hernandez were able to make these allegations due to their roles at Kaiser, making them precisely the "whistle-blowing insiders" that Congress wanted to encourage through the FCA. Both worked for Kaiser in leadership positions – Bryant in senior national leadership, and Hernandez in regional medical coding leadership. Am. Compl. ¶¶ 20-21. As their complaint shows, this insider access gave them insight into the fraud engaged in by Kaiser throughout *all* of its main divisions across the entire country: the health plan division, the hospital division, and the provider network division. The *Bryant/Hernandez* Complaint names as a defendant Kaiser Foundation Hospitals. Am. Compl. ¶ 28. *Osinek* focuses solely on Kaiser's other two divisions and a single region. Kaiser's fraud related to hospital visits – alleged for the first time by Bryant and Hernandez – is very different from its fraud related to provider visits.[3]

In *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co*., No. 4:14-cv-5002-EFS, 2015 WL 5794357 (E.D. Wash. Oct. 1, 2015), the first-filed lawsuit alleged that a government contractor for the Department of Energy's Hanford Site, WCH, conspired with a sub-contractor, FE & C, and violated the FCA. *Id*. at *3. Based on information learned in discovery, the relator filed a second lawsuit alleging that a second government contractor working at the Hanford Site, CHPRC, engaged in the same scheme with FE & C. *Id*. The court observed that both lawsuits "allege a similar fraudulent scheme, i.e., a prime contractor colluded with FE & C to create small, disadvantaged businesses to apply for subcontracts when the work would be performed by FE & C. . . . " *Id*. at *9. WCH (the contractor in the first case) and CHPRC (the contractor in the second case) were related entities; CH2M Hill Companies Ltd. owned all of CHPRC, and 30% of WCH. *Id*. The court concluded that the first-to-file bar was inapplicable despite the overlap between the cases and defendants, as "the allegations involve different essential facts regarding fraudulent schemes involving distinct prime contractors and distinct subcontracts at the Hanford site." *Id*. The court held that the corporate overlap between the two defendants "does not impact the determination" that the

[3] Though Kaiser's Motion makes no argument comparing *Bryant/Hernandez* to the complaints in *Arefi* and *Stein*, those earlier-filed complaints do name Kaiser hospital entities as defendants. However, neither *Arefi* nor *Stein* say anything about vent dependence or the ACA; instead, they too allege schemes involving different material facts, and thus do not trigger the first-file-to bar with respect to the *Bryant/Hernandez* Complaint.

two cases were "materially different." *Id*. *See also United States ex rel. Chin v. CVS Pharmacy, Inc.*, No. CV 09-1293 PSG PJWx, 2017 WL 4174416, at *5 (C.D. Cal. Aug. 15, 2017) (first-filed complaint named Walgreens as defendant, but contained allegations against CVS; later-filed complaint against CVS not barred since the first complaint "does not plead any material facts necessary to establish a valid FCA claim against CVS or contain any allegations regarding CVS's specific conduct, such that the government would be on sufficient notice to investigate.").

By adding allegations about an entirely different division of the Kaiser empire, as well as allegations about all regions throughout the nation that Kaiser operates in, Bryant and Hernandez have alleged a "more far-reaching scheme to defraud the federal government," taking their complaint outside the ambit of the first-to-file rule. *See United States ex rel. Heath v. AT & T, Inc.*, 791 F.3d 112, 121 (D.C. Cir. 2015). The *Osinek* Complaint's allegations, which say nothing about Kaiser's hospital network, did not provide the government with reason to investigate that distinct arm of Kaiser. *Id*. at 123 ("one subsidiary's infractions do not presumptively symptomize a corporate-pervading problem. A single broken branch does not meant that the entire tree is diseased.").

Kaiser's argument that the first-to-file rule bars later lawsuits against "different members of the same corporate family" fails with respect to the *Bryant/Hernandez* Complaint, and Kaiser's cases are distinguishable. Motion at 17. In *United States ex rel. Hampton v. Columbia/HCA Healthcare Corp*., 318 F.3d 214, 218 (D.C. Cir. 2003), the first relator filed suit against HCA, and alleged a corporate-wide fraud perpetrated through numerous but unnamed subsidiaries. The court held that the first-to-file rule barred a later suit against an HCA subsidiary that operated in Georgia. *Id*. *Hampton* is inapposite because *Osinek* makes no allegations at all about Kaiser's hospital division. Bryant and Hernandez do not just add a regional subsidiary of the same corporate parent; they allege fraud by a different division of the Kaiser corporate family entirely. As Kaiser's other cited case observed, one reason that the first-to-file bar can apply to claims against related subsidiaries is that "they will often be jointly liable for the same underlying conduct." *In re Nat. Gas Royalties Qui Tam Litig.*, 566 F.3d 956, 962 (10th Cir. 2009). Kaiser does not argue that its hospital division is jointly liable with its health plan or healthcare provider divisions, yet another reason why the first-to-file bar is inapplicable to Bryant and Hernandez.

C. The First-to-File Doctrine Should Have No Impact on Bryant's and Hernandez's Status as Relators in the Intervened Complaint in These Consolidated Cases

The government's election to intervene, in part, in the *Bryant/Hernandez* Complaint, along with the other consolidated cases, renders decision on the first-to-file issue premature, at least as it relates to those claims that are proceeding on an intervened basis. "If, as it does here, the Government intervenes in multiple overlapping *qui tam* actions, its complaint in intervention will necessarily incorporate the material elements of fraud from the earliest-filed complaints containing those elements." *United States v. Berkeley Heartlab, Inc.*, 225 F. Supp. 3d 487, 495 (D.S.C. 2016). Thus, the government's complaint-in-intervention "necessarily" incorporates material elements of fraud first alleged in *Bryant/Hernandez* and in each of the other consolidated cases. See U.S. Compl. ¶¶ 12-18 .

In the event there is a judgment or settlement in the United States' intervened case, there may come a time when first-to-file issues will be ripe amongst the relators to determine which allegations form the basis of the intervened case's resolution, and then who was the first relator to allege them. But that time is not now. Kaiser cites no authority for the proposition that a FCA defendant, through early first-to-file motion practice, can strip from the government's complaint-in-intervention in a series of consolidated cases all references to one or more relators and their cases. Bryant and Hernandez should continue to be relators in the intervened case regardless of Kaiser's first-to-file challenge.

IV. CONCLUSION

The *Bryant/Hernandez* Complaint survives Kaiser's first-to-file challenge because it alleges key, distinct material facts when compared to *Osinek's* (or any other relator's) complaint. Without the hard work and diligence of Bryant and Hernandez, the government would have no reason to suspect wrongdoing by Kaiser related to vent dependence, Kaiser's hospital arm, and the ACA, all taking place throughout Kaiser's entire geographic footprint. Bryant and Hernandez's diligence and courage in coming forward with their claims brought these aspects of Kaiser's fraud to light. Punishing them as Kaiser asks because, completely unbeknownst to Bryant and Hernandez, someone else filed related but materially different lawsuits runs afoul of the FCA. *See*, *e.g.*,

Hartpence, 792 F.3d at 1132. The Court should deny Kaiser's Motion as to Relators Bryant and Hernandez.

Dated: February 15, 2022

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
San Francisco Division

UNITED STATES OF AMERICA and STATE OF CALIFONRIA, *ex rel.* MICHAEL BICOCCA,

Plaintiffs,

v.

KAISER PERMANENTE, *et al.*,

Defendants.

Case No. 3:21-cv-03124-EMC

OPPOSITION TO MOTION TO DISMISS

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

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RELATOR MICHAEL BICOCCA'S OPPOSITION TO DEFENDANTS' MOTION TO DISMISS MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Relator Michael Bicocca filed his original *qui tam* Complaint against Defendants The Permanente Medical Group, Southern California Permanente Medical Group, and The Permanente Federation on February 10, 2020. *Bicocca* Dkt. No. 1 ¶¶ 1–24[1]. Bicocca filed a First Amended Complaint eight months later, on October 9, 2020, adding Kaiser Foundation Health Plan as a Defendant. *Bicocca* Dkt. No. 16 ¶¶ 13–20. In his Amended Complaint, Bicocca alleges that Defendants (collectively "Kaiser") violated the False Claims Act, 31 U.S.C. § 3729 *et seq.* by intentionally instructing physicians to include diagnoses in patients' charts regardless of whether the physicians, during the course of a face-to-face visit, confirmed the existence of a then-present condition affecting patient care, treatment or management, and that as a result, Defendants inflate risk adjustment scores submitted to the government to receive higher capitated amounts from the government. *Id.* at ¶¶ 2–5.

After the government revealed that there were numerous other filed cases and relators, on June 25, 2021, the Court ordered the cases to be consolidated, including Relator Bicocca and the first-to-file Relator Osinek, among others. *Osinek* Dkt. No. 61. On July 27, 2021, the government filed a Notice of Intervention in the consolidated cases (*Osinek* Dkt. No. 64) and filed its Complaint in Intervention on October 25, 2021. *Osinek* Dkt. No. 110. On January 18, 2022, Kaiser filed a motion to dismiss the later-filed relators' cases, including Bicocca's Complaint, citing the

[1] Bicocca's original complaint is first on the docket under his original Northern District of California Case No. 3:21-cv-03124-EMC. Bicocca originally filed in the Eastern District of California, then filed a First Amended Complaint in the Eastern District, Dkt. No. 16. The case was then transferred to the Northern District on April 28, 2021, and consolidated with the other relators' cases on June 25, 2021, under Case No. 3:13-cv-03891-EMC.

first-to-file bar provision of the False Claims Act, 31 U.S.C. § 3730(b)(5). *Osinek* Dkt. No. 141.

As part of Defendants' first-to-file analysis, Kaiser compares the later-filed relators' original Complaints to Osinek's original Complaint. Bicocca does not dispute that the claims alleged in his original Complaint are barred by Osinek's original Complaint based on the first-to-file rule. However, Bicocca's Amended Complaint supersedes the original Complaint and includes an additional, specific theory of False Claims Act liability that Osinek did not allege, and that the government did not intervene on, and is therefore not barred by the first-to file bar. As such, Bicocca respectfully requests the Court deny, in part, Kaiser's Motion to Dismiss.

II. BACKGROUND

Relator Bicocca's Amended Complaint describes "two sources" of diagnoses that Kaiser requires physicians to add. *Bicocca* Dkt. 16 ¶ 108. One of these sources is addenda that Kaiser gives physicians *after* a patient visit, which include additional diagnoses for the physician to *retroactively* add to the patient's chart. *Id.* at ¶¶ 106, 110. The other is a list of the patient's past diagnoses, which Kaiser gives to physicians *before* the physician meets with the patient, with the intention that the physician will re-diagnose each of the specific diagnoses *during* the visit ("upfront list"). *Id.* at ¶ 109.

Nowhere in her Complaint does Osinek describe the latter source of diagnoses. Instead, she focuses on the former – describing addenda to capture "missed opportunities" that were "not addressed at the time of a [patient] encounter." *Osinek* Dkt. 1 ¶¶ 24, 28. Osinek alleges that Kaiser directed physicians to add addenda to patient records "often many months after visits." *Id.* at ¶ 28. Osinek provides examples of Kaiser instructing physicians to include addenda diagnoses two months, four months, seven months, and one year after the corresponding patient visits. *Id.* at ¶¶ 29–31.

As outlined in Kaiser's Motion to Dismiss, all relators and the United States have alleged that Kaiser engaged in fraud against the Medicare Advantage program. Through the Medicare Advantage program, CMS authorizes certain private health insurance plans, like Kaiser, to provide Medicare benefits in exchange for a "capitated" monthly payment to the private health insurance plan. CMS determines the capitated rate through an annual bidding process and then CMS applies a risk-adjustment payment model, which adjusts the payment rate based on various factors including age, gender, and – notably – medical diagnoses. 42 U.S.C. § 1395w-23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2). Medicare Advantage Organizations must ensure that diagnosis codes submitted for risk-adjustment payments are accurate, complete, and truthful. *Osinek* Dkt. No. 110 ¶ 79. The diagnosis codes submitted for risk-adjustment payments are valid only if they are documented in the medical record as a result of a face-to-face visit between a patient and physician, and in conformance with the International Classification of Diseases ("ICD") Guidelines, which only permit the coding of documented conditions that both exist at the visit and that "require or affect patient care treatment or management." *Id.* at ¶¶ 80-81 (internal citations omitted).

Bicocca's allegation regarding Kaiser's scheme to use an upfront list of past diagnoses for physicians to re-diagnose during a patient's visit is a separate, distinct theory of False Claims Act liability that Bicocca illustrates in great detail in his First Amended Complaint. Bicocca describes these "hard copy" lists that are provided to physicians for their daily Medicare patients that include "the patient's chronic conditions that [Kaiser] wanted the doctor to check off in the EMR." *Bicocca* Dkt. No. 16 ¶ 94. Bicocca draws a distinction between these reports and the "addenda" for diagnoses "confirmed after the [patient visit]." *Id.* at ¶ 106. The upfront diagnoses list involves Kaiser requiring physicians "to go through the list of chronic conditions with every public benefits patient, check up on the status of those diagnoses, and confirm them, regardless of whether physicians have the time or qualifications to do so." *Id.* at

¶ 107. Bicocca even walks through an example of how a physician would be required to add a previously known diagnosis from the upfront list. *Id.* at ¶ 112.

Further, Bicocca also describes the underlying issues with Kaiser directing physicians to add previously known diagnoses from the upfront list. First, most physicians simply do not have the time necessary to properly diagnose and confirm all of the diagnoses from the list. *Id.* at ¶ 114. Bicocca explains that after his typical day's appointments, he is usually left with five minutes to "describe, discuss, and cover the nearly two dozen chronic conditions" on a patient's upfront list of diagnoses. *Id.* at ¶¶ 115–117. Second, a physician who is not a specialist in a certain area of medicine likely does not have the expertise or ability to manage and diagnose conditions involving that area of medicine. *Id.* at ¶¶ 112, 118. For example, Bicocca, an anesthesiologist who primarily focuses on pain management, does not have the expertise to properly review or manage a patient with heart failure or hypertension the way a cardiologist can. *Id.* at ¶ 120. Thus, the end result of Kaiser's upfront diagnoses list scheme is the creation of a false record in the patient's electronic medical records ("EMR") that these previous diagnoses were re-diagnosed, confirmed, and discussed with the patient during the visit.

Kaiser made it very clear to Bicocca that he was expected to re-diagnose the previous diagnoses from the upfront list. Bicocca recalls Kaiser's trainers in 2015 telling physicians that "these diagnoses are vital to [the physicians'] paychecks." *Id.* at ¶ 144. The trainers told Bicocca that "each of the chronic conditions" from a patient's upfront diagnoses list had to be checked off "every year" in order for Kaiser to be reimbursed for its services for the patient. *Id.* In or around 2015, Kaiser's Assistant Physicians in Charge ("APIC") and Chief of Gastroenterology, Jason Guardino, gave Bicocca and other physicians a directive to the effect of, "you must check and discuss every chronic condition, and then you're done." *Id.* at ¶ 147. Furthermore, Dr. Steve Olson, Kaiser's Regional Physician Director of Clinical Documentation and Coding, instructed Bicocca to merely ask the patient if they still had the previous diagnosis,

and to use a patient's "yes" response as a green light to include the diagnosis once more in the patient's EMR – falsely certifying that the physician had properly diagnosed, discussed, and confirmed the diagnosis with the patient. *Id.* at ¶¶ 166–169.

III. ARGUMENT

A. Bicocca's Amended Complaint is the Operative Complaint in this Matter.

As part of Defendants' first-to-file analysis, Kaiser compares the later-filed relators' original Complaints to Osinek's original Complaint. However, Bicocca's Amended Complaint supersedes the original Complaint, and therefore is the operative Complaint in this matter. *Rhodes v. Robinson*, 621 F.3d 1002, 1005 (9th Cir. 2010) (holding that an amended complaint supersedes the original complaint, and the original complaint is then treated as non-existent) (citing *Loux v. Rhay*, 375 F.2d 55, 57 (9th Cir. 1967)).

Kaiser's discussion regarding amended complaints is without merit. *Osinek* Dkt. 141 at 17. First, *United States ex rel. Carter v. Halliburton Co* is an Eastern District of Virginia case and thus not binding on this Court, and *Carter* itself recognizes that "at least two [other] district courts [have concluded] that a relator may avoid the first-to-file bar by amending." 144 F. Supp. 3d 869, 882 (E.D. Va. 2015); *see also U.S. ex rel. Kurnik v. PharMerica Corp.*, 2015 WL 1524402, at *6 (D.S.C. Apr. 2, 2015) (holding that the "operative complaint" for the Court's first-to-file analysis was plaintiff-relator's amended, not original, complaint); *U.S. ex rel. Palmieri v. Alpharma, Inc.*, 928 F. Supp. 2d 840, 851 (D. Md 2013) ("first-to-file rule does not bar [plaintiff-relator's] Amended Complaint" because if the Court "were to dismiss the Amended Complaint, it would do so without prejudice, and the first-to-file rule would not preclude [plaintiff-relator] from filing an identical pleading under a new case number tomorrow.").

Second, the Court in *Carter* only addressed plaintiff-relator's amended complaint in the context of determining whether another action was pending such that the plaintiff's

claim would be barred by first-to-file and did not conduct any comparison regarding the similarity of the elements of fraud alleged, which is the very issue here.

Third, *U.S. ex rel. Lujan v. Hughes Aircraft Co.* does not concern any issue pertaining to an amended complaint whatsoever. 243 F.3d 1181 (9th Cir. 2001). The words "amended" and "original" in relation to a complaint appear nowhere in the opinion, making Kaiser's citation to *Lujan* confusing and inappropriate.

Finally, Kaiser also cites *Morongo Band of Mission Indians v. California State Bd. of Equalization* – a non-FCA-related case discussing jurisdiction and an amended complaint in the context of an interpleader claim. 858 F.2d 1376, 1381 (1988). As such, Kaiser's discussion regarding amended complaints is without merit and Bicocca's Amended Complaint should be considered the operative Complaint in this matter.

B. Bicocca Alleges a Distinct, Separate Theory of Fraud from the Material Elements of Osinek's Earlier-Filed Fraud Allegations, and Thus is Not Barred by the First-to-File Rule.

In its Motion to Dismiss, Kaiser acknowledges that the first-to-file rule may bar "portions" of a later-filed complaint, rather than the entirety of the complaint. *Osinek* Dkt. 141 at 18. To the extent that some of Bicocca's allegations overlap with the same essential elements of the fraud scheme Osinek alleges – specifically the addenda claims – Bicocca does not dispute that these allegations are barred by the first-to-file rule. However, Bicocca's Amended Complaint includes a separate, distinct FCA fraud scheme – Kaiser's use of upfront diagnoses lists to re-diagnose patients – which is not discussed anywhere in Osinek's Complaint. Because Bicocca's Complaint includes an entirely new fraud scheme, Bicocca is not barred by the FCA's first-to-file rule.

Two competing *qui tam* complaints can "allege a similar fraudulent scheme" and still contain distinct material elements that overcome the first-to-file bar as to the later-filed complaint. *United States ex rel. Chin v. CVS Pharmacy, Inc.*, 2017 WL 4174416, at *5 (C.D. Cal. Aug. 15, 2017). In *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, the Court found that the first-to-file bar did not preclude a

later-filed Medicare fraud *qui tam* complaint, even though the later-filed complaint named the same defendants and involved the same fraudulent billing practices over the same time period, because the two complaints alleged separate, distinct fraud schemes that differed as to the applicable rules for the use of billing codes. 792 F.3d 1121, 1131–32 (9th Cir. 2015). The *Hartpence* Court noted that the later relator's action *did* provide an additional benefit to the government because it alerted the government of a wholly different, additional type of fraud that it might not have otherwise discovered. *Id.* at 1131 ("[Later-relator] provided information about a different form of fraud, and without that information the government might not have investigated beyond [Defendant's additional fraudulent practices].").

Likewise, the D.C. Circuit in *United States ex rel. Heath v. AT&T, Inc.*, held that two competing *qui tam* complaints were distinct enough to overcome the first-to-file bar as to the later-filed complaint because although both complaints centered on an alleged AT&T price manipulation fraud scheme, the scheme "manifested itself in sufficiently distinct ways" such that "the material elements of the fraud scheme differ[ed]" between them. 791 F.3d 112, 122–23 (D.C. Cir. 2015).

Kaiser argues that once the government is on "notice of the essential facts of an alleged fraud," then the first-to-file bar "stops repetitive claims." *Osinek* Dkt. 141 at 14–15, citing *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1186–87 (9th Cir. 2001). However, the Eastern District of Washington held that the government notice analysis "does not serve the FCA's purpose of providing private parties the opportunity to pursue actions alleging fraud," – in other words, fraud schemes with similar, yet distinct material elements of fraud should be considered as separate claims under the first-to-file bar. *U.S. ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, 2015 WL 5794357 at *8–9 (E.D. Wash. Oct. 1, 2015).

Bicocca's Amended Complaint carves out a separate, materially different claim that Osinek did not originally put the government on notice of. Like in *Hartpence*, Bicocca and Osinek's complaints are centered around, essentially, the same group of

defendants, over the same general period of time, for generally similar fraud schemes. *Hartpence* at 1131–32. Both complaints allege a fraud scheme involving inaccurate and manipulated patient diagnoses to obtain increased reimbursements from the government. But mere similarity alone does not trigger the first-to-file bar. This case is akin to *Heath*, where the fraud schemes, which had a similar foundation, diverged in the material, essential elements of fraud. *Heath* at 122–123. Here, whereas Osinek alleged that Kaiser used addenda lists provided *after* a patient visit to increase a patient's total diagnoses, Bicocca presented the government with a wholly distinct fraud scheme – Kaiser's use of an upfront diagnoses list given to a physician *before* visiting with a patient, rather than the use of addenda *after* the physician had already met with the patient. Thus, Bicocca presents a separate and distinct method by which Kaiser is defrauding the government, which indicates that Osinek's Complaint did not have the requisite "essential facts" to discover the entirety of Defendants' "fraudulent scheme." *Osinek* Dkt. 141 at 16, citing *Lujan*, 243 F.3d at 1189.

Further, Bicocca's identification of a completely different fraudulent scheme does not constitute a mere addition of "factual details" to an already existing fraud claim. *Id.*, citing *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 378 (5th Cir. 2009). Unlike *Marion*, which Kaiser cites to, Bicocca is not simply presenting a "factual variation" of the same scheme, but rather a completely different and separate scheme altogether. *Id.* at 16-17, citing *United States ex rel. Marion v. Heald Coll., LLC*, 2015 WL 4512843, at *3 (N.D. Cal. July 24, 2015). The explicit difference between the two fraud schemes illustrates that Osinek and Bicocca's complaints do not allege the same material elements of fraud, thereby supporting the argument that Bicocca's Amended Complaint, in part, is not barred by Osinek's first-filed Complaint.

Finally, dismissal of Bicocca's Complaint would not serve the purpose of the first-to-file bar, which seeks to "promote incentives for whistle-blowing insiders." *Hartpence* at 1131 (citing *Lujan* at 1187). As *Hartpence* emphasized, even if

"increasing the class of potential qui tam claimants reduces the potential incentive for any individual plaintiff to bring suit… allowing claims for related but distinct fraud claims encourages broader investigation and increases the total potential for recovery." *Id.* Thus, here, Bicocca's identification of an additional fraud scheme encourages the government to examine Kaiser's diagnosing practices and reimbursement fraud more widely and deeply, and adds to the total amount the government can recover.

C. Bicocca Alleges a Distinct, Separate Theory of Fraud from the Material Elements of the Other Relators that Filed Before Bicocca.

Relators (1) Taylor; (2) Arefi, Kumar, and Prime Healthcare Service ("Arefi"); (3) Stein and Bone ("Stein"); and (4) Bryant and Hernandez ("Bryant") all filed complaints after Osinek, and before Bicocca in time. Relator Arefi filed a Non-Opposition to Kaiser's Motion to Dismiss on January 24, 2022. *Osinek* Dkt. No 143. As such, to the extent that the Court sees the first-to-file bar as jurisdictional, Bicocca does not need to compare his Amended Complaint to Arefi's Complaint, but may compare his Amended Complaint with Taylor, Stein, and Bryant's Complaints. Such comparison shows that Bicocca should still be regarded as first-to-file with respect to his sole remaining claim, the upfront diagnoses list fraud scheme.

Relator Taylor filed a Complaint on October 22, 2014, and a First Amended Complaint immediately after on November 3, 2014. *Taylor* Dkt. No. 1, 4. Nowhere in his Amended Complaint does Taylor allege that before a physician meets with a patient, Kaiser provides the physician with a list of the patient's previous diagnoses to re-diagnose during the visit. Instead, Taylor alleges numerous other sources of diagnoses that Kaiser used to add to a patient's EMR, including diagnoses from external providers (*Taylor* Dkt. No. 4 ¶¶ 78–93), diagnoses identified in probe audits (*Id.* at ¶¶ 94–154), diagnoses identified through high risk filters (*Id.* at ¶¶ 155–161), and invalid diagnoses that should never have been included in a patient's chart in the first place (*Id.* at ¶¶ 162–164). None of these liability theories are the same as

Bicocca's allegation regarding the upfront diagnoses lists. Thus, Taylor's Complaint does not bar Bicocca's Complaint as to Bicocca's sole remaining claim.

The Stein Relators filed a Complaint on May 16, 2016. *Stein* Dkt. No. 1. Stein's Complaint discusses upcoding the severity of high value codes such as sepsis and malnutrition diagnoses (*Id.* at ¶¶ 50–79) and refreshing missing diagnoses from a patient's medical record (*Id.* at ¶¶ 80–103) but does not discuss the introduction of a patient's complete diagnoses list before a patient's visit, with the understanding that the physician was expected to re-diagnose all of the patient's previous conditions during the visit. Thus, Stein's Complaint does not bar Bicocca's Complaint as to Bicocca's sole remaining claim.

Finally, the Bryant Relators filed a Complaint on March 1, 2018. *Bryant* Dkt. No. 1. Bryant alleges an upcoding scheme for "missed opportunity" high value codes (*Id.* at ¶¶ 54–82), upcoding for ventilator-dependent patients (*Id.* at ¶¶ 83–106), sepsis-specific upcoding (*Id.* at ¶¶ 107–128), additional high value condition-specific upcoding schemes (*Id.* at ¶¶ 129–149), query templates used to add additional diagnoses to a patient's EMR (*Id.* at ¶¶ 155–164), and additional upcoding schemes including data-mining, computer assisted coding, clinical documentation improvement programs, and related schemes (*Id.* at ¶¶ 165–202). Bryant does not allege the same material fraud scheme as Bicocca – the use of upfront diagnoses lists. As such, Bryant's Complaint does not bar Bicocca's Complaint as to Bicocca's sole remaining claim.

In sum, although the remainder of Bicocca's Complaint is precluded by the first to file rule as to Osinek's Complaint – and as to Taylor, Stein, and Bryant's Complaints – none of the preceding complaints alleged the same material fraud scheme as Bicocca with regard to the upfront diagnosis lists, and therefore Kaiser's Motion to Dismiss Bicocca's Amended Complaint based on first-to-file grounds should be denied as to that specific allegation.

IV. CONCLUSION

Relator Bicocca's Amended Complaint put the government on notice of an entirely new and materially distinct fraud scheme. While Osinek's original Complaint precludes most of Bicocca's allegations under the FCA's first-to-file bar, Bicocca's Amended Complaint should not be dismissed in its entirety. Bicocca's claim as to Kaiser's creation and presentation of falsified patient electronic medical records through the use of an upfront diagnoses list given to physicians, all for the sake of obtaining higher reimbursements from the government through Medicare, should be preserved. Bicocca respectfully requests that the Court deny Kaiser's Motion to Dismiss as to this theory of fraud and allow Bicocca to proceed with discovery.

February 15, 2022

Respectfully submitted,

/s/ Janel Quinn

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Certificate of Service

I certify that on Tuesday, February 15, 2022, I served a copy of Relator Michael Bicocca's Opposition to Motion to Dismiss on counsel for Defendants Kaiser Permanente, *et al.* via the Court's Electronic Case Filing system.

/s/ Janel Quinn
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TAB 9

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA *ex. rel.*, NASER AREFI, *et al.*,

Plaintiffs,

vs.

KAISER FOUNDATION HEALTH PLAN, INC., *et al.*,

Defendants.

Case No. 3:16-cv-01558-EMC
(Consol. Case No. 3:13-cv-03891-EMC)

RELATORS' RESPONSE AND NON-OPPOSITION TO KAISER DEFENDANTS' MOTION TO DISMISS COMPLAINT PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

Relators Naser Arefi, Ajith Kumar, and Prime Healthcare Services, Inc. ("Relators"), by and through their counsel of record, hereby file their response and non-opposition to the Kaiser Defendants' motion to dismiss their complaint in Case No. 3:16-cv-01558-EMC pursuant to the first-to-file bar of the False Claims Act, 31 U.S.C. §§ 3729-3733.

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DATED: January 24, 2022

By: /s *M. S. Hardiman*

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No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
VOLUME 3 of 9

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiffs, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:21-cv-03894-EMC **REQUEST FOR JUDICIAL NOTICE IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

I. INTRODUCTION

Pursuant to Federal Rule of Evidence 201, Defendants[1] hereby request that the Court take judicial notice of the date and contents of four subpoenas issued by the Office of the Inspector General of the U.S. Department of Health and Human Services ("HHS-OIG"), an agency of the U.S. government, to Kaiser Foundation Health Plan, The Permanente Medical Group, Southern California Permanente Medical Group, and Kaiser Foundation Hospitals on December 4, 2013. HHS-OIG issued these subpoenas after Relator Ronda Osinek filed a *qui tam* complaint against "Kaiser Permanente" in this matter on August 22, 2013. *See* Dkt. No. 1. The four subpoenas are attached to the accompanying Declaration of David Deaton ("Deaton Declaration").

Defendants also request that the Court take judicial notice of the contents of a letter from the U.S. Department of Justice ("DOJ") to David Deaton, counsel for Defendants, about the production of documents from the Colorado region pursuant to a subpoena issued on December 4, 2013. This letter is also attached to the Deaton Declaration.

Finally, Defendants request that the Court take judicial notice of the fact that the California Secretary of State website does not list "Kaiser Permanente" as a registered business entity. A printout of a webpage from the California Secretary of State website is attached as an exhibit to the Deaton Declaration. This request for judicial notice is made in support of Defendants' Motion to Dismiss Pursuant to the False Claims Act's First-to-File Bar.

II. ARGUMENT

The Court may take judicial notice of matters "not subject to reasonable dispute" in that they "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b). Courts may "consider . . . matters of judicial notice . . .

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[1] "Defendants" are Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and Permanente Federation, LLC.

without converting the motion to dismiss into a motion for summary judgment." *United States v. Ritchie*, 342 F.3d 903, 908 (9th Cir. 2003).

A. HHS-OIG Subpoenas and DOJ Letter

The date and contents of the four HHS-OIG subpoenas and the DOJ letter listed below are subject to judicial notice. Government records are the proper subject of judicial notice when the facts being noticed therein are not "subject to reasonable dispute." *See Disabled Rights Action Comm. v. Las Vegas Events, Inc.*, 375 F.3d 861, 866 n.1 (9th Cir. 2004). Courts routinely take judicial notice of government-issued "letters," "memos," and "bulletins." *City & Cty. of San Francisco v. Sessions*, 372 F. Supp. 3d 928, 937 n.1 (N.D. Cal. 2019). Government letters and similar documents need not be publicly available to be judicially noticeable. *See, e.g.*, *Lee v. Delta Air Lines Inc.*, 2021 WL 4527955, at *2 (C.D. Cal. Aug. 23, 2021) (taking judicial notice of a California Department of Fair Employment and Housing Determination letter "because it [is] a record of an administrative governmental body, and the accuracy of the source of the document cannot be reasonably questioned"). For example, the Ninth Circuit has taken judicial notice of a licensing agreement between a state entity and a private party. *See Disabled Rights Action Comm.*, 375 F.3d at 866 n.1.

Defendants request that the Court take judicial notice of the following government documents:

1. **Exhibit A** is a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Kaiser Foundation Health Plan, and advising that the subpoena applies to "all . . . subsidiaries, regions, . . . [and] affiliates" of Kaiser Foundation Health Plan. Ex. A at 5. This subpoena includes two attachments: Attachment A and Attachment B, though Defendants request judicial notice of the contents of Attachment A only. Attachment A includes twelve pages of definitions and instructions followed by thirteen specifications, many of which have subparts, calling for the production of documents. *Id.* at 4–20. These specifications request "all documents" about a variety of topics, including "goals or objectives . . . related . . . to . . . diagnoses or diagnosis codes or HCCs," "training or education . . . [regarding] diagnoses or diagnosis codes or HCCs," "audits," and "systems . . . used to determine, document, assign,

review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees." *Id.* at 16–20. Attachment B includes protected health information of Medicare Advantage members, and Defendants do not request judicial notice of its contents; it is not included in the Exhibit.

2. **Exhibit B** is a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to The Permanente Medical Group. Like the subpoena issued to Kaiser Foundation Health Plan, it includes two attachments requesting the same categories of records that were requested from Kaiser Foundation Health Plan. As with the request for judicial notice of Exhibit A, Defendants only request judicial notice of Attachment A.

3. **Exhibit C** is a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Southern California Permanente Medical Group. Like the subpoena issued to Kaiser Foundation Health Plan, it includes two attachments requesting the same categories of records that were requested from Kaiser Foundation Health Plan. As with the request for judicial notice of Exhibit A, Defendants only request judicial notice of Attachment A.

4. **Exhibit D** is a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Kaiser Foundation Hospitals. Like the subpoena issued to Kaiser Foundation Health Plan, it includes two attachments requesting the same categories of records that were requested from Kaiser Foundation Health Plan. As with the request for judicial notice of Exhibit A, Defendants only request judicial notice of Attachment A.

5. **Exhibit E** is a letter dated June 7, 2017 sent from Senior Trial Counsel Arthur Di Dio, Assistant U.S. Attorney Erica Hitchings, and Assistant U.S. Attorney Edwin Winstead of DOJ to David Deaton of O'Melveny & Myers LLP. This letter communicated to Mr. Deaton "a prioritization of document requests for the Colorado Region" pursuant to the December 4, 2013 HHS-OIG subpoenas. Ex. E at 1.

These exhibits are all properly subject to judicial notice. First, all of the exhibits are documents issued by an agency of the United States, making them government records. Second, Defendants submit these records to show only (1) that the subpoenas were issued to Kaiser Foundation Health Plan, The Permanente Medical Group, Southern California Permanente

Medical Group, and Kaiser Foundation Hospitals on December 4, 2013; (2) that a letter was sent to counsel for Defendants prioritizing the production of documents related to the Colorado region pursuant to that subpoena; and (3) the contents of the requests within the subpoenas—all of which are not "subject to reasonable dispute." *See Disabled Rights Action Comm.*, 375 F.3d at 866 n.1.

B. California Secretary of State Website

"Kaiser Permanente" is not listed as a registered business entity on the California Secretary of State website. The absence of a record showing that Kaiser Permanente is a registered entity in the State of California is also information subject to judicial notice.[2] "[I]nformation made publicly available on a website maintained by a government entity is judicially noticeable." *Platte River Ins. Co. v. P & E Automation, Inc.*, 2013 WL 12123688, at *2 (C.D. Cal. June 19, 2013) (judicially noticing documents available on the California Secretary of State's website). Therefore, courts in the Ninth Circuit routinely take judicial notice of the contents of the California Secretary of State's website. *See, e.g.*, *Phan v. Costco Wholesale Corp.*, 2019 WL 6050903, at *1 n.2 (N.D. Cal. Nov. 15, 2019) (judicially noticing information from the California Secretary of State website); *Green v. First Tenn. Bank Nat'l Ass'n*, 2021 WL 4846952, at *2 (N.D. Cal. Oct. 18, 2021) (same); *Breckenridge Prop. Fund 2016, LLC v. Gonzalez*, 2017 WL 3381155, at *2 n.2 (N.D. Cal. Aug. 7, 2017) (same); *L'Garde, Inc. v. Raytheon Space & Airborne Sys.*, 805 F. Supp. 2d 932, 938 (C.D. Cal. 2011) ("The Court finds that the accuracy of the results of records searches from the Secretary of State for the State of California corporate search website can be determined by readily accessible resources whose accuracy cannot reasonably be questioned.").

Exhibit F shows the results of a search for "Kaiser Permanente" on the California Secretary of State website.[3] The Court should take judicial notice of the fact that the California Secretary of State website does not show any registered business entity listed as "Kaiser

[2] Because the *Osinek* complaint identifies "Kaiser Permanente" as being "headquartered in Oakland California," only search results from the California Secretary of State website are included in this request for judicial notice. *See* Dkt. No. 1 ¶ 6.

[3] These search results are also accessible at https://businesssearch.sos.ca.gov/CBS/SearchResults?filing=&SearchType=CORP&SearchCriteria=kaiser+permanente&SearchSubType=Keyword.

Permanente."

III. CONCLUSION

The Court should grant Defendants' request and take judicial notice of (1) the December 4, 2013 subpoenas issued by HHS-OIG to Kaiser Foundation Health Plan, The Permanente Medical Group, Southern California Permanente Medical Group, and Kaiser Foundation Hospitals; (2) the June 7, 2017 letter sent to counsel for Defendants; and (3) the absence of "Kaiser Permanente" on the California Secretary of State website, as requested herein.

Dated: January 18, 2022

Respectfully submitted,

By: /s/ *K. Lee Blalack, II*
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DAVID J. LEVISS
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Attorneys for Defendants

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA,

Plaintiffs,

v.

PERMANENTE MEDICAL GROUP, INC., et al.,

Defendants.

Case No. 3:21-cv-03124-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:21-cv-03894-EMC

DECLARATION OF DAVID DEATON IN SUPPORT OF REQUEST FOR JUDICIAL NOTICE

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

I, David Deaton, hereby declare and state as follows:

1. I am an active member in good standing of the State Bar of California. I am a partner of O'Melveny & Myers LLP, counsel of record for Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and Permanente Federation, LLC (collectively, "Defendants") in the above-captioned cases. I submit this declaration in support of Defendants' Motion to Dismiss Pursuant to the False Claims Act's First-to-File Bar. This declaration is based upon my personal knowledge and, if called as a witness, I could and would testify to the matters set forth below.

2. A true and correct copy of a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of the Office of the Inspector General of the U.S. Department of Health and Human Services ("HHS-OIG") to Kaiser Foundation Health Plan is attached hereto as **Exhibit A**.

3. A true and correct copy of a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to The Permanente Medical Group is attached hereto as **Exhibit B**.

4. A true and correct copy of a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Southern California Permanente Medical Group is attached hereto as **Exhibit C**.

5. A true and correct copy of a subpoena dated December 4, 2013 sent from General Investigator Ellen M. Kotler of HHS-OIG to Kaiser Foundation Hospitals is attached hereto as **Exhibit D**.

6. A true and correct copy of a letter dated June 7, 2017 sent from U.S. Department of

Justice Senior Trial Counsel Arthur Di Dio, Assistant U.S. Attorney Erica Hitchings, and Assistant U.S. Attorney Edwin Winstead to me is attached hereto as **Exhibit E**.

7. A true and correct copy of the results for a search of "Kaiser Permanente" on the website of the California Secretary of State performed at my direction by an attorney at my firm on December 29, 2021 is attached hereto as **Exhibit F**. These search results are also accessible at https://businesssearch.sos.ca.gov/CBS/SearchResults?filing=&SearchType=CORP&SearchCriteria=kaiser+permanente&SearchSubType=Keyword. The results of this search show no registered entity with that name.

8. I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

EXECUTED this 18th day of January, 2022.

/s/ David Deaton
David Deaton

EXHIBIT A

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS
1855 GATEWAY BLVD. #585
CONCORD, CA 94520

December 4, 2013

RECEIVED
DEC 15 2013
LEGAL DEPARTMENT

Custodian of Records
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza
Oakland, CA 94612

Dear Sir or Madam:

Accompanying this letter is a subpoena addressed to you returnable at the Office of Inspector General (OIG), Office of Investigations, San Francisco Regional Office, before my designee, General Investigator Ellen M. Kotler. The subpoena has been issued pursuant to the authority provided to the Inspector General by Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is "required by law" (see 45 C.F.R. §§ 164.512(a), 164.103), and will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before December 27, 2013, to:

General Investigator Ellen M. Kotler
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigations
90 7th Street, Suite 3-600
San Francisco, CA 94103

If you have any questions, please feel free to contact General Investigator Kotler at (415) 437-7976.

Sincerely,

Ivan Negroni
Special Agent in Charge
San Francisco Regional Office

Enclosure

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

SUBPOENA DUCES TECUM

Control No.: 15428

To: *Custodian of Records*
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza
Oakland, CA 94612

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE General Investigator Ellen M. Kotler, an official of the Office of Inspector General, at 90 7th Street, Suite 3-600, in the City of San Francisco, and State of California, ***on the 27th day of December, 2013, at 9:00 o'clock, A.M. of that day, in connection with*** *an investigation relating to claims submitted to Title XVIII (Medicare) of the Social Security Act; and you are hereby required to bring with you and produce at said time and place the following:*

See Attachments A and B

which are necessary in the performance of the responsibility of the Inspector General under Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504, to conduct and supervise audits and investigations and to promote economy, efficiency and effectiveness in the administration of and to prevent and detect fraud and abuse in the programs and operations of the Department of Health and Human Services.

IN TESTIMONY WHEREOF

Ivan Negroni, the undersigned official of the Office of Inspector General of said DEPARTMENT OF HEALTH AND HUMAN SERVICES; has hereunto set his hand this 4th day of December, 2013.

Special Agent in Charge
San Francisco Regional Office

ATTACHMENT A

DEFINITIONS

1. The term "COMMUNICATION" means any contact between two or more persons or companies and shall include, without limitation, written contact by such means as e-mails, letters, memoranda, telegrams, telex, or by any DOCUMENTS, and oral contact by such means as face-to-face meetings and telephone conversations.

2. The terms "CONCERNS" or "CONCERNING" include REFERRING TO, alluding to, responding to, RELATING TO, connected with, commenting on, in respect of, about, regarding, discussing, showing, describing, mentioning, reflecting, analyzing, constituting, pertaining to and/or comprising, whichever definition makes the request most inclusive.

3. The terms "REFERRING TO," "RELATING TO" or "RELATED TO" shall mean pertaining to, CONCERNING, describing, discussing, reflecting, evidencing, constituting or resulting from the matter specified, whichever definition makes the request most inclusive.

4. The term "DOCUMENT" means "writing" as defined in Rule 34(a)(1) of the Federal Rules of Civil Procedure and Federal Rule of Evidence 1001, and thus includes, by way of illustration only and not by way of limitation, the original or a copy of handwriting, typewriting, printing, photostating, photocopying, and every other means of recording upon any tangible thing any form of communication or representation, including e-mails, letters, words, pictures, sounds, or symbols, or combinations thereof, including without limitation, correspondence, memoranda, notes, diaries, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, charts, maps, inter-office and intra-office communications, notations of any sort of conversation, bulletins, printed matter, computer printouts, teletypes, telefax, worksheets and drafts, alterations, modifications, changes or amendments of any of the foregoing, graphic or aural records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, videotape, recordings, motion pictures) and electronic, mechanical or electric records or representations of any kind (including, without limitation, tapes, cassettes, mag cards, discs, and recordings).

5. The term "ALL DOCUMENTS" means every DOCUMENT as above defined known to YOU and every such DOCUMENT which can be located or discovered by reasonably diligent efforts.

6. The term "CMS" means the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services.

7. The term "MEDICARE ADVANTAGE" means the program established by Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

8. The terms "YOU" and "YOUR" mean the person or entity to which this subpoena is addressed and includes all individuals and entities specified in definition 10.

9. The term "PERSON" refers to a natural person, firm, association, organization, partnership, joint venture, business, trust, corporation, or government body, commission, board, agency, branch, department, component, or element thereof, and every other form and kind of public or private entity, whether domestic or foreign. Reference herein to any "person" includes officials, representatives, agents, and employees of such "person."

10. The term "KAISER FOUNDATION HEALTH PLAN, INC. " refers to the person or entity with its primary offices located at One Kaiser Plaza, Oakland, California, and also includes **all current and former**: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, subsidiaries, regions, segments, branches, groups, affiliates, and divisions; and joint ventures of which it is a part.

11. The words "AND" and "OR" in this subpoena shall be read in both the conjunctive and the disjunctive (i.e., "and/or"), so as to give each document request its broadest meaning. The singular form of a word shall be construed to include within its meaning the plural form of the word, and vice versa, and the use of any tense of any verb shall be considered also to include all other tenses, in a manner that gives each document request its broadest possible meaning.

12. The time period for which responsive DOCUMENTS are requested is **January 1, 2005 to the present**. The subpoena requires the production of all responsive DOCUMENTS that were in effect and/or referred to during the specified time period regardless of whether they were prepared before, during, or after the specified time period.

13. "HIERARCHICAL CONDITION CATEGORIES" or "HCCs" refer to the disease groupings consisting of DIAGNOSIS CODES intended to predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to Medicare Advantage payments.

14. The phrase "DIAGNOSES OR DIAGNOSIS CODES" refers to any statements of a diagnosis or diagnosis codes relevant to the determination of HCCs under the Medicare Advantage program.

15. The phrase "DETERMINATION, DOCUMENTATION, ASSIGNMENT, REVIEW, ANALYSIS, REPORTING, DATA MINING, ADDENDING, UPDATING, OR REFRESHING OF DIAGNOSES OR DIAGNOSIS CODES OR HCCs" includes (but is not limited to) any subsequent additions, addendums, or other changes to DIAGNOSES OR DIAGNOSIS CODES or HCCs.

INSTRUCTIONS

1. All documents provided in response to this subpoena are to include all versions of responsive documents with marginalia and post-it notes and other similar documents attached thereto, as well as all preliminary drafts or revisions, any attachments or enclosures, and any copies or duplicates that are not identical to the original because of additions, deletions, alterations or notations.

2. This subpoena requires the production of all responsive documents that are under your possession, custody or control. To the extent that documents responsive to this subpoena once were, but no longer are, in your possession, custody, or control, this subpoena requires production of all existing indices, lists, or documents in your possession, custody, or control which reflect the transfer or destruction of, or references to, such documents. If no documents exist that are responsive to a specification, a written statement to that effect shall be provided at the time of production.

3. To the extent that documents responsive to this subpoena are publicly available, it shall be sufficient to provide a list of such documents provided that such documents will be made promptly available to the Office of Inspector General (OIG) upon request.

4. Where a subpoena specification includes the limiting language "FOR MEDICARE ADVANTAGE ENROLLEES" a document is responsive to the specification if it either concerns Medicare Advantage enrollees specifically or concerns a broader category of patients or enrollees that includes Medicare Advantage enrollees.

5. **Collection of Electronically Stored Information (ESI)**
The following instructions shall apply to the production of Electronically Stored Information (ESI) and digitized (scanned) images. Careful consideration should be given to the methodology, implementation and documentation of ESI collection to ensure that all responsive data and metadata are preserved in the collection process.

a. **Specification Modifications**
Any modifications or deviations from the Production Specifications may be done only with the express permission of the OIG.

b. **Production Format of ESI and Imaged Hard Copy**
Responsive ESI and imaged hard copy shall be produced in the format outlined below. All ESI, except as outlined below in sections i-q, shall be rendered to type TIFF image format, and accompanied by a Concordance® Image Cross Reference file. All applicable metadata (see section c below) shall be extracted and provided in Concordance® load file format.

i. **Image File Format:** All images, paper documents scanned to images, or rendered ESI, shall be produced as 300 dpi single-page TIFF files, CCITT Group IV (2D Compression). Documents should be uniquely and sequentially Bates numbered with an endorsement burned into each image.

A. All TIFF file names shall include the unique Bates number burned into the image.

B. Each Bates number shall be a standard length, include leading zeros in the number, and be unique for each produced page.

C. All TIFF image files shall be stored with the ".tif" extension.

D. Images should be able to be OCR'd using standard COTS products, such as LexisNexis LAW PreDiscovery™.

E. All pages of a document or all pages of a collection of documents that comprise a folder or other logical grouping, including a box, should be delivered on a single piece of media.

F. No image folder shall contain more than 1000 images.

ii. **Concordance® Image Cross Reference file:** Images should be accompanied by a Concordance® Image Cross Reference file that associates each Bates number with its corresponding single-page TIFF image file. The Cross Reference file should also contain the image file path for each Bates numbered page.

A. Image Cross Reference Sample Format:

```
ABC00000001,OLS,D:\DatabaseName\Images\001\
ABC00000001.TIF,Y,,,
ABC00000002,OLS,D:\DatabaseName\Images\001\
ABC00000002.TIF,,,,
ABC00000003,OLS,D:\DatabaseName\Images\001\
ABC00000003.TIF,,,,
ABC00000004,OLS,D:\DatabaseName\Images\001\
ABC00000004.TIF,Y,,,
```

iii. **Concordance® Load File**: Images should also be accompanied by a "text load file" containing delimited text that will populate fields in a searchable, flat database environment. The file should contain the required fields listed in section c below.

A. ASCII text delimited load files are defined using the following delimiters:

Field Separator	*^ or Code 094*
Text Qualifier	*| or Code 124*

Substitute Carriage Return or New Line () or Code 013

B. The extracted/OCR text should always be the final delimited field in the text load file.

C. The text file should also contain hyperlinks to applicable native files, such as Microsoft Excel or Word files.

D. There should be one line for every record in a collection.

E. The load file must contain a field map/key listing the metadata fields in the order they appear within the data file. For example, if the data file consists of a First Page of a Record (Beginning Bates), Last Page of a Record (End Bates), Document Range (a.k.a. Family Range), Document Date, File Name, and a Title, then the structure may appear as follows:
|BEGBATES|^|ENDBATES|^|FAMILYRNG|^|DOCDATE|^|FILENAME|^|TITLE|

F. Example of a minimal text load file:
BEGBATES	^	ENDBATES	^	OCR
ABC00000001	^	ABC000000003	^	OCR TEXT
ABC00000004	^	ABC000000022	^	OCR TEXT
ABC00000023	^	ABC000000150	^	OCR TEXT
ABC00000151	^	ABC000000200	^	OCR TEXT

c. **Required Metadata/Database Fields**

i. An "X" denotes that the indicated field should be present in the load file produced.

ii. "Other ESI" includes non-email or hard copy documents, including but not limited to data discussed in sections f-h, and l-o below.

Field name	Field Description	Field Type	Field Value	Hard Copy	E-Mail	Other ESI
COMPANY	Company/Organization submitting data	Full Text	Unlimited	X	X	X
BOX#	Submission/volume/box number	Note Text	10	X	X	X
CUSTODIAN	Custodian(s)/Source(s) - format: Last, First or ABC Dept	Multi-Entry	Unlimited	X	X	X
AUTHOR	Creator of the document	Note Text	160			X
BEGDOC#	Start Bates (including prefix) - No spaces	Note Text	60	X	X	X
ENDDOC#	End Bates (including prefix) - No spaces	Note Text	60	X	X	X

Field name	Field Description	Field Type	Field Value	Hard Copy	E-Mail	Other ESI
DOCID	Unique document bates # or populate with the same value as Start Bates (DOCID = BEGDOC#)	Note Text	60	X	X	X
PGCOUNT	Page Count	Integer	10	X	X	X
PARENTID	Parent's DOCID or Parent's Start Bates (for EVERY document including all Child documents)	Note Text	60	X	X	X
ATTACHIDs	Child document list; Child DOCID or Child Start Bates	Multi-Entry	60	X	X	X
ATTACHLIST	List of Attachment bates numbers	Multi Entry	Unlimited		X	X
BEGATTACH	Start Bates number of first attachment	Note Text	60	X	X	X
ENDATTACH	End Bates number of last attachment	Note Text	60	X	X	X
PROPERTIES	Privilege notations, Redacted, Document Withheld Based On Privilege	Multi-Entry	Unlimited	X	X	X
RECORD TYPE	File, E-mail, Attachment, or Hardcopy	Note Text	60	X	X	X
FROM	Author - format: Last name, First name	Note Text	160		X	X
TO	Recipient- format: Last name, First name	Multi-Entry	Unlimited		X	X
CC	Carbon Copy Recipients - format: Last name, First name	Multi-Entry	Unlimited		X	X
BCC	Blind Carbon Copy Recipients - format: Last name, First name	Multi-Entry	Unlimited		X	X
SUBJECT	Subject/Document Title	Note Text	Unlimited		X	X
DOCDATE	Document Date/Date Sent - Format MM/DD/YYYY	Date Keyed	MM/DD/YYYY			X
BODY	E-mail body, Other Electronic Document Extracted text, or OCR	Full Text	Unlimited	X	X	X
TIMESENT	Time e-mail was sent	Time	10		X	
DATECRTD	Date Created	Date	MM/DD/YYYY		X	X
DATESVD	Date Saved	Date	MM/DD/YYYY		X	X

Field name	Field Description	Field Type	Field Value	Hard Copy	E-mail	Other ESI
DATEMOD	Date Last Modified	Date Keyed	MM/DD/YYYY		X	X
DATERCVD	Date Accessed/Received	Date	MM/DD/YYYY	X	X	X
FILESIZE	File Size	Note Text	10			X
FILENAME	File name - name of file as it appeared in its original location	Full Text	Unlimited			X
APPLICATION	Application used to create native file (e.g. Excel, Outlook, Word)	Note Text	160		X	X
FILEPATH	Data's original source full folder path	Full Text	Unlimited		X	X
NATIVELINK	Current file path location to the native file	Full Text	Unlimited		X	X
FOLDERID	E-mail folder path (e.g. Inbox\Active) or Hard Copy container information (e.g. Folder or binder name)	Full Text	Unlimited	X	X	
PARAGRAPH	Subpoena/request paragraph number to which the document is responsive	Multi-Entry	Unlimited	X	X	X
HASH	Hash value (used for deduplication or other processing)	Note Text	Unlimited		X	X
MESSAGEHEADER	Email header. Can contain IP address	Full Text	Unlimited		X	
ATTACHMCOUNT	Number of attachments to an email	Note Text	10		X	
FILETYPE	Identifies the application that created the file	Note Text	160		X	X
COMMENTS	Identifies whether the document has comments associated with it	Note Text	10		X	X

d. **De-duplication, Near-duplicate Identification, Email Conversation Threading and Other Culling Procedures**

De-duplication of exact copies within a custodian's data may be done, but all "filepaths" must be provided for each duplicate document. Any other procedure which attempts to cull, filter, group, separate or de-duplicate, etc. (i.e., reduce the volume of material) shall not be done without the express approval of the OIG. All objective coding (e.g., near

dupe ID or e-mail thread ID) shall be discussed and produced to the OIG as additional metadata fields.

e. **Hidden Text**

All hidden text (e.g. track changes, hidden columns, mark-ups, notes) shall be expanded and rendered in the image file. For files that cannot be expanded the native files shall be produced with the image file.

f. **Embedded Files**

All non-graphic embedded objects (Word documents, Excel spreadsheets, .wav files, etc.) that are found within a file shall be extracted and produced. For purposes of production the embedded files shall be treated as attachments to the original file, with the parent/child relationship preserved.

g. **Image-Only Files**

All image-only files (non-searchable .pdfs, multi-page TIFFs, Snipping Tool [and other] screenshots, etc., as well as all other images that contain text) shall be produced with associated OCR text and metadata fields identified in section c above for "Other ESI."

h. **Hard Copy Records**

i. All hard copy material shall reflect accurate document unitization including all attachments and container information (to be reflected in the ParentID, AttachID, beg attach, end attach and group ID). Unitization in this context refers to identifying and marking the boundaries of documents within the collection, where a document is defined as the smallest physical fastened unit within a bundle (e.g., staples, paperclips, rubber bands, folders, or tabs in a binder). The first document in the collection represents the parent document and all other documents will represent the children.

ii. All documents shall be produced in black and white TIFF format unless the image requires color. An image "requires color" when color in the document adds emphasis to information in the document, or is itself information that would not be readily apparent on the face of a black and white image. Images identified as requiring color shall be produced as color 300 dpi single-page JPEG files.

iii. All objective coding (e.g., document date or document author) shall be discussed and produced to the OIG as additional metadata fields.

i. **Production of Email Repositories**

Email repositories, also known as email databases (e.g., Outlook .PST, Lotus .NSF, etc.), can contain a variety of items, including: messages, calendars, contacts, tasks etc. For purposes of production, responsive items shall provide the "Email" metadata fields outlined in section c above, including but not limited to all parent items (mail, calendar, contacts, tasks, notes, etc.) and child files (attachments of files to email or other items) with the parent/child relationship preserved. Email databases from operating systems

other than Microsoft Exchange shall be produced after consultation and only with the express approval of the OIG.

j. **Production of Items Originally Generated in E-Mail Repositories but Found and Collected Outside of Email Repositories, i.e., "Stand-alone" Items**
If parent email or other parent items (e.g., calendar, contacts, tasks, notes, etc.) are found and collected outside of email repositories (e.g., items having extensions like .MSG, .HTM, .MHT, etc.), then all such produced items shall provide the "Email" metadata fields outlined in section c above, including but not limited to any attachments, maintaining the family (parent/child) relationship.

k. **Production of Instant Messenger (IM), Voicemail Data, etc.**
The responding party shall identify, collect, and produce any and all data which is responsive to the requests which may be stored in cell phone/PDA/Blackberry/smart phone data, voicemail messaging data, instant messaging, text messaging, conference call data and related/similar technologies. However, such data, logs, metadata or other files related thereto, as well as other less common but similar data types, shall be produced after consultation and only with the express approval of the OIG.

l. **Productions of Structured Data**
Prior to any production of responsive data from a structured database (e.g., Oracle, SQL, MySQL, QuickBooks, etc.), the producing party shall provide the database dictionary and a list of all reports that can be generated from the structured database. The list of reports shall be provided in native Excel (.xls) format.

m. **Productions of Structured Data from Proprietary Applications**
Prior to any production of structured data from proprietary applications (e.g., proprietary timekeeping, accounting, etc.) the producing party shall provide the database dictionary and a list of all reports that can be generated from the structured database. The list of reports shall be produced in native Excel (.xls) format.

n. **Production of Photographs with Native File or Digitized ESI**
Photographs shall be produced as single-page .JPG files with a resolution equivalent to the original image as it was captured/created. All .JPG files shall have extracted metadata fields provided in a Concordance® load file format as defined in the field specifications for "Other ESI" as outlined in section c above.

o. **Images from which Text Cannot be OCR Converted**
An exception report shall be provided when limitations of paper digitization software/hardware or attribute conversion do not allow for OCR text conversion of certain images. The report shall include the electronic bates, document id or Bates number(s) corresponding to each such image.

p. **Production of Native Files (When Applicable Pursuant to These Specifications)**
All native file productions shall have extracted metadata fields provided in a

Concordance® load file format as defined in the field specifications for "Other ESI" as outlined in section c above.

i. **Common files to be produced in Native Format.** All spreadsheet and presentation files shall be produced in the unprocessed "as kept in the ordinary course of business" state (i.e., in native format). The file produced should maintain the integrity of all source, custodian, application, embedded and related file system metadata. No alteration shall be made to file names or extensions for responsive native electronic files.

ii. **Uncommon Files to be produced in Native Format.** ESI shall be produced in a manner which is functionally useable. The following are examples:

A. AutoCAD data, e.g., .DWG, .DXF, shall be processed/converted and produced as single-page .JPG image files and accompanied by a Concordance® Image formatted load as described above. The native files shall be placed in a separate folder on the production media and linked by a hyperlink within the text load file.

B. GIS data shall be produced in its native format and be accompanied by a viewer such that the mapping or other data can be reviewed in a manner that does not detract from its ability to be reasonably understood.

C. Audio and video recordings shall be produced in native format and be accompanied by a viewer if such recordings do not play in a generic application (e.g., Windows Media Player).

iii. **Electronic Bates (DocID) Convention.** Eletronic Bates (DocID) shall not exceed 30 characters in length and shall include leading zeros in the numeric portion; the Electronic Bates (DocId) shall be a unique name/number common to each document. If the OIG agrees to a rolling production, the naming/numbering convention shall remain consistent throughout the entire production. There shall be no spaces between the prefix and numeric value. If suffixes are required, please use "dot notation". Below is a sample of dot notation:

PREFIX0000001	PREFIX0000003
PREFIX0000001.001	PREFIX0000003.001
PREFIX0000001.002	PREFIX0000003.002

q. **Format of ESI from Non-PC or Windows-based Systems**
The format of ESI from non-PC or Windows-based Systems (e.g., Apple, IBM mainframes and UNIX machines) shall be the subject of discussion and shall only be produced with the express approval of the OIG.

r. **Media Formats for Storage and Delivery of Production Data**
Electronic documents and data shall be delivered on any of the following media:

i. CD-ROMs and/or DVD-R (+/-) formatted to ISO/IEC 13346 and Universal Disk Format 1.02 specifications.

ii. External hard drives, USB 2.0 (or better) or eSATA, formatted to NTFS format specifications.

iii. Storage media used to deliver ESI shall be appropriate to the size of the data in the production.

iv. Media should be labeled with the case name, production date, bates range, and producing party.

s. **Virus Protection and Security for Delivery of Production Data**
Production data shall be free of computer viruses. Any files found to include a virus shall be quarantined by the producing party and noted in a log to be provided to the OIG. Password protected or encrypted files or media shall be provided with corresponding passwords and specific decryption instructions. No encryption software shall be used without the approval of the OIG.

t. **Compliance and Adherence to Generally Accepted Technical Standards**
Production shall be in conformance with standards and practices established by the National Institute of Standards and Technology ("NIST" at www.nist.gov), U.S. National Archives & Records Administration ("NARA" at www.archives.gov), American Records Management Association ("ARMA International" at www.arma.org), American National Standards Institute ("ANSI" at www.ansi.org), International Organization for Standardization ("ISO" at www.iso.org), and/or other U.S. Government or professional organizations.

u. **Transmittal Letter to Accompany Deliverables**
All deliverables shall be accompanied by a transmittal letter including all of the following information at a minimum: production date, case name and number, request paragraph responding to, identity of producing party, production volume name, electronic Bates number (document id or control numbering), Bates number ranges referenced, custodian names, and total number of records.

v. **Read Me Text File**
All deliverables shall include a read me text file at the root directory containing: total number of records, total number of images/pages or files, mapping of fields to plainly identify field names, types, lengths and formats. The file shall also indicate the field name to which images will be linked for viewing, date and time format, and confirmation that the number of files in load files matches the number of files produced.

w. **Exception Log**

An Exception Log shall be included documenting any production anomalies utilizing by the electronic Bates number (document id or control numbering) assigned during the collection, processing and production phases.

6. **Privilege Logs**

Productions that include claims of privilege or confidentiality, (resulting in documents, or portions of documents, being withheld), shall be accompanied by a Privilege Log that identifies the document(s) by Bates range and the basis for each claim or privilege. The Privilege Log shall be electronically produced in native Excel (.xls) or Access (.mdb) and for any document withheld on the ground of any claimed privilege shall include:

a. The type of document being withheld (e.g., letter, memorandum, handwritten notes, marginalia, etc.);

b. The name and title of the author (and if different, the preparer and signatory);

c. The name(s) and title(s) of the individual(s) to whom the document was addressed;

d. The name(s) and title(s) of the individuals to whom the document or a copy of the document was sent or to whom the document or a copy, or any part thereof, was shown;

e. The date of the document;

f. The number of pages;

g. A brief description of the subject matter;

h. A statement of the specific basis on which privilege is claimed; and

i. The paragraph or subparagraph under the heading **"SPECIFICATIONS"** to which it is responsive.

SPECIFICATIONS

You are required to produce the following:

1. Related to Medicare Advantage enrollees, all communications and documents constituting, discussing, or referring to:

a. Goals or objectives related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

b. Any form of bonus or incentive compensation offered or awarded, or any form of consequence, referral, sanction, penalty, disciplinary action or other unfavorable action, related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

c. (i) the reimbursement impact of diagnoses, diagnosis codes or HCCs (including diagnosis coding or HCC projects or initiatives); (ii) actual, projected, or targeted changes in diagnosis coding or HCC patterns, trends, or ratios; (iii) comparisons of the diagnosis coding or HCC patterns, trends, or ratios of one or more Kaiser Foundation Health Plan, Inc. facilities or other groups with one or more other Kaiser Foundation Health Plan, Inc. facilities or other groups or with any peer group; or (iv) the diagnosis coding or HCC patterns, trends, or ratios of any physicians who provide services at Kaiser Foundation Health Plan, Inc. facilities or of any contractors or employees in the components referred to in Specification 2; and/or

d. Data analysis, including but not limited to data mining, to identify opportunities for adding, addending, updating, refreshing, or otherwise amending diagnoses or diagnosis codes.

2. All organizational charts for all Kaiser Foundation Health Plan, Inc. components involved in:

a. The determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees; and

b. The auditing, monitoring, oversight, review, or legal or regulatory compliance of the components specified in 2(a).

3. All organizational charts for all Kaiser Foundation Health Plan, Inc. components to which the components specified in 2(a) and 2(b) report and/or are overseen by.

4. For all individuals involved in the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and all individuals responsible for supervising, managing, or overseeing those individuals:

a. Documents sufficient to identify their complete names and social security numbers; employing entities; employment positions and titles; current employment status; last known home and work addresses and home, work, and cellular telephone numbers; and (if applicable) State licensing numbers. (In lieu of these documents you may produce a chart or spreadsheet setting forth this information.)

b. All documents relating to job descriptions and job responsibilities;

c. All documents relating to pay plans, including documents concerning incentive pay or bonuses; and

d. All personnel evaluations and other personnel records that concern the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or Medicare Advantage reimbursement related to diagnoses or diagnosis codes or HCCs.

5. All documents concerning laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) (including, but not limited to those applicable to physicians who render services at Kaiser Foundation Health Plan, Inc. facilities) concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

6. All documents constituting or referring to training or education (including, but not limited to that involving physicians who render services at Kaiser Foundation Health Plan, Inc. related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

7. All documents constituting, discussing or referring to all meetings (whether one-on-one or involving a larger group), including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recordings, where the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees was discussed or referred to.

8. All documents concerning either (a) internal or external reviews or audits, investigations, or compliance or monitoring activities related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or (b) calculated, estimated, or

projected overpayments and/or error rates related to the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Communications, including all related reports, analyses, review, discussion, responses and other internal or external communications, audits, and correspondence;

b. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

c. Notes and any other records of telephone calls;

d. Working papers and analyses, including all documents related to coding reviews;

e. Complaints;

f. Recommendations;

g. All communications and documents concerning calculated, estimated, or projected error rates or overpayments;

h. Considered and/or established accounting or financial reserves; and

i. Considered and/or implemented resolutions, including corrective action, disciplinary action, disclosure to the United States Department of Health and Human Services Office of Inspector General, or any other voluntary disclosure or voluntary repayment.

9. For any relationship between Kaiser Foundation Health Plan, Inc. and any auditor, reviewer, consultant, contractor or other third party related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Bids, proposals, contracts, agreements, invoices, and payments;

b. Communications, including reports, audits, correspondence, memos, and notes;

c. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

d. Notes and any other records of telephone calls;

e. Working papers and analyses, including documents related to coding reviews;

f. Recommendations;

g. Documents reviewed or referred to by the auditor, reviewer, consultant, contractor or other third party;

h. Training materials, guidance or other instruction provided by the auditor, reviewer, consultant, contractor or other third party; and

i. Assessments or evaluations of the auditor, reviewer, consultant, contractor, or other third party's performance, including the retention or non-retention (initial or continued) of its services.

10. Regarding the systems (including computer software systems) used to determine, document, assign, review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees:

a. Documents sufficient to identify each such system and the dates used; and

b. Concerning diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees, all documents constituting, discussing or referring to:

(i) Instructions, operations, policies or procedures;

(ii) Pre- and post-implementation testing;

(iii) Medical records entries, including addendums to original medical records entries, that are able to be generated (in whole or in part) by a computer keystroke or command (e.g., a computer macro) as opposed to typing the full entry;

(iv) The systems' accuracy, validity, and/or compliance (or inaccuracy, invalidity, and/or non-compliance) with any laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) related to diagnoses or diagnoses codes or HCCs for Medicare Advantage enrollees; and

(v) Any formal or informal complaints or other expressions of concern.

11. For all diagnosis codes reported to the CMS for Medicare Advantage enrollees and/or any resulting HCCs, all medical and coding records and any other records concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of those diagnosis codes and/or the accuracy or validity (or inaccuracy or invalidity) of those codes or HCCs. [Note: At this time, except for those documents specified in Attachment B, documents responsive to this Specification need be only fully preserved rather than produced to the OIG provided that they will be made fully available to the OIG upon request and within a reasonable amount of time.]

12. To the extent not already called for, any communication to or from CMS or any CMS contractors, related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

13. All documents concerning:

a. Your policies and/or procedures for document retention and destruction; and

b. The destruction of any documents related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

EXHIBIT B

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS
1855 GATEWAY BLVD. #585
CONCORD, CA 94520

December 4, 2013

Custodian of Records
The Permanente Medical Group
1950 Franklin Street, 18th floor
Oakland, CA 94612

Dear Sir or Madam:

Accompanying this letter is a subpoena addressed to you returnable at the Office of Inspector General (OIG), Office of Investigations, San Francisco Regional Office, before my designee, General Investigator Ellen M. Kotler. The subpoena has been issued pursuant to the authority provided to the Inspector General by Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is "required by law" (see 45 C.F.R. §§ 164.512(a), 164.103), and will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before December 27, 2013, to:

General Investigator Ellen M. Kotler
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigations
90 7th Street, Suite 3-600
San Francisco, CA 94103

If you have any questions, please feel free to contact General Investigator Kotler at (415) 437-7976.

Sincerely,

Ivan Negron
Special Agent in Charge
San Francisco Regional Office

Enclosure

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

SUBPOENA DUCES TECUM

Control No.: 15429

To: *Custodian of Records*
The Permanente Medical Group
1950 Franklin Street, 18th floor
Oakland, CA 94612

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE General Investigator Ellen M. Kotler, an official of the Office of Inspector General, at 90 7th Street, Suite 3-600, in the City of San Francisco, and State of California, ***on the 27th day of December, 2013, at 9:00 o'clock, A.M. of that day, in connection with*** *an investigation relating to claims submitted to Title XVIII (Medicare) of the Social Security Act; and you are hereby required to bring with you and produce at said time and place the following:*

See Attachments A and B

which are necessary in the performance of the responsibility of the Inspector General under Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504, to conduct and supervise audits and investigations and to promote economy, efficiency and effectiveness in the administration of and to prevent and detect fraud and abuse in the programs and operations of the Department of Health and Human Services.

IN TESTIMONY WHEREOF

Ivan Negroni, the undersigned official of the Office of Inspector General of said DEPARTMENT OF HEALTH AND HUMAN SERVICES, has hereunto set his hand this 4th day of December, 2013.

Special Agent in Charge
San Francisco Regional Office

RETURN OF SERVICE

I, being a person over 18 years of age, hereby certify that a copy of this subpoena was duly served on the person named herein by means of -

1. *personal delivery to an individual, to wit:*

_____
(Name)

_____
(Title)

_____
(Address)

2. *personal delivery to an address, to wit:*

_____
(Description of premises)

_____
(Address)

_____
(Address)

3. *registered or certified mailing to:*

_____
(Name)

_____
(Address)

_____
(Address)

at _____ *( ) a.m.*
( ) p.m. on _____

_____
(Signature)

_____
(Title)

UNITED STATES OF AMERICA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Upon contumacy or refusal to obey, this subpoena shall be enforceable by order of the appropriate United States District Court.

Case 3:23-cv-03891-EMC Document 1-3 Filed 07/10/23 Page 13 of 94

ATTACHMENT A

DEFINITIONS

1. The term "COMMUNICATION" means any contact between two or more persons or companies and shall include, without limitation, written contact by such means as e-mails, letters, memoranda, telegrams, telex, or by any DOCUMENTS, and oral contact by such means as face-to-face meetings and telephone conversations.

2. The terms "CONCERNS" or "CONCERNING" include REFERRING TO, alluding to, responding to, RELATING TO, connected with, commenting on, in respect of, about, regarding, discussing, showing, describing, mentioning, reflecting, analyzing, constituting, pertaining to and/or comprising, whichever definition makes the request most inclusive.

3. The terms "REFERRING TO," "RELATING TO" or "RELATED TO" shall mean pertaining to, CONCERNING, describing, discussing, reflecting, evidencing, constituting or resulting from the matter specified, whichever definition makes the request most inclusive.

4. The term "DOCUMENT" means "writing" as defined in Rule 34(a)(1) of the Federal Rules of Civil Procedure and Federal Rule of Evidence 1001, and thus includes, by way of illustration only and not by way of limitation, the original or a copy of handwriting, typewriting, printing, photostating, photocopying, and every other means of recording upon any tangible thing any form of communication or representation, including e-mails, letters, words, pictures, sounds, or symbols, or combinations thereof, including without limitation, correspondence, memoranda, notes, diaries, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, charts, maps, inter-office and intra-office communications, notations of any sort of conversation, bulletins, printed matter, computer printouts, teletypes, telefax, worksheets and drafts, alterations, modifications, changes or amendments of any of the foregoing, graphic or aural records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, videotape, recordings, motion pictures) and electronic, mechanical or electric records or representations of any kind (including, without limitation, tapes, cassettes, mag cards, discs, and recordings).

5. The term "ALL DOCUMENTS" means every DOCUMENT as above defined known to YOU and every such DOCUMENT which can be located or discovered by reasonably diligent efforts.

6. The term "CMS" means the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services.

7. The term "MEDICARE ADVANTAGE" means the program established by Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

8. The terms "YOU" and "YOUR" mean the person or entity to which this subpoena is addressed and includes all individuals and entities specified in definition 10.

9. The term "PERSON" refers to a natural person, firm, association, organization, partnership, joint venture, business, trust, corporation, or government body, commission, board, agency, branch, department, component, or element thereof, and every other form and kind of public or private entity, whether domestic or foreign. Reference herein to any "person" includes officials, representatives, agents, and employees of such "person."

10. The term "THE PERMANENTE MEDICAL GROUP" refers to the person or entity with its primary offices located at 1950 Franklin Street, 18th floor, Oakland, California, and also includes **all current and former**: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, subsidiaries, regions, segments, branches, groups, affiliates, and divisions; and joint ventures of which it is a part.

11. The words "AND" and "OR" in this subpoena shall be read in both the conjunctive and the disjunctive (i.e., "and/or"), so as to give each document request its broadest meaning. The singular form of a word shall be construed to include within its meaning the plural form of the word, and vice versa, and the use of any tense of any verb shall be considered also to include all other tenses, in a manner that gives each document request its broadest possible meaning.

12. The time period for which responsive DOCUMENTS are requested is **January 1, 2005 to the present**. The subpoena requires the production of all responsive DOCUMENTS that were in effect and/or referred to during the specified time period regardless of whether they were prepared before, during, or after the specified time period.

13. "HIERARCHICAL CONDITION CATEGORIES" or "HCCs" refer to the disease groupings consisting of DIAGNOSIS CODES intended to predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to Medicare Advantage payments.

14. The phrase "DIAGNOSES OR DIAGNOSIS CODES" refers to any statements of a diagnosis or diagnosis codes relevant to the determination of HCCs under the Medicare Advantage program.

15. The phrase "DETERMINATION, DOCUMENTATION, ASSIGNMENT, REVIEW, ANALYSIS, REPORTING, DATA MINING, ADDENDING, UPDATING, OR REFRESHING OF DIAGNOSES OR DIAGNOSIS CODES OR HCCs" includes (but is not limited to) any subsequent additions, addendums, or other changes to DIAGNOSES OR DIAGNOSIS CODES or HCCs.

SPECIFICATIONS

You are required to produce the following:

1. Related to Medicare Advantage enrollees, all communications and documents constituting, discussing, or referring to:

a. Goals or objectives related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

b. Any form of bonus or incentive compensation offered or awarded, or any form of consequence, referral, sanction, penalty, disciplinary action or other unfavorable action, related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

c. (i) the reimbursement impact of diagnoses, diagnosis codes or HCCs (including diagnosis coding or HCC projects or initiatives); (ii) actual, projected, or targeted changes in diagnosis coding or HCC patterns, trends, or ratios; (iii) comparisons of the diagnosis coding or HCC patterns, trends, or ratios of one or more The Permanente Medical Group facilities or other groups with one or more other The Permanente Medical Group facilities or other groups or with any peer group; or (iv) the diagnosis coding or HCC patterns, trends, or ratios of any physicians who provide services at The Permanente Medical Group facilities or of any contractors or employees in the components referred to in Specification 2; and/or

d. Data analysis, including but not limited to data mining, to identify opportunities for adding, addending, updating, refreshing, or otherwise amending diagnoses or diagnosis codes.

2. All organizational charts for all The Permanente Medical Group components involved in:

a. The determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees; and

b. The auditing, monitoring, oversight, review, or legal or regulatory compliance of the components specified in 2(a).

3. All organizational charts for all The Permanente Medical Group components to which the components specified in 2(a) and 2(b) report and/or are overseen by.

4. For all individuals involved in the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis

codes or HCCs for Medicare Advantage enrollees and all individuals responsible for supervising, managing, or overseeing those individuals:

a. Documents sufficient to identify their complete names and social security numbers; employing entities; employment positions and titles; current employment status; last known home and work addresses and home, work, and cellular telephone numbers; and (if applicable) State licensing numbers. (In lieu of these documents you may produce a chart or spreadsheet setting forth this information.)

b. All documents relating to job descriptions and job responsibilities;

c. All documents relating to pay plans, including documents concerning incentive pay or bonuses; and

d. All personnel evaluations and other personnel records that concern the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or Medicare Advantage reimbursement related to diagnoses or diagnosis codes or HCCs.

5. All documents concerning laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) (including, but not limited to those applicable to physicians who render services at The Permanente Medical Group facilities) concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

6. All documents constituting or referring to training or education (including, but not limited to that involving physicians who render services at The Permanente Medical Group related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

7. All documents constituting, discussing or referring to all meetings (whether one-on-one or involving a larger group), including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recordings, where the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees was discussed or referred to.

8. All documents concerning either (a) internal or external reviews or audits, investigations, or compliance or monitoring activities related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or (b) calculated, estimated, or projected overpayments and/or error rates related to the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Communications, including all related reports, analyses, review, discussion, responses and other internal or external communications, audits, and correspondence;

b. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

c. Notes and any other records of telephone calls;

d. Working papers and analyses, including all documents related to coding reviews;

e. Complaints;

f. Recommendations;

g. All communications and documents concerning calculated, estimated, or projected error rates or overpayments;

h. Considered and/or established accounting or financial reserves; and

i. Considered and/or implemented resolutions, including corrective action, disciplinary action, disclosure to the United States Department of Health and Human Services Office of Inspector General, or any other voluntary disclosure or voluntary repayment.

9. For any relationship between The Permanente Medical Group and any auditor, reviewer, consultant, contractor or other third party related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Bids, proposals, contracts, agreements, invoices, and payments;

b. Communications, including reports, audits, correspondence, memos, and notes;

c. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

d. Notes and any other records of telephone calls;

e. Working papers and analyses, including documents related to coding reviews;

f. Recommendations;

g. Documents reviewed or referred to by the auditor, reviewer, consultant, contractor or other third party;

h. Training materials, guidance or other instruction provided by the auditor, reviewer, consultant, contractor or other third party; and

i. Assessments or evaluations of the auditor, reviewer, consultant, contractor, or other third party's performance, including the retention or non-retention (initial or continued) of its services.

10. Regarding the systems (including computer software systems) used to determine, document, assign, review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees:

a. Documents sufficient to identify each such system and the dates used; and

b. Concerning diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees, all documents constituting, discussing or referring to:

(i) Instructions, operations, policies or procedures;

(ii) Pre- and post-implementation testing;

(iii) Medical records entries, including addendums to original medical records entries, that are able to be generated (in whole or in part) by a computer keystroke or command (e.g., a computer macro) as opposed to typing the full entry;

(iv) The systems' accuracy, validity, and/or compliance (or inaccuracy, invalidity, and/or non-compliance) with any laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) related to diagnoses or diagnoses codes or HCCs for Medicare Advantage enrollees; and

(v) Any formal or informal complaints or other expressions of concern.

11. For all diagnosis codes reported to the CMS for Medicare Advantage enrollees and/or any resulting HCCs, all medical and coding records and any other records concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of those diagnosis codes and/or the accuracy or validity (or inaccuracy or invalidity) of those codes or HCCs. [Note: At this time, except for those documents specified in Attachment B, documents responsive to this Specification need be only fully preserved rather than produced to the OIG provided that they will be made fully available to the OIG upon request and within a reasonable amount of time.]

12. To the extent not already called for, any communication to or from CMS or any CMS contractors, related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

13. All documents concerning:

a. Your policies and/or procedures for document retention and destruction; and

b. The destruction of any documents related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

EXHIBIT C

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS
1855 GATEWAY BLVD. #585
CONCORD, CA 94520

December 4, 2013

Custodian of Records
Southern California Permanente Medical Group
Walnut Center
393 East Walnut Street
Pasadena, CA 91188

Dear Sir or Madam:

Accompanying this letter is a subpoena addressed to you returnable at the Office of Inspector General (OIG), Office of Investigations, San Francisco Regional Office, before my designee, General Investigator Ellen M. Kotler. The subpoena has been issued pursuant to the authority provided to the Inspector General by Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is "required by law" (see 45 C.F.R. §§ 164.512(a), 164.103), and will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before December 27, 2013, to:

General Investigator Ellen M. Kotler
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigation
90 7th Street, Suite 3-600
San Francisco, CA 94103

If you have any questions, please feel free to contact General Investigator Kotler at (415) 437-7976.

Sincerely,

Ivan Negroni
Special Agent in Charge
San Francisco Regional Office

Enclosure

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

SUBPOENA DUCES TECUM

Control No.: 15430

To: *Custodian of Records*
Southern California Permanente Medical Group
Walnut Center
393 East Walnut Street
Pasadena, CA 91188

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE General Investigator Ellen M. Kotler, an official of the Office of Inspector General, at 90 7th Street, Suite 3-600, in the City of San Francisco, and State of California, ***on the 27th day of December, 2013, at 9:00 o'clock, A.M. of that day, in connection with*** *an investigation relating to claims submitted to Title XVIII (Medicare) of the Social Security Act; and you are hereby required to bring with you and produce at said time and place the following:*

See Attachments A and B

which are necessary in the performance of the responsibility of the Inspector General under Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504, to conduct and supervise audits and investigations and to promote economy, efficiency and effectiveness in the administration of and to prevent and detect fraud and abuse in the programs and operations of the Department of Health and Human Services.

IN TESTIMONY WHEREOF

Ivan Negroni, the undersigned official of the Office of Inspector General of said DEPARTMENT OF HEALTH AND HUMAN SERVICES, has hereunto set his hand this 4th day of December, 2013.

Special Agent in Charge
San Francisco Regional Office

RETURN OF SERVICE

I, being a person over 18 years of age, hereby certify that a copy of this subpoena was duly served on the person named herein by means of -

1. *personal delivery to an individual, to wit:*

_____
(Name)

_____
(Title)

_____
(Address)

2. *personal delivery to an address, to wit:*

_____
(Description of premises)

_____
(Address)

_____
(Address)

3. *registered or certified mailing to:*

_____
(Name)

_____
(Address)

_____
(Address)

at _____( ) a.m. ( ) p.m. on _____

_____
(Signature)

_____
(Title)

UNITED STATES OF AMERICA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Upon contumacy or refusal to obey, this subpoena shall be enforceable by order of the appropriate United States District Court.

Case 3:23-cv-03891-EMC Document 1-3 Filed 07/18/23 Page 6 of 34

ATTACHMENT A

DEFINITIONS

1. The term "COMMUNICATION" means any contact between two or more persons or companies and shall include, without limitation, written contact by such means as e-mails, letters, memoranda, telegrams, telex, or by any DOCUMENTS, and oral contact by such means as face-to-face meetings and telephone conversations.

2. The terms "CONCERNS" or "CONCERNING" include REFERRING TO, alluding to, responding to, RELATING TO, connected with, commenting on, in respect of, about, regarding, discussing, showing, describing, mentioning, reflecting, analyzing, constituting, pertaining to and/or comprising, whichever definition makes the request most inclusive.

3. The terms "REFERRING TO," "RELATING TO" or "RELATED TO" shall mean pertaining to, CONCERNING, describing, discussing, reflecting, evidencing, constituting or resulting from the matter specified, whichever definition makes the request most inclusive.

4. The term "DOCUMENT" means "writing" as defined in Rule 34(a)(1) of the Federal Rules of Civil Procedure and Federal Rule of Evidence 1001, and thus includes, by way of illustration only and not by way of limitation, the original or a copy of handwriting, typewriting, printing, photostating, photocopying, and every other means of recording upon any tangible thing any form of communication or representation, including e-mails, letters, words, pictures, sounds, or symbols, or combinations thereof, including without limitation, correspondence, memoranda, notes, diaries, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, charts, maps, inter-office and intra-office communications, notations of any sort of conversation, bulletins, printed matter, computer printouts, teletypes, telefax, worksheets and drafts, alterations, modifications, changes or amendments of any of the foregoing, graphic or aural records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, videotape, recordings, motion pictures) and electronic, mechanical or electric records or representations of any kind (including, without limitation, tapes, cassettes, mag cards, discs, and recordings).

5. The term "ALL DOCUMENTS" means every DOCUMENT as above defined known to YOU and every such DOCUMENT which can be located or discovered by reasonably diligent efforts.

6. The term "CMS" means the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services.

7. The term "MEDICARE ADVANTAGE" means the program established by Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

8. The terms "YOU" and "YOUR" mean the person or entity to which this subpoena is addressed and includes all individuals and entities specified in definition 10.

9. The term "PERSON" refers to a natural person, firm, association, organization, partnership, joint venture, business, trust, corporation, or government body, commission, board, agency, branch, department, component, or element thereof, and every other form and kind of public or private entity, whether domestic or foreign. Reference herein to any "person" includes officials, representatives, agents, and employees of such "person."

10. The term "SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP " refers to the person or entity with its primary offices located at Walnut Center, 393 East Walnut Street, Pasadena, California, and also includes **all current and former**: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, subsidiaries, regions, segments, branches, groups, affiliates, and divisions; and joint ventures of which it is a part.

11. The words "AND" and "OR" in this subpoena shall be read in both the conjunctive and the disjunctive (i.e., "and/or"), so as to give each document request its broadest meaning. The singular form of a word shall be construed to include within its meaning the plural form of the word, and vice versa, and the use of any tense of any verb shall be considered also to include all other tenses, in a manner that gives each document request its broadest possible meaning.

12. The time period for which responsive DOCUMENTS are requested is **January 1, 2005 to the present**. The subpoena requires the production of all responsive DOCUMENTS that were in effect and/or referred to during the specified time period regardless of whether they were prepared before, during, or after the specified time period.

13. "HIERARCHICAL CONDITION CATEGORIES" or "HCCs" refer to the disease groupings consisting of DIAGNOSIS CODES intended to predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to Medicare Advantage payments.

14. The phrase "DIAGNOSES OR DIAGNOSIS CODES" refers to any statements of a diagnosis or diagnosis codes relevant to the determination of HCCs under the Medicare Advantage program.

15. The phrase "DETERMINATION, DOCUMENTATION, ASSIGNMENT, REVIEW, ANALYSIS, REPORTING, DATA MINING, ADDENDING, UPDATING, OR REFRESHING OF DIAGNOSES OR DIAGNOSIS CODES OR HCCs" includes (but is not limited to) any subsequent additions, addendums, or other changes to DIAGNOSES OR DIAGNOSIS CODES or HCCs.

SPECIFICATIONS

You are required to produce the following:

1. Related to Medicare Advantage enrollees, all communications and documents constituting, discussing, or referring to:

a. Goals or objectives related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

b. Any form of bonus or incentive compensation offered or awarded, or any form of consequence, referral, sanction, penalty, disciplinary action or other unfavorable action, related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

c. (i) the reimbursement impact of diagnoses, diagnosis codes or HCCs (including diagnosis coding or HCC projects or initiatives); (ii) actual, projected, or targeted changes in diagnosis coding or HCC patterns, trends, or ratios; (iii) comparisons of the diagnosis coding or HCC patterns, trends, or ratios of one or more Southern California Permanente Medical Group facilities or other groups with one or more other Southern California Permanente Medical Group facilities or other groups or with any peer group; or (iv) the diagnosis coding or HCC patterns, trends, or ratios of any physicians who provide services at Southern California Permanente Medical Group facilities or of any contractors or employees in the components referred to in Specification 2; and/or

d. Data analysis, including but not limited to data mining, to identify opportunities for adding, addending, updating, refreshing, or otherwise amending diagnoses or diagnosis codes.

2. All organizational charts for all Southern California Permanente Medical Group components involved in:

a. The determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees; and

b. The auditing, monitoring, oversight, review, or legal or regulatory compliance of the components specified in 2(a).

3. All organizational charts for all Southern California Permanente Medical Group components to which the components specified in 2(a) and 2(b) report and/or are overseen by.

4. For all individuals involved in the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis

codes or HCCs for Medicare Advantage enrollees and all individuals responsible for supervising, managing, or overseeing those individuals:

a. Documents sufficient to identify their complete names and social security numbers; employing entities; employment positions and titles; current employment status; last known home and work addresses and home, work, and cellular telephone numbers; and (if applicable) State licensing numbers. (In lieu of these documents you may produce a chart or spreadsheet setting forth this information.)

b. All documents relating to job descriptions and job responsibilities;

c. All documents relating to pay plans, including documents concerning incentive pay or bonuses; and

d. All personnel evaluations and other personnel records that concern the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or Medicare Advantage reimbursement related to diagnoses or diagnosis codes or HCCs.

5. All documents concerning laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) (including, but not limited to those applicable to physicians who render services at Southern California Permanente Medical Group facilities) concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

6. All documents constituting or referring to training or education (including, but not limited to that involving physicians who render services at Southern California Permanente Medical Group) related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

7. All documents constituting, discussing or referring to all meetings (whether one-on-one or involving a larger group), including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recordings, where the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees was discussed or referred to.

8. All documents concerning either (a) internal or external reviews or audits, investigations, or compliance or monitoring activities related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or (b) calculated, estimated, or projected overpayments and/or error rates related to the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Communications, including all related reports, analyses, review, discussion, responses and other internal or external communications, audits, and correspondence;

b. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

c. Notes and any other records of telephone calls;

d. Working papers and analyses, including all documents related to coding reviews;

e. Complaints;

f. Recommendations;

g. All communications and documents concerning calculated, estimated, or projected error rates or overpayments;

h. Considered and/or established accounting or financial reserves; and

i. Considered and/or implemented resolutions, including corrective action, disciplinary action, disclosure to the United States Department of Health and Human Services Office of Inspector General, or any other voluntary disclosure or voluntary repayment.

9. For any relationship between Southern California Permanente Medical Group and any auditor, reviewer, consultant, contractor or other third party related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Bids, proposals, contracts, agreements, invoices, and payments;

b. Communications, including reports, audits, correspondence, memos, and notes;

c. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

d. Notes and any other records of telephone calls;

e. Working papers and analyses, including documents related to coding reviews;

f. Recommendations;

g. Documents reviewed or referred to by the auditor, reviewer, consultant, contractor or other third party;

h. Training materials, guidance or other instruction provided by the auditor, reviewer, consultant, contractor or other third party; and

i. Assessments or evaluations of the auditor, reviewer, consultant, contractor, or other third party's performance, including the retention or non-retention (initial or continued) of its services.

10. Regarding the systems (including computer software systems) used to determine, document, assign, review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees:

a. Documents sufficient to identify each such system and the dates used; and

b. Concerning diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees, all documents constituting, discussing or referring to:

(i) Instructions, operations, policies or procedures;

(ii) Pre- and post-implementation testing;

(iii) Medical records entries, including addendums to original medical records entries, that are able to be generated (in whole or in part) by a computer keystroke or command (e.g., a computer macro) as opposed to typing the full entry;

(iv) The systems' accuracy, validity, and/or compliance (or inaccuracy, invalidity, and/or non-compliance) with any laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) related to diagnoses or diagnoses codes or HCCs for Medicare Advantage enrollees; and

(v) Any formal or informal complaints or other expressions of concern.

11. For all diagnosis codes reported to the CMS for Medicare Advantage enrollees and/or any resulting HCCs, all medical and coding records and any other records concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of those diagnosis codes and/or the accuracy or validity (or inaccuracy or invalidity) of those codes or HCCs. [Note: At this time, except for those documents specified in Attachment B, documents responsive to this Specification need be only fully preserved rather than produced to the OIG provided that they will be made fully available to the OIG upon request and within a reasonable amount of time.]

12. To the extent not already called for, any communication to or from CMS or any CMS contractors, related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

13. All documents concerning:

a. Your policies and/or procedures for document retention and destruction; and

b. The destruction of any documents related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

EXHIBIT D

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF INVESTIGATIONS
1855 GATEWAY BLVD. #585
CONCORD, CA 94520

December 4, 2013

DEC / 5 2013

LEGAL DEPARTMENT

Custodian of Records
Kaiser Foundation Hospitals
One Kaiser Plaza
Oakland, CA 94612

Dear Sir or Madam:

Accompanying this letter is a subpoena addressed to you returnable at the Office of Inspector General (OIG), Office of Investigations, San Francisco Regional Office, before my designee, General Investigator Ellen M. Kotler. The subpoena has been issued pursuant to the authority provided to the Inspector General by Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504.

Under the health information privacy regulation that implements the Health Insurance Portability and Accountability Act of 1996, also known as HIPAA, providing the information requested by the attached subpoena is a permitted disclosure since it is "required by law" (see 45 C.F.R. §§ 164.512(a), 164.103), and will be used for "health oversight" activities by OIG, which meets the definition of a "health oversight agency" (see 45 C.F.R. §§ 164.512(d), 164.501).

Fully legible and complete copies of the records called for by the subpoena will be accepted in response to the subpoena, provided that the original records will be made available to employees of my office, upon request, during normal business hours. Otherwise, original documents (including copies as maintained in your files) should be produced.

Failure to appear at the time and place specified in the subpoena may be taken as a failure to comply with the subpoena. However, as a convenience and in lieu of your personal appearance, you may assemble the documents requested and mail them by certified mail on or before December 27, 2013, to:

General Investigator Ellen M. Kotler
U.S. Department of Health and Human Services
Office of Inspector General
Office of Investigations
90 7th Street, Suite 3-600
San Francisco, CA 94103

If you have any questions, please feel free to contact General Investigator Kotler at (415) 437-7976.

Sincerely,

Ivan Negroni
Special Agent in Charge
San Francisco Regional Office

Enclosure

UNITED STATES OF AMERICA

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

SUBPOENA DUCES TECUM

Control No.: 15427

To: *Custodian of Records*
Kaiser Foundation Hospitals
One Kaiser Plaza
Oakland, CA 94612

YOU ARE HEREBY COMMANDED TO APPEAR BEFORE General Investigator Ellen M. Kotler, an official of the Office of Inspector General, at 90 7th Street, Suite 3-600, in the City of San Francisco, and State of California, ***on the 27th day of December, 2013, at 9:00 o'clock, A.M. of that day, in connection with*** *an investigation relating to claims submitted to Title XVIII (Medicare) of the Social Security Act; and you are hereby required to bring with you and produce at said time and place the following:*

See Attachments A and B

which are necessary in the performance of the responsibility of the Inspector General under Public Law 95-452 (see 5 U.S.C. App. 3 § 6(a)(4)), as amended by Public Law 100-504, to conduct and supervise audits and investigations and to promote economy, efficiency and effectiveness in the administration of and to prevent and detect fraud and abuse in the programs and operations of the Department of Health and Human Services.

IN TESTIMONY WHEREOF

Ivan Negroni, the undersigned official of the Office of Inspector General of said DEPARTMENT OF HEALTH AND HUMAN SERVICES, has hereunto set his hand this 4th day of December, 2013.

Special Agent in Charge
San Francisco Regional Office

ATTACHMENT A

DEFINITIONS

1. The term "COMMUNICATION" means any contact between two or more persons or companies and shall include, without limitation, written contact by such means as e-mails, letters, memoranda, telegrams, telex, or by any DOCUMENTS, and oral contact by such means as face-to-face meetings and telephone conversations.

2. The terms "CONCERNS" or "CONCERNING" include REFERRING TO, alluding to, responding to, RELATING TO, connected with, commenting on, in respect of, about, regarding, discussing, showing, describing, mentioning, reflecting, analyzing, constituting, pertaining to and/or comprising, whichever definition makes the request most inclusive.

3. The terms "REFERRING TO," "RELATING TO" or "RELATED TO" shall mean pertaining to, CONCERNING, describing, discussing, reflecting, evidencing, constituting or resulting from the matter specified, whichever definition makes the request most inclusive.

4. The term "DOCUMENT" means "writing" as defined in Rule 34(a)(1) of the Federal Rules of Civil Procedure and Federal Rule of Evidence 1001, and thus includes, by way of illustration only and not by way of limitation, the original or a copy of handwriting, typewriting, printing, photostating, photocopying, and every other means of recording upon any tangible thing any form of communication or representation, including e-mails, letters, words, pictures, sounds, or symbols, or combinations thereof, including without limitation, correspondence, memoranda, notes, diaries, statistics, letters, telegrams, minutes, contracts, reports, studies, checks, statements, receipts, returns, summaries, pamphlets, books, charts, maps, inter-office and intra-office communications, notations of any sort of conversation, bulletins, printed matter, computer printouts, teletypes, telefax, worksheets and drafts, alterations, modifications, changes or amendments of any of the foregoing, graphic or aural records or representations of any kind (including without limitation, photographs, charts, graphs, microfiche, videotape, recordings, motion pictures) and electronic, mechanical or electric records or representations of any kind (including, without limitation, tapes, cassettes, mag cards, discs, and recordings).

5. The term "ALL DOCUMENTS" means every DOCUMENT as above defined known to YOU and every such DOCUMENT which can be located or discovered by reasonably diligent efforts.

6. The term "CMS" means the Centers for Medicare and Medicaid Services, an agency of the United States Department of Health and Human Services.

7. The term "MEDICARE ADVANTAGE" means the program established by Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173.

8. The terms "YOU" and "YOUR" mean the person or entity to which this subpoena is addressed and includes all individuals and entities specified in definition 10.

9. The term "PERSON" refers to a natural person, firm, association, organization, partnership, joint venture, business, trust, corporation, or government body, commission, board, agency, branch, department, component, or element thereof, and every other form and kind of public or private entity, whether domestic or foreign. Reference herein to any "person" includes officials, representatives, agents, and employees of such "person."

10. The term "KAISER FOUNDATION HOSPITALS" refers to the person or entity with its primary offices located at One Kaiser Plaza, Oakland, California, and also includes **all current and former**: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, subsidiaries, regions, segments, branches, groups, affiliates, and divisions; and joint ventures of which it is a part.

11. The words "AND" and "OR" in this subpoena shall be read in both the conjunctive and the disjunctive (i.e., "and/or"), so as to give each document request its broadest meaning. The singular form of a word shall be construed to include within its meaning the plural form of the word, and vice versa, and the use of any tense of any verb shall be considered also to include all other tenses, in a manner that gives each document request its broadest possible meaning.

12. The time period for which responsive DOCUMENTS are requested is **January 1, 2005 to the present**. The subpoena requires the production of all responsive DOCUMENTS that were in effect and/or referred to during the specified time period regardless of whether they were prepared before, during, or after the specified time period.

13. "HIERARCHICAL CONDITION CATEGORIES" or "HCCs" refer to the disease groupings consisting of DIAGNOSIS CODES intended to predict average healthcare spending. HCCs represent the disease component of the enrollee risk score that are applied to Medicare Advantage payments.

14. The phrase "DIAGNOSES OR DIAGNOSIS CODES" refers to any statements of a diagnosis or diagnosis codes relevant to the determination of HCCs under the Medicare Advantage program.

15. The phrase "DETERMINATION, DOCUMENTATION, ASSIGNMENT, REVIEW, ANALYSIS, REPORTING, DATA MINING, ADDENDING, UPDATING, OR REFRESHING OF DIAGNOSES OR DIAGNOSIS CODES OR HCCs" includes (but is not limited to) any subsequent additions, addendums, or other changes to DIAGNOSES OR DIAGNOSIS CODES or HCCs.

SPECIFICATIONS

You are required to produce the following:

1. Related to Medicare Advantage enrollees, all communications and documents constituting, discussing, or referring to:

a. Goals or objectives related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

b. Any form of bonus or incentive compensation offered or awarded, or any form of consequence, referral, sanction, penalty, disciplinary action or other unfavorable action, related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs;

c. (i) the reimbursement impact of diagnoses, diagnosis codes or HCCs (including diagnosis coding or HCC projects or initiatives); (ii) actual, projected, or targeted changes in diagnosis coding or HCC patterns, trends, or ratios; (iii) comparisons of the diagnosis coding or HCC patterns, trends, or ratios of one or more Kaiser Foundation Hospitals facilities or other groups with one or more other Kaiser Foundation Hospitals facilities or other groups or with any peer group; or (iv) the diagnosis coding or HCC patterns, trends, or ratios of any physicians who provide services at Kaiser Foundation Hospitals facilities or of any contractors or employees in the components referred to in Specification 2; and/or

d. Data analysis, including but not limited to data mining, to identify opportunities for adding, addending, updating, refreshing, or otherwise amending diagnoses or diagnosis codes.

2. All organizational charts for all Kaiser Foundation Hospitals components involved in:

a. The determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees; and

b. The auditing, monitoring, oversight, review, or legal or regulatory compliance of the components specified in 2(a).

3. All organizational charts for all Kaiser Foundation Hospitals components to which the components specified in 2(a) and 2(b) report and/or are overseen by.

4. For all individuals involved in the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis

codes or HCCs for Medicare Advantage enrollees and all individuals responsible for supervising, managing, or overseeing those individuals:

a. Documents sufficient to identify their complete names and social security numbers; employing entities; employment positions and titles; current employment status; last known home and work addresses and home, work, and cellular telephone numbers; and (if applicable) State licensing numbers. (In lieu of these documents you may produce a chart or spreadsheet setting forth this information.)

b. All documents relating to job descriptions and job responsibilities;

c. All documents relating to pay plans, including documents concerning incentive pay or bonuses; and

d. All personnel evaluations and other personnel records that concern the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or Medicare Advantage reimbursement related to diagnoses or diagnosis codes or HCCs.

5. All documents concerning laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) (including, but not limited to those applicable to physicians who render services at Kaiser Foundation Hospitals facilities) concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

6. All documents constituting or referring to training or education (including, but not limited to that involving physicians who render services at Kaiser Foundation Hospitals related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

7. All documents constituting, discussing or referring to all meetings (whether one-on-one or involving a larger group), including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recordings, where the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees was discussed or referred to.

8. All documents concerning either (a) internal or external reviews or audits, investigations, or compliance or monitoring activities related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees and/or (b) calculated, estimated, or projected overpayments and/or error rates related to the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Communications, including all related reports, analyses, review, discussion, responses and other internal or external communications, audits, and correspondence;

b. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

c. Notes and any other records of telephone calls;

d. Working papers and analyses, including all documents related to coding reviews;

e. Complaints;

f. Recommendations;

g. All communications and documents concerning calculated, estimated, or projected error rates or overpayments;

h. Considered and/or established accounting or financial reserves; and

i. Considered and/or implemented resolutions, including corrective action, disciplinary action, disclosure to the United States Department of Health and Human Services Office of Inspector General, or any other voluntary disclosure or voluntary repayment.

9. For any relationship between Kaiser Foundation Hospitals and any auditor, reviewer, consultant, contractor or other third party related, in whole or in part, to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees. The foregoing includes, but is not limited to:

a. Bids, proposals, contracts, agreements, invoices, and payments;

b. Communications, including reports, audits, correspondence, memos, and notes;

c. Meeting records, including agendas, sign-in sheets or other attendance lists, minutes, presentation slides, notes, handouts, memoranda, and audiotapes, videotapes and any other recording;

d. Notes and any other records of telephone calls;

e. Working papers and analyses, including documents related to coding reviews;

f. Recommendations;

g. Documents reviewed or referred to by the auditor, reviewer, consultant, contractor or other third party;

h. Training materials, guidance or other instruction provided by the auditor, reviewer, consultant, contractor or other third party; and

i. Assessments or evaluations of the auditor, reviewer, consultant, contractor, or other third party's performance, including the retention or non-retention (initial or continued) of its services.

10. Regarding the systems (including computer software systems) used to determine, document, assign, review, analyze, report, data mine, addend, update, or refresh the diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees:

a. Documents sufficient to identify each such system and the dates used; and

b. Concerning diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees, all documents constituting, discussing or referring to:

(i) Instructions, operations, policies or procedures;

(ii) Pre- and post-implementation testing;

(iii) Medical records entries, including addendums to original medical records entries, that are able to be generated (in whole or in part) by a computer keystroke or command (e.g., a computer macro) as opposed to typing the full entry;

(iv) The systems' accuracy, validity, and/or compliance (or inaccuracy, invalidity, and/or non-compliance) with any laws, regulations, rules, policies, procedures, guidelines, directions, or professional standards (whether external or internal) related to diagnoses or diagnoses codes or HCCs for Medicare Advantage enrollees; and

(v) Any formal or informal complaints or other expressions of concern.

11. For all diagnosis codes reported to the CMS for Medicare Advantage enrollees and/or any resulting HCCs, all medical and coding records and any other records concerning the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of those diagnosis codes and/or the accuracy or validity (or inaccuracy or invalidity) of those codes or HCCs. [Note: At this time, except for those documents specified in Attachment B, documents responsive to this Specification need be only fully preserved rather than produced to the OIG provided that they will be made fully available to the OIG upon request and within a reasonable amount of time.]

12. To the extent not already called for, any communication to or from CMS or any CMS contractors, related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

13. All documents concerning:

a. Your policies and/or procedures for document retention and destruction; and

b. The destruction of any documents related to the determination, documentation, assignment, review, analysis, reporting, data mining, addending, updating, or refreshing of diagnoses or diagnosis codes or HCCs for Medicare Advantage enrollees.

EXHIBIT E

U.S. Department of Justice

Robert C. Troyer
Acting United States Attorney
District of Colorado

Edwin G. Winstead
Assistant United States Attorney
Civil Health Care Fraud Coordinator

1801 California Street, Ste 1600 *(303) 454-0100*
Denver, Colorado 80202 *(303) 454-0404 Fax*

Via E-Mail

June 7, 2017

David Deaton, Esq.
O'Melveny & Myers, LLP.
610 Newport Center Drive, 17th Floor
Newport Beach, CA 92660

RE: Request for Kaiser Colorado Region Documents

Dear David:

Pursuant to my telephone call with you on June 2nd, and consistent with an earlier call on February 10, 2017, we would like to prioritize your production under the Department of Health and Human Services, Office of Inspector General subpoena issued December 4, 2013. Requests 1-24 are specific to Kaiser's Colorado Region, including its interactions with Kaiser's national office. Requests 24 through 28 are not so limited; for these requests, Kaiser should produce relevant documents from all regions.

Please note that this letter is a prioritization of document requests for the Colorado Region and does not indicate a limitation of the production requests as specified in the December 4, 2013 subpoena. Moreover, this request is consistent with, and is not intended to disrupt, the production priorities contained in Erica Hitchings' e-mail of February 5, 2016 describing the "next wave of document productions" and any production projects already under way. This letter prioritizes the production of documents for the Colorado Region and provides detailed requests to assist you in expediting the production. To allow us to better track your production for these Colorado Region requests we ask that you add a "CO" to the bates identifier for documents produced in response to this letter.

To assist you in understanding the requests, we first provide definitions of some of the key terms used in the requests:

Defined Terms

"Accuracy" means whether diagnoses and/or HCCs submitted for Risk Adjustment by Kaiser to CMS were valid and supported by documentation in the medical record. This term is usually associated with determining if Kaiser's claims were inappropriately up-coded or over-coded.

"Addendum" is an addition to a patient medical record at some time after the date of a face-to-face encounter with a patient.

"Chart Review" means an audit or other review of a patient's medical records intended to find diagnosis codes not previously submitted as part of a Risk Adjustment Claim and/or review the accuracy of diagnoses previously submitted as part of a Risk Adjustment Claim.

"Chronic Refreshable Diagnosis" means a diagnosis that generally does not resolve, meaning once a patient has that diagnosis he or she typically has it for life. Examples include, *inter alia*, (1) Chronic Kidney Disease (HCC 131); (2) Peripheral Vascular Disease (HCC 105); (3) Congestive Heart Failure (HCC 80); (4) Diabetes with Renal or Peripheral Circulatory Manifestation (HCC 15); and (5) Diabetes with Neurologic or Other Specified Manifestation (HCC 16).

"Coders/Auditors" means any person within one of the groups with Kaiser Colorado responsible for coding and risk adjustment issues including: (1) the "Risk Adjustment" or "RA" group or "Medicare Risk Business Services" or "MRBS coders responsible for coding all hospital discharge charts and one-off revenue enhancement projects; (2) the "Resolute Coders" involved generally with fee-for-service claims; (3) the "Coding Educators" responsible for auditing the Kaiser physicians; and (4) the "Coding Quality Assurance" or "QA" department responsible for auditing all other coders.

"Diagnosis Validation Audits" are Reviews that determine the Accuracy of HCCs submitted for Risk Adjustment.

"Missed Opportunity" means any diagnosis that could have been submitted to CMS for Risk Adjustment but was not.

"NLP Process" means application of computer-assisted coding software to a patient's medical records to find diagnosis codes not previously submitted as part of a Risk Adjustment Claim.

"Pre-Submission Diagnosis Review" means a review or audit of whether diagnosis codes submitted to Kaiser by hospitals, physicians, or other providers Validate before those diagnosis codes are submitted to CMS in connection with a Risk Adjustment Claim. The term Pre-Submission Diagnosis Review includes, but is not limited to: (1) the selection of all claims with a given diagnosis code for review by coders before the diagnosis is released for submission to CMS; (2) the use of a Best Practice Alert ("BPA") or other warning in the electronic medical record to warn a provider if he or she enters a diagnosis code that appears inconsistent with other information in the

medical record (*e.g.*, a diagnosis of acute stroke during an office visit); or (3) the use of logic in the claims processing system to prevent certain diagnosis codes from being submitted if they are inconsistent with other information in the medical record (*e.g.*, the submission of a diagnosis code for Sick Sinus Syndrome when the patient has a pacemaker that is functioning normally).

"Refreshable Delete Review" (also known as a "Stop Prompt") means a Review of diagnosis codes that were the basis for a Risk Adjustment Claim in one year, but were not coded or were otherwise inactivated in the patient's medical record in the following year.

"Region" means the geographic area, physician group, and Kaiser subsidiaries affiliated with each Medicare Advantage health plan offered by Kaiser Permanente and/or its affiliates in Colorado.

"Review" means an audit or other process whereby a coder, physician or other similar person determines whether one or more Risk Adjustment Claims and/or the diagnosis code that provides the basis for the Risk Adjustment Claims are Validated.

"Reviewed" means that a coder, physician, or other similar person determines whether a Risk Adjustment Claim and/or the diagnosis code that provides the basis for the Risk Adjustment Claim is Validated.

"Risk Adjustment Claim" refers to a diagnosis code: (a) that falls into an HCC that qualifies for a per-member-per-month risk Adjustment payment under the Medicare Advantage program; (b) that was submitted by or on behalf of Kaiser to the United States; and (c) for a Kaiser member. This term only includes claims that resulted in a per-member-per-month payment to Kaiser. This term includes claims that were submitted by or on behalf of Kaiser to CMS, resulted in a payment from CMS to Kaiser, but were later deleted by Kaiser. If more than one diagnosis codes that fall within the same HCC were submitted to CMS for a given patient in a given year, either from the same provider or from multiple providers, this counts as only one Risk Adjustment Claim.

"True Positive Diagnosis" means a diagnosis in a patient's medical record that has been identified through an NLP Process as not previously submitted as part of a Risk Adjustment Claim and found appropriate for submission to CMS as part of a Risk Adjustment Claim by two non-Kaiser coders.

"Validate[d]" means that a diagnosis code that was the basis for a Risk Adjustment Claim is supported by medical record documentation and otherwise complies with CMS rules governing the submission of Risk Adjustment Claims.

Documents Requested

1. Produce all documents[1] relating to all Reviews conducted by or on behalf of Kaiser, including, but not limited to, annual "probe" audits, Risk Adjustment Data Validation ("RADV")

[1] Please refer to the original HHS-IG December 4, 2013 subpoena for the definition of documents and other terms used in this letter.

audits, pre-RADV audits, audits of claims submitted by external providers (*i.e.*, providers who are not directly employed by or affiliated with Kaiser) (*e.g.*, 2011 Exempla audit performed by Treska Francis, Southern Colorado Forms Review), audits conducted by external vendors such as, *inter alia*, Peak Health Solutions, and/or audits targeted at Risk Adjustment Claims submitted for specific diseases or diagnoses (*e.g.*, 2014 audit of acute stroke diagnoses submitted for 2013 dates of service). For this request it is not necessary to produce the underlying medical records that were the subject of the Reviews.

2. For each of the three types of Pre-Submission Diagnosis Reviews specifically enumerated in the definition of Pre-Submission Diagnosis Review, produce all documents concerning the design, implementation, modification, and/or termination of the computer program and any reports or analysis regarding the operation and results of the computer program.

3. Produce all documents related to policies and procedures used to Validate any True Positive Diagnosis Code after the Colorado Region receives the diagnosis from the NLP Process but before the diagnosis codes are submitted to CMS in connection with a Risk Adjustment Claim.

4. Produce copies of the minutes taken at, agendas prepared for, and all written materials presented in connection with Kaiser Colorado's Medicare Advantage working groups, including, but not limited to, the Medicare Steering Committee, the Medicare Initiatives Group, the Coding Sponsors group, and the Medicare Risk Initiatives group.

5. All directions, policies, procedures, guidelines and guidance provided to Kaiser Colorado Coder/Auditors concerning:

a. Chronic Refreshable Diagnoses;
b. NLP;
c. contact with physicians;
d. EMR Prompts to physicians;
e. high risk HCC's;
f. "Epic Electronic Refresh"; and,
g. coder authorization based on information in a medical record to add diagnoses.

6. Produce all e-mails from physicians to Coder/Auditors in response to prompts or communications concerning diagnosis coding or the Refreshable Delete Review initiative.

7. Produce all general information (not individual patient specific), guidance, training, policies, and educational audits provided by Kaiser Coder/Auditors to physicians concerning coding issues.

8. Produce all documents relating to economic or percentage goals, performance plans, evaluations, quotas, incentive plans and/or goals, given to Coder/Auditors concerning the Medicare

Advantage Plan including, but not limited to goals for Refresh rate, Accuracy, and/or Missed Opportunities.

9. Produce all documents relating to performance plans, evaluations, quotas, incentive plans, and/or goals for Kaiser Physicians or outside providers concerning the Medicare Advantage plans.

10. Produce all documents relating to any response or action taken by the Colorado Region concerning issues and coding errors identified by the National Compliance Office audits or RADV audits including, but not limited to, any additional audits performed as a result of Accuracy issues raised by those audits.

11. Produce all contracts or amendments to contracts between Kaiser and Colorado outside providers including, but not limited to, Swedish Medical Center, Pueblo Clinic, SLC Health (formerly Exempla) Good Samaritan, SLC Health Lutheran Medical Center, SLC Health Good Samaritan Medical Center, Centura St. Thomas More Hospital, Memorial Hospital, SLC Health St. Joseph's Hospital and Life Care Centers of America.

12. Produce all documents from Kaiser physicians or outside providers to Kaiser Colorado Coder/Auditors concerning any coding issues.

13. Produce all documents relating to extrapolation of Review findings and/or using probe audit findings to do additional reviews of patient records.

14. Produce all documents relating to return on investment (ROI) calculations or estimates for Review projects.

15. Produce all documents including lists entitled "Medicare Risk Projects" and or "Audit Projects" and all documents relating to these lists.

Kaiser Colorado Custodians and Files

Please provide all e-mails for the following current and former Kaiser Colorado or Kaiser National employees in addition to all documents in files currently or previously controlled by them as indicated for each individual:

16. Valerie Clark, Kaiser Colorado Director of Claims Quality (previously Kaiser Colorado Manager of Coding Compliance): Please produce all Valerie Clark's e-mail and all other documents related to:

a. Kaiser Colorado external provider coding issues;

b. Kaiser Colorado internal provider diagnosis-specific coding issues; and,

c. Kaiser Colorado's annual probes and corrective action plans (CAPs).

17. Robert DeRush, Medicare Advantage Data Analyst: Please produce all Robert DeRush's e-mail and all other documents related to:

a. internal filters; and,
b. filters for external providers.

18. Treska Francis, Kaiser Colorado Quality Manager for Medicare Advantage (previously Kaiser Colorado Manager of Medicare Risk Coding): Please produce all of Treska Francis' e-mail as well as all documents contained in in her computer or to which her computer was mapped relating to her duties as Quality Manager for Medicare Advantage and/or Manager of Medicare Risk Coding including, but not limited to:

a. Kaiser Colorado external provider coding issues (including a contract with Peak Health Solutions for an audit of external providers);
b. reports generated through the upside-only Chart Review work of MRBS and MedPartners;
c. all materials related to Treska's audit of the Southern Colorado external hospitals;
d. Chart Reviews for the annual probes;
e. Kaiser Colorado internal provider diagnosis-specific coding issues;
f. Chart Reviews for the annual probes; and,
g. MRBS upside-only hospital chart review.

19. Rusalyn Maitlen, former Kaiser Colorado Manager of Medicare Advantage Risk Coding: Please produce all Rusalyn Maitlen's e-mail and all other documents related to:

a. Kaiser Colorado external provider coding issues (including the PEAK audit);
b. Kaiser Colorado internal provider diagnosis-specific coding issues (including Kaiser Colorado's internal filters); and,
c. Kaiser Colorado internal filters including the creation, maintenance, administration, and discontinuation of Kaiser Colorado's internal filters.

20. Elyse McNulty, Kaiser Colorado Coding Director: Please produce all of Elyse McNulty's e-mail as well as all documents contained on all Medicare-related Kaiser Colorado drives to which her computer is or has been mapped. These documents should include, but not be limited to:

a. Kaiser Colorado external provider coding issues (including the PEAK audit and use of MedPartners);
b. Kaiser Colorado internal provider diagnosis-specific coding issues (including Kaiser Colorado's internal filter);
c. natural language processing issues; and,
d. coding of Chronic Refreshable Diagnoses.

21. Dr. James Taylor, former CPMG Medical Director of Revenue Cycle/Claims: Please produce all e-mails to and from Dr. Taylor along with all document related to the following subjects:

a. external provider coding issues;
b. Kaiser Colorado internal provider diagnosis-specific coding issues;
c. natural language processing;
d. coding of Chronic Refreshable Diagnoses; and,
e. "re-sweeping" and submission of Kaiser Colorado's deleted diagnoses.

22. Jeremy Walsleben, Member of National Medicare Finance team (previously Manager of the Kaiser Colorado Medicare Advantage Division): Please produce all Jeremy Walsleben's e-mail and all other documents related to:

a. the deleted diagnoses in Colorado being "re-swept" and submitted to CMS after Hawaii took over Colorado's claims processing;
b. Kaiser Colorado external provider coding issues; and,
c. Kaiser Colorado internal provider diagnosis-specific coding issues (including Kaiser Colorado's internal filter).

23. Dr. Teresa Welsh, CPMG Physician Director of Coding: Please produce all Dr. Welsh's e-mail and all other document related to:

a. physician incentives;
b. external providers diagnosis specific issues, (e.g., stroke issues);
c. natural language processing; and,
d. internal filters.

Requests Not Limited to the Colorado Region

24. Please provide all e-mails for the following Kaiser National employee in addition to all documents in files currently or previously controlled by the employee:

Janet Franklin, Director of Kaiser National Medicare Compliance: Please produce all Janet Franklin's e-mail and all other documents related to:

a. "mismapping" issues in Kaiser's EMR system; and,
b. auditing of Kaiser's EDG file.

25. Produce copies of agendas prepared for, and/or minutes taken at, and all written materials presented in connection with, Kaiser's Regional Reporting Group ("RRG") meetings, including pre-sessions providing Medicare Advantage introductory materials, including, but not limited to Simon Cohn's presentation on the fundamentals of the Risk Adjustment program, since 2004, including the versions of the materials presented at the RRG meetings, and the versions of the materials posted to

Kaiser's internal website. This request reiterates the February 5, 2016 e-mail request of Erica Hitchings.

26. Produce all documents that relate to situations where the display diagnosis shown in Kaiser's national Electronic Medical Record system (HealthConnect) mismapped to an incorrect ICD-9 diagnosis code (*e.g.*, "oral contraceptive" mismapped to the diagnosis code for oral cancer; neurogenic claudication mismapped to vascular claudication).

27. Produce all documents related to correction plans for error rates found in any Reviews including, but not limited to, annual National Compliance Office probe audits and RADV audits.

28. For all Reviews conducted by the National Compliance Office, produce all documents relating to the method and criteria used to construct the audit including, but not limited to:

a. the sample frame sizes for each strata (i.e. Tier) in all probe audits;
b. the details of each sample unit including, but not limited to:
    i. the strata;
    ii. the original HCC;
    iii. the audited HCC;
    iv. the original payment amount;
    v. the adjusted payment amount under the audited HCC;
    vi. the result of the audit (i.e. the category of discrepancies, if any);
    vii. relevant demographic information; and,
    viii. relevant procedure or encounter level information.
c. an explanation of how sample sizes were determined; and,
d. an explanation of the random selection methodology that was used for sample selection.

Please feel free to call if you have any questions concerning this request.

Sincerely,

Arthur Di Dio by EOW

Arthur S. Di Dio
Senior Trial Counsel,
Civil Fraud Section
U.S. Department of Justice

Erica Hitchings by EOW

Erica Blachman Hitchings
Assistant U.S. Attorney
U.S. Attorney's Office
Northern District of California

Edwin G. Winstead
Assistant U.S. Attorney
U.S. Attorney's Office
District of Colorado

Cc: Hope S. Foster, Esq.

EXHIBIT F

Dr. Shirley N. Weber
California Secretary of State

Business Search - Results

The California Business Search is updated daily and reflects work processed through Tuesday, December 28, 2021. Please refer to document **Processing Times** for the received dates of filings currently being processed. The data provided is not a complete or certified record of an entity.

- Select an entity name below to view additional information. Results are listed alphabetically in ascending order by entity name, or you can select a column title to change the sort order.
- To refine the search results, enter a word or a string of words in the "Narrow search results" box. The "Narrow search results" will search on all fields of the initial search results.
- For information on checking or reserving a name, refer to **Name Availability**.
- For information on requesting a more extensive search, refer to **Information Requests**.
- For help with searching an entity name, refer to **Search Tips**.
- For descriptions of the various fields and status types, refer to **Frequently Asked Questions**.

Results of search for Corporation Name keyword "kaiser permanente" returned 9 entity records (out of 9 records found).

Show 10 entities per page

Narrow search results:

Entity Number	Registration Date	Status	Entity Name	Jurisdiction	Agent for Service of Process
C1892763	06/27/1994	SOS/FTB SUSPENDED	KAISER PERMANENTE - ASIAN PACIFIC AMERICAN NETWORK	CALIFORNIA	SANDY WU
C1864563	08/13/1993	DISSOLVED	KAISER PERMANENTE AFRICAN AMERICAN ASSOCIATION	CALIFORNIA	MICHAEL STINE, JR
C3887000	03/22/2016	ACTIVE	KAISER PERMANENTE BERNARD J. TYSON SCHOOL OF MEDICINE, INC.	CALIFORNIA	CORPORATION SERVICE COMPANY WHICH WILL DO BUSINESS IN CALIFORNIA AS CSC - LAWYERS INCORPORATING SERVICE (C1592199)

Entity Number	Registration Date	Status	Entity Name	Jurisdiction	Agent for Service of Process
C1884872	03/22/1994	ACTIVE	KAISER PERMANENTE INSURANCE COMPANY	CALIFORNIA	CORPORATION SERVICE COMPANY WHICH WILL DO BUSINESS IN CALIFORNIA AS CSC - LAWYERS INCORPORATING SERVICE (C1592199)
C1964001	03/18/1996	ACTIVE	KAISER PERMANENTE INTERNATIONAL	CALIFORNIA	CORPORATION SERVICE COMPANY WHICH WILL DO BUSINESS IN CALIFORNIA AS CSC - LAWYERS INCORPORATING SERVICE (C1592199)
C0280716	12/03/1953	MERGED OUT	KAISER PERMANENTE PACIFIC CREDIT UNION	CALIFORNIA	JOSEPH S MELCHIONE
C2062457	12/09/1997	DISSOLVED	KAISER PERMANENTE VENTURES	CALIFORNIA	THE PRENTICE-HALL CORPORATION SYSTEM, INC. (C0257078)
C0216180	04/19/1947	DISSOLVED	KAISER-PERMANENTE ADVISORY SERVICES	CALIFORNIA	THE PRENTICE-HALL CORPORATION SYSTEM, INC. (C0257078)
C0254653	06/07/1951	DISSOLVED	KAISER-PERMANENTE HEALTH PLAN	CALIFORNIA	ARTHUR H BERNSTEIN

Showing 1 to 9 of 9 entities

Previous 1 Next

Modify Search New Search

TAB 11

DAVID DEATON (S.B. # 205713)
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Attorneys for Defendants

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA, SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE, et al.,

Defendants.

Case No. 3:13-cv-03891-EMC

NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES

Hearing Date: March 31, 2022
Time: 1:30 PM
Judge: Hon. Edward M. Chen
Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:18-cv-01347-EMC **NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiffs, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:21-cv-03894-EMC **NOTICE OF MOTION AND MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR; MEMORANDUM OF POINTS AND AUTHORITIES** Hearing Date: March 31, 2022 Time: 1:30 PM Judge: Hon. Edward M. Chen Courtroom: 5, 17th Floor

NOTICE OF MOTION AND MOTION

TO THE COURT, ALL PARTIES, AND THEIR COUNSEL OF RECORD:

PLEASE TAKE NOTICE that on March 31, 2022, at 1:30 p.m., or as soon thereafter as counsel may be heard, in the courtroom of the Honorable Edward M. Chen (Courtroom 5) of the above-entitled Court, located at 450 Golden Gate Avenue, San Francisco, California 94102, Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and The Permanente Federation, LLC (collectively, "Defendants") will and hereby do move this Court to dismiss all or portions of the following complaints under Federal Rule of Civil Procedure 12(b)(1):

- *United States ex rel. Taylor v. Kaiser Permanente*, Case No. 3:21-cv-03894-EMC (N.D. Cal.);
- *United States ex rel. Arefi v. Kaiser Foundation Health Plan, Inc.*, Case No. 3:16-cv-01558-EMC (N.D. Cal.);
- *United States ex rel. Stein v. Kaiser Foundation Health Plan, Inc.*, Case No. 3:16-cv-05337-EMC (N.D. Cal.);
- Counts 1 through 4, *United States ex rel. Bryant v. Kaiser Permanente*, Case No. 3:18-cv-01347-EMC (N.D. Cal.); and
- Counts 1 and 2, *United States ex rel. Bicocca v. Permanente Medical Group, Inc.*, Case No. 3:21-cv-03124-EMC (N.D. Cal.).

Defendants bring this Motion on the grounds that the above-listed complaints and causes of action are barred under the False Claims Act's first-to-file bar, 31 U.S.C. § 3730(b)(5). The first-to-file bar is jurisdictional and provides that once a relator brings a *qui tam* action, "no

person other than the Government may intervene or bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5); *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1186-87 (9th Cir. 2001). Each of the above-captioned *qui tam* complaints alleges virtually the same fraudulent scheme—that Defendants (or some combination of Defendants) knowingly submitted or caused to be submitted false diagnosis codes to the U.S. Centers for Medicare and Medicaid Services ("CMS") for purposes of obtaining higher reimbursement relating to health insurance coverage that certain Defendants offered their Medicare Advantage members. Because the fraudulent scheme alleged in all five complaints is related to the same fraudulent scheme alleged in Ronda Osinek's earlier-filed *qui tam* complaint, the first-to-file bar precludes the later-filed actions. Defendants therefore respectfully request that the Court dismiss the above-listed causes of action and *qui tam* complaints.

The Motion is based on this Notice of Motion, the accompanying Memorandum of Points and Authorities, the Request for Judicial Notice, the Declaration of David Deaton in support of the Request for Judicial Notice, any reply memorandum, and such other written and oral argument as may be presented to the Court.

Dated: January 18, 2022

Respectfully submitted,

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MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Eight years ago, Ronda Osinek filed a *qui tam* action under the False Claims Act ("FCA"), alleging that Kaiser Permanente[1] knowingly presented false claims for payment to the Medicare Advantage program. Specifically, she contends that Kaiser Permanente engaged in an unlawful "upcoding" scheme in which it reported diagnosis codes for Medicare Advantage members[2] to the U.S. Centers for Medicare and Medicaid Services ("CMS") that Kaiser Permanente knew did not comply with CMS coding and documentation requirements and that these diagnosis codes resulted in overpayments from the Medicare Advantage program. Alerted to an allegedly fraudulent, enterprise-wide scheme, the U.S. Department of Justice ("DOJ") commenced an investigation of Osinek's allegations in 2013. In the subsequent seven years, a stampede of other individuals seeking to cash in on the FCA's bounty system filed *qui tam* complaints of their own against various healthcare organizations operating under the Kaiser Permanente trade name, all alleging a similar "upcoding" scheme to defraud the Medicare Advantage program. Despite the first-filed *Osinek* complaint having already given the United States notice of the alleged fraud on the Medicare Advantage program, ***five more*** FCA suits (the "Later-Filed Complaints") now plead duplicative theories based on the same essential facts. The FCA's first-to-file bar compels the Court to dismiss all or portions of these five subsequent *qui tam* complaints.[3]

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[1] Kaiser Permanente is not a legal entity, *see* Request for Judicial Notice ("RJN"), Ex. F, but rather a trade name that refers to the nationwide collaboration among nonprofit health plans, nonprofit hospitals, and provider-directed medical groups to render healthcare services to their members, including millions of Medicare Advantage members, *see United States ex rel. Taylor v. Kaiser Permanente*, Case No. 3:21-cv-03894-EMC (N.D. Cal.), Dkt. No. 1 ¶¶ 16–17.

[2] "Members" refers to the individual Medicare beneficiaries who are enrolled in the Medicare Advantage program and receive their healthcare coverage through a private insurer known as a Medicare Advantage Organization ("MAO"). Members become patients when they receive medical care covered by the Medicare Advantage program. Thus, for purposes of this Motion, the terms "members," "beneficiaries," and "patients" are synonymous unless otherwise stated.

[3] This Motion seeks dismissal of the Later-Filed Complaints—*Taylor*, *Arefi*, *Stein*, *Bryant*, and *Bicocca*—in their entirety except for the retaliation causes of action in the operative *Bryant* complaint (Counts 5 through 8) and the California False Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4), as those claims are not subject to dismissal under the FCA's first-to-file bar.

The FCA incentivizes private individuals, called "relators," to alert the United States to potential fraud by bringing a *qui tam* complaint. But Congress understood that only a single complaint is needed to serve this purpose—where two suits raise "essentially the same claims, permitting the second suit to go forward [i]s not necessary to alert the government to the underlying facts of a fraudulent scheme." *Campbell v. Redding Med. Ctr.*, 421 F.3d 817, 821 (9th Cir. 2005). Congress sought to preclude duplicative *qui tam* suits when it amended the FCA in 1986 to add the so-called "first-to-file bar." This jurisdictional bar provides that after a relator brings a *qui tam* action, "no person other than the Government may intervene or bring a related action ***based on the facts underlying the pending action***." 31 U.S.C. § 3730(b)(5) (emphasis added). The first-to-file bar not only eliminates repetitive lawsuits that needlessly drain judicial and party resources, but also creates a virtuous race to the courthouse with incentives for would-be whistleblowers to quickly file their complaints.

This case is an extreme illustration of why Congress enacted the first-to-file bar. It features not just one repetitive suit alleging the same fraudulent scheme as the original complaint—but ***six separate qui tam actions brought by ten relators*** alleging the same essential elements of fraud on the Medicare Advantage program. As originally pleaded, Relators' complaints total over 300 pages, not to mention amendments and exhibits.[4] But all six complaints allege essentially the same wrongdoing: that Defendants knowingly upcoded diagnosis codes for Medicare Advantage members and that improper practice caused CMS to remit overpayments to health plans sponsored by some of the Defendants.[5]

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[4] "Relators" are (i) Ronda Osinek (complaint filed in 2013); (ii) James Taylor (complaint filed in 2014); (iii) Naser Arefi, Ajith Kumar, and Prime Healthcare Services, Inc. (complaint filed in 2015); (iv) Marcia Stein and Rodolfo Bone (complaint filed in 2016); (v) Gloryanne Bryant and Victoria Hernandez (complaint filed in 2018); and (vi) Michael Bicocca (complaint filed in 2020).

[5] "Defendants" are Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic

The first-filed *Osinek* complaint alleged an enterprise-wide fraud that put the United States on notice of the Medicare Advantage upcoding schemes subsequently alleged in the Later-Filed Complaints, and DOJ actively investigated those allegations for years. The upcoding schemes alleged in the Later-Filed Complaints do nothing to serve the policy goals of the FCA, as the *Osinek* complaint put the United States on notice of the alleged fraud in 2013. Allowing these duplicative allegations to continue would only further complicate this litigation, burden the Court's docket unnecessarily, and waste the parties' resources. This Court should therefore dismiss all or portions of the Later-Filed Complaints under the FCA's first-to-file bar.[6]

II. BACKGROUND

A. The Medicare Advantage Program

Medicare is a federal health insurance program for older adults and individuals with disabilities. *UnitedHealthcare Ins. Co. v. Becerra*, 16 F.4th 867, 872 (D.C. Cir. 2021). CMS, an agency within the U.S. Department of Health and Human Services, administers the Medicare program. *Id.* The traditional Medicare program consists of Medicare Part A, which covers inpatient hospital care, and Medicare Part B, which covers outpatient medical care. *Id.* CMS also administers Medicare Part C, which is known as Medicare Advantage, through which Medicare Advantage beneficiaries receive healthcare coverage from private insurers known as MAOs. *Id.* All of the *qui tam* complaints at issue in this Motion allege a scheme to defraud the Medicare Advantage program.

Under the traditional Medicare program, CMS compensates healthcare providers directly for all services rendered to Medicare beneficiaries. *United States ex rel. Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under the Medicare Advantage program, however,

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Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and The Permanente Federation, LLC. Because the various complaints do not name all of the same defendants, "Defendants" or "Kaiser" refers to the defendants named in the complaint(s) referenced in the relevant portion of the Motion, unless otherwise indicated. Although Kaiser Permanente is not a legal entity, *supra* note 1, "Defendants" and "Kaiser" include Kaiser Permanente where named in the complaint at issue.

[6] To assist the Court in its evaluation of this Motion, Appendix A includes a chart comparing the allegations of the *qui tam* complaints.

private health insurance plans "provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage." *Becerra*, 16 F.4th at 872. CMS determines this flat monthly rate through an annual bidding process, and then CMS applies a risk-adjustment payment model, which adjusts the payment rate based on various demographic and health factors that can affect healthcare expenses, including age, gender, and medical diagnoses. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2).

Healthcare providers typically record member diagnoses after member visits using "diagnosis codes" and send those codes to the members' Medicare Advantage plans. *Silingo*, 904 F.3d at 672; *see also* 42 U.S.C. § 1395w-23(a)(1)(C)(i). The plans then report the codes to CMS, which uses them to calculate payment rates for each Medicare Advantage member. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i). CMS compensates Medicare Advantage plans based on only those medical conditions diagnosed in the previous payment year. *Silingo*, 904 F.3d at 672.

CMS's risk-adjustment payment model groups diagnosis codes into Hierarchical Condition Categories ("HCCs"). *Id.* Each HCC is assigned a different "relative factor," which corresponds to that HCC's relative effect on the payment amount to the Medicare Advantage plan. *Becerra*, 16 F.4th at 874–75. During the period at issue, CMS determined the relative factors for each HCC through its statistical analysis of the average costs of treating members with those reported conditions in traditional Medicare. *Id.* Because the relative factors differ among HCCs, some HCCs have a larger effect on the payment amount to Medicare Advantage plans. *Id.* CMS uses the relative factors associated with each HCC applicable to a given Medicare Advantage member to calculate what it calls a "risk score," and this risk score is then used to compute the risk adjustment to the flat monthly payment for that member. *Id.*

The D.C. Circuit recently offered this example of how the HCC payment model works: "a 72-year-old woman living . . . with diabetes without complications (relative factor 0.118), and multiple sclerosis (relative factor 0.556)" has a particular risk score keyed to her age, gender, other demographic factors, and medical diagnoses. *Id.* at 875. Both medical conditions raised her risk score by a "relative factor," but multiple sclerosis resulted in a higher increase in that score because CMS had previously determined that treating that condition costs the traditional

Medicare program more than treating ordinary diabetes without complications. *See id.* In other words, under the HCC-payment model, some medical conditions will result in higher risk scores and, in turn, higher CMS payments to Medicare Advantage plans because those conditions are associated with comparatively higher average medical costs than other conditions.

B. The First-Filed *Osinek* Complaint

Ronda Osinek filed the first of the *qui tam* complaints on August 22, 2013. Osinek was a medical coder employed by The Permanente Medical Group, which operates in Northern California. Dkt. No. 1 ¶¶ 5, 23.[7] Osinek's original complaint names a single defendant, Kaiser Permanente. She distinguishes Kaiser Permanente from regional entities operating within Kaiser Permanente and alleges that it directed these entities to engage in various documentation and diagnosis coding practices. *See, e.g.*, *id.* ¶¶ 5–6, 23, 37–38 (alleging that Kaiser exerted "competitive pressure" "between regions").

The crux of Osinek's complaint is that Kaiser "defrauded the United States through a sophisticated scheme to upcode diagnoses to ensure Medicare [Advantage] payments for reimbursable, high-value [medical] conditions." *Id.* ¶ 2. She defines "upcoding" as using diagnosis codes to make Medicare Advantage members "appear less healthy than they actually are." *Id.* ¶ 25. The alleged fraud implicates a range of Kaiser's purported business practices—referred to below as Data Mining/Algorithms, Refresh, Addenda, Boilerplate Phrases, Pressure to Diagnose Risk-Adjusting Medical Conditions, and Guidance & Policies—which subsequent Relators also cited in their *qui tam* complaints.

Data Mining/Algorithms. Osinek alleges that around 2007, Kaiser began a process called "data mining." *Id.* ¶¶ 24–25. Through data mining, Kaiser allegedly identified "higher value HCCs and then determined the diagnoses its [healthcare providers] would need to make to

[7] Unless otherwise indicated, docket references are to the docket in *United States ex rel. Osinek v. Kaiser Permanente*, Case No. 3:13-cv-03891-EMC (N.D. Cal.), under which the Later-Filed Complaints have been consolidated. References to dockets in the other consolidated cases are indicated by case name. Defendants dispute the factual allegations and legal assertions in all of the *qui tam* complaints. The characterization of the complaints in this Motion is for the sole purpose of explaining that the complaints allege the same fraudulent scheme—a scheme that Defendants deny. Nothing herein constitutes an admission of any allegation in those complaints.

support the HCCs Kaiser wanted to submit for Medicare reimbursement." *Id.* Then Kaiser allegedly used "algorithms to identify . . . [medical] conditions for data mining" in members' medical records to ensure that it did not fail to report potentially reimbursable medical conditions to CMS. *See id.* Indeed, Osinek contends that Kaiser employed data mining to eliminate instances where a healthcare provider could have recorded a diagnosis for a member but did not, omissions that Kaiser allegedly called "missed opportunities." *See id.* After Kaiser identified "missed opportunities," it allegedly prompted healthcare providers to add the identified medical conditions to member medical records. *Id.* ¶ 33. According to Osinek, the purpose of data mining is to submit diagnosis codes to CMS for "high value [medical] conditions for which Kaiser can maximize its reimbursement from Medicare and increase its revenue." *Id.* ¶ 25. She alleges that Kaiser would target specific medical conditions for data mining medical records, including chronic kidney disease, congestive heart failure, depression, chronic respiratory failure, cachexia/protein calorie malnutrition, and obesity. *See id.*

Refresh. Because CMS compensates Medicare Advantage plans based on only those medical conditions diagnosed in the previous payment year, *see supra* at 4, plans must record and report chronic medical conditions for members each year. According to Osinek, Kaiser uses the term "refresh" to describe its efforts to re-diagnose chronic conditions each year. *See id.* ¶ 37. She contends that Kaiser implemented organized efforts to refresh members' "chronic [medical] conditions" year over year to eliminate "missed opportunities." *Id.* ¶¶ 33, 37. She further alleges that Kaiser used data mining and this refresh initiative to improperly increase Kaiser's "billings for high value . . . HCCs." *Id.* ¶ 24. According to Osinek, Kaiser directly tied compensation to affiliated medical facilities to "refresh and data mining rates" in order to incentivize healthcare providers to submit more diagnosis codes for reimbursable medical conditions. *Id.* ¶¶ 39–40.

Addenda. Osinek alleges that Kaiser violated CMS guidance about when a healthcare provider can modify or amend a medical record following a member visit. According to Osinek, a provider typically enters relevant information about a member "into a medical record at the time of service." *Id.* ¶ 20. But sometimes a provider will amend a medical record with additional information, including additional medical diagnoses, after the face-to-face visit with the member.

See id. These post-encounter amendments to the medical record are called "addenda." *See id.* ¶¶ 20, 28. Osinek asserts that, under CMS guidelines about addenda, healthcare providers "must verify that they considered a diagnosis or treated a diagnosis during the [patient] encounter, which means a [provider] must address what was contemporaneously considered if he or she addends a diagnosis." *Id.* ¶ 28. She contends, however, that Kaiser's healthcare providers addended medical records "with supporting statements or documentation [for medical conditions] that were not addressed at the time of an encounter." *Id.* After a member visit, Kaiser allegedly instructed healthcare providers "to go back to see what [the] member's previous test results showed to make diagnoses," and "prompted" healthcare providers to addend records with specific diagnoses based on, for example, laboratory tests. *Id.* ¶¶ 29–30. She broadly asserts that Kaiser "also addended and submitted diagnostic codes for complex [medical] conditions without proper support (i.e., not a true causal connection)." *Id.* ¶ 31.

Boilerplate Phrases. Osinek alleges that Kaiser created "boilerplate phrases" for use in documenting a member encounter in the medical record and that these "boilerplate phrases" helped healthcare providers "justify" additions to the medical record. *Id.* ¶ 32. She contends that these phrases allow healthcare providers to "systematically addend [members'] records retroactively—often many months after visits—with cloned or boilerplate language to make the [] record appear to comply with CMS instructions." *Id.* ¶ 28. She further explains that healthcare providers "are expected to use these phrases rather than their own language and discretion based on what they recall from [member] visits." *Id.* ¶ 32.

Pressure to Diagnose Risk-Adjusting Medical Conditions. Osinek also alleges that Kaiser "pressures" healthcare providers "to addend diagnoses and capture the high value HCCs" to eliminate "missed opportunities." *Id.* ¶ 33. As part of this pressure, Kaiser allegedly uses "data mining prompts," which are requests sent to healthcare providers to add diagnoses to medical records when Kaiser discovers "missed opportunities." *Id.* Osinek contends there is an "escalation process" for those healthcare providers who disagree with the prompts and that this escalation process requires healthcare providers to "explain their refusal" to diagnose the prompted medical conditions. *Id.* She also alleges that Kaiser ties healthcare providers'

compensation directly to their performance on data-mining and refresh efforts. *Id.* ¶ 34. And she asserts that Kaiser sponsored so-called "coding parties," created competitions, and awarded cash prizes to encourage healthcare providers to participate in upcoding of diagnosis codes. *Id.* ¶¶ 35–37. As one example, she cites documents that she alleges demonstrate a competition between Kaiser's regional organizations to pressure healthcare providers to increase the number of risk-adjusting diagnoses reported from member visits. *Id.* ¶ 37.

Guidance & Policies. Finally, Osinek alleges that Kaiser instituted policies and guidance meant to target high-value HCCs. *Id.* ¶¶ 26–30. She insists that, as a general matter, Kaiser instructs its affiliated-healthcare providers "to change diagnoses to upcode to higher value and more complicated forms of diseases" rather than medical conditions that members' symptoms actually reflect. *Id.* ¶ 30. She also alleges that Kaiser's policies caused healthcare providers to "take into consideration HCCs and the Medicare [Advantage] payment system when coding and recording [member] encounters." *Id.* ¶ 26. And she asserts that "when CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser tells its [healthcare providers] to change coding practices to reflect new reimbursable [HCCs]." *Id.* ¶ 27.

C. The Later-Filed Complaints

Like *Osinek*, each of the Later-Filed Complaints alleges that Defendants relied on "upcoding" techniques to identify and report to CMS "higher value" HCCs for the purposes of defrauding the Medicare Advantage program. And all five of the Later-Filed Complaints describe the same techniques that allegedly facilitated the scheme that Osinek first described in her initial complaint.

1. *Taylor* (2014)

James Taylor is a physician and former employee of Defendant Colorado Permanente Medical Group. *Taylor* Dkt. No. 1 ¶ 12. On October 22, 2014, he filed a *qui tam* complaint against "Kaiser Permanente" as well as national and regional Kaiser-affiliated entities, including Defendants Kaiser Foundation Health Plan, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest. *Id.* ¶¶ 18, 21–24. His allegations date back to when Kaiser implemented new Medicare Advantage

policies in 2004 following the creation of the risk-adjustment model that is at issue in this litigation. *Id.* ¶ 5.

Like Osinek's complaint the year before, Taylor details a scheme to "upcode" diagnoses submitted to CMS for Medicare Advantage members. *Id.* ¶¶ 61, 101. He alleges that Defendants "submit false claims to CMS when they know, or in the exercise of reasonable care should know, that: (1) the [members] do not have the diagnoses for which a risk adjustment claim was submitted; and/or (2) the diagnosis" did not meet purported CMS requirements—specifically, the diagnosis "a) was neither treated nor affected the treatment provided; b) in a face-to-face visit; c) with an appropriate provider; d) in the year at issue." *Id.* ¶ 5.

Taylor provides examples of allegedly false risk-adjustment data, *id.* ¶ 81, including "examples of diagnoses and HCCs identified as frequently upcoded" in Kaiser's internal audits. *Id.* ¶ 101. He lists many of the same medical conditions that Osinek identifies in her complaint, such as cancer, malnutrition, respiratory conditions, and renal conditions. *Id.* ¶¶ 131, 135, 139, 151. Taylor also alleges that Kaiser engaged in the same types of business practices and techniques that Osinek described in her complaint:

Data Mining/Algorithms. Taylor alleges that Kaiser relied on algorithms and "audits" to identify "certain diagnoses" in member medical records to increase the number and value of the HCCs that Kaiser reported to CMS. *Id.* ¶¶ 62, 177, 191, 197. Like Osinek, Taylor focuses on technology, citing one program called "Natural Language Processing," which he states "uses an algorithm to search [medical records] to find words that, individually or in combination, indicate that a [member] has certain diagnoses." *Id.* ¶ 191.

Refresh. Like Osinek, Taylor asserts that Kaiser improperly used a "program designed to 'refresh' chronic [medical conditions]." *Id.* ¶ 186. He contends that some medical conditions identified via refresh initiatives and reported to CMS "were likely false." *Id.* ¶¶ 186–88. He also contends that a 2009 "refresh" audit concluded that more "data mining" of specific conditions was needed. *See id.*

Addenda. Taylor also contends that, through use of addenda, healthcare providers impermissibly added diagnoses to medical records after face-to-face encounters. *See id.* ¶ 138.

He asserts that "Kaiser routinely submitted [diagnosis codes] where the only documentation to support the diagnosis was a radiologic or lab test, or other non-face-to-face service." *Id.* ¶ 160.

Pressure to Diagnose Risk-Adjusting Medical Conditions. Taylor, like Osinek, also alleges that Kaiser "pressured" healthcare providers to diagnose "higher-value" medical conditions. *Id.* ¶ 134. As an example, he explains that Kaiser pressured healthcare providers "to use the diagnosis code for chronic bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk adjust)." *Id.* He also describes provider "scores" that allegedly were affected by participation in Kaiser's upcoding initiatives. *Id.*

2. *Arefi* (2015)

On September 4, 2015, three more relators—Naser Arefi, Ajith Kumar, and Prime Healthcare Services, Inc. ("Prime") (collectively, the "*Arefi* Relators")—filed a third *qui tam* complaint against more than ten Kaiser-affiliated entities. *Arefi* Dkt. No. 1. Arefi is a former employee of Defendant The Permanente Medical Group, and he and Kumar are current Prime employees. *Id.* ¶¶ 8–9. Prime owns and operates 35 acute care hospitals across 11 states and treats Medicare Advantage members, including some Kaiser members, for emergency medical conditions. *Id.* ¶ 10. The *Arefi* complaint's allegations date back to 2009. *See Arefi* Dkt. No. 67; Dkt. No. 64.

The *Arefi* Relators follow the familiar pleading pattern evident from the *Osinek* and *Taylor* complaints, alleging that Kaiser perpetrated a "Medicare Advantage diagnosis upcoding scheme" by "reporting false . . . diagnoses to CMS for Medicare Advantage plan enrollees." *Arefi* Dkt. No. 1 ¶¶ 42, 78. Similar to Osinek, the *Arefi* Relators allege that Kaiser used ***addenda*** to "add[] or substitut[e]" medical conditions to members' medical records after encounter dates. *Id.* ¶ 47. The complaint further alleges that Kaiser relied on medical record reviewers to identify and addend HCC-triggering "diagnoses that were not made by the treating [healthcare provider] at the time of the required face-to-face encounter" with the member. *Id.* ¶ 45.

3. *Stein* (2016)

On May 16, 2016, Marcia Stein and Rodolfo Bone (the "*Stein* Relators") brought a fourth *qui tam* action, naming over a dozen national and regional Kaiser-affiliated entities as defendants

along with "Kaiser Permanente." *Stein* Dkt. No. 1. Stein is a Registered Health Information Administrator who was previously employed by Defendants Kaiser Foundation Hospitals and Southern California Permanente Medical Group. *Id.* ¶ 25. Bone is a coder who was formerly employed by Defendant Kaiser Foundation Hospitals. *Id.* ¶ 27. The *Stein* allegations date back to 2010. *Id.* ¶ 36.

Like the previous Relators, the *Stein* Relators allege "a fraudulent scheme to up-code and falsely diagnose" Medicare Advantage members. *Id.* ¶ 50. They also point to the same specific techniques first alleged by Osinek and then again by other Relators:

Data Mining/Algorithms & Refresh. In their *qui tam* complaint, the *Stein* Relators describe "an improper program designed to identify 'missing' [] diagnosis codes and have the [healthcare providers] 'refresh' the missing [diagnosis codes]." *Id.* ¶ 83. They allege that Defendant Kaiser Foundation Health Plan's "contracted medical groups compil[ed] a 'hit-list' of high value HCC[s] . . . and their related . . . diagnosis codes," and that the list included chronic medical conditions. *Id.* ¶ 84. As part of this alleged scheme to refresh previously diagnosed medical conditions, Kaiser would purportedly "data-mine" the members' medical records for medical conditions that correspond to "high value" HCCs to identify members with a history of diagnoses on the "hit-list." *Id.*

Addenda. The *Stein* Relators also contend that Kaiser used addenda and "improper late medical record entries" to amend medical records "without valid face-to-face encounters" between healthcare providers and members. *Id.* ¶¶ 80, 87–91.

Pressure to Diagnose Risk-Adjusting Medical Conditions. The *Stein* Relators allege that Kaiser sent prompts or "queries" to healthcare providers to encourage providers to diagnose medical conditions. They allege that these "leading queries" pressured healthcare providers to "refresh" medical conditions through addenda that would translate into high-value HCCs, and that coders would meet with healthcare providers "to ensure" the conditions were coded for submission to CMS. *Id.* ¶ 84; *see also id.* ¶¶ 80, 89, 91. They also allege that Kaiser "tracked . . . the [healthcare providers] who 'refreshed' the HCC diagnoses" and that "coders then met with the [healthcare providers] to ensure that the hit-list HCC diagnoses were refreshed." *Id.* ¶¶ 83–84.

Guidance & Policies. The *Stein* Relators also allege that Defendants Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, and the Permanente Medical Groups imposed "unwritten policies" that prevented coders from querying healthcare providers for additional support when the providers diagnosed sepsis, a "high-value" medical condition that would "increase CMS's capitation payments" to Kaiser. *Id.* ¶¶ 50–51, 68–69. They also allege that Kaiser "instructed" healthcare providers to use inaccurate diagnosis and coding standards that increased Medicare Advantage members' risk scores through over-diagnosing medical conditions that increased CMS's payments to Kaiser. *Id.* ¶¶ 50, 53–54, 60, 68–69.

4. *Bryant* (2018)

Gloryanne Bryant and Victoria Hernandez (the "*Bryant* Relators") filed a fifth *qui tam* complaint on March 1, 2018, naming eleven national and regional Kaiser-affiliated entities as well as "Kaiser Permanente." *Bryant* Dkt. No. 1. Bryant and Hernandez are coders and former employees of Defendants Kaiser Foundation Health Plan and The Permanente Medical Group, respectively. *Id.* ¶¶ 10, 22–23. Their allegations date back to 2009. *Id.* at 3.

Similar to *Osinek* and the other previously filed *qui tam* actions, the *Bryant* complaint alleges that "Defendants 'upcode' risk adjustment [data]" through various techniques, such as "manipulating the documentation and submitting [risk-adjustment data] to the Medicare Advantage program for diagnoses that the member does not have or for which the member was not treated in the relevant year," or claiming that a member was "treated for a more serious [medical] condition" than the member actually has. *Id.* ¶ 11. The *Bryant* Relators also cite the "upcoding" of specific medical conditions, many of which Osinek also references in her complaint—such as malnutrition, respiratory conditions, depression, obesity, aortic atherosclerosis, and renal conditions. *Id.* ¶¶ 59, 89, 111, 130, 137, 144–45, 148.

The *Bryant* Relators contend that Kaiser implemented the alleged fraud using the same upcoding practices first alleged by Osinek:

Data Mining/Algorithms. The *Bryant* Relators describe Kaiser's alleged efforts to "mine" medical records for "missed opportunities," which resulted in the "systematic over-documenting, over-coding and upcoding of [diagnosis codes corresponding to] certain high value

HCCs." *Id.* ¶¶ 54, 79. The complaint explains that the "'data mining' team . . . used 'algorithms' . . . to identify and capture possible missed [diagnosis codes] . . . referred to as 'missed opportunities.'" *Id.* ¶ 193.

Addenda. Similar to Osinek, the *Bryant* Relators also allege that Kaiser sent "leading" prompts to healthcare providers to "add" diagnosis codes to members' medical records through improper addenda. *Id.* ¶¶ 155, 159–63.

Boilerplate Phrases. The *Bryant* Relators allege the improper use of the same type of boilerplate phrases that Osinek first described in her 2013 complaint: "To provide 'documentation' that would constitute evidence of the clinical significance of [a diagnosis]," Defendant The Permanente Medical Group "developed a 'SMARTPHRASE' to automatically populate the medical record . . . that would . . . falsely state that the diagnosis was significant[.]" *Id.* ¶¶ 62, 69.

Pressure to Diagnose Risk-Adjusting Medical Conditions. The *Bryant* Relators contend that Kaiser employed "leading" queries that encouraged healthcare providers to diagnose medical conditions that corresponded to HCCs in the CMS payment model and would increase Kaiser's reimbursement from CMS. *See id.* ¶¶ 124–25, 134, 137–38, 141–42, 155–59, 161–64, 182–83, 186. The complaint explains that the "queries are always, or almost always, directed toward an HCC diagnosis for maximizing reimbursement capture and not for overall quality documentation . . . ." *Id.* ¶ 162.

Guidance & Policies. According to the *Bryant* Relators, "Kaiser consistently publishes and enforces internal company policies and procedures that contravene coding and diagnostic principles that are widely accepted and enforced within the broader coding community." *Id.* ¶ 151. Like Osinek, the *Bryant* Relators allege that Kaiser relied on diagnosis coding and documentation standards that instructed coders and healthcare providers to report medical conditions that increased Kaiser's reimbursement from CMS where it was not appropriate to do so. *Id.* ¶¶ 59–60, 86–87, 111–13, 131, 137.

5. *Bicocca* (2020)

Michael Bicocca filed the latest *qui tam* action on February 10, 2020, naming Defendants

The Permanente Medical Group; Southern California Permanente Medical Group; and The Permanente Federation. *Bicocca* Dkt. No. 1 ¶¶ 1–24. Bicocca is an anesthesiologist who formerly worked at "Kaiser Hospitals" in California. *Id.* ¶¶ 15–16. His allegations date back to 2015. *Id.* ¶ 91. Bicocca's complaint focuses on the alleged false submission of chronic medical conditions, an alleged practice that Osinek first described in her complaint.

Boilerplate Phrases. Like other Relators, Bicocca describes in his complaint boilerplate phrases that Kaiser supposedly directed healthcare providers to use in medical records. *Id.* ¶¶ 98, 137–45. He contends that these phrases were used to make it appear that CMS guidelines were satisfied when they were not. *Id.* ¶¶ 99–101.

Pressure to Diagnose Risk-Adjusting Medical Conditions. Bicocca also alleges a fraud scheme based on pressuring healthcare providers. He asserts that Kaiser "pressures" healthcare providers to improperly diagnose chronic medical conditions by certifying that the providers "managed" the member's "chronic [medical] conditions, even though they have not managed the chronic [medical] condition . . . ." *Id.* ¶¶ 2, 142. Like Osinek, he also alleges that Kaiser tracked healthcare provider participation in various diagnosis-coding initiatives. *Id.* ¶ 132. And he alleges that Kaiser encouraged healthcare providers to add diagnosis codes to members' medical records with monetary incentives and disincentives, including a "reduction in bonus" for healthcare providers who did not meet diagnosis-coding requirements. *Id.* ¶ 129.

Guidance & Policies. Like Osinek, Bicocca alleges that Kaiser instructed healthcare providers to apply diagnosis-coding and documentation standards that were inconsistent with CMS guidance: "Defendants do not require, and effectively discourage [healthcare providers] from complying with CMS regulations." *Id.* ¶ 6. He further alleges that Kaiser created "trainings and policy changes" that "contained inaccurate information" directing healthcare providers to fraudulently diagnose chronic medical conditions. *Id.* ¶¶ 91–96.

D. *Qui Tam* Consolidation and Intervention by United States

On June 25, 2021, this Court consolidated *Osinek* and the Later-Filed Complaints at the request of the United States, with no opposition from Relators. Dkt. No. 61. The consolidation order cited the overlapping allegations in the complaints and explained: "The six actions each

allege that Kaiser submitted claims to the Medicare Advantage Program . . . for risk-adjustment payments for diagnoses that [members] did not actually have and/or that were not actually addressed by the treating [healthcare provider] during a [member] encounter as required by Medicare billing rules." *Id.* at 2.

On July 27, 2021, after nearly eight years of investigating the allegations that Osinek first asserted in 2013, the United States filed a notice of its intent to intervene ***partially*** in the consolidated *qui tam* actions. Dkt. No. 64. The intervention applies only to "allegations that [Defendants][8] submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added ***via addenda*** under Medicare [Advantage] from the years 2009 until present." *Id.* at 1 (emphasis added).

On December 30, 2021, the *Arefi* Relators dismissed their claims with prejudice to the extent that the United States did not intervene in their case. *See Arefi* Dkt. Nos. 67 & 68. Thus, only their post-2008 allegations pertaining to addenda practices remain for litigation. All other causes of action in *Osinek* and the other Later-Filed Complaints remain to be litigated.

III. ARGUMENT

A. The FCA's First-to-File Bar Prohibits Additional *Qui Tam* Actions Alleging the Same Material Elements of Fraud as an Earlier-Filed *Qui Tam*

The FCA's first-to-file bar encourages private citizens to promptly alert the government to alleged fraud while also prohibiting duplicative suits that benefit neither the public nor DOJ's investigation of the original fraud allegations. To advance this dual purpose, the first-to-file bar creates a race to the courthouse by permitting only the first *qui tam* action containing related fraud allegations to proceed through litigation. Once a relator brings a *qui tam* action, "no person other than the Government may intervene or bring a related action based on the facts underlying the pending action." 31 U.S.C. § 3730(b)(5). The policy reason for this prohibition is simple: the first-filed action gives "the government notice of the essential facts of an alleged fraud, while the

[8] The United States' intervention applies only to Defendants Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.

first-to-file bar stops repetitive claims." *See United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1186–87 (9th Cir. 2001). Accordingly, § 3730(b)(5) provides "incentives for whistle-blowing insiders" to file suit early. *Id.*

The first-to-file bar is broad. It absolutely prohibits *qui tam* suits that allege "the ***same material elements*** of fraud" as an earlier *qui tam* suit, even if the allegations "incorporate somewhat different details." *Id.* at 1189 (emphasis added). The focus of the analysis under § 3730(b)(5) is whether the United States "has enough information to discover related frauds" once it "knows the essential facts of a fraudulent scheme." *Id.* (quotations omitted); *see United States ex rel. Batiste v. SLM Corp.*, 659 F.3d 1204, 1209 (D.C. Cir. 2011) (first-to-file bar applied where "the allegations of the first complaint [gave] the government grounds to investigate all that is in the second").

The Ninth Circuit has rejected a more narrow test under § 3730(b)(5) that asks whether the two actions share "identical facts." *United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir. 2015). Indeed, the statute speaks of "related," not "identical," actions. *Lujan*, 243 F.3d at 1189 (citing 31 U.S.C. § 3730(b)(5)). In *Lujan*, the Ninth Circuit found that a bar only of "identical" actions would "decrease incentives to promptly bring qui tam actions," allow "recovery for the same conduct," and permit FCA claims to proceed that "have no additional benefit for the government" since the first-filed action already gave DOJ grounds to investigate the alleged fraud. *Id.*

Because the first-to-file bar is so broad, "simply adding factual details . . . to the essential or material elements of a fraud claim" will not save a subsequent *qui tam* suit from dismissal. *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 378 (5th Cir. 2009); *see also United States ex rel. Marion v. Heald Coll., LLC*, 2015 WL 4512843, at *3 (N.D. Cal. July 24, 2015). For example, in *Marion*, the relator was one of several whistleblowers who alleged that a for-profit college had defrauded the U.S. Department of Education. 2015 WL 4512843, at *2. The relator argued that the first-to-file bar should not apply because her complaint, unlike any earlier complaint, detailed a scheme to enroll "phantom students" without their consent and collect financial aid on their behalf. *Id.* at *3. Though the relator's allegations

on this point were "more detailed" than earlier *qui tam* complaints, this district court held that the first-to-file bar required dismissal of her complaint because an earlier complaint had referenced the defendant's collection of student aid for "improperly enrolled students," and thus the "phantom student" allegation was just a factual variation of the same scheme. *See id.*

Nor will geographic or temporal differences between complaints suffice to overcome the bar. *Batiste*, 659 F.3d at 1209. In *Batiste*, the first relator alleged a company-wide fraud but claimed it stopped at his particular office. *Id.* A subsequent relator alleged an ongoing fraud at a different regional office of the company. *Id.* Such differences were "immaterial," the D.C. Circuit held, because if DOJ had investigated the alleged fraud in the first-filed complaint "on a nationwide basis," it would have discovered continuing fraud at the second relator's office. *Id.*

Relators likewise cannot avoid § 3730(b)(5) by naming "different members of the same corporate family," *In re Nat. Gas Royalties Qui Tam Litig.*, 566 F.3d 959, 962 (10th Cir. 2009), especially where the first-filed complaint alleges a "corporate-wide problem" that would give DOJ grounds to investigate all corporate entities, *United States ex rel. Hampton v. Columbia/HCA Healthcare Corp.*, 318 F.3d 214, 218 (D.C. Cir. 2003). In *Hampton*, the first-filed *qui tam* complaint named a single company, while the second-filed *qui tam* complaint named the same company and regional subsidiaries and employees not named or mentioned in the first action. *Id.* Despite these differences in corporate defendants, the second-filed complaint could not avoid dismissal under the first-to-file bar because the first complaint alleged a "corporate-wide problem" and provided only "examples" and "samplings" of how the fraud occurred. *Id.* Given the first-filed complaint's "broad allegations," the second complaint's focus on specific subsidiaries and naming of employees "were merely variations" on the same alleged fraud in the original *qui tam* action. *Id.*

Finally, relators cannot avoid the first-to-file bar through amendment. *United States ex rel. Carter v. Halliburton Co.*, 144 F. Supp. 3d 869, 880 (E.D. Va. 2015) ("[A]n amendment will not cure the first-to-file bar."). The bar is jurisdictional and requires courts to compare original complaints. *See Lujan*, 243 F.3d at 1186. While a relator can amend to show jurisdiction existed at the time of filing, it may not amend to create jurisdiction. *Morongo Band of Mission Indians v.*

Cal. State Bd. of Equalization, 858 F.2d 1376, 1380 (9th Cir. 1988) ("In determining federal court jurisdiction, we look to the original, rather than to the amended, complaint. Subject matter jurisdiction must exist as of the time the action is commenced."); *see also* Moore et al., *Moore's Federal Practice* § 15.14[3], at 15–34 (3d ed. 1999) (similar). Accordingly, here, the Court must determine whether the first-to-file bar requires dismissal of each Later-Filed Complaint by examining the factual allegations as they were alleged "at the time that action was brought." *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1279 (10th Cir. 2004).

B. The First-to-File Bar Requires Dismissal of All or Portions of the Later-Filed Complaints

The first-filed *Osinek* complaint requires dismissal of all or portions of the five subsequent *qui tam* actions. Osinek alleges a broad, enterprise-wide scheme by "Kaiser Permanente" to defraud the Medicare Advantage program by "upcoding" diagnoses of Medicare Advantage members from at least 2007 to the present. Dkt. No. 1 ¶¶ 2, 6, 24. Her complaint describes techniques that Kaiser allegedly used to perpetrate this scheme—including data-mining and refresh initiatives to eliminate "missed opportunities" to increase reimbursement, pressuring healthcare providers to diagnose risk-adjusting medical conditions, amending medical records through addenda without adequate support, using boilerplate phrases in medical records to feign compliance with allegedly applicable CMS guidelines, and setting policies that allegedly contravened CMS requirements. *Id.* ¶¶ 24–40.

Each of the Later-Filed Complaints repeats allegations about the essential facts of the upcoding scheme first alleged in *Osinek*. That alone triggers the first-to-file bar, as any reasonable DOJ investigation would attempt to identify the various business practices and techniques that produced such "upcoding." But the Later-Filed Complaints even detail many of the exact same practices and techniques that *Osinek* first alleged. The time periods alleged in the Later-Filed Complaints also overlap with the time period at issue in *Osinek*. And while the Later-Filed Complaints name regional and national Kaiser-affiliated entities not named in *Osinek*, those geographic differences are immaterial given *Osinek*'s enterprise-wide allegations about "Kaiser Permanente" as a whole. *See Hampton*, 318 F.3d at 218; *Batiste*, 659 F.3d at 1206–07.

Because *Osinek* and the Later-Filed Complaints allege the same factual scheme to defraud the Medicare Advantage program through the submission of knowingly false risk-adjustment data to CMS, the allegations in the Later-Filed Complaints provide the United States with notice of no new fraud allegations and therefore do not satisfy the purposes of the FCA's *qui tam* provisions. *See Batiste*, 659 F.3d at 1209.

1. *Taylor*

The first-to-file bar requires dismissal of Taylor's complaint in full. The underlying fraudulent scheme alleged by both Osinek and Taylor is the same: Defendants engaged in a systematic effort to "upcode" the diagnoses of Medicare Advantage members. *Taylor* Dkt. No. 1 ¶¶ 5, 61. And many of the factual details about how Kaiser allegedly perpetrated the scheme are the same. Both describe alleged "data mining" algorithms used to identify medical conditions in medical records for upcoding. *Compare* Dkt. No. 1 ¶ 25 *with Taylor* Dkt. No. 1 ¶ 197. Both describe "pressure" supposedly exerted on healthcare providers to diagnose medical conditions that would increase Kaiser's reimbursements under the HCC payment model. *Compare* Dkt. No. 1 ¶¶ 33, 35–36, 40 *with Taylor* Dkt. No. 1 ¶ 134. And both identify many of the same illustrative medical conditions to show how these upcoding schemes allegedly worked: cancer, malnutrition, renal conditions, and respiratory conditions. *Compare* Dkt. No. 1 ¶¶ 25, 27, 37 *with Taylor* Dkt. No. 1 ¶¶ 131, 135, 139, 151. By reading *Osinek*, DOJ had all of the information needed to discover and investigate the allegations in *Taylor*.

Taylor cannot overcome the first-to-file bar by pointing to immaterial factual differences between his complaint and the prior complaint filed by Osinek. For example, that Taylor alleges the fraudulent conduct commenced in 2004, while Osinek alleges it began in 2007, does not save his complaint from dismissal. A mere expansion of an otherwise overlapping date range by the subsequent relator does not overcome the first-to-file bar. *See Batiste*, 659 F.3d at 1209. This rule makes sense: Any reasonable investigation by DOJ into the upcoding practices alleged in *Osinek* would have examined earlier time periods to determine when those alleged practices actually commenced.

Taylor also cannot avoid dismissal simply because he points to examples of the alleged

scheme that occurred in Kaiser's Colorado region whereas Osinek cites examples from Northern California. Courts routinely find that differences in geographic focus are not enough to circumvent the first-to-file bar, particularly where, as here, the first-filed complaint suggests a nationwide fraud. *See, e.g.*, *Hampton*, 318 F.3d at 218; *Batiste*, 659 F.3d at 1206–07. Osinek names a single alleged national defendant—"Kaiser Permanente." Dkt. No. 1. And while she makes clear that the alleged fraud originated with the broader Kaiser Permanente collective, she alleges that Kaiser Permanente encouraged other Kaiser regions to engage in similar upcoding techniques, resulting in an enterprise-wide fraud. *See, e.g.*, *id.* ¶¶ 23, 37. She also cites examples of the alleged scheme from outside the Northern California region, including specific examples from Southern California. *Id.* ¶ 37. In other words, the United States would have discovered the practices alleged in *Taylor* by reasonably investigating the *Osinek* allegations on a nationwide basis. And the United States attempted to do just that—issuing subpoenas in 2013, after the filing of *Osinek*, to Kaiser Foundation Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, and Southern California Permanente Medical Group that applied to "all . . . subsidiaries, regions, . . . [and] affiliates" of the subpoenaed entities. RJN, Exs. A–D at 2; *see id.*, Ex. E at 1 (clarifying that the 2013 subpoena encompassed the Colorado region).

Nor can Taylor avoid dismissal by pointing to allegations in his Second Amended Complaint that do not appear in his original complaint. Allegations that are not in Taylor's original complaint cannot be used to cure the jurisdictional deficiencies from the time of filing. *See supra* at 17–18. Regardless, the added allegations are still just factual variations of Osinek's broader allegation that Kaiser requires healthcare providers to "review and addend records" to capture diagnoses that will generate additional revenue. *See, e.g.*, Dkt. No. 1 ¶ 33. Specifically, Taylor alleges that in Colorado, Kaiser conducted a retrospective review of medical records to independently identify which diagnosis codes the records supported, a process known as "chart review." Dkt. No. 118 ¶ 120. Taylor contends that this practice resulted in the submission of false diagnosis codes to the Medicare Advantage program and overpayments from CMS. *Id.* ¶ 127. But these allegations describe nothing more than a low-tech version of Osinek's data-mining allegations. While Taylor may add detail about the broader practice, additional detail

alone does not circumvent the first-to-file bar. *See Marion*, 2015 WL 4512843, at *3.

2. *Arefi*

The Court also should dismiss the *Arefi* complaint under the first-to-file bar. Because the *Arefi* Relators have dismissed all claims with prejudice to the extent the United States did not intervene, *Arefi* Dkt. Nos. 67 & 68, the remaining allegations in the complaint concern only an alleged "Medicare Advantage diagnosis upcoding scheme" focused on improper addenda, *Arefi* Dkt. No. 1 ¶¶ 2, 45–47, 78. But § 3730(b)(5) bars these claims because *Osinek* already alleged an upcoding scheme based, in part, on improper addenda. *See* Dkt. No. 1 ¶¶ 20, 29–31.

3. *Stein*

The first-to-file bar requires dismissal of *Stein* in its entirety. The *Stein* Relators allege "a fraudulent scheme to up-code and falsely diagnose" Medicare Advantage members—the same fraudulent scheme first alleged in *Osinek*. *See Stein* Dkt. No. 1 ¶ 50; *see also id.* ¶ 70. In discussing the alleged upcoding scheme, the *Stein* Relators assert three causes of action focused on two specific medical conditions—sepsis and malnutrition—and Kaiser's "refresh" practices. *See generally id. Osinek*, too, focuses on an alleged initiative to "refresh" risk-adjusting diagnoses from prior years. *See* Dkt. No. 1 ¶¶ 34, 37. And *Osinek*'s broad focus on upcoding put DOJ on notice of the same alleged scheme at issue in *Stein*, which permitted DOJ to investigate allegations about refresh practices and upcoding involving sepsis and malnutrition.

While the *Stein* Relators' allegations focus on sepsis and malnutrition coding initiatives, these allegations do not describe unique fraud schemes. *See Stein* Dkt. No. 1 ¶¶ 50–79. As noted *supra* at 16-17, the Northern District of California concluded in *Marion* that a relator's "more detailed" explanation of a fraud alleged by a prior relator did not allow her to avoid dismissal under the first-to-file bar. *See Marion*, 2015 WL 4512843, at *3. Similarly, in *Batiste*, the D.C. Circuit affirmed dismissal of a relator's complaint under the first-to-file bar because the two complaints alleged variations on the same fraudulent loan scheme. 659 F.3d at 1206–07. The first-filed complaint "focused on the fabrication of oral forbearance requests," while the later-filed complaint "focused on the offering of forbearances to unqualified borrowers." *Id.* While the competing complaints alleged different methods to perpetrate a similar fraud, the differences

were immaterial to the analysis under § 3730(b)(5) because "the allegations of the first complaint [gave] the government grounds to investigate all that is in the second." *Id.*

So too here, *Osinek*'s broad allegations gave DOJ enough factual basis to investigate the condition-specific fraud alleged in *Stein*. The *Stein* Relators purport to explain how Kaiser used incorrect diagnostic standards for both sepsis and malnutrition that improperly increased the rates at which those conditions were reported to CMS. *See Stein* Dkt. No. 1 ¶¶ 50–79. While Osinek does not focus on malnutrition or sepsis, she generally alleges that Kaiser submitted diagnosis codes for complex medical conditions without proper support and that healthcare providers took "HCCs and the Medicare payment system" into account when recording diagnoses, which resulted in upcoding. Dkt. No. 1 ¶¶ 26, 31. *Stein*'s focus on the alleged use of incorrect diagnostic standards for sepsis and malnutrition does no more than repackage *Osinek*'s broader allegations about diagnosing medical conditions without proper support under applicable CMS guidance.[9] The allegations in *Osinek* therefore were sufficient to put DOJ on notice of the alleged fraud, and § 3730(b)(5) requires dismissal of *Stein*. Indeed, the United States' 2013 subpoenas requested documents that encompassed Kaiser's internal diagnostic standards for all medical conditions, demonstrating that *Osinek* gave DOJ the information it needed to investigate Kaiser's diagnosis standards for sepsis and malnutrition. RJN, Ex. A at 14 (requesting documents about "policies, procedures, guidelines, or professional standards (whether internal or external)" related to "diagnoses or diagnosis codes"), 16 (requesting documents about "systems" used to determine "diagnoses or diagnosis codes").

4. *Bryant* (Counts 1–4)

The *Bryant* complaint likewise should be dismissed except for Counts 5 through 8 of the operative complaint, in which Relators allege illegal retaliation that is not subject to the first-to-

[9] In their operative amended complaint, the *Stein* Relators add allegations that Kaiser instructed coders to improperly assign the diagnosis code for "aortic atherosclerosis" any time that condition appeared in a medical record. Dkt. No. 116 ¶¶ 85, 89. Again, the Court should not consider these allegations because they were not included in the original complaint. *See supra* at 17–18. Regardless, they are merely examples of the same upcoding scheme that Osinek already had alleged, and thus do not change the analysis under § 3730(b)(5).

file bar. Like *Osinek*, *Bryant* describes in the *qui tam* complaint "HCC maximization techniques" that allegedly resulted in "systematic over-documenting, over-coding and ***upcoding*** of certain high value HCCs." *Bryant* Dkt. 1 ¶ 54 (emphasis added). The *Bryant* Relators explain that "Kaiser's . . . 'data mining' team . . . used 'algorithms' in the [Northern California] region to identify and capture possible missed [diagnosis codes] . . . referred to as 'missed opportunities.'" *Id.* ¶ 193. This "missed opportunity" allegation mirrors almost exactly the allegations in *Osinek* about "a system to capture 'missed opportunities,' which are brought to the attention of [healthcare providers] to ensure that all possible Medicare [Advantage] billing opportunities are captured." Dkt. No. 1 ¶ 24. Also mirroring *Osinek*, the *Bryant* Relators cite the specific "upcoding" of malnutrition, respiratory conditions, obesity, and renal conditions. *Compare id.* ¶¶ 25, 27, 37 *with Bryant* Dkt. No. 1 ¶¶ 89, 111, 130, 137, 144–45.

And though *Bryant* cites additional medical conditions not discussed in *Osinek*—such as upcoding of aortic atherosclerosis and vent dependence—these examples are not enough to change the § 3730(b)(5) analysis because the business practices and motives alleged to target these conditions are the same in both complaints. *Compare Bryant* Dkt. No. 1 ¶ 87 (alleging that Kaiser issued "directives" to healthcare providers that "contravene" guidance on vent-dependence coding issued by the American Hospital Association's Coding Clinic) *with* Dkt. No. 1 ¶ 29 (alleging that Kaiser Permanente "tells" healthcare providers to make diagnoses in a way that is not appropriate under "CMS guidelines" and "best practices"). *Bryant*'s allegations are just factual variations on *Osinek*'s allegation that Kaiser Permanente "used a variety of algorithms to identify [certain medical] conditions for data mining, which leads to upcoding." *Compare* Dkt. No. 1 ¶ 25 *with Bryant* Dkt. No. 1 ¶ 59 (alleging that Kaiser "implemented an HCC initiative . . . to review and capture [aortic atherosclerosis] diagnoses in all clinic, emergency, outpatient surgery, and inpatient encounters, even when incidental to the encounter").

The *Bryant* complaint also identifies a number of purported ways that "Kaiser emphasizes financial results over compliance and accuracy," citing to a clinical documentation integrity program and meetings of a "Regional Reporting Group." *Bryant* Dkt. No. 1 ¶¶ 178–79, 187–88. The *Osinek* complaint likewise describes a focus on "HCCs and the Medicare payment system

when coding and recording [member] encounters" and efforts to share successful coding initiatives across regions, even though she does not name the Regional Reporting Group or the clinical documentation integrity program specifically. Dkt. No. 1 ¶¶ 26, 37. Accordingly, for purposes of § 3730(b)(5), *Bryant*'s allegations do not meaningfully differentiate the alleged fraud scheme from the scheme alleged in *Osinek*.

5. *Bicocca* (Counts 1 & 2)

Finally, the Court also should dismiss *Bicocca*'s FCA claims under the first-to-file bar. The thrust of the *Bicocca* complaint is that Kaiser "pressured" specialist providers, such as pain-management physicians, to diagnose medical conditions that the specialists "may not have the expertise to address." *Bicocca* Dkt. No. 1 ¶ 105. Bicocca alleges that Kaiser "directs its [healthcare providers] to check off all chronic [medical] conditions that could conceivably apply to a [member] and place a certifying statement in the [member's] record." *Id.* ¶ 94. He also alleges that healthcare providers could receive "a reduction in bonus" if they failed to meet certain coding "threshold[s]." *Id.* ¶ 128–29. Osinek likewise alleges that Kaiser pressured healthcare providers to add diagnoses to members' charts and that healthcare providers "often give in and use the diagnoses that management asks for rather than using their own, original judgment in coding diagnoses." Dkt. No. 1 ¶ 33. And she also focuses on physician incentives, asserting that Kaiser "tracks and rewards [healthcare providers] based on the percentage of chronic conditions they are able to capture and refresh." *Id.* ¶ 37.

Bicocca focuses on upcoding pressure directed at specialists, who he alleges "do not have the expertise to fully advise their patients on the various ailments" that the specialists had to address. *Bicocca* Dkt. No. 1 ¶¶ 110–19. While Osinek does not explicitly mention specialists, Bicocca's allegations do not differ materially from Osinek's broader allegations that Kaiser pressured ***all healthcare providers*** to refresh "99%" of chronic medical conditions, Dkt. No. 1 ¶ 39, which encompass the subset of specialists at issue in *Bicocca*.

In addition, Bicocca's allegations that Kaiser's efforts to diagnose chronic medical conditions without meeting the requirements of a CMS chronic care program are simply a subset of Osinek's allegations that Kaiser violated CMS diagnosis coding and documentation guidelines.

For example, Bicocca alleges that a "trainer stated that if a [member] states in response to a question that he or she is taking medication for a certain condition, this would satisfy the [chronic care program] requirements" for adding a chronic medical condition to the medical record, but this statement "is in direct contradiction to the foregoing guidelines." *Bicocca* Dkt. No. 1 ¶ 126. Osinek similarly alleges that "Kaiser tells [providers] to go back to see what a member's previous test results showed to make diagnoses, which is not an appropriate data source for coding a diagnosis under CMS guidelines." Dkt. No. 1 ¶ 29. In sum, both complaints allege that Kaiser instructed healthcare providers to add diagnoses to members' medical records using methods that allegedly violated CMS guidelines.

IV. CONCLUSION

Allowing the upcoding allegations in the Later-Filed Complaints to proceed would subvert the purpose of the first-to-file bar not once, but five times over. With the contentions in the *Osinek* complaint, DOJ had sufficient information to investigate the upcoding allegations in the five Later-Filed Complaints. The Court should therefore grant Defendants' Motion and dismiss the *Taylor*, *Arefi*, and *Stein* complaints in their entirety, as well as Counts 1 through 4 of the operative *Bryant* complaint and Counts 1 and 2 of the operative *Bicocca* complaint.

Dated: January 18, 2022

Respectfully submitted,

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APPENDIX A

Alleged Fraud: "Upcoding" Medicare Advantage Member Diagnoses					
***Osinek* (2013)**	***Taylor* (2014)**	***Arefi* (2015)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
"Kaiser defrauded the United States through a sophisticated scheme to ***upcode diagnoses*** to ensure Medicare [Advantage] payments for reimbursable, high-value [medical] conditions." ¶ 2.[1]	Defendants engaged in a scheme to "***upcode***" diagnoses of Medicare Advantage members. ¶¶ 5, 61, 74, 81, 101.	Defendants engaged in a "***Medicare Advantage diagnosis upcoding scheme***," by "reporting false . . . diagnoses to CMS for Medicare Advantage plan enrollees . . . ." ¶¶ 42, 78.	Defendants engaged in "a fraudulent scheme to ***up-code and falsely diagnose***" Medicare Advantage members. ¶¶ 50, 70.	"***Defendants 'upcode' risk adjustment claims*** by manipulating the documentation and submitting claims and codes to the Medicare Advantage program for diagnoses that the [member] does not have . . . or by claiming that a member was treated for a more serious [medical] condition than the member actually has . . . ." ¶ 11.	Defendants required healthcare providers to "certify that they have managed their patients' chronic [medical] conditions, even though they have not managed the chronic [medical] condition" in order to "***receive additional, undeserved capitation amounts***" from the Medicare Advantage program. ¶¶ 2–3.

[1] Paragraph citations correspond to the relevant original complaint. All emphases are added.

Alleged "Upcoding" Technique 1: Use of Data Mining/Algorithms to Identify Diagnoseable Medical Conditions			
***Osinek* (2013)**	***Taylor* (2014)**	***Stein* (2016)**	***Bryant* (2018)**
"Kaiser effectuated its scheme through ***data mining*** . . . ." ¶ 2. Kaiser used "***algorithms*** to identify . . . [medical] conditions for data mining . . . ." ¶¶ 24–25. Kaiser used "a system to capture '***missed opportunities***,' . . . to ensure that all possible Medicare billing opportunities are captured . . . ." ¶ 24. "Kaiser focuses its ***data mining*** on high value [medical] conditions for which Kaiser can maximize its reimbursement from Medicare and increase its revenue." ¶ 25.	Kaiser "uses an ***algorithm*** to search [medical records] to find words that, individually or in combination, indicate that a [member] has certain diagnoses." ¶ 191. "[A] PowerPoint presented at the Fall 2010 RRG Meeting outlined the results of the 'NLP HCC ***Data Mining*** Pilot." ¶ 197.	Kaiser "performed a ***computer search*** to ***data-mine*** the [data] submissions from the last . . . year to identify the [Medicare Advantage members] with a history of hit-list HCC diagnoses, and used those results to determine which [members'] medical records did not have such hit-list HCC diagnoses submitted . . . ." ¶ 84; *see also* ¶ 100.	"Kaiser's internal data establishes that its ***efforts to mine*** for [aortic atherosclerosis] succeeded in capturing and submitting an enormous increase of [aortic atherosclerosis] codes to Medicare . . . ." ¶ 79. Kaiser has a "'***data mining***' team . . . [which] used '***algorithms***' . . . to identify and capture possible missed HCCs to create 'add files,' referred to as '***missed opportunities***' . . . ." ¶ 193. Kaiser used a ***computer tool*** that "identifies wording and/or full sentences within the electronic health record which contains signs, symptoms, diagnoses and procedures for which a code may possibly be assigned once confirmed and validated by the coding professional." ¶ 198.

Alleged "Upcoding" Technique 2: Refreshing Previously Diagnosed Medical Conditions		
***Osinek* (2013)**	***Taylor* (2014)**	***Stein* (2016)**
By relying on "what Kaiser terms '***refreshing***' . . . Kaiser was able to increase its billings for high value hierarchical condition categories or HCCs." ¶ 24. "Kaiser tracks and rewards [healthcare providers] based on the percentage of chronic [medical] conditions they are able to capture and ***refresh***." ¶ 37. "Kaiser ties funding allocations to a facility's ***refresh*** . . . rates . . . ." ¶ 39.	Kaiser uses a "program designed to '***refresh***' chronic diagnosis that are submitted one year but not the next." ¶ 186.	Kaiser "submitted or caused to be submitted false and fraudulent [data]resulting from [Kaiser Foundation Health Plan]'s practice of '***refreshing***' missing HCC diagnosis codes." ¶ 80. Kaiser "implemented an improper program designed to identify 'missing' HCC diagnosis codes and have the [healthcare providers] '***refresh***' the missing HCC diagnoses." ¶ 83. "The progress and success of the ***refresh program*** was internally well documented, and tracked the [Medicare Advantage members'] medical records, the HCC diagnoses to be '***refreshed***,' the [healthcare providers] who '***refreshed***' the HCC diagnoses, the HCC diagnosis codes submitted to CMS as [data] as a result of the ***refresh process***, and the increased risk adjustment scores resulting from the ***refresh process***." ¶ 83.

Alleged "Upcoding" Technique 3: Improper Addenda Practices				
***Osinek* (2013)**	***Taylor* (2014)**	***Arefi* (2015)**	***Stein* (2016)**	***Bryant* (2018)**
"Kaiser's Medicare [Advantage member] medical records include ***addenda*** with supporting statements or documentation that were ***not addressed at the time of an encounter***." ¶ 28. Kaiser "prompted" healthcare providers "to ***addend*** diabetes diagnoses to include hyperlipidemia . . . ." ¶ 30.	Kaiser relied on a "radiology report or other test result, rather than a diagnosis documented by an appropriate [healthcare] provider in a face-to-face visit" to support additions to the medical record. ¶ 138. "Kaiser routinely submitted claims where the only documentation to support the diagnosis was a radiologic or lab test, or other ***non-face-to face service***." ¶ 160.	Kaiser submitted diagnosis codes based on "***after-the-fact*** medical record reviews" and "retrospective mining of clinical data." ¶ 2. Kaiser used "queries to induce treating [healthcare providers] to ***add such false and after-the-fact ICD-9-CM diagnoses*** to . . . [members'] charts . . . ." ¶ 8. "Kaiser Defendants . . . [sent] leading and coercive 'physician queries' to improperly induce the treating [provider] to ***change the electronic record*** of the . . . [member's] most recent face-to face encounter by ***adding or substituting the HCC diagnosis*** . . . ." ¶ 47.	Kaiser "***amend[ed]*** the medical record without valid face-to-face encounters . . . ." ¶ 80. "The ***addenda*** refreshing HCC diagnoses were [] invalid . . . ." ¶ 90.	"Coding professionals are permitted . . . to ***query [healthcare] providers for clarification and additional documentation***," but Kaiser used "improper query templates" which "introduce clinical indicators for specific HCC diagnoses to the providers, who in turn routinely follow the suggestion to ***add a reimbursable diagnosis where none existed and should not have been added***." ¶¶ 155, 159, 161.

Alleged "Upcoding" Technique 4: Boilerplate Phrases Used to Indicate Compliance with Alleged Diagnosis Coding Guidelines		
***Osinek* (2013)**	***Bryant* (2018)**	***Bicocca* (2020)**
Kaiser instructs healthcare providers to use "***cloned or boilerplate language*** to make the [member's] record appear to comply with CMS instructions." ¶ 28. "Kaiser also provides ***boilerplate phrases*** . . . [that] can be ***automatically inserted*** through a combination of key strokes . . . ." ¶ 32.	Kaiser "developed a '***SMARTPHRASE***' to ***automatically populate*** the medical record" when diagnosing aortic atherosclerosis. ¶ 62; *see also* 68–69. Kaiser used "'***SMARTPHRASE***' acknowledgments of dietician diagnoses of PCM with a co-signature of dietary notes" when diagnosing malnutrition. ¶ 137.	Kaiser "***provide[d] the language for the certifying statements***" and "directed" healthcare providers to write specific language "in their charts." ¶¶ 97–98. Kaiser instructed healthcare providers to use a ***".FOL" smartphrase*** to support diagnosis coding of chronic medical conditions in medical records. ¶¶ 137–45.

Alleged "Upcoding" Technique 5: Pressure on Healthcare Providers to Diagnose Risk-Adjusting Medical Conditions				
***Osinek* (2013)**	***Taylor* (2014)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
"Kaiser ***pressures*** its [healthcare providers] to addend diagnoses and capture the high value HCCs . . . ." ¶ 33. "Kaiser instituted an ***escalation process*** for [providers] who do not agree with the data mining prompts." ¶ 33. Healthcare providers "have ***personal report cards*** based on how they perform in certain areas, which are tied to their ***compensation***." ¶ 34. "Kaiser has mandatory meetings called '***coding parties***,' where [providers] are gathered in a single room . . . and asked to review past progress notes for addenda related to revised medical diagnoses." ¶ 35.	Kaiser "***pressured*** [healthcare providers] to use the diagnosis code for chronic bronchitis (which risk adjusts) rather than acute bronchitis . . . ." ¶ 134.	Kaiser "tracked . . . the [healthcare providers] who 'refreshed' the HCC diagnoses." ¶ 83. "Kaiser's coders then ***met with the [providers] to ensure that the hit-list HCC diagnoses were refreshed***." ¶ 84.	"Kaiser's various regions . . . ***compete*** with each other on which region manages to capture the highest number of HCCs and improved risk scores." ¶ 190. Kaiser used "***leading***" queries that "***improperly suggested***" the appropriate diagnosis. ¶¶ 124, 134, 137–38, 141–42, 155–59, 161–64, 182–83, 186.	"Defendants ***intentionally instruct*** [healthcare providers] to certify that they have managed [members'] chronic [medical] conditions . . . ." ¶ 2. "Defendants . . . ***effectively discourage*** [providers] from complying with CMS regulations . . . ." ¶ 6. "Defendants . . . implied that [providers] would be ***disciplined*** or otherwise ***adversely acted upon*** if they did not [address chronic medical conditions]. Examples of this were a ***reduction of bonus***." ¶ 129. "[T]he administrative chiefs of every department received

Alleged "Upcoding" Technique 5: Pressure on Healthcare Providers to Diagnose Risk-Adjusting Medical Conditions				
***Osinek* (2013)**	***Taylor* (2014)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
Kaiser "***pressures***" healthcare providers to diagnose Medicare Advantage members "through incentive Programs" such as monetary rewards. ¶ 36. "***[C]ompetitive pressure*** is not only exerted between regions, but within the region" to have the highest risk scores. ¶¶ 37, 38.				emails detailing which doctors were not checking at least 90% of the listed chronic [medical] conditions with every [member]. In meetings between department chiefs, the group would discuss which departments were most successful in meeting this criterion." ¶¶ 132–33.

Alleged "Upcoding" Technique 6: Guidance & Policies			
***Osinek* (2013)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
"Kaiser ***told its [healthcare providers] to diagnose*** chronic kidney disease instead of" lower-value medical conditions. ¶ 26. "[W]hen CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser ***tells its [providers] to change coding practices*** to reflect new reimbursable codes." ¶ 27. "Kaiser ***tells [providers] to go back to see what a member's previous test results showed to make diagnoses***, which is not an appropriate data source for coding a diagnosis under CMS guidelines . . . ." ¶ 29. "Kaiser ***tells its [providers] to change diagnoses to upcode*** to higher value and more complicated forms of diseases." ¶ 30.	Kaiser relied on an "***improper Sepsis diagnostic standard*** that overstated the frequency of Sepsis diagnoses . . . ." ¶ 50. Kaiser relied on "***coding instructions and query restrictions*** [that] violate ICD-9 Guidelines and AHIMA ethical coding guidelines." ¶ 54. Kaiser relied on a malnutrition ***documentation standard that "fails"*** to meet CMS requirements. ¶ 71.	Kaiser relied on ***inaccurate diagnostic standards*** for certain medical conditions. ¶¶ 59–60, 67, 69–72, 75, 86–88, 96, 99–101, 111–13, 117–121, 123, 130, 137, 146. "Kaiser consistently publishes and ***enforces internal company policies and procedures that contravene coding and diagnostic principles*** that are widely accepted and enforced within the broader coding community." ¶ 151. "Many of Kaiser's ***proprietary policies*** regarding diagnosing and coding are intentionally ***constructed to be less restrictive than the norm*** in furtherance of the company's emphasis on profit over compliance." ¶ 152.	Kaiser trained healthcare providers to select diagnosis codes based on ***inaccurate diagnostic standards***. ¶¶ 6, 88–96, 103–118, 124–127, 143–152.

Alleged "Upcoding" Technique 6: Guidance & Policies			
***Osinek* (2013)**	***Stein* (2016)**	***Bryant* (2018)**	***Bicocca* (2020)**
Healthcare "providers were ***told to capture diagnoses*** of Peripheral Vascular Disease [] and Diabetic Peripheral Vascular Disease [] using Carotid Artery Stenosis as evidence." ¶ 31.			

TAB 12

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

KAISER PERMANENTE,

Defendant.

Case No. 3:13-cv-03891-EMC

JOINT STIPULATION AND ~~[PROPOSED]~~ ORDER REGARDING FIRST-TO-FILE BRIEFING SCHEDULE

(CAPTION CONTINUED)

UNITED STATES OF AMERICA ex rel. ANASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC., Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **JOINT STIPULATION AND ~~[PROPOSED]~~ ORDER REGARDING FIRST-TO-FILE BRIEFING SCHEDULE**
UNITED STATES OF AMERICA ex rel. MARCIA STEIN and RODOLFO BONE, Plaintiff, v. KAISER FOUNDATION HEALTH PLAN, INC., et al, Defendants.	Case No. 3:18-cv-05337-EMC **JOINT STIPULATION AND ~~[PROPOSED]~~ ORDER REGARDING FIRST-TO-FILE BRIEFING SCHEDULE**
UNITED STATES OF AMERICA ex rel. GLORYANNE BRYANT and VICTORIA HERNANDEZ, Plaintiff, v. KAISER PERMANENTE, et al, Defendants.	Case No. 3:18-cv-01347-EMC **JOINT STIPULATION AND ~~[PROPOSED]~~ ORDER REGARDING FIRST-TO-FILE BRIEFING SCHEDULE**

(CAPTION CONTINUED)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiffs, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **JOINT STIPULATION AND ~~[PROPOSED]~~ ORDER REGARDING FIRST-TO-FILE BRIEFING SCHEDULE**

UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:21-cv-03894-EMC **JOINT STIPULATION AND ~~[PROPOSED]~~ ORDER REGARDING FIRST-TO-FILE BRIEFING SCHEDULE**

Pursuant to Civil Local Rules 6-1(b), 6-2, and 7-12, Relators Ronda Osinek, James Taylor, M.D., Naser Arefi, Ajith Kumar, Prime Healthcare Services, Inc., Marcia Stein, Rodolfo Bone, Gloryanne Bryant, Victoria Hernandez, and Michael Bicocca, M.D. (collectively, "Relators"); the United States of America; and Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (collectively, "Defendants") hereby recite, stipulate, and request as follows:

1. The Court held a case management conference on November 16, 2021 regarding Defendants' Motion to Stage Fed. R. Civ. P. 12 Briefing (ECF No. 107);

2. At the conference, an agreement was reached whereby Defendants may file motions to dismiss under the False Claims Act's first-to-file bar and, following the Court's ruling, may then file any remaining Rule 12(b) motions to dismiss;

3. Following the conference, the Court entered a minute entry setting a briefing schedule for first-to-file motions that was consistent with the October 10, 2021 stipulation of the parties, which was entered before the parties had agreed to or the Court had ordered staged briefing;

4. That minute entry set a case management conference for January 11, 2022, but clarified that discovery would still be keyed to the previously scheduled February 15, 2022 case management conference, *see* Dkt. No. 119;

5. In light of the initial briefing now being limited to first-to-file issues, the parties have met and conferred and, through their respective counsel and subject to the Court's approval, stipulate that the following schedule will be implemented:

Event	**Current Deadline**	**Proposed Deadline**
Deadline for Defendants to file their first-to-file motion	January 18, 2022	January 18, 2022
Deadline for responses to Defendants' first-to-file motion	March 18, 2022	**February 15, 2022**

Event	Current Deadline	Proposed Deadline
Deadline for Defendants' replies to their first-to-file motion	April 18, 2022	**March 17, 2022**
Hearing on Defendants' first-to-file motion	May 5, 2022	**March 31, 2022**
Deadline for Defendants to file any remaining Rule 12(b) motions to dismiss	-	**45 days after entry of an order on all first-to-file motions**
Deadline for responses to Defendants' motions to dismiss	-	**45 days after motions are filed**
Deadline for Defendants' replies to their motions to dismiss	-	**30 days after oppositions are filed**
Hearing on Defendants' Rule 12(b) motions to dismiss	-	**At the Court's convenience**

6. Additionally, consistent with their understanding of the discussion at the November 16, 2021 case management conference and the Court's related minute entry that keys discovery to the original February 15, 2022 case management conference date, the parties stipulate to the following discovery-related deadlines:

Event	Deadline
Deadline for Rule 26(f) conference	January 25, 2022
Deadline for submission of Rule 26(f) report	February 8, 2022
Rule 16 conference	February 15, 2022 or, at the Court's earliest convenience

7. The parties agree that this stipulation will also serve as the report the Court has required filed by January 4, 2022 in advance of the January 11, 2022 case management conference. *See* Dkt. No. 119.

IT IS SO STIPULATED.

Dated: December 21, 2021 By: __*/s/ Amy M. Zeman*_____

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PURSUANT TO STIPULATION, IT IS SO ORDERED.

Dated: December 29, 2021

HONORABLE EDWARD M. CHEN
UNITED STATES DISTRICT JUDGE

TAB 13

OFFICE OF THE CLERK
UNITED STATES DISTRICT COURT
Northern District of California

CIVIL MINUTES

Date: November 16, 2021 **Time:** 1:30-1:44 = 14 Minutes **Judge:** EDWARD M. CHEN

Case No.: 13-cv-03891-EMC **Case Name:** Osinek v. Kaiser Permanente

Attorneys for Plaintiff: Ben Wolinsky, Amy Zeman, Shiwon Choe, Abram Zinberg, Michael Ronickher, Janel Quinn
Attorneys for Defendant: David Leviss, Anne Steinberg

Deputy Clerk: Angella Meuleman **Court Reporter:** Belle Ball

PROCEEDINGS HELD BY ZOOM WEBINAR

Initial Case Management Conference held.

SUMMARY

Parties stated appearances.

The Court addressed the parties' dispute as to whether Rule 12 briefing should be staged. The Court proposed dealing with the first-to-file issue first, and reserving for afterward 12(b)(6) merits motions. This would address Relators' concern that Kaiser would otherwise be given two bites at the apple on the merits. Neither Kaiser nor the Relators objected to the Court's proposal.

Kaiser's first-to-file motion shall be filed by 1/18/2022; opposition by 3/18/2022; and reply by 4/18/2022. The hearing on the first-to-file motion is set for 5/5/2022.

At this time, Kaiser is not required to file a response to the Relators and/or government's complaints.

After the Court rules on the first-to-file motion, Kaiser shall file its 12(b)(6) motion(s). The parties should meet and confer re the timing of the 12(b)(6) motion(s) (*e.g.*, 30 days after the Court issues its order on the first-to-file motion) and promptly submit a stipulation.

The Court noted that the first-to-file motion could potentially be obviated should the Relators reach some kind of agreement.

Further Case Management Conference set for 2/15/2022 is vacated and advanced to 1/11/2022 at 2:30PM. Joint cmc statement due 1/4/2022. Court further confirmed that discovery is keyed to the original cmc date (2/15/2022).

TAB 14

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, FOUNDATION HEALTH PLAN, INC., and THE PERMANENTE MEDICAL GROUP, INC., Defendants.	Consolidated Case No. 3:13-cv-03891 -EMC SECOND AMENDED COMPLAINT BY RELATOR JAMES M. TAYLOR, M.D., FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT **JURY TRIAL DEMANDED**
UNITED STATES OF AMERICA, *ex rel.* JAMES M. TAYLOR, M.D., Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HEALTH PLAN OF COLORADO, COLORADO PERMANENTE MEDICAL GROUP, P.C., THE PERMANENTE MEDICAL GROUP, INC., and SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, Defendants.	(Original N.D. Cal. Case No. 3:21-cv-03894-EMC) SECOND AMENDED COMPLAINT BY RELATOR JAMES M. TAYLOR, M.D., FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT **JURY TRIAL DEMANDED**

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On October 22, 2014, James M. Taylor, M.D., filed a sealed *qui tam* complaint as Relator on behalf of the United States of America against various Kaiser entities[1], alleging violations of the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-33. By his complaint, Relator alleged that the Kaiser entities engaged in fraud on the Medicare program, both nationally and within Colorado, by their intentional submission of inaccurate and unsupported diagnosis codes that inflated Kaiser's reimbursements from Medicare Part C, known as the Medicare Advantage Program. On November 3, 2014, Relator filed a First Amended Complaint with substantially the same allegations.

On July 29, 2021, the Government filed a notice of election to intervene in part and decline in part in Relator's and five other cases, and Relator's complaint was subsequently unsealed.[2] On October 25, 2021, the United States filed its Complaint-in-Intervention against Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, P.C., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C., alleging FCA violations based on a coordinated scheme to unlawfully obtain payments from the Medicare Advantage Program by systematically altering patient medical records to retrospectively add diagnoses, via addendum, that either did not exist or were unrelated to the patient's visit with a Kaiser physician.

The United States did not intervene with regard to Relator's allegations of FCA violations relating to Kaiser's improper one-way look chart reviews of non-Kaiser hospitals in Colorado, or its failure to correct codes and return overpayments based on unsupported diagnoses discovered during audits of Kaiser physicians or external providers more generally.

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[1] Defendants named in Relator Taylor's initial complaint were Kaiser Permanente, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest.

[2] Specifically, in its Notice of Election to Intervene in Part and to Decline to Intervene in Part, the United States intervened on the allegations that Kaiser "submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda under Medicare Part C from the years 2009 until present." (Dkt. 65).

Nor did the United States intervene as to any allegations prior to 2009. Therefore, through this Second Amended Complaint, Relator—upon knowledge with respect to his own acts and those he personally witnessed, and upon information and belief with respect to all other matters—maintains his allegations on behalf of the United States, including as to those non-intervened claims, as follows:

PRELIMINARY STATEMENT

1. This *qui tam* case is brought against Defendants for knowingly defrauding the federal Government in connection with the Medicare program in violation of the federal False Claims Act, 31 U.S.C. § 3729 *et seq*.

2. Since at least 2004 to present, Defendants and/or their agents and employees have perpetrated a systematic fraud on the Medicare Advantage ("MA") program and Medicare Part D. They routinely submit false claims to the Centers for Medicare & Medicaid Services ("CMS") when they know, or in the exercise of reasonable care should know, that their beneficiaries' medical records do not support the diagnoses for which a risk adjustment claim was submitted.

3. Defendants have also knowingly retained overpayments when they refused to correct (and refused to reimburse Medicare for) previously submitted risk adjustment claims when they discover, or in the exercise of reasonable care should discover, that those previously submitted claims were false.

4. Kaiser had extensive knowledge of its false claims. Relator and others, as well as various national, regional, and diagnosis-specific audits, regularly identified red flags in Kaiser's coding: categories of claims that had extremely high rates of falsity. Yet Kaiser willfully disregarded this falsity, taking few steps to review its claims and shutting down the few successful controls that Relator and others were able to put in place, in order to pursue ever higher revenue.

5. This disregard contrasts starkly with Kaiser's considerable efforts and substantial commitment of resources to audit current and past claims in search of additional revenue, by identifying new diagnoses that it could use to submit additional risk adjustment claims.

6. These opposite approaches are starkly apparent in Kaiser's handling of diagnosis coding by certain non-Kaiser hospitals in Colorado that provide care to Kaiser beneficiaries. Relator and repeated audits made Kaiser well-aware that these external healthcare providers had egregiously high error rates in their coding. Yet Kaiser passed their codes along to CMS for payment without reviewing them, willfully disregarding its obligations to claim only accurate payments.

7. Kaiser created a program to review records from certain non-Kaiser hospitals, which should have improved the accuracy in its coding. But instead Kaiser only looked at the upside of that review: it added legitimate codes that the hospitals had missed, while deliberately ignoring the results that would have shown all the unsupported codes for which it was seeking, or had already sought, payment.

8. On its internal coding, Kaiser took only limited steps to filter certain diagnoses, which further confirmed that physicians often upcoded those diagnoses, leading (absent intervention) to the submission of false claims. Despite this knowledge, Kaiser chose not to apply these filters to its prior years' submissions to identify and correct these false diagnoses. It also shut down these remedial measures, over Relator's objections.

9. Kaiser's refusal to take reasonable steps to prevent the submission of false claims, and to make a reasonable inquiry into previously submitted false claims, constitutes reckless disregard as to, and/or deliberate ignorance of, the falsity of those claims.

10. In certain instances, Kaiser had actual knowledge that specific claims it previously submitted to CMS were false. Kaiser's refusal to delete those claims and refund the resulting overpayments to the United States also constitutes a violation of the False Claims Act.

11. Through this scheme, Kaiser has defrauded the United States of millions of dollars.

12. Based on the foregoing laws, *Qui Tam* Plaintiff-Relator Dr. James M. Taylor, seeks, through this action, to recover damages and civil penalties arising from the false or fraudulent records, statements, and/or claims that Defendants made or caused to be made in connection with false and/or fraudulent claims for inflated Medicare Advantage payments.

PARTIES

13. Relator Dr. James M. Taylor ("Relator") is a resident of Colorado and an employee of Colorado Permanente Medical Group ("CPMG"). Dr. Taylor joined Kaiser's Colorado branch in 1995 as a clinician, following eight years in private practice in rural Ohio. In the early 2000s, Dr. Taylor became heavily involved with Kaiser's national Electronic Medical Record ("EMR") and physician coding practices. He is a certified professional coder and AHIMA approved ICD-10 trainer.

14. Dr. Taylor was elected to the Board of Directors of CPMG and served as chair for two years. He was Kaiser's national co-chair of the Compliance Committee for ICD-10; a member of Kaiser's national Coding Governance Group (the only delegate representing all physicians for the regions outside of California); and CPMG's Medical Director of Revenue Cycle/Claims. From 2002 to 2007, he served as CPMG's Physician Director of Coding. He is the only physician to have received Kaiser's National Revenue Cycle "Distinguished Leadership" award.

15. Relator has extensive experience in risk adjustment payments, processes, audits, and compliance. He is a nationally recognized speaker on topics such as EMR documentation, coding, and compliance. He has written articles, created webinars, and presented at national conventions for the American Health Information Association, National Health Care Anti-Fraud Association, Health Care Compliance Association, National Health Care Auditors and Educators Association, and American Association of Professional Coders.

16. Relator not only was a key figure involved in all facets of risk adjustment in Kaiser, but he consistently interfaced with Kaiser personnel at the national level on risk adjustment audits and initiatives. Relator was directly involved in the Colorado probe audit process, routinely identified issues and errors with external providers, worked with the region on corrective action plans, attended various group meetings to discuss Colorado risk adjustment initiatives and presented on a regular basis at national Regional Reporting Group ("RRG") meetings.

17. Kaiser Permanente is a "nonprofit integrated health care provider" headquartered in Oakland, California that includes three main groups: (1) the Kaiser Foundation Health Plan, Inc. and its subsidiaries; (2) the Kaiser Foundation Hospitals and their subsidiaries; and (3) the Permanente Medical Groups. Together, they operate publicly as "Kaiser Permanente." In its annual report, Kaiser Permanente proclaims that the "interconnectedness and interdependence of the hospitals, health plan, and medical groups that make up Kaiser Permanente have advanced our efforts to operate seamlessly as an enterprise."

18. Kaiser is one of the largest managed care organizations in the United States. Opened to public enrollment in 1945, it now boasts millions of members throughout various states, including California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia.

19. Kaiser has over 210,000 employees (including over 20,000 physicians). In 2020, Kaiser reported more than $80 billion in operating revenue.

20. Kaiser offers Medicare HMO plans, called "Kaiser Permanente Senior Advantage Plans," in California, Colorado, Georgia, Hawaii, Oregon, and Washington.

21. Some regions, such as California, operate using almost exclusively Kaiser affiliated medical providers. In these regions, Kaiser owns or controls the hospitals and physician offices that provide services to members of Kaiser's insurance plans. In other regions, such as Colorado, Kaiser maintains more limited provider resources. For example, in Colorado,

Kaiser's members are seen by physicians in CPMG, a Kaiser affiliate. But because Kaiser does not operate hospitals in Colorado, when members require inpatient or outpatient care, they are seen by non-Kaiser hospitals with whom Kaiser has contracted to provide care to its members. Throughout this document, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, and Colorado Permanente Medical Group P.C., are referred to as "Kaiser" or "Defendants."

22. Defendant Kaiser Foundation Health Plan, Inc. ("the Health Plan") is a non-profit health maintenance organization ("HMO") headquartered in Oakland, California.

23. Defendant Kaiser Foundation Health Plan of Colorado ("the Colorado Health Plan") is a non-profit HMO headquartered in Oakland, California.

24. Colorado Permanente Medical Group P.C. ("Colorado Medical Group") is a multi-specialty physician group of over 1,000 physicians that contracts with Defendant Kaiser Foundation Health Plan of Colorado to provide medical care to its members.

25. Throughout this complaint, Defendants Kaiser Foundation Health Plan of Colorado and Colorado Permanente Medical Group P.C. are referred to jointly as "Kaiser Colorado."

26. Defendant The Permanente Medical Group, Inc. ("N. California Medical Group") is headquartered in Oakland, California and employs approximately 9,500 physicians. It provides medical services for Kaiser's Northern California region.

27. Defendant the Southern California Permanente Medical Group, a California partnership ("S. California Medical Group") is headquartered in Pasadena, California, and employs approximately 7,800 physicians. The Southern California Medical Group provides medical services for Kaiser's Southern California region.

JURISDICTION AND VENUE

28. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

29. Under 31 U.S.C. § 3730(e) there has been no statutorily relevant public disclosure of the "allegations or transactions" in this Complaint. Even if there had been any such public disclosure, Relator is the original source of the allegations herein because he has direct, independent, and material knowledge of the information that forms the basis of this Complaint, and voluntarily disclosed that information to the Government before filing.

30. This Court has personal jurisdiction over Defendants, pursuant to 31 U.S.C. § 3732(a), as one or more Defendants can be found in, reside in, transact business in, and have committed acts related to the allegations in this Complaint in the Northern District of California.

31. Venue is proper, pursuant to 31 U.S.C. § 3732(a), as one or more Defendants can be found in, reside in, and/or transact business in the Northern District of California, and because many of the violations of 31 U.S.C. § 3729 discussed herein occurred within this judicial district.

THE FALSE CLAIMS ACT

32. The FCA was enacted in 1863, over a century before Medicare. From the outset, and through several amendments enacted over the past twenty-five years to increase the scope and reach of the statute, both Congress and the Supreme Court have repeatedly highlighted that (1) the FCA is to be applied broadly and flexibly to reach all types of fraud that cause financial loss to the Government, and (2) private parties (relators) should be strongly encouraged to bring actions under the statute to supplement the Government's limited resources to combat fraud.

33. When evaluating claims under the FCA, the Supreme Court has repeatedly acknowledged and deferred to these twin goals of the statute and "consistently refused to accept a rigid, restrictive reading." *United States v. Neifert-White Co.*, 390 U.S. 228, 232 (1968). Instead, it has applied the law recognizing that "Congress wrote [it] expansively, meaning to

reach all types of fraud, without qualification, that might result in financial loss to the Federal Government." *Cook Cnty. v. United States ex rel. Chandler*, 538 U.S. 119, 129 (2003) (internal quotation marks omitted). *See also Rainwater v. United States*, 356 U.S. 590, 592 (1958) ("It seems quite clear that the objective of Congress was broadly to protect the funds and property of the Government . . . ."); *Neifert-White*, 390 U.S. at 233 (the FCA "reaches beyond 'claims' which might be legally enforced, to all fraudulent attempts to cause the Government to pay out sums of money.").

34. Likewise, "[e]ach time Congress has weighed in on the purpose and power of the False Claims Act, it has endorsed a reading of that statute as a robust remedial measure aimed at combatting fraud against the federal government as firmly as possible." *United States ex rel. Kane v. Healthfirst, Inc.*, 120 F. Supp. 3d 370, 391 (S.D.N.Y. 2015). The FCA together with its amendments "reflect Congress's more than 150-year commitment to deterring fraud against the federal government and ensuring that Government losses due to fraud are recouped in a timely fashion." *Id*.

35. A defendant violates the FCA when it "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval"; "knowingly makes, uses or causes to be made or used, a false record or statement material to a false or fraudulent claim"; or "knowingly makes, uses or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(A), (B), (G).

36. After the 2009 amendments to the FCA by the Fraud Enforcement and Recovery Act of 2009 ("FERA"), Pub. L. 111-21 (May 20, 2009), a defendant violates the FCA when it "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)(B). Prior to FERA, a defendant violated this

provision of the FCA when it "knowingly [made], use[d], or cause[d] to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government."

37. In May 2009, Congress amended the "reverse false claims act" provision of the FCA to provide that a defendant violates the FCA when it "knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G). Prior to FERA, this provision of the FCA provided that a defendant violates the FCA when it "knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government." After FERA, a defendant violates this provision of the FCA when it "knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G).

38. The terms "knowing" and "knowingly" include "actual knowledge of the information," "deliberate ignorance of the truth or falsity of the information," or "reckless disregard of the truth or falsity of the information" and "require no proof of specific intent to defraud." *Id.* § 3729(b)(1)(A), (B). The FCA permits but does not require proof that the defendants specifically intended to commit fraud. *Id.* Congress included "deliberate ignorance" in its definition of the terms "knowing" and "knowingly" to hold a defendant accountable for failing to make the inquiry that a reasonable and prudent person or entity would have made under the circumstances to be reasonably certain that he, she, or it was entitled to the money that he, she, or it sought from the Government.

39. A defendant violates the FCA when it "knowingly conceals *or* knowingly and improperly avoids *or* decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G) (emphasis added). Even if an overpayment arises out

of an innocent billing error or through a mistake of the contractor, the obligation to return the overpayment still attaches.

40. The term "material," as used in the FCA, "means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

41. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery.

MEDICARE PARTS C AND D

42. Medicare is a federally funded health insurance program which provides for certain medical expenses for persons who are over 65, who are disabled, or who suffer from End Stage Renal Disease. Medicare was established by Title XVIII of the Social Security Act of 1965 (codified as amended at 42 U.S.C. § 1395 *et seq.*). The Medicare program is administered through the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS"). *See, e.g.*, 42 U.S.C. §§ 1395b-1, 1395b-2, 1395b-3, 1395b-4, 1395b-7, 1395r and 1395u.

43. The Medicare program has four parts. Under Parts A and B ("traditional Medicare"), the Government reimburses healthcare providers using a fee-for-service system, in which providers submit claims to CMS for healthcare services actually rendered, such as a provider office visit or hospital stay. CMS then pays the providers directly for each service based on payment rates predetermined by the Government.

44. In 1997, Congress created Part C, which provides similar benefits to Medicare members, but does so using a managed care model, rather than the traditional fee-for-service model. Under Part C, rather than pay providers directly, Medicare pays private managed care organizations (later named "Medicare Advantage Organizations" or "MAOs") a capitation rate (per member per month) and those plans are responsible for paying providers for the services they provide to members of that specific MA plan.

45. In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act, creating Medicare Part D, which provides prescription drug coverage. These managed care model plans are provided under both Part D prescription drug plans, which offer only prescription drug coverage, and Part C plans, which integrate the prescription drug coverage with the Part C health care coverage.[3]

46. MAOs' obligations to the MA Program and the requirements for them to participate in the Program are set forth in federal regulations and, each year, the MAOs must agree in writing to comply with those regulations and to other terms and conditions in order to participate in the MA Program. 42 C.F.R. §§ 422.504 & 422.505 (Part C); 42 C.F.R. §§ 423.504 & 423.505 (Part D). In addition, MAOs must comply with requirements set forth in statutes, such as the FCA, and guidance documents, such as the Medicare Managed Care Manual, the Medicare Prescription Drug Benefit Manual, the Risk Adjustment Participant Guides,[4] and Medicare Advantage operating instructions.

I. Risk Adjustment and Claims Submission

47. Through the MA program, CMS allows private health insurers to set up managed care plans to cover Medicare beneficiaries. CMS pays a monthly capitation rate for each beneficiary enrolled as a member of an MA plan, known as a "per-member, per-month" payment. This predetermined base payment varies for each MA Plan depending on various factors, including amounts set forth in the MA Plan's bid submitted to the Government, the scope of medical services covered by the Plan's benefit package, and the amount of premiums,

[3] This Complaint refers, collectively, to MAOs with and without Part D coverage as "MAOs."

[4] For the early years of the program, CMS put out a periodic "Participant Guide" with detailed guidance on required compliance. The names varied somewhat each year—for example, the Regional Risk Adjustment Training for Medicare+Choice Organizations Participant Guide; the Risk Adjustment Data Basic Training for MAOs Participant Guide; Risk Adjustment Technical Assistance for MAOs Participant Guide; etc.—but will be referred to throughout as the "Participant Guide," with the year of issue.

deductibles, and co-pays for which an enrollee in the Plan is responsible. *See* 242 U.S.C. § 1395w-23(a)(1)(C).

48. MA plans must then use that money to pay hospitals, physicians, and other health care providers for the services the plan members receive and to cover the plans' administrative expenses. MA plans with Part D coverage are also given money to pay for the plan members' prescription drugs.

49. Under both types of plans, CMS adjusts the capitation rate for each beneficiary to reflect that beneficiary's individual demographics (*e.g.*, age and gender), geographic location, and health status. *See* 42 U.S.C. § 1395w-23 (a)(1)(C).

50. The adjustment for each member's health status is a significant component of the capitation rate. Individuals with multiple and/or serious health conditions account for more health care costs than healthy members. Accordingly, CMS pays a substantially higher capitation rate for members who have been recently treated for one or more serious, expensive diseases or conditions. *See* 42 U.S.C. § 1395w-23(a)(1)(C). These increased payments are known as "risk adjustment" payments.

51. The purpose of risk adjustment is to "allow[] CMS to pay plans for the risk of the beneficiaries they enroll" and to "make appropriate and accurate payments for enrollees with differences in expected costs." Medicare Managed Care Manual, Ch. 7, § 20 (rev. 118, Sept. 19, 2014).

52. Since 2004, the Secretary has employed the Hierarchical Conditions Category ("HCC") model to carry out risk adjustment. With respect to health status, the model takes into account diagnoses from physician office visits and hospital outpatient encounters as well as hospital inpatient stays. The medical conditions included in the model are grouped into HCCs, which are categories of clinically related medical diagnoses. *See* 42 C.F.R. § 422.2. The diagnoses grouped into HCCs include major, severe, and/or chronic illnesses. Related groups of diagnoses are ranked on the basis of disease severity and the cost associated with their treatment.

Between 2004 and 2013, the CMS-HCC model included 70 HCCs. Starting in 2014, the CMS-HCC model included 79 HCCs.

53. To obtain payments based on adjustments for health status, MAOs submit diagnosis codes to the Government for the beneficiaries in their Plans. These diagnosis codes are from the beneficiaries' medical encounters with healthcare providers (*e.g.,* physician office visits and hospital stays) during the year prior to the actual payment year (often referred to as the "data collection" year or the "date of service" year). Payments are based on diagnoses from the prior year, which are used to predict the expected healthcare needs of a beneficiary for the payment year.

54. Under Medicare Part D, payments to PD or MAPD Plans for prescription drug benefits are also risk-adjusted based on health status. As with Part C, Part D employs a health-based risk adjustment model known as the Rx Hierarchical Condition Categories ("RxHCC") model. Like HCCs, RxHCCs are also groups of clinically-related medical diagnoses that are ranked by disease severity and the cost associated with the pharmaceutical drugs used to treat them.

55. The Government assigns a relative numerical value to each HCC and RxHCC group that correlates to the predicted incremental costs of care associated with treating the medical conditions in each category. It currently determines the relative values based on an analysis of the amounts that it paid on average for the treatment of these major, severe, and chronic medical conditions under Parts A and B of the Medicare Program. Higher relative values are assigned to HCCs and RxHCCs that include diagnoses with greater disease severity and greater costs associated with their treatment. Generally, the more HCCs or RxHCCs a beneficiary has assigned to them, the higher the monthly payment from CMS to the beneficiary's MAO will be.

56. In sum, using the diagnosis codes submitted by or on behalf of MAOs, the Government calculates a risk score for each beneficiary, which is used to calculate monthly

payments to the MAO for that beneficiary for the payment year. In general, the more numerous and severe the conditions identified by the diagnosis codes, the higher the risk score for a beneficiary and, thus, the greater the risk adjustment payments made to the MAO for that beneficiary for the payment year. On average, CMS pays MA plans close to $3,000 per year for each unique condition coded for a member that results in a risk adjustment payment.

II. MAO Requirements and Certifications

57. The Medicare Advantage payment model creates clear incentives for MAOs like Kaiser to exaggerate the expected healthcare costs for the beneficiaries in their Plans by submitting invalid diagnosis codes or failing to comply with their obligation to retract invalid diagnoses. To combat these incentives and protect the Government from fraud, CMS requires that submitted diagnoses be supported and, thus, validated by the beneficiaries' medical records for medical encounters during the relevant data collection year. It is a well-established requirement that all diagnosis codes submitted to the Government for risk adjustment payments must be unambiguously supported by information included in the beneficiaries' medical records. As the D.C. Circuit recently recognized, "Neither Congress nor CMS has ever treated an unsupported diagnosis for a beneficiary as valid grounds for payment to a Medicare Advantage insurer." *UnitedHealthCare Ins. Co. v. Becerra,* No. 18-5326, 9 F.4th 868, 868 (D.C. Cir. Aug. 13, 2021). Hence, a beneficiary's medical records are the "source of truth" for the purpose of receiving and retaining risk adjustment payments.

58. The medical records that must support the diagnosis codes are not provided to the Government as part of the payment process. Instead, the Government requires that each MAO expressly certify that the diagnosis codes it has submitted for risk adjustment payments are accurate and truthful. 42 C.F.R. § 422.504(l)(2). Each MAO must exercise due diligence prior to this express certification and "[a]dopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with [the Government's]

program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." 42 C.F.R. § 422.503(b)(4)(vi).

59. As explained by the Ninth Circuit, CMS made clear in 2000 that

> Medicare Advantage organizations have always had "an obligation to take steps to ensure the accuracy, completeness, and truthfulness of the [medical] encounter data" [*i.e.*, diagnoses] and "an obligation to undertake 'due diligence' to ensure the accuracy, completeness, and truthfulness of encounter data submitted to [CMS]." . . . CMS made perfectly clear that Medicare Advantage organizations would be "held responsible for making good faith efforts to certify the accuracy, completeness, and truthfulness of encounter data submitted."

United States ex rel. Swoben v. UnitedHealthcare Insurance Co., 848 F.3d 1161, 1174 (9th Cir. 2016) (quoting 65 Fed. Reg. 40,170 at 40,268 (June 29, 2000)). The Ninth Circuit further explained that the requirement that MAOs take affirmative steps to address errors in their data is further demonstrated by "§ 422.503, which since 2005 has required Medicare Advantage organizations to have effective compliance programs in place, including '[p]rocedures for internal monitoring and auditing' and 'for ensuring prompt response to detected offenses'." *Id.* (quoting 42 C.F.R. § 422.503(b)(4)(vi), (vi)(F), (vi)(G) (2005)).

60. To participate in the MA Program, Defendant MAOs were required to agree in writing to comply with the Part C and D regulations and any other terms and conditions CMS deemed appropriate. 42 C.F.R. §§ 422.504 & 422.505 (Part C); 42 C.F.R. §§ 423.504 & 423.505 (Part D). Each year during the relevant time period, one or more executives of one or more of the Defendants or their predecessors executed these written agreements or renewals of these written agreements between the Defendant MAOs and CMS.

61. Certain entities—like the Permanente Medical Groups—enter into agreements with MAOs to provide health care services to MA plan beneficiaries. These entities are called first tier and downstream entities. *See*, e.g., 42 C.F.R. § 422.500 ("First tier entity means any party that enters into an acceptable written arrangement with an MAO or contract applicant to provide administrative services or health care services for a Medicare eligible individual."); *id.*

("Downstream entity means any party that enters into an acceptable written arrangement below the level of the arrangement between an MAO and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services."); *see also, e.g.,* 42 C.F.R. § 422.504(i) (listing some of the obligations).

62. The Permanente Medical Groups must, among other things, agree in their contracts with the MAO to terms that commit them to comply with the MAO's contractual obligations to CMS, 42 C.F.R. § 422.504(i)(3)(iii), and agree to "comply with all applicable Medicare laws, regulations, and CMS instructions," *id*. § 422.504(i)(4)(v). Furthermore, if the entity generates data relating to an MAO's claims for payment, it must certify the accuracy, completeness, and truthfulness of that data. *Id*. § 422.504(l)(3).

63. In addition to the contracts, since 2003, MAOs and entities that submit risk adjustment data on their behalf also have been required to execute Electronic Data Interchange ("EDI") agreements prior to submitting risk adjustment date. These EDI agreements are considered contracts by which the MAOs attest to the accuracy of the data submitted. Even if another entity submits the data, the MAOs are still responsible for the content of the submissions. *See* 2003 Participant Guide § 6.1; 2004 Participant Guide § 4.1; 2005 Participant Guide § 4.1; 2006 Participant Guide § 4.1; 2007 Participant Guide § 4.1; 2008 Participant Guide § 4.1; Risk Adjustment 101 Participant Guide § 2.1 (2013). *See also* Medicare Managed Care Manual, Ch. 7, § 111.6.1 (rev. 57, Aug. 13, 2004); *id*. § 120.2.1 (Rev. 114, 06-07-13). By executing these EDI forms, the MAOs agree that (i) they will be responsible for all risk adjustment data submitted to CMS by themselves, their employees, and their agents; (ii) they will submit risk adjustment data that is accurate, complete, and truthful based on best knowledge, information, and belief; (iii) *they will research and correct risk adjustment data discrepancies*; and (iv) CMS has the right to audit and confirm the risk adjustment data, including diagnoses, submitted by the MAO and the right of access to the beneficiaries' medical records to conduct such audits.

64. The International Classification of Diseases ("ICD") codes set forth the standards used by CMS and the healthcare industry for the identification of patient diagnoses by their physicians. *See* 45 C.F.R. § 162.1002(a)(1)(i), (b)(1), (c)(2)(i); 42 C.F.R. § 422.310(d)(1); Medicare Managed Care Manual, Ch. 7, Ex. 30 (rev. 57, Aug. 13, 2004). The ICD system assigns each diagnosis a specific code, which is "used to describe the clinical reason for a patient's treatment." 2005 Participant Guide § 5.2.

65. The applicable standards for these ICD diagnosis codes are set forth in the International Classification of Diseases, Ninth Revision, Clinical Modification ("ICD-9") through October 1, 2015, and thereafter the International Classification of Diseases, Tenth Revision, Clinical Modification ("ICD-10"). *See* Medicare Managed Care Manual, Ch. 7, Ex. 30 (Aug. 13, 2004). To ensure accuracy, the patient diagnoses must result from a face-to-face encounter between the physician and patient during the relevant year and must be appropriately documented in the patient's medical record at the time of the encounter. *See Silingo*, 904 F.3d at 673 ("Every diagnosis code submitted to CMS must be based on a 'face-to-face' visit that is documented in the medical record.").

66. In addition, codes should be based on documented conditions that require or affect patient care, treatment, or management. *See* Medicare Managed Care Manual, Ch. 7, § 111.8 (rev. 47, Feb. 20, 2004); 2008 Participant Guide § 7.1.5. Codes cannot be submitted for diagnoses that are only probable or suspected, for diagnoses that are questionable, or for a condition that the provider is trying to rule out. *See* Medicare Managed Care Manual, Ch. 7, Ex. 30 (Aug. 13, 2004).

67. The requirement that all diagnosis codes submitted by MAOs must be supported by medical record documentation is well established. The 2004 Medicare Managed Care Manual stated that "M+C organizations [now known as MAOs] must submit risk adjustment data that are substantiated by the physician or provider's full medical record." Medicare Managed Care Manual, Ch. 7, § 111.8 (Aug. 13, 2004). The 2013 Medicare Managed Care Manual (the first

revision since 2004) similarly states that MAOs "must . . . [e]nsure the accuracy and integrity of risk adjustment data to CMS. All diagnosis codes submitted must be documented in the medical record . . . ." Medicare Managed Care Manual, Ch. 7, § 40 (June 2013). Also similarly, the 2003 Participant Guide stated that MAOs "must submit risk adjustment data that are substantiated by the patient's medical record." 2003 Participant Guide § 4.1.[5]

68. In connection with the requirement that the patient's medical record support the diagnosis(es) reported for him or her, the 2004 Medicare Managed Care Manual also provided that "M+C organizations must maintain sufficient information to trace the submitted diagnosis back to the hospital or physician that originally reported the diagnosis. Since M+C organizations may submit summary level transactions without a link to a specific encounter or claim, establishing an appropriate audit trail to the original source of the data requires diligent information management on the part of the M+C." Medicare Managed Care Manual, Ch. 7, § 111.8 (Aug. 13, 2004). Again, in the 2005 Participant Guide § 8.7.3, CMS advised that "MA organizations should take steps to ensure that they have, or have access to, the proper medical documentation to support diagnoses being submitted for risk adjustment. MA organizations are responsible for the accuracy of the data they submit to CMS. Where necessary, they should obtain the proper documentation to support diagnoses and maintain an efficient system for tracking diagnoses back to medical records."[6]

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[5] This requirement was reiterated in the following CMS training guides and materials since 2003: 2003 Participant Guide §§ 12.3, 12.6; 2004 Participant Guide §§ 5.1, 5.5, 6.1.3; 2005 Participant Guide §§ 4.1, 5, 5.1, 5.5, 8.7.3, 9.1, 9.2; 2006 Participant Guide §§ 5.1, 5.4, 5.5, 7.7.3, 8.1, 8.2; 2007 Participant Guide §§ 6.1, 6.4, 7.1, 7.2, 8.7.3; 2008 Participant Guide §§ 5.6, 6, 6.1, 6.4, 6.5, 7.1, 7.2; 2012 Participant Guide § 2.2; Risk Adjustment 101 Participant Guide §§ 3.2.4; 4.3 (2013); Risk Adjustment Webinar at 48 (July 1, 2014). Furthermore, CMS from the outset of the program has advised MAOs to "[t]ake steps to ensure that medical documentation supports submitted diagnoses." 2003 Regional Risk Adjustment Training for Medicare+Choice Organizations at 8-19.

[6] This requirement was reiterated in the following CMS training guides: 2003 Participant Guide § 12.2; 2004 Participant Guide § 6.1.3; 2004 Medicare+Choice Organizations Resource Guide at 20; 2005 Participant Guide §§ 5.1, 9.1.3; 2006 Participant Guide §§ 5.1, 7.7.3, 8.7.3; 2007

69. Because CMS recognizes that risk adjusting based on health status creates a strong incentive for MAOs to report invalid diagnoses, CMS engages in a variety of program integrity activities, including training MAOs about their obligations to submit valid data and withdraw invalid data. For example, in a 2003 Regional Risk Adjustment Training for Medicare+Choice Organization Questions & Answers document, CMS stated all information that is submitted must be correct. If a plan identifies incorrect or invalid information that has been submitted, it must delete that information." Likewise, in an August 9, 2005 Regional Training presentation made jointly by CMS and its contractor, Aspen Systems Corporation, called "Risk Adjustment Data Basic Training", MAOs were told that they "must . . . Delete a diagnosis when any data in that cluster are in error."

70. CMS cannot feasibly audit all risk adjustment data submitted by MAOs, and must therefore rely, when making risk adjustment payments, on MAOs to exercise due diligence to ensure that provider-reported diagnoses are supported by beneficiaries' medical records and are otherwise accurate and truthful. Thus insurance companies that want to participate in the MA Program must agree, through their Part C and D agreements and their EDI agreements, to provide valid diagnostic data and investigate and delete invalid data. Moreover, this is why insurance companies that want to participate in the MA Program must (i) establish and implement effective compliance programs to ensure the integrity of their payment data, 42 C.F.R. § 422.503(b)(4)(vi) (Part C compliance program regulation); 42 C.F.R. § 423.504(b)(4)(vi) (Part D compliance program regulation); (ii) annually attest to the accuracy and truthfulness of the diagnosis data that they submit for risk adjustment payments, 42 C.F.R. § 422.504(l) (Part C regulation); 42 C.F.R. § 423.505(k) (Part D regulation); and (iii) "comply with . . . Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law [and] the False

Participant Guide §§ 6.1, 7.1.4, 8.7.3; 2008 Participant Guide §§ 5.6.3, 6.1; 2012 Participant Guide § 2.2.

Claims Act (31 USC §§ 3729 et seq.)." 42 C.F.R. § 422 (Part C regulation); 42 C.F.R. § 423 (Part D regulation).

71. The implementation of an effective compliance program is a prerequisite to an MAO obtaining and retaining payments under both Parts C and D of the Medicare Program. *Id.* §§ 422.503(a) (Part C) & 423.504(b)(4)(vi) (Part D). One purpose of requiring a compliance program is to ensure that MAOs submit accurate and truthful information to CMS. 65 Fed. Reg. 40170-01 at 40264 (June 29, 2000).

72. Specifically, each MAO must "[a]dopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS's program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." 42 C.F.R. § 422.503(b)(4)(vi) (Part C); 42 C.F.R. § 423.504(b)(4)(vi) (Part D). The compliance program "must, at a minimum, include [certain] core requirements."

73. Finally, to ensure the accuracy of submitted diagnoses, MAOs must attest to the validity of their risk-adjustment data in a Risk Adjustment Attestation submitted to CMS annually. Specifically, the chief executive officer, chief financial officer, or an individual delegated with authority to sign on behalf of one of these officers and who reports directly to such officer, must certify that the risk-adjustment data that the MAO submitted to CMS is accurate, complete, and truthful. *See* 42 C.F.R. § 422.504(l); Medicare Managed Care Manual, Ch. 11, § 130 (rev. 79, Feb. 17, 2006).

74. In its contracts with CMS, Kaiser (like all MAOs) agreed that: "[a]s a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G," it must attest to "the accuracy, completeness and truthfulness of the data identified on these attachments." CMS's regulations further specify that the MAO's submission of attestations regarding "the accuracy, completeness, and truthfulness" of this data is "a condition for receiving a monthly payment" from CMS. 42 C.F.R. § 422.504(l).

75. During Relator's time at Kaiser, Rick Newsome, then the vice president of finance and the chief financial officer for the Colorado region, was involved in the Colorado region's attestations, and Kathy Lancaster, the executive vice president and chief financial officer for Kaiser Foundation Health Plan, Inc., was involved in these attestations at the national level.

KAISER VIOLATED THE FALSE CLAIMS ACT

76. Defendants have engaged in a deliberate scheme to defraud the United States by submitting thousands of false claims for risk adjustment payments to CMS. Kaiser has submitted and caused the submission of these claims for risk adjustment payments even though it knew, or in the exercise of reasonable care should have known, that the Medicare patients upon whom the claims were based did not have the claimed diagnoses, had not been treated for those diagnoses in the prior year in a face-to-face visit with an appropriate provider type, or that the claims were unsupported by appropriate medical records or otherwise ineligible for risk adjustment payments under CMS rules.

77. In their constant search for additional revenue, Defendants deliberately ignored red flags about their coding practices, willfully disregarding their obligation to submit only accurate diagnosis codes to Medicare, and their obligation to delete diagnosis codes determined to be incorrect from Medicare's systems.

78. In Colorado, Kaiser reviewed every inpatient medical record entry from several of their non-Kaiser hospital contractors, yet it acted only on the data that would add codes and thus get them more revenue. Defendants knowingly disregarded all the findings of false codes that would have identified overpayments that they were obligated to return.

79. With respect to diagnosis codes generated by Kaiser-owned hospitals, provider groups, and facilities, Kaiser repeatedly saw red flags, many raised by Relator, that gave it knowledge it was required to act upon to prevent future false codes and correct prior false

submissions. Instead, Kaiser deliberately turned a blind eye, retained overpayments from false codes, and continued their revenue-generating practices.

80. Relator tried over the course of his employment at Kaiser to convince Kaiser to address the issues set forth in this Complaint. As described in greater detail below, as he discovered issues with the submission of false risk adjustment claims associated with specific provider types, diagnoses, or other issues, he repeatedly proposed solutions. At times, Kaiser appeared to be implementing his suggestions or taking other steps to address the problems. Unfortunately, Relator later learned that Kaiser either did not take the steps it had claimed it was taking or began implementing corrective actions only to stop them later, undoing the improvement.

81. Although many of the representative examples detailed below are for Kaiser's Colorado region, Relator is aware, based on reports he reviewed showing audit results for other regions and Kaiser nationally, his attendance at Regional Reporting Group ("RRG") Meetings, and work with employees in other Kaiser regions, that some or all of Kaiser's other regions knowingly submitted false risk adjustment claims for similar reasons and for similar diagnosis codes as Kaiser Colorado. The Regional Reporting Groups are comprised of representatives from each Kaiser region who are responsible for conducting audits and other initiatives related to risk adjustment. Relator regularly attended the twice-annual RRG meetings held to discuss risk adjustment issues faced by the various regions. Therefore, Relator has knowledge about the risk adjustment practices and audit results of every Kaiser region.

82. On the basis of reviewing the audit results for other regions and Kaiser nationally, his attendance at RRG Meetings and work with employees in other Kaiser regions, Relator alleges that at all times material to this action, *i.e.,* from at least 2004 to present, the fraudulent risk adjustment practices identified herein regarding Colorado were typical of Kaiser at some or all of its other regions, including without limitation, California, Georgia, Hawaii, Oregon, and Washington.

83. In addition, although many of the representative examples detailed below cover HCCs rather than RxHCCs, to the extent that Kaiser's audits also covered RxHCCs (which many of them did), they identified similar patterns of knowing submission of false claims for RxHCCs.

84. On this basis, Relator alleges that Kaiser has submitted, and fraudulently refused to delete and repay CMS for, tens of thousands of risk adjustment claims that it knows, within the meaning of the False Claims Act, are false and/or fraudulent.

I. Kaiser's Aggressive Push for MA Revenue

85. Kaiser's Medicare business focused on revenue first and foremost.

86. Annually, Colorado Health Plan leadership, including Chris Tholen, the former Executive Director of National Medicare Finance for Kaiser Permanente Health Plan, Tom Rennell, the former Executive Director of Finance at KFHP Colorado, and Rick Newsome, the former CFO and VP of Finance at KFHP Colorado, prioritized revenue and increased risk scores by setting revenue generation goals that had no connection to coding accuracy.

87. Kaiser Colorado set up various groups in pursuit of these goals. For example, as early as 2009, Relator Taylor and Tholen, amongst other Kaiser employees, were both on a group called the "MA governance group." The goal of the group was to ensure a maximum return of investment within the MA business and identification of revenue opportunities, with no regard for compliance or accuracy.

88. Kaiser Colorado also had a report called "filling the tank," on which Tholen commonly presented during his time at Kaiser. The goal of the report was to track expected average risk score (and hence expected revenue) basis point by basis point to capture as much revenue as possible. These reports were presented at various meetings that included Kaiser executives and quantified the amount of expected revenue from various initiatives, including the review of all inpatient medical charts discussed below.

89. Kaiser's risk score goals were driven by revenue generation, and demands for revenue were often driven from the top. For example, in a 2011 meeting regarding Kaiser

Colorado's Medicare business, Tholen reported that Newsome was looking for an increase of 2.5 to 3 "points" (a point is used to describe an additional .01 in average risk score). Relator was in attendance at this meeting and urged caution, believing that the data the company had at the time was not complete enough to be confident in hitting that goal while maintaining accuracy.

90. Kaiser Colorado ran a serious of revenue-boosting projects, several of which are described in detail below. These included the review of all inpatient diagnoses from certain external provider hospitals, the use of data mining to find suspected diagnosis and then pursue them, and encouraging physicians to re-diagnose patients who had been diagnosed with chronic conditions in previous years without regard to that condition being treated or evaluated in a subsequent service year. Kaiser Colorado did not expend anything like the resources behind these projects towards any compliance goals.

II. Kaiser Knew the CMS Standard for Submission of RA Diagnoses

91. Despite Kaiser's emphasis on revenue generation, it was well aware of its obligations under the MA program to submit accurate diagnosis data supported by the beneficiaries' medical records.

92. For instance, in a review of 2004/2005 data, a period of time prior to the risk adjustment system being fully implemented, Kaiser conducted a "pre close" audit ahead of an annual deadline to submit data to CMS. The audit noted the importance of accuracy and the fact that each submitted diagnosis must be supported by an appropriate medical record. Diane Morrissette, the then Executive Director of National Medicare Finance for Kaiser, was the key executor of this audit.

93. Kaiser regions, including Colorado, Southern California, Northern California, Georgia, the Northwest, and Hawaii also conducted annual "probe" audits, which generally mimic "Risk Adjustment Data Validation" or "RADV" audits that CMS on occasion performs. A national probe audit was conducted annually as well. Those audits repeatedly noted the

importance of medical record documentation and verified diagnosis codes in accordance with the ICD, as required by CMS. These audits had mixed results, as discussed below.

94. In addition to audits, Kaiser also, on occasion, actually deleted diagnosis codes after determining that they were not accurate. For instance, in 2007, Kaiser audited a subset of cancer diagnosis codes and, after concluding that several of the diagnoses ought to have been coded as history of cancer, made roughly $6 million worth of deletes.

95. Relator also repeatedly presented on issues of compliance internally to both executives higher in the corporate structure than him and to physicians employed by Kaiser, stressing the importance of accurate coding and compliance with CMS rules and guidance.

III. Kaiser's Claim Submission Process

96. Given his position, Relator was intimately familiar with Kaiser's coding review and claims submissions processes.

97. Diagnosis codes that Kaiser MAOs submitted to CMS for payment were derived from several sources. One source was the codes that Kaiser-employed physicians entered into Kaiser Colorado's Electronic Medical Record system, HealthConnect. Those codes were later submitted to a Kaiser claims database.

98. Additional sources of diagnosis codes, including those from external providers and those from Kaiser's review of medical records described in detail below, flow directly into the same Kaiser claims database.

99. This claims database then flowed through Kaiser's National Medicare Finance pre-submission processing and de-duplication processes, which prepared the diagnoses for submission and formatted the data in accordance with CMS requirements.

100. From there the filtered, de-duplicated, and reformatted information flowed into another database, Kaiser's Risk Adjustment Tracking System or "RATS," which is the Kaiser database that interfaced with CMS's Risk Adjustment databases. Kaiser submitted the codes from RATS to CMS for risk adjustment payments.

101. Although Relator did not often work directly with the RATS system, he knows the system architecture, and he reviewed reports of Kaiser's coding, its accuracy, and the resulting revenue impacts that together confirm that the diagnosis codes that he discusses herein were in fact submitted to CMS as the basis for claims for payment by Kaiser.

IV. Kaiser Conducted Impermissible One-Way Look Chart Reviews of Colorado External Providers

102. In Kaiser's Colorado region, the most dramatic example of Kaiser's push for revenue overriding its concerns with CMS rules involves a program to capture additional codes from certain non-Kaiser healthcare providers, while ignoring the rampant false coding that it knew to be present.

103. Several of Kaiser's regions rely heavily on providers at hospitals or other facilities that are not owned by Kaiser, known as external providers, to furnish inpatient care to Kaiser's HMO members. These regions included Colorado and Hawaii. These external providers submit claims to Kaiser for services provided to Kaiser members. Kaiser then uses the diagnoses coded on these claims as the basis for risk adjustment claims Kaiser submits to CMS.

104. Kaiser Colorado heavily relies on diagnoses submitted by external providers, particularly hospitals. The largest external hospitals contracting with Kaiser in Colorado were run by Exempla. On average, codes from external providers yield roughly 13% of the region's risk adjustment claims, yielding tens of millions of dollars in annual payments from CMS.

A. Kaiser Knew Many of Its Colorado External Provider Codes Were False

105. Kaiser's probe and other audits have identified significant error rates in risk adjustment claims Kaiser submitted to CMS based on diagnoses provided by external providers.

106. For example, for the Colorado region, the error rates for internal providers were as follows:

Year	Internal HCCs Audited	Errors	Error Rate
2007	156	14	9%

2008	119	11	9%
2009	277	29	10%
2010	371	47	13%
2011	341	28	8%
2012	370	18	5%
2013	227	14	6%

107. The error rates for Colorado's external providers have been up to **ten times** higher:

Year	External HCCs Audited	Errors	Error Rate
2007	51	11	22%
2008	12	8	67%
2009	53	9	17%
2010	57	23	40%
2011	54	27	50%
2012	28	11	39%
2013	11	7	64%

108. The error rates for codes Kaiser submits from certain large hospitals are striking. For example, in the 2010 Probe Audit, the hospital Exempla Good Samaritan had an error rate of 40% (4 of 10 HCCs), Exempla St. Joseph had an error rate of 53% (9 of 17 HCCs), and Swedish Medical Center had an error rate of 40% (2 of 5 HCCs).[7]

109. The 2011 Probe Audit found that:

a. Exempla Good Samaritan Medical Center had an error rate of 93% (13 of 14 HCCs reviewed were erroneous);

b. Exempla Lutheran Medical Center had an error rate of 100% (4 of 4 HCCs reviewed were erroneous);

c. Exempla St. Joseph Hospital had an error rate of 67% (24 of 36 HCCs reviewed were erroneous);

d. Pueblo Clinic had an error rate of 92% (11 of 12 HCCs reviewed were erroneous); and

[7] Although some of these sample sizes are small, it is telling that these and other audits consistently show high error rates.

e. Swedish Medical Center had an error rate of 73% (8 of 11 HCCs reviewed were erroneous).

110. In the 2012 Probe Audit, Exempla[8] St. Joseph again showed a high error rate of 42% (5 of 12 HCCs were wrong).

111. The Exempla chain hospitals are the primary providers of inpatient care for Kaiser patients in Colorado, making their consistently elevated error rates of particular concern.

112. Inaccurate coding by external providers is not limited to the Colorado region. Diagnoses submitted by external providers are known to be a significant source of errors across the Kaiser regions.

113. Kaiser was aware of this deficiency. In 2009, a review of external provider codes headed by Diane Morrissette, then the Executive Director of National Medicare Finance for Kaiser, concluded that external provider codes were less well monitored than those of Kaiser internal physicians and were likely to have higher error rates.

114. Unlike Colorado, most Kaiser regions subject diagnoses submitted solely by external providers to enhanced scrutiny. The Northern California, Hawaii, and Northwest regions review all (or nearly all) HCCs that are supported only by a diagnosis from an external provider. The Georgia and Southern California regions conduct targeted samples of some claims provided by certain high volume external providers.

115. Kaiser Colorado's executives are aware that this is a continuing issue. For example, the Kaiser CFO, CPMG Associate Medical Director (Vice President), CPMG CFO, and Executive Director of Revenue Cycle have all been present at meetings where the results of annual probe audits were discussed. In Fall 2010, Relator presented at the RRG meeting on hospital discharge review in Colorado, where he discussed problems with external providers.

116. Moreover, around late 2011, Treska Francis, the leader of the Kaiser Colorado coder group, personally performed an audit of about 100 diagnoses received from Exempla St.

[8] Exempla has since been acquired by Sisters of Charity Leavenworth.

Joseph's Hospital and Exempla Good Samaritan Medical Center. She found a 40% to 60% error rate. She reported this to her boss, Rusalyn Maitlen, the Manager of Medicare Risk Business, who ignored the report. Francis then reported the problem to her boss' boss, Tom Rennell, Executive Director of Revenue Cycle for Kaiser Colorado. Mr. Rennell told her to "leave it alone."

117. Because of Relator's concerns with these consistently high errors, in or around 2009, he pushed Kaiser Colorado to perform another audit of external hospitals. The audit was supposed to cover three southern Colorado hospitals. One hospital refused to participate. The initial results from the other two hospitals were described in the Kaiser Colorado Medicare Initiative Meeting as "unsettling" and "disturbingly high." Specifically, 18% of the 357 diagnoses audited at St. Thomas More Hospital were invalid, and 20% of the 678 diagnoses at Memorial Hospital were invalid. Relator does not know if the audit was ever completed, and the final results were never released.

118. The prevalence of external providers in Colorado, and their high error rates, should have led Kaiser to closer scrutiny of external diagnoses, as Relator encouraged. Instead of taking affirmative steps to ensure the accuracy and integrity of its coding data, as required by CMS rules and guidance, Kaiser instead thrust its head further in the sand. Each year it selected fewer and fewer diagnoses from external providers to analyze in probe audits. When diagnosis codes from external providers were isolated and analyzed as part of a probe audit, they sometimes led to corrective action plans that Relator tried to help implement, but on which Kaiser rarely followed through. Eventually Kaiser's probe audits ceased isolating diagnosis codes from external providers.

B. Kaiser's Retrospective, One-Way Look Chart Review Program

119. While the external providers were consistently demonstrating high rates of false coding, Kaiser launched a program to milk more revenue from CMS, while turning a blind eye to the rampant false coding of which it was well aware.

120. Beginning in 2010, Kaiser Colorado has conducted a retrospective chart review project on external hospital claims. That project, which involves a coder reviewing records from every Exempla hospital stay at an external provider to look for any diagnoses supported by the chart, gives Kaiser complete knowledge of the proper coding for all of its Colorado external provider records, which it knew were otherwise riddled with false codes.

121. Yet contrary to its legal obligation to ensure the accuracy, completeness, and truthfulness of coding data, Kaiser treated the results differently depending on whether they would generate revenue. Kaiser captured and passed through to CMS any codes that had not previously been coded by the treating physician, yielding additional payments to Kaiser. Yet at the same time, despite having all the necessary information to see whether codes previously submitted by the external providers were accurate, Kaiser did nothing. It simply passed them through to CMS for payment or, if they had already been submitted, did not delete them. Many of the diagnoses codes at issue were exactly the same diagnoses codes that multiple Kaiser audits found to have consistently high error rates. *See supra* ¶¶ 105-118.

122. Such a program, known as a one-way look chart review, is a violation of the False Claims Act. *See United States ex rel. Poehling v. UnitedHealth Group, Inc.*, No. CV-16-08697-MWF, 2018 WL 1363487 (C.D. Cal. Feb. 12, 2018) (denying Defendant's Motion to Dismiss against similar allegations); *United States ex rel. Ormsby v. Sutter Health*, 444 F. Supp. 3d 1010 (N.D. Cal. 2020) (same).

123. To run its program, Kaiser collected all medical charts generated by the Exempla providers for Kaiser's beneficiaries and proceeded to send each chart through an additional level of review.

124. The coder reviewing the chart did not know which diagnoses the claim previously generated, a common process in the industry known as "blind" review. The coder would review the record and find any supported diagnosis codes. Kaiser would capture these diagnoses and submit the resulting additional risk-adjusting diagnoses codes for CMS for increased payment.

125. However, when the results of a chart review revealed that a previously submitted diagnosis code was not supported by the medical record, Kaiser did not delete that code from CMS databases, as required by CMS, which would have resulted in lower payments.

126. As an example of how this process worked, say a hypothetical Kaiser beneficiary, "A," was admitted to an Exempla hospital for cancer treatment and the hospital also coded A (erroneously) as diabetic. Kaiser would have submitted two risk-adjusting diagnoses from that encounter: cancer and diabetes. That chart then would undergo an additional round of coding at Kaiser, where the Kaiser coder confirmed the cancer diagnosis and also found that the medical record supported the risk-adjusting diagnosis of chronic kidney disease ("CKD") but found no evidence of diabetes. Kaiser would then submit the diagnoses of CKD to CMS, but it would not remove the diagnosis of diabetes for which its own coder found no support.

127. The program was born out of Kaiser's knowledge that physician coding was highly inaccurate, which was repeatedly demonstrated through various audits that Kaiser performed. Kaiser's reaction to this fact was to correct provider coding only in ways that were beneficial to its bottom line, while ignoring inaccuracies that would cost it money. It thus improperly retained millions of dollars in payments from diagnoses it submitted to CMS that were not supported by the medical records.

128. The program was launched in summer 2010 with Treska Francis, the leader of the Kaiser Colorado coder group, in charge and Kaiser employees including Rusalyn Maitlen, Stephanie White, Denise Campbell, Becky Bowlen, Beth Cox, Peggy O'Neil, and Donna Rohde on the project team. The first phase of the project included only two hospitals, Exempla Good Samaritan and Exempla St. Joseph's, and only analyzed six months of hospital discharges, the first half of 2010. It generated over $10 million in revenue.

129. At all times during the chart review program's existence, Kaiser had the ability to compare which diagnoses its coders found with the diagnoses that providers submitted. It chose

to ignore the data in violation of its affirmative legal obligation to ensure the accuracy, completeness, and truthfulness of its coding data, opting to retain ill-gotten revenue instead.

130. Because of Relator's knowledge of Kaiser's systems and the reports of the revenue from CMS, Relator knows that Kaiser submitted new and unique codes from this one-way look chart review to CMS to claim increased risk adjustment payments. He also knows that Kaiser did not submit deletes to remove its previously submitted codes that this review demonstrated were erroneous.

131. The program continued to grow, generating approximately $30 million in revenue based on an analysis of 2014 discharges, and it was still expanding at the time Relator left Kaiser.

132. In addition to the program giving Kaiser information that previously submitted diagnosis codes were false, the program also rendered Kaiser's annual risk adjustment attestations false. The knowledge that Kaiser gained through these audits regarding the falsity of its codes also meant that Kaiser's affirmation that its data was truthful, accurate, and complete was not true.

133. Relator repeatedly raised concerns regarding this program. As early as 2011, Relator made internal presentations regarding the inaccurate diagnosis coding on Exempla claims and recommended auditing those claims.

134. For years, Relator has requested that a filter be created to tag high-risk codes from external providers for review. Instead, Kaiser Colorado created a filter to review codes received from internal providers.

135. Moreover, despite Kaiser Colorado's consistent problems with data from external providers, it has not performed larger audits or instituted a pre-submission review. In fact, Kaiser Colorado's only action appears to have been to attempt to stop reporting error rates associated with data from external providers separately from error rates associated with data from internal providers, so as not to call attention to the problem. The initial version of the 2013

Probe Audit did not identify whether errors were from internal or external providers. Relator insisted that the audit be reopened and amended to add this information.

136. As a result of Kaiser's deliberate and knowing refusal to delete codes it knew were false, codes that external providers had previously submitted to Kaiser, Kaiser passed onto CMS for payment, and later determined to be incorrect are violations of the False Claims Act and caused millions of dollars of harms to the United States. Because Kaiser, through this program, knew that its data was not accurate, complete, and truthful, the annual attestations Kaiser submitted to CMS are also in violation of the False Claims Act.

V. Kaiser Ignored and Failed to Correct Widespread False Coding by Internal Providers

137. Kaiser knows that it is routinely submitting false diagnosis codes from its internal providers, as well. Relator oversaw and encouraged numerous regional audits, and he helped review the results of Kaiser's nationwide audits—all of which demonstrated a pervasive problem at Kaiser with false coding.

A. Kaiser Ignored Numerous Red Flags That Gave It Knowledge of False Claims from Internal Providers

138. Every year, Kaiser's National Compliance Office ("NCO") conducts a nationwide "probe" audit to test the accuracy of risk adjustment claims submitted the prior year. The NCO chooses the patients and/or diagnoses to be audited but each region conducts the audit work. Kaiser deliberately designs these audits so that the sample size is too small for the results to be used for statistically significant extrapolation with respect to the error rates for individual HCCs. Instead, it is intended to provide an overall accuracy rate, by region, and to serve as a "flag" or "tripwire" to identify potential problems with individual HCCs.

139. In addition to the annual probe audits, Kaiser conducted nationwide audits in anticipation of CMS's Risk Adjustment Data Validation ("RADV") audits. These pre-RADV audits routinely identified similar problems as the probe audits.

1. Kaiser's Audits Were a Red Flag About Its False Coding

140. In addition to the high rates of falsity from its Colorado external providers discussed above, these probe and other audits have put Kaiser on notice that it has submitted and continues to submit a substantial number of other false risk adjustment claims each year.

141. For the Colorado region, the annual probe audits identified the following error rates (including both HCCs and RxHCCs) between 2007 and 2013:

Year	Total HCCs Audited	Errors	Error Rate
2007	207	25	12%
2008	131	19	15%
2009	330	38	12%
2010	428	70	16%
2011	395	55	14%
2012	398	29	7%
2013	238	21	9%

142. Kaiser's audits of other regions, and of national error rates, showed similar results. For example, in both 2006 and 2007, Kaiser conducted pre-RADV audits. Kaiser's audits found an error rate of between 14% and 16% (depending on how strictly certain rules were applied).

143. These probe, pre-RADV, and other ad hoc audits show consistent errors in certain types of risk adjustment claims across the Kaiser system. For example, many of the errors in the 2006 and 2007 national RADV audits were for issues or diagnoses that repeatedly show up as upcoded in subsequent probe audits in Colorado and elsewhere, such as coding historical conditions as active, improperly coding based on probable, suspected, or ruled out diagnoses, and coding for specific diagnoses such as cancer, arrhythmia, stroke, vascular disease, ulcers, vertebral fractures, major depression, and diabetes with complications. Relator repeatedly asked for all regions' probe audits results to be combined, so Colorado could learn from other regions' errors.

144. In 2010, Kaiser's Northern California region audited data in its claims systems for care provided to patients in 2009. Of the "Top Ten Failed HCCs by Volume" were several that

the Colorado region also found to be routinely problematic, including HCCs for cancer, stroke, arrhythmia, and vascular disease. This audit will be discussed in greater detail below.

145. Examples of risk adjustment claims that the Kaiser audits have identified as routinely false include: (a) false claims submitted based on diagnoses from external providers, (b) high rates of diagnosis specific false claims identified during the probe audits; (c) false claims submitted due to other process-based coding violations; and (d) diagnoses that Kaiser identified as upcoded through the use of its "high risk" filter program. These examples (described below) are illustrative of the types of false claims of which Kaiser had knowledge but they do not include each and every false claim.

146. As described below, despite its knowledge that the categories of risk adjustment claims described below are false a significant percentage of the time, Kaiser routinely fails to take reasonable steps to identify which of these claims are false (*i.e.*, Kaiser does not extend its review beyond the discrete audit sample and into previous years' claims submissions), and then to prevent their submission in the first place or to delete them after submission. Instead, Kaiser's reaction to this knowledge on a national and regional level has been (except in isolated instances) to avoid conducting retrospective audits to correct previously submitted false data. Additionally, once Kaiser learned of false submissions within its data, its annual attestations claiming that submitted data was accurate, true, and complete, were rendered false.

2. Kaiser Knew Certain of Its Diagnosis Codes Were Frequently False

147. The following are examples of diagnoses and HCCs identified as frequently upcoded during Kaiser's probe audits. Although Relator has the most knowledge about the probe audit results from the Colorado region, he also knows, from his attendance at RRG meetings and work with other Kaiser regions, that these HCCs often were found to be upcoded in other regions as well. Moreover, these are not all of the problematic HCCs that were identified for either the Colorado region or for other regions; instead, they are representative examples of

some of the top problems Relator identified and are illustrative of the types of false claims that, during the times relevant to this action (i.e., from 2004 to present), Kaiser submitted to CMS.

148. **Cancer**: Kaiser's probe audits have consistently identified cancer (HCCs 7 – 10) as the most upcoded condition. Improper claims for diagnoses of active cancer have shown up in every single probe audit from 2006 to 2013.

149. The most significant and consistent error is that Kaiser providers submit diagnosis codes representing active, current treatment of cancer when in fact, the patient's cancer is cured, in remission, or otherwise irrelevant to the services provided to the patient.

150. A diagnosis of cancer is permissible under the ICD-9 coding guidelines when there is evidence of active disease. Where a diagnosis of active cancer appears, one would expect to see evidence of treatment (chemotherapy, radiation, surgery, or palliative care) in the patient's medical chart as well.

151. Once there is no evidence of an existing malignancy, the proper diagnosis code is for "history of cancer." "History of cancer" diagnoses fall within the v10 category of HCC codes and do not risk adjust.

152. Colorado is not the only Kaiser region to have significant problems with the submission of false risk adjustment claims for cancer. At RRG meetings attended by Relator, all other Kaiser regions have noted that they also consistently find high error rates in their risk adjustment claims where a patient has a history of cancer improperly coded as active cancer. This is consistently the biggest issue in the annual probe audits across the Kaiser organization.

153. The source of these errors is in part historical. Kaiser's physician groups, since 2004, have used an EMR system called HealthConnect. When Kaiser first launched HealthConnect, physicians could not easily enter a diagnosis of "history of cancer"—it simply was not an option in the drop-down menu of diagnoses. Instead, physicians would code a diagnosis of active cancer and note "history of" in the comments field. Although Kaiser has long known this is a problem, when the data from these charts is filtered for submission to CMS, only

the diagnosis code of active cancer is submitted and the notation of "history of" is ignored for purposes of data submission to CMS.

154. Although HealthConnect (Kaiser's EMR) now has "history of" codes available, physicians are still accustomed to documenting "history of cancer" in this way (*i.e.*, coding active cancer and noting "history of cancer" in the comments field).

155. In an attempt to identify how big a problem this was, in 2007 Dr. Taylor conducted an audit of over 6,000 risk adjustment claims for breast or prostate cancer submitted by CPMG physicians in 2006 and 2007. The audit showed an error rate of 78% for breast cancer and 52% for prostate cancer, resulting in more than $6 million dollars in false claims. Kaiser deleted the false claims identified in this audit and, accordingly, refunded the overpayments to CMS.

156. Based on these findings, Relator convinced Kaiser Colorado to make changes to its EMR system to try to "prompt" physicians to change their coding behavior. HealthConnect, Kaiser's EMR, was modified so that every time a CPMG physician entered a diagnosis of cancer an alert would pop up, offering a brief explanation of when a diagnosis of active cancer is appropriate and ensuring that was the intended diagnosis as opposed to history of cancer. For example, the breast cancer pop-up said:

> "DISEASE MANAGEMENT REMINDER: To use this diagnosis, you must have documented in your note that the cancer is active or exists and/or the current treatment for the cancer.
>
> ACTION: IF NOT ACTIVE, use History of Breast Cancer – enter Hx Breast in the Encounter Diagnosis field to select."

157. The use of this pop-up alert reduced the error rate substantially, improving coding to an accuracy rate of 96% for breast cancer and 93% for prostate cancer.

158. Unfortunately, the improvement was short-lived. In 2010, Kaiser turned off the alert and replaced it with a limited, far less useful internal filter. This "filter" program is discussed in greater detail below.

159. With the manual review associated with the filter, the error rate in Kaiser Colorado for improper cancer diagnoses remained below the error rates seen before the alert was implemented. However, in late 2011 or early 2012, Kaiser Colorado decided to turn off the filter to save money and coding resources. As shown by the probe audits since, the error rate for cancer diagnoses has rebounded. Despite the fact that the alert and filter were obviously preventing the submission of false claims, Kaiser has not turned either back on. Doing so would cost it revenue—revenue that it has no basis to claim.

160. Moreover, despite the substantial volume of cancer HCC submissions, and increased error rates since the filter was turned off, Kaiser Colorado has not conducted another broad cancer audit such as the one performed in 2007. Instead, Kaiser has responded to the renewed evidence of high cancer error rates with only limited and prospective fixes.

161. For example, Kaiser Colorado's corrective action plan ("CAP") developed after the 2011 Probe Audit called for targeted retrospective audits of diagnoses of active cancer. However, to Relator's knowledge, no such audits were ever performed. The CAP similarly called for Relator and Dr. Teresa Welsh, the CPMG Physician Director of Coding, to visit the CPMG oncologists and discuss the coding accuracy of their cancer diagnoses. Dr. Welsh conducted some follow-up training, but reported back to Relator that, to be effective, such training would have to be done annually given the high turnover rate for oncologists. Kaiser does not conduct this training annually.

162. For years, Relator has recommended a broad retrospective audit of diagnosis codes known to be problematic, including cancer. In 2011, Kaiser Colorado hired an external vendor to conduct such an audit. This was known as the "Peak" project. Relator believes that part of this project was to review past cancer diagnoses submitted for risk adjustment to CMS.

Any findings of the Peak audit have been withheld from Relator. However, he was told by Treska Francis, the leader of the Kaiser Colorado coder group, shortly after the audit began that the findings were "not looking good," *i.e.*, that the error rates were substantial.

163. **Stroke**: Kaiser identified problems with claims submitted for HCC 96, Ischemic or Unspecified Stroke, in probe audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, and 2011.

164. As with cancer, Kaiser knew stroke was commonly coded as an active event, when in fact, the patient should have been classified as having a history of stroke. A diagnosis of a cerebrovascular accident (CVA)/stroke (ICD-9 codes 430-437) is appropriate for the initial acute stroke episode.

165. During RRG meetings, Relator learned that CVA/stroke is a diagnosis for which all Kaiser regions show high error rates, especially Kaiser's Northwest region (Oregon and Washington).

166. Given the clinical profile of acute stroke, it would be particularly easy for Kaiser to audit past claims submissions and/or filter current claims to address this issue before submission. In almost all cases, when a patient is having a stroke, she is treated in a hospital. A patient typically is not allowed to leave the hospital until after the stroke is over. Once the acute incident is over, the patient should be diagnosed as either having a history of stroke, or receiving treatment for the late effects of the prior stroke. Thus, in almost all cases, if a physician submits a diagnosis for acute stroke for a patient treated in the physician's office (or any setting other than a hospital), that diagnosis is likely erroneous.

167. Applying this principle, Relator convinced Kaiser to fund a pilot project to have a physician review all of the acute stroke diagnoses made in CPMG physician offices in 2010. Dr. Christina Marchioni, the CPMG physician who performed the review determined that Kaiser had submitted to CMS approximately $3.1 million in false acute stroke claims during the audit period. In fact, she determined that all but two of these claims were false. She also determined

that Kaiser could have submitted replacement claims for treatment of the aftereffects of stroke for these patients, worth approximately $1.2 million per year.

168. Despite these results, Kaiser did not delete these erroneous codes (and correspondingly repay CMS), or conduct a similar audit for prior years. Instead, Kaiser simply had the reviewing physician correct the problem list in the patient's chart to reflect that the patient had a "history of stroke" or the "late effects" of stroke to minimize the chance that the error would be repeated in future years.

169. This project temporarily reduced the error rate for risk adjustment claims submitted for stroke in the following year. However, in 2011 Relator's funding for this project was cut and the work stopped. Since then, the error rate for stroke diagnoses has increased again.

170. Relator has recently begun a new program whereby all claims for an acute stroke diagnosis submitted based on an office visit by an internal provider are flagged for further review by Kaiser Colorado coders. If the coders identify errors, they reach out to the internal provider that submitted the diagnosis and ask her to correct the error. Unfortunately, the coders are not authorized to correct the errors themselves to prevent the false claims from being submitted, or to compel the internal providers to correct their errors. Thus, approximately 25% to 30% of the errors the coders identify are ultimately submitted to CMS as risk adjustment claims because the internal provider that submitted the diagnosis ignores the coders' efforts to correct the code.

171. **Vertebral Fractures**: In probe audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, and 2011, Kaiser identified problems with claims submitted for HCC 157, Vertebral Fractures without Spinal Cord Injury. This is another diagnosis where Kaiser found that it often submitted false risk adjustment claims to CMS because physicians improperly coded the condition as active when in fact, the patient only had a "history of" the condition.

172. **Vascular Disease**: In probe audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCCs 104, Vascular Disease with Complications, and/or 105, Vascular Disease.

173. The audit documents and additional research by Kaiser identified at least two causes for these errors. First, some claims erroneously claimed the patient had current vascular disease, when in fact, they had only a history of the condition.

174. This was particularly true for cases where the patient had a history of pulmonary embolism, a condition when one or more pulmonary arteries in the patient's lungs become blocked. In most cases, pulmonary embolism is caused by blood clots that travel to the lungs from the legs. Patients who have one or more pulmonary emboli are often treated with anti-coagulants to prevent the development of additional emboli. Until a recent rule change, it was improper to classify patients being treated with anti-coagulants to prevent emboli as being treated for pulmonary embolism; they were properly coded as having only a history of pulmonary embolism. Kaiser knew that physicians routinely misapplied this rule, coding patients on anti-coagulants as having pulmonary embolism, thus causing the submission of false claims for HCC 104.

175. Second, certain claims were false because of a "mismapping" problem with HealthConnect, Kaiser's EMR. HealthConnect, used throughout all of its regions, allows physicians to choose a descriptive diagnosis (as opposed to a specific ICD-9 code) when entering clinical information. HealthConnect then "maps" this descriptive diagnosis to a specific ICD-9 diagnosis code, which is then inserted into the medical record documentation. For certain diagnoses, however, this "diagnosis" file in the past has linked a descriptive term to the wrong ICD-9 diagnosis code.

176. For example, pain in the legs associated with physical activity may be a result of a lack of blood supply to the legs (vascular claudication) or nerve root compression (neurogenic claudication). Relator discovered that when a physician attempted to diagnose a patient with the

neurologic condition, it incorrectly mapped to the ICD-9 code for the vascular disorder. For this reason, false claims were submitted for a vascular condition (HCC 104 or 105) when the physician attempted to diagnose a patient with nerve compression (a condition that does not risk adjust).

177. **Chronic Bronchitis**: In probe audits conducted in 2007 (the "2006 Wrap-up Report"), 2009, 2010, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCC 108, Chronic Obstructive Pulmonary Disease ("COPD").

178. The probe audits regularly found COPD claims erroneous based on lack of documentation in the record, or because the doctor failed to document the patient's condition with sufficient specificity to determine if the patient actually had COPD.

179. In addition, Kaiser's problematic diagnosis file also affected claims for HCC 108. Because of mismapping, when a physician attempted to diagnose a patient with bronchitis (a diagnosis that does not risk adjust), it was incorrectly mapped to an ICD-9 code for chronic bronchitis, and thus classified as HCC 108 (which does risk adjust). The 2010 Probe Audit specifically flagged this problem, even though it did not affect any risk adjustment claims audited that year.

180. Kaiser's EMR also pressured physicians to use the diagnosis code for chronic bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk adjust). If a physician chose acute bronchitis as a diagnosis, HealthConnect (Kaiser's EMR) warned them that this could affect their score on certain quality measures. HealthConnect also informed them that if they selected simple bronchitis or chronic bronchitis instead, the quality measure at issue would not be negatively affected.

181. **Metastatic Cancer**: In probe audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, 2011, and 2012, Kaiser identified problems with claims submitted for HCC 7, Metastatic Cancer and Acute Leukemia.

182. While some of these errors were caused by improper use of codes for active cancer, when the patient actually had a "history of" cancer, there was at least one other cause. Again, errors in Kaiser's diagnosis file led to the insertion of an incorrect diagnosis code in the file, indicating metastasis in circumstances where the physician selected a non-metastatic descriptive diagnosis. Metastatic cancer is a condition where cancer spreads from one organ to another and results in significant additional risk adjustment payments.

183. **Myocardial Infarction and Old Myocardial Infarction**: In probe audits conducted in 2006 (2007 audit of 2005 data), 2010, and 2011, Kaiser identified problems with claims submitted for HCCs 81, Acute Myocardial Infarction ("MI"), and/or 83, Angina Pectoris/Old Myocardial Infarction ("old MI").

184. An MI is a heart attack. Kaiser's probe audits identified multiple issues with the claims submitted for HCCs 81 and 83. In some cases, a claim was submitted for an acute MI, when the proper claims should have been for old MI. In other cases, the only support for an old MI diagnosis was a radiology report or other test result, rather than a diagnosis documented by an appropriate provider in a face-to-face visit. In other cases, Kaiser simply concluded that the medical record documentation did not support the diagnosis of an MI or old MI at all.

185. **Malnutrition**: In probe audits conducted in 2009 and 2011, Kaiser identified problems with claims submitted for HCC 21, Protein-Calorie Malnutrition.

186. Kaiser identified several causes for these problems. In some cases, the condition was diagnosed as current when the patient actually only had a "history of" the condition.

187. In other cases, the false claim resulted from Kaiser coders and/or computer systems adding a malnutrition diagnosis where the treating physician had not. This often happened when a physician used the term "cachexia" in his or her treatment note. Cachexia can be used as a specific diagnosis, indicating that patient has chronic malnutrition or a specific wasting disease. Alternatively, physicians sometimes use variations of the term cachexia as an adjective to indicate that a patient appears malnourished, even where the patient has not been

diagnosed with the disease cachexia (*e.g.*, the patient "looks cachetic"). In the latter case, it is inappropriate for a coder to decide that a patient has cachexia, because only a physician (or other appropriate provider) can determine that a patient has a given condition.

188. **Decubitus Ulcers**: In probe audits conducted in 2009 and 2011, Kaiser identified problems with claims submitted for HCC 148, Decubitus Ulcer of Skin.

189. There are two primary ulcer types: (1) decubitus ulcers, due to pressure; and (2) venous stasis ulcers, where the skin breaks down because of prolonged swelling in the extremities due to poor circulation. When properly coded, decubitus ulcers support a risk adjustment claim for HCC 148; venous stasis ulcers do not risk adjust. One reason Kaiser was submitting false claims for HCC 148 is that physician documentation often failed to sufficiently identify the cause of a patient's ulcer. For example, the audit notes for the 2011 Probe Audit report that one claim was found to be false because "record supported skin breakdown due to maceration rather than an ulcer due to pressure."

190. Decubitus ulcers were also improperly claimed when no ulcer was present. For example, another claim from the 2011 Probe Audit invalidated a diagnosis of decubitus ulcer noting that "NCO [Kaiser's National Compliance Office] could find no documentation to support that the patient [had] an ulcer. The physician documented that the SNF nursing staff reported no skin problems."

191. **Sick Sinus Syndrome**: In probe audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCC 92, Specified Heart Arrhythmias.

192. Sick sinus syndrome ("SSS") is the name for a group of heart rhythm problems (arrhythmias) in which the sinus node—the heart's natural pacemaker—does not work properly. A person with SSS may have heart rhythms that are too fast, too slow, punctuated by long pauses, or a combination of these rhythm problems. SSS is often treated with the implantation of a pacemaker.

193. Under established coding guidelines, once a patient has received a pacemaker to treat her SSS, it is no longer appropriate to code her condition as acute SSS (assuming the pacemaker is effectively treating the SSS). Instead, her condition should be coded to reflect the presence of the pacemaker.

194. One reason for the number of false claims submitted for HCC 92 is that, as Kaiser knows, physicians routinely submit a diagnosis code for SSS when they only should be submitting the code for the presence of the pacemaker. As Kaiser noted in one record for the 2011 Probe Audit: "The record documents that the patient is on a pacemaker for SSS, and per Coding Clinic guidelines in the situation the SSS may only be coded if . . . the SSS is addressed or there is a problem with the pacemaker."

195. Kaiser could easily prevent the submission of false claims for Sick Sinus Syndrome by setting up a process in its claims and billing software to flag situations where a claim includes a diagnosis of SSS and the presence of a pacemaker, and delete the diagnosis for SSS. It is notable that Kaiser has chosen not to use such a claims processing rule to fix this problem because Kaiser uses such rules to add new diagnoses if such a change will allow Kaiser to submit additional risk adjustment claims to CMS. For example, in cases where a patient is being treated with a type of drug that typically indicates major depression (a diagnosis that risk adjusts) but the patient has only been diagnosed with standard depression (a diagnosis that does not risk adjust), these claims are flagged for review to potentially code major depression.

196. In a similar way, Kaiser could easily conduct a retrospective audit of previously submitted claims based on a diagnosis of SSS by selecting any such claims that also had a diagnosis code for presence of a pacemaker. Nonetheless, Kaiser has not done so.

197. **Renal Insufficiency**: In probe audits conducted in 2009, 2011, and 2013, Kaiser identified problems with claims submitted for HCC 131, Renal Failure.

198. Chronic kidney disease ("CKD") is a condition that is often miscoded, and can have significant impact on risk adjustment scores. Although CKD is classified as Levels I to V,

depending on the seriousness of the disease, all five levels of CKD map to the same HCC—HCC 131.

199. Kaiser knew that patients were often incorrectly diagnosed with low level CKD (Levels I and II), but failed to conduct any targeted audits to test these claims. Such audits would have been particularly straightforward because the diagnosis of CKD Levels I and II is largely driven by two lab test values: (a) the patient's glomerular filtration rate ("GFR") rate; and (b) the presence of protein in the patient's urine.

200. Kaiser often fails to delete the claims or otherwise repay Medicare for diagnoses identified as false in these audits, including for the 2010 stroke pilot project. When it does delete previously submitted false codes, it often later re-submits those same claims, thus seeking (and receiving) payment for the diagnoses that it knows to be false. Kaiser Colorado and Kaiser Hawaii do this because of a problem in their claims processing systems. When codes are deleted after an audit, the system for Colorado and Hawaii does not have a flag or other mechanism to indicate that the audit found these diagnoses to be invalid. Nor are the diagnoses removed from the patient's medical record. Thus, when Kaiser conducts "resweeps"—a process designed to re-examine the EMR system to capture diagnoses that were added to patients' medical records after the initial submission of data to Kaiser's risk adjustment claims system—the system picks up the previously deleted diagnoses. Thereafter, Kaiser submits new risk adjustment claims for these diagnoses that Kaiser already determined to be invalid. Kaiser is aware that the flaw in Colorado and Hawaii's claims processing systems has this effect.

B. Despite Its Knowledge of Falsity, Kaiser Submitted False Claims for Payments Based on Internal Provider Coding

201. Despite knowing of the consistent errors in diagnoses codes appearing in claims data that Kaiser uses as a basis for its risk adjustment to as basis for payment to CMS, Kaiser refused to take corrective action. Worse, it shut down corrective efforts that Relator and others put in place to make sure its submissions accurately reflect what was supported by its

beneficiaries' medical records. Additionally, once Kaiser learned of false submissions within its data, its annual attestations claiming that submitted data was accurate, true, and complete, were rendered false.

1. Kaiser Submitted False Claims for Certain "High Risk" Diagnoses

202. As detailed above, Kaiser had knowledge that it routinely submitted false claims for certain diagnoses, yet it willfully disregarded the falsity of those claims when it shut down a high risk filter Relator had participated in the creation of that Kaiser knew prevented them.

203. From approximately 2010 through early 2012, Kaiser's Colorado region used a "filter" program to review certain "high risk" diagnoses, including many of those discussed above, submitted by Kaiser providers before those diagnoses were submitted to CMS for risk adjustment payments. The filter tagged specified diagnoses for manual review by one of Kaiser Colorado's coders, every time one of the "high risk" diagnoses was received from a Kaiser physician. If the Kaiser coders determined that the diagnosis was invalid, it would be flagged to prevent Kaiser from submitting that diagnosis to CMS.

204. The filter was successful in reducing the error rate for many of the diagnoses it targeted. However, for other diagnoses, the filter showed that Kaiser continued to have a high error rate.

205. The audits conducted in connection with the filter identified not only specific HCCs that had high error rates, but also the individual diagnosis codes that were prone to error.

206. For example, as of July 2011, the filter program reviewed the following HCCs and found the following error rates:

HCC	Description	HCCs Reviewed	Invalid HCCs	Error Rate
8	Lung, Upper Digestive Tract, & Other Severe Cancers	472	67	14%
9	Lymph, Head & Neck, Brain, & Other Major Cancers	364	45	12%

10	Breast, Prostate, Colorect & Other Cancers & Tumors	3,013	509	17%
32	Pancreatic Disease	361	51	14%
44	Severe Hematological Disorders	5	5	100%
92	Specified Heart Arrhythmias	7,113	1,084	15%
96	Ischemic or Unspecified Stroke	460	215	47%
104	Vascular Disease with Complications	582	172	30%
157	Vertebral Fractures without Spinal Cord Injury	320	115	36%
158	Hip Fracture/Dislocation	530	153	29%
164	Major Complications of Medical Care and Trauma	52	19	37%

207. Much to Relator's frustration, though, the filter did not address the category of claims with the highest error rate—external providers. Of course, Kaiser had its own, upside-only audit, for those claims.

208. In approximately early 2012, Kaiser ended the filter program itself, even though the audits conducted pursuant to the program continued to show high error rates in the coding for these "high risk" diagnoses, which the filter could help reduce.

209. Ironically, Kaiser eliminated the filter precisely because of its success. By blocking unsupported diagnoses, the program was becoming too harmful to revenue. With its removal, Kaiser restored the bump to its revenue from submitting the false codes. Additionally, once Kaiser learned of false submissions within its data, its annual attestations claiming that submitted data was accurate, true, and complete, were rendered false.

210. In contrast, Kaiser took a very different approach when it knew or suspected a certain condition was often missed by providers and caused forego revenue. Kaiser regularly invests substantial resources in audits to find additional diagnosis codes representing these conditions. When Kaiser finds additional diagnosis codes through these reviews, it always submits risk adjustment codes for those conditions.

211. For example, in 2006, Kaiser's Colorado region conducted "Reimbursement Recovery Audits" ("RRA") looking for new diagnosis codes to submit for at least 19 different clinical pathways or diagnoses. None of these audits targeted claims with high error rates, even though Kaiser knew that some of the same conditions (*e.g.*, MI) were often false. In 2007, Kaiser Colorado conducted at least 22 such targeted clinical audits.

212. In 2010, Kaiser's Colorado region conducted more than 30 such RRA audits to find additional diagnosis codes. Again, several of the audits targeted diagnoses that Kaiser knew were also routinely false (*e.g.*, breast cancer, prostate cancer, arrhythmia, chronic kidney disease, COPD, MI), yet these audits only looked for additional diagnosis codes to submit.

213. This pattern was not unique to Kaiser's Colorado region. In 2010, Kaiser's Northern California region did take some steps to attempt to remedy falsely coded conditions. It audited data in its claims systems for 2009 Dates of Service. This audit appears to have been conducted before these diagnoses were used to submit risk adjustment claims. When the audit found false diagnoses, Kaiser, correctly, blocked them so that they would not be used as the basis for future risk adjustment claims. Of the 4,566 diagnoses audited, 1,781 (39%) "did not have supporting documentation." Kaiser "blocked" these diagnoses so that no risk adjustment diagnoses codes were submitted for them. Notably, Kaiser also found an additional 475 diagnoses that should have been included in the claims data.

214. This is exactly the type of due diligence that Kaiser should have been performing across all regions and for all plan years to identify problems with its medical record documentation before those errors led to the submission of false claims. Instead, it was a short-lived anomaly. At a September 16, 2008 RRG meeting, Dr. Robert Klein presented the results of Kaiser's Northern California region's 2008 targeted clinical audits for missed claims. The region audited at least 12 different clinical pathways. As with the Colorado region's RRA audits, several of these audits targeted the same diagnoses (*e.g.*, MI, Chronic Kidney Disease) that Kaiser knew were often false. No audits were performed to find false claims for these diagnoses.

Moreover, Dr. Klein proposed the addition of further retrospective reviews designed to find examples where, *inter alia*, metastatic cancer (HCCs 7 and 10), was not coded. No similar proposal was made to find examples of false cancer codes.

2. Kaiser Submitted False Claims Due to Systematized Violations of Coding Rules

215. The Colorado and national probe audits also revealed that Kaiser consistently misapplied basic risk adjustment coding rules, leading to false claims. These process-oriented problems could have been addressed easily using Kaiser's Natural Language Process program (discussed in greater detail below), if Kaiser had chosen to do so.

216. In its probe audits, Kaiser found that false claims were routinely submitted to CMS where the diagnosis was listed in medical documentation of a physician or hospital outpatient visit as probable, ruled out, or suspected. CMS rules prohibit the use of such a diagnosis for a risk adjustment claim. 2008 Participant Guide § 6.4.2.

217. For example, in the 2011 Colorado Probe Audit, a stroke HCC was deemed invalid because the suspected stroke had been "ruled out by time of discharge but coded as if present." Another claim, for a diagnosis of vascular disease (based on a reported pulmonary embolism), was invalidated because the record specifically stated "P[ulmonary] E[mbolism] ruled out."

218. Again, in the 2013 Colorado Probe Audit, the audit identified a claim submitted for deep vein thrombosis (DVT) where the diagnosis had been "ruled out by work-up."

219. The probe audits also found that Kaiser routinely submitted claims where a non-chronic diagnosis was listed on a problem list or elsewhere in the medical record without any notation or other evidence that the diagnosis was treated or affected the treatment provided. CMS rules prohibit the submission of claims based on such diagnoses.

220. For example, in the 2010 Probe Audit, 7% of all errors were based on a submitted diagnosis for a non-systemic condition where there "was no documentation to support that the condition had been addressed, evaluated, treated, or considered."

221. The probe audits also found that Kaiser routinely submitted claims where the only documentation to support the diagnosis was a radiologic or lab test, or other non-face-to- face service. CMS rules prohibit the submission of claims based on such diagnoses.

222. For example, in the 2010 Probe Audit, two of the invalidated HCCs were found to be invalid because they were based on diagnostic radiology reports.

223. Kaiser had knowledge that its coding approach produced these consistent types of false claims, yet it continued to submit them. Additionally, once Kaiser learned of false submissions within its data, its annual attestations claiming that submitted data was accurate, true, and complete, were rendered false.

3. Kaiser's Natural Language Processing Audit Program Caused the Submission of False Claims

224. Beginning in approximately 2009, Kaiser developed a Natural Language Processing ("NLP") audit program to try to find new diagnosis codes to submit. Broadly speaking, the NLP program uses an algorithm to search EMRs to find words that, individually or in combination, indicate that a patient has certain diagnoses. If done properly, NLP analysis can be an effective tool to find diagnoses that were properly documented in the physician treatment notes but not submitted in the claims data.

225. For that matter, a good NLP program can also identify situations where a diagnosis was submitted with the claims data but is not documented in the medical record. Several existing NLP programs on the market provide such functionality. They have a user interface that would permit the user to view all previously reported diagnoses as well as ones added by the software and confirmed by the coders. Further, clicking on any diagnosis would take the reviewer to the corresponding portion of the note.

226. In fact, Kaiser uses such programs (sold by 3M and Optum) to conduct NLP analysis of its hospital radiology and Emergency Department claims for health plans other than its Medicare Advantage plans, *e.g.*, its commercial plans.

227. Some of the problems identified in Kaiser's probe audits that, as discussed above, are not necessarily easy to target in a diagnosis-specific audit (*e.g.*, non-chronic conditions that were listed in the record without documentation of treatment; use of radiological test results as the basis for a claim; coding diagnoses that were listed as possible, probable or rule-out) could readily be targeted through a NLP audit and later corrected/deleted.

228. Rather than use an established NLP program, Kaiser built its own—even though Kaiser uses established NLP products from 3M and Optum for other purposes. Notably, Kaiser's NLP program was built without any function to allow it to audit the validity of previously submitted claims.

229. All face-to-face visits to a physician or hospital by members of Kaiser's MA plans are run through the NLP software to identify new diagnoses that might be appropriate to use for the submission of additional risk adjustment claims. The results are grouped into four categories: (a) True Positive: diagnoses that have been confirmed by two Kaiser coders; (b) More Information Needed: diagnoses that may be present, but further analysis is required to confirm; (c) Problem List Only: diagnoses that show up only on the member's problem list with no documentation of treatment; and (d) False Positives or Found Elsewhere.

230. Kaiser allows the various regions to decide how to use this information. For example, a PowerPoint presented at the Fall 2010 RRG Meeting outlined the results of the "NLP HCC Data Mining Pilot." Three regions had participated in the pilot: (a) Georgia, (b) Hawaii, and (c) Northwest. The Northwest region appears to have simply passed along all of its "True Positive" diagnoses to its risk adjustment claims submission system (which submits the claims to CMS) without further review. The Georgia region passed along most (278 of 294) of the

diagnoses to its risk adjustment claims submission system, which submits the claims to CMS. It is unclear from the presentation why some diagnoses were not passed along.

231. The Hawaii region, on the other hand, audited all of the "True Positives" before passing them on. Remarkably it found a 29% error rate in these claims that had supposedly been confirmed by two Kaiser coders. It now continues to audit all "True Positives." Relator spoke with Terri Keliinoi, Kaiser Hawaii's manager of risk coding, on October 14, 2014. The manager reported that as of the review of the 2014 file, they are still finding a 20% error rate in the "True Positives."

232. This is consistent with Relator's own experience. He personally reviewed over 100 of the supposedly "True Positive" claims for the Colorado region and found a 10% error rate. In particular, he noted that it appears that the NLP software picks up, and the reviewing coders have validated, diagnoses that appear in problem lists but which lack additional notation of treatment. As described above, a diagnosis may not be submitted for risk adjustment purposes if it just appears in a problem list. There must be further indication that the physician considered or treated the diagnosis.

233. Notwithstanding this high error rate, Kaiser continues to allow its regions to determine whether they will conduct any additional review of the True Positives before submission to CMS. The Colorado region passes the True Positive diagnoses to its claims submission system with no further review, even though Kaiser knows that many of these claims are likely false. Likewise, the Northwest region passes through all True Positive diagnoses with the exception of diagnoses of cachexia (which are known to have very high error rates). The Hawaii region, on the other hand, has both a coder and a physician audit 100% of the "True Positives."

234. By failing to take corrective action to prevent the submission of false diagnosis data, knowing that in the absence of action such data would be submitted, Kaiser knowingly submitted false claims to CMS for risk adjustment payments. Additionally, once Kaiser learned

of false submissions within its data, its annual attestations claiming that submitted data was accurate, true, and complete, were rendered false.

FIRST CLAIM FOR RELIEF

False Claims Act: Presenting or Causing to be Presented False Claims
31 U.S.C. § 3729(a)(1)(A) (formerly 31 U.S.C. § 3729(a)(1))

235. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 234 of this Complaint.

236. Defendants violated 31 U.S.C. § 3729(a)(1)(A) by knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval to CMS, resulting in their receiving inflated Medicare payments from CMS to which they were not entitled.

237. Specifically, Defendants presented or caused to be presented false claims for risk-adjustment payments in the form of false diagnosis codes for Defendants' Medicare beneficiaries, as well as in the form of false risk adjustment attestations certifying the completeness, accuracy, and truthfulness of Defendants' risk adjustment data, in violation of CMS regulations and policies, which Defendants agreed to and were obligated to comply with.

238. If CMS had known that Defendants had presented or caused to be presented false claims based on these improper codes, CMS would have refused to make risk-adjustment payments based on the improper coding and/or taken other appropriate actions to ensure that Defendants did not receive or retain risk-adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions.

239. By reason of the false claims that Defendants knowingly presented or caused to be presented, the United States has been damaged in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

SECOND CLAIM FOR RELIEF

False Claims Act: Making or Using False Records or Statements
31 U.S.C. § 3729(a)(1)(B) (formerly 31 U.S.C. § 3729(a)(2))

240. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 234 of this Complaint.

241. Defendants violated 31 U.S.C. § 3729(a)(1)(B) by knowingly making, using, and causing to be made or used, false records or statements material to false or fraudulent claims resulting in their receiving inflated Medicare payments from CMS to which they were not entitled.

242. If CMS had known that Defendants had presented or caused to be presented false claims based on these improper codes, CMS would have refused to make risk-adjustment payments based on the improper coding and/or taken other appropriate actions to ensure that Defendants did not receive or retain risk-adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions.

243. By reason of the false claims that Defendants knowingly presented or caused to be presented, the United States has been damaged in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

THIRD CLAIM FOR RELIEF

False Claims Act: Reverse False Claims
31 U.S.C. § 3729(a)(1)(G) (formerly 31 U.S.C. § 3729(a)(7)))

244. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 234 of this Complaint.

245. Defendants violated 31 U.S.C. § 3729(a)(1)(G) by knowingly concealing and improperly avoiding or decreasing an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly concealed or knowingly and improperly avoided or decreased an obligation to repay risk adjustment payments to which they were not entitled from CMS.

246. If CMS had known that Defendants had presented or caused to be presented false claims based on these improper codes, CMS would have refused to make risk-adjustment payments based on the improper coding and/or taken other appropriate actions to ensure that

Defendants did not receive or retain risk-adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions.

247. By reason of the false claims that Defendants knowingly presented or caused to be presented, the United States has been damaged in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

PRAYER

WHEREFORE, Relator, on behalf of himself and the United States, requests that judgment be entered in his favor and against Defendants as follows:

(a) That Defendants cease and desist from violating the False Claims Act, 31 U.S.C. § 3729 *et seq.*;

(b) That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained because of Defendants' actions, plus a civil penalty of between $5,500-$11,000, for conduct occurring prior to November 2, 2015 and a civil fine of between $10,957 and $21,916, for conduct occurring after November 2, 2015, for each violation of 31 U.S.C. § 3729, plus any increase as specified under the Federal Civil Penalties Adjustment Act of 1990;

(c) That Relator be awarded a "relator's share" in an amount that the Court decides is reasonable, which shall not be less than 15% nor more than 30% of the proceeds or settlement of any related administrative, criminal, or civil actions, including the monetary value of any equitable relief, fines, restitution, or disgorgement to the United States, and/or third parties;

(d) That Relator be granted a trial by jury;

(e) That Relator and the United States be awarded pre-judgment interest;

(f) That Relator be awarded all costs of this action, including attorneys' fees and costs pursuant to 31 U.S.C. §§ 3730(d) and 3730(h);

(g) That Defendants be enjoined from concealing, removing, encumbering, or disposing of assets that may be required to pay the civil monetary penalties imposed by the Court;

(h) That Defendants disgorge all sums by which they have been enriched unjustly by their wrongful conduct;

(i) That the Government and Relator obtain such other relief as the Court deems just and proper.

JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands trial by jury.

DATED: November 15, 2021

Respectfully submitted,

By: s/*Michael J. Ronickher*

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:13-c-v-03891-EMC (Consolidated)
UNITED STATES OF AMERICA, *ex rel.* GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs-Relators, v.	Case No. 3:18-cv-01347-EMC

KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HOSPITALS, THE PERMANENTE MEDICAL GROUP, INC., SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, COLORADO PERMANENTE MEDICAL GROUP, P.C., THE SOUTHEAST PERMANENTE MEDICAL GROUP, INC., HAWAII PERMANENTE MEDICAL GROUP, INC., MID-ATLANTIC PERMANENTE MEDICAL GROUP, P.C,, NORTHWEST PERMANENTE, P.C., WASHINGTON PERMANENTE MEDICAL GROUP, P.C., KAISER FOUNDATION HEALTH PLAN OF COLORADO, KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC., KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, and KAISER FOUNDATION HEALTH PLAN OF WASHINGTON, Defendants.	AMENDED COMPLAINT BY RELATORS GLORYANNE BRYANT AND VICTORIA M. HERNANDEZ FOR VIOLATIONS OF FEDERAL FALSE CLAIMS ACT DEMAND FOR JURY TRIAL

COMES NOW, Plaintiffs and *Qui Tam* Relators Gloryanne Bryant ("Ms. Bryant") and Victoria M. Hernandez ("Ms. Hernandez," and together with Ms. Bryant, "Relators"), individually and on behalf of the United States of America, to recover treble damages and civil penalties under the federal False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, for monies unlawfully obtained and/or retained from the federal Medicare Program by Defendant Kaiser Foundation Health Plan, Inc. and various of its direct and indirect subsidiaries and affiliates (together, "Kaiser" or the "Kaiser Defendants"), and allege as follows:

INTRODUCTION

The Kaiser Defendants are now and have been, in some cases since at least 2009, engaged in a widespread scheme to knowingly submit, or cause to be submitted, false claims for payment to the United States by submitting false "risk adjustment" information to the Centers for Medicare & Medicaid Services ("CMS") in order to improperly increase the amounts CMS pays them. Likewise, the Kaiser Defendants have knowingly retained overpayments received from CMS as a result of their false risk adjustment submissions.

1. Millions of elderly and disabled individuals throughout the United States receive their Medicare benefits through the Medicare Advantage Program (also referred to as "Medicare Part C"). A central, distinguishing feature of the Medicare Advantage Program is the provision of Medicare benefits by private healthcare insurance organizations. Medicare beneficiaries enroll in managed healthcare insurance plans called Medicare Advantage Plans ("MA Plans") that are owned and operated by these private organizations, called Medicare Advantage Organizations ("MA Organizations"). This case involves, in large part, conduct by Kaiser — which operates one of the nation's largest MA Organizations — to improperly obtain or avoid returning payments under the Medicare Advantage Program that it was not entitled to receive.

2. The Government pays each MA Organization a fixed monthly payment for each Medicare beneficiary enrolled in its plans. The Government adjusts these payments for various risk factors that affect expected healthcare expenditures, including the health status of each enrollee. The adjustments are intended to ensure that MA Organizations are paid more for those enrollees expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower costs.

3. To obtain payments based on adjustments for health status, MA Organizations submit diagnosis codes to the Government for the beneficiaries in their MA Plans. These diagnosis codes are from the beneficiaries' medical encounters (*e.g.*, office and hospital visits). Using these diagnosis codes, the Government calculates a risk score for each beneficiary. The beneficiary's risk score is then used to calculate monthly payments to the MA Organization for that beneficiary for the following year. In general, the more numerous the conditions diagnosed, and the more severe the conditions, the higher the risk score for a beneficiary and, thus, the greater the risk-adjusted payments made to the MA Organization for that beneficiary.

4. This payment model creates powerful incentives for MA Organizations to over-report diagnosis codes in order to exaggerate the expected healthcare costs for their enrollees. In order to combat these incentives and protect the Government from making erroneous payments to MA Organizations, the Government requires that submitted diagnoses be supported and validated

by the beneficiaries' medical records. It is a well-established requirement that all diagnosis codes submitted to the Medicare Program for risk adjustment payments must be unambiguously supported by clinical documentation included in the beneficiaries' medical records. Kaiser knew that these medical records are the "source of truth" for the purpose of receiving and retaining risk adjustment payments, and for each individual member's medical history and clinical profile.

5. In addition, each MA Organization must expressly certify in "Risk Adjustment Attestations" submitted to CMS that the diagnosis codes it has provided are accurate and truthful. 42 C.F.R. § 422.504(1)(2). Each MA Organization must also "[a]dopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with [the Government's] program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." 42 C.F.R. § 422.503(b)(4)(vi).

6. In excess of one million elderly and disabled Medicare beneficiaries are currently enrolled in MA Plans that are owned and operated by Kaiser throughout the United States, and that number is growing. In 2011, approximately one million Medicare beneficiaries in the United States were enrolled in Kaiser's MA Plans. In 2015, Kaiser's MA Plans had grown to 1.3 million beneficiaries, in 2016 to 1.4 million, and in 2021 to 1.7 million.

7. The United States also contributes to premiums paid by individuals to private health insurance companies, including Kaiser, under the Affordable Care Act (sometimes referred to as the "ACA"). The Affordable Care Act authorizes the Department of Health and Human Services (HHS) to utilize criteria and methods similar to those utilized under the Medicare Advantage program to implement risk adjustment, and requires similar attestations/certifications from health insurance companies as to the accuracy and documentation of their risk adjustment data. The HHS risk adjustment methodology developed by and on behalf of the Centers for Medicare & Medicaid Services ("CMS") is based on the premise that premiums should reflect the differences in plan benefits, quality, and efficiency, and not the health status of the enrolled population. Accordingly, as under the Medicare Advantage program, the ACA risk adjustment model creates powerful incentives for private health insurance companies like Kaiser to over-report diagnosis

codes in order to exaggerate the expected healthcare costs for their enrollees; the more codes that are reported, the higher premiums the companies are permitted to charge, and the higher contributions will be made to such premiums by the United States.

8. The United States pays billions of taxpayer dollars each year to Kaiser for the Medicare beneficiaries enrolled in its MA Plans and ACA Plans. Risk adjustment payments account for a substantial amount of these dollars. The diagnoses submitted by Kaiser drive a large percentage of the payments it receives from the Medicare Program. It is not surprising then that Kaiser is not a passive conduit of diagnoses from healthcare providers to the Medicare Program. Rather, for many years, Kaiser has conducted programs and engaged in other activities to increase the amount of risk adjustment payments from Medicare. This includes programs and other efforts to directly influence and capture both the number of diagnoses and the severity of the medical conditions reported by providers and coded by Kaiser staff.

9. Ms. Bryant, until her retirement on October 3, 2017, was National Director for Kaiser's national coding quality group, and, prior to that, was Managing Director of Kaiser's Health Information Management program ("HIM") for the Kaiser Foundation Health Plan in Kaiser's Northern California ("NCAL") region. Ms. Hernandez was employed by the Kaiser Defendants in various positions from June 1995 through October 2015, and as a Kaiser contract employee through May 2016, in functions that included Regional Director of auditing and coding services for The Permanente Medical Group in Kaiser's NCAL region.

10. In these positions, Relators discovered that the Kaiser Defendants were and are engaged in fraudulent schemes pursuant to which they routinely and systematically overcharge the following government programs in the following ways:

a. Medicare Advantage

(i) Defendants "upcode" risk adjustment claims by manipulating the documentation and submitting claims and codes to the Medicare Advantage program for diagnoses that the member does not have or for which the member was not treated in the relevant year, or by claiming that a member was treated for a more serious condition than

the member actually has, or by documenting and submitting a diagnosis that was labeled significant when it was not, or by training, educating, and programming its personnel and systems to support these fraudulent activities; and

(ii) Defendants refuse to implement and ignore processes to correct (and refuse to reimburse Medicare for) previously submitted risk adjustment claims when the Defendants discover, or in the exercise of reasonable care should discover, that those previously submitted claims were false, and subvert and ignore Kaiser's internal compliance function and pressure it to cooperate; and

(iii) Defendants manipulate and falsify risk-adjustment data in a deliberate scheme to over-charge the Medicare Advantage program.

b. Affordable Care Act

Similarly, Defendants overdocument and upcode risk adjustment claims relevant to individuals covered by the ACA in the same manner and pursuant to the same schemes as relevant to the Medicare Advantage program, and similarly refuse to correct or reimburse Medicare for overpayments caused by this conduct, in a deliberate scheme to over-charge the Medicare program.

c. Through this fraudulent scheme, the Kaiser Defendants have defrauded the United States of hundreds of millions—and likely billions—of dollars for more than nine years.

11. Defendants' conduct alleged herein violates the federal False Claims Act. The federal False Claims Act (the "FCA") was originally enacted during the Civil War. Congress substantially amended the Act in 1986—and, again, in 2009 and 2010—to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. The Act was amended after Congress found that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the amendments would create incentives for individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or

Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf.

12. The FCA prohibits, inter alia: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government; and (d) conspiring to violate any of these three sections of the FCA. 31 U.S.C. §§3729(a)(1)(A)-(C), and (G). Any person who violates the FCA is liable for a civil penalty of up to $21,916 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. §3729(a)(1).

13. For purposes of the FCA, a person "knows" a claim is false if that person: "(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. §3729(b)(1). The FCA does not require proof that the defendants specifically intended to commit fraud. Id. Unless otherwise indicated, whenever the words "know," "learn," discover" or similar words indicating knowledge are used in this Complaint, they mean knowledge as defined in the FCA.

14. Each claim for risk adjustment payments that defendants have submitted or caused to be submitted to CMS, where the patient was not treated by a qualified provider for that condition in the year in question, and/or the treatment and condition are not properly documented in the medical record is a false and/or fraudulent claim within the meaning of the FCA, so long as defendant knew that the claim was false when it was submitted, or the defendant later discovered its falsity and refused to correct the claim.

15. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. The FCA requires that

the Complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

16. Based on the foregoing laws, Relators Gloryanne Bryant and Victoria M. Hernandez seek, through this action, to recover damages and civil penalties arising from the false or fraudulent records, statements and/or claims that the Defendants made or caused to be made in connection with false and/or fraudulent claims for Medicare Advantage risk adjustment payments, and Affordable Care Act insurance premiums.

JURISDICTION

17. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

18. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides in, transacts business in, or has committed the alleged acts in the Northern District of California.

VENUE AND INTRADISTRICT ASSIGNMENT

19. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claims occurred in San Francisco County and Alameda County, and within the Division and Courthouse in which this action has been commenced.

PARTIES

I. PLAINTIFFS

20. Plaintiff-Relator Gloryanne Bryant is an individual who, currently and during all times relevant to this action, resides in this judicial district. After her distinguished career in senior coding compliance positions with other California-based health care companies, Kaiser hired Ms. Bryant in May 2009 into a senior leadership position as Managing Director HIM for the Kaiser Foundation Health Plan, Northern California Revenue Cycle. Ms. Bryant remained at Kaiser until

her retirement, effective as of October 3, 2017. In September 2013, Ms. Bryant was promoted to National Director Coding Quality, Education, Systems and Support for Kaiser's National Revenue Cycle Program Office, a position which she held until her retirement. Ms. Bryant is a nationally recognized expert and educator in coding, clinical documentation improvement, and physician querying, and speaks and teaches regularly to state, regional, and national audiences. She holds professional designations of RHIA, RHIT, CCS, CDIP, and CCDS, and is an AHIMA-Approved ICD-10-CM/PCS Trainer.

21. Plaintiff-Relator Victoria M. Hernandez is an individual who, currently and during all times relevant to this action, resides in this judicial district. Ms. Hernandez is a coding professional with over 25 years of experience in the healthcare field. She was employed by the Kaiser Defendants in various coding leadership positions from January 2000 through October 2015, including: (i) Regional Director of Auditing & Coding Services for TPMG from October 2014 through October 2015; (ii) Regional Director of Hospital Coding Audit & Education for Kaiser Foundation Health Plan from April 2012 through October 2014; and (iii) Regional Coding Review Manager for Kaiser Foundation Health Plan's Revenue Cycle HIM from February 2010 through April 2012. She holds professional designations of RHIA, CDIP, CCS, CCS-P and is an AHIMA-Approved ICD-10-CM/PCS Trainer.

22. The United States, on whose behalf Relator brings this suit, is the real party in interest. The United States has ongoing contracts with Defendants through CMS, in accordance with Defendants' participation in the Medicare and Medicaid programs.

II. THE DEFENDANTS

23. Kaiser Foundation Health Plan, Inc. is part of Kaiser Permanente, an integrated healthcare consortium, that operates one of the nation's largest health plans, serving over 12 million members. Kaiser employs doctors and other medical professionals and provides medical services through its Permanente Medical Groups, a for-profit set of regional affiliates that includes The Permanente Medical Group ("TPMG") in Northern California, Southern California Permanente Medical Group ("SCPMG") in Southern California, and five other regional areas including Hawaii,

the Pacific Northwest, Colorado, Georgia and the Mid-Atlantic States. Kaiser owns and operates acute care hospitals in four regions (Northern California, Southern California, Northwest and Hawaii), and provides care in other settings through its non-profit Kaiser Foundation Hospitals ("KFH").

24. Kaiser's private health insurance plan covers the majority of its patient population. Kaiser Foundation Health Plan, Inc. and its subsidiary health plans also operate, however, various MA Plans, including Medicare Advantage HMO plans called "Senior Advantage," serving approximately 1.7 million members in 2021, and 1.4 million members in 2016, in approximately seven states and one district. As of 2016, Kaiser's Medicare Advantage Program served approximately 10% of Kaiser's overall patient population (10.7 million total as of 2016), but generated approximately 30% of Kaiser's overall profits.

25. Kaiser reported overall operating revenue of $88.7 billion in 2020, compared to $64.6 billion in 2016 and $60.7 billion in 2015. Kaiser reported net income of $6.4 billion in 2020, compared to $3.1 billion in 2016 and$1.9 billion in 2015.

Kaiser Permanente Total Health Plan Membership, by Region (as of early 2017)

Northern California:	4,134,194
Southern California:	4,390,653
Colorado:	671,500
Georgia:	306,806
Hawaii:	250,221
Mid-Atlantic States (Va., Md., D.C.):	702,516
Northwest (Ore./Wash.):	575,688
Washington:	677,050

Source: https://share.kaiserpermanente.org/article/fast-facts-about-kaiser-permanente/

26. Pursuant to inter-company agreements, the Kaiser Foundation Health Plan, Inc. and its subsidiaries share moneys received from federal and state governments with Kaiser's various Permanente Medical Groups and Kaiser Foundation Hospitals. Accordingly, all of the named Kaiser Defendants possess financial interests in maximizing the amounts claimed to and paid by the governments, and each Kaiser Defendant has participated in various aspects of the fraudulent practices, as described further herein.

27. Defendant Kaiser Foundation Health Plan, Inc. is a California corporation with its principal place of business in Oakland, California within this judicial district.

28. Defendant Kaiser Foundation Hospitals is a California corporation with its principal place of business in Oakland, California within this judicial district.

29. Defendant The Permanente Medical Group, Inc. ("TPMG") is a California corporation with its principal place of business in Oakland, California within this judicial district. TPMG operates all Kaiser medical group operations in the Northern California region ("NCAL region").

30. Defendant Southern California Permanente Medical Group ("Southern California PMG" or "SCPMG") is a California corporation with its principal place of business in Pasadena, California. SCPMG operates all Kaiser medical group operations in the Southern California region ("SCAL region").

31. Defendant Colorado Permanente Medical Group, P.C. ("Colorado PMG") is a Colorado corporation with its principal place of business in Denver, Colorado. The Colorado PMG operates all Kaiser medical group operations in the Colorado region.

32. Defendant The Southeast Permanente Medical Group, Inc. ("Southeast PMG") is a Georgia corporation with its principal place of business in Atlanta, Georgia. The Southeast PMG operates all Kaiser medical group operations in the Southeast region.

33. Defendant Hawaii Permanente Medical Group, Inc. ("Hawaii PMG") is a Hawaii corporation with its principal place of business in Honolulu, Hawaii. The Hawaii PMG operates all Kaiser medical group operations in the Hawaii region.

34. Defendant Mid-Atlantic Permanente Medical Group, PC ("Mid-Atlantic PMG") is a Maryland corporation with its principal place of business in Rockville, Maryland. The Mid-Atlantic PMG operates all Kaiser medical group operations in the Mid-Atlantic region, including Georgia.

35. Defendant Northwest Permanente, P.C. ("Northwest PMG") is an Oregon corporation with its principal place of business in Portland, Oregon. The Northwest PMG operates all Kaiser medical group operations in the Northwest region, including Oregon.

36. Defendant Washington Permanente Medical Group, P.C. ("Washington PMG") is a Washington corporation with its principal place of business in Seattle, Washington. The Washington PMG operates all Kaiser medical group operations in the Washington region.

37. TPMG, Southern California PMG, Colorado PMG, Southeast PMG, Hawaii PMG, Mid-Atlantic PMG, Northwest PMG, and Washington PMG are referred to collectively herein as "The Permanente Medical Groups" or "PMGs". The PMGs have a national leadership and consulting organization, the Permanente Federation, which is run by the leadership of the PMGs. Unless stated otherwise, references to Kaiser actions or conduct taking place in a particular Kaiser region refers to the actions or conduct of the specific Permanente Medical Group that operates in that region.

38. Defendants Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Health Plan of the Northwest, and Kaiser Foundation Health Plan of Washington are corporations organized under the laws of, and with their principle places of businesses in, Colorado, Georgia, Maryland, Oregon and Washington, respectively, and are subsidiaries of Kaiser Foundation Health Plan, Inc.

THE LAW

A. Medicare Advantage (Medicare Part C)

39. Under Medicare Part C, the Medicare Program pays each MA Organization a predetermined monthly amount for each Medicare beneficiary in the plan. This monthly payment is known as a "per-member, per-month" payment (or "PMPM"). This capitated payment for each plan varies depending on various factors, including amounts set forth in the plan's bid submitted to CMS. Since 2000, Congress has also required that the payments be risk adjusted for each beneficiary based on demographic factors (*e.g.*, gender, age) and health status. By risk adjusting for health status, Congress required that more be paid for beneficiaries with higher risk scores than be paid for beneficiaries with lower risk scores. CMS currently employs a health-based risk adjustment model — known as the Hierarchical Conditions Category ("HCC") model — that takes into account diagnoses from inpatient hospital stays, emergency and outpatient surgery encounters, and physician office visits.

40. The HCC model is prospective, meaning that it relies on diagnoses for certain medical conditions assigned to beneficiaries by their physicians in a one calendar year timeframe (referred to by CMS as the "data collection" year but also generally known as the "date of service" or "DOS" year) to set the payment for each beneficiary for the following year (often referred to as the "payment year" or "PY"). The medical conditions included in the model are grouped into HCCs, which are categories of clinically-related medical diagnoses. *See* 42 C.F.R. § 422.2. The diagnoses grouped into HCCs include major, severe/acute, and/or chronic illnesses. Related groups of diagnoses are ranked on the basis of disease severity and the cost associated with their treatment. Between 2004 and 2013, the CMS-HCC model included 70 HCCs. Starting in 2014, the CMS-HCC model included 79 HCCs.

41. The Government assigns a relative numerical value/weight to each HCC group that correlates to the predicted incremental costs of care associated with treating the medical conditions in each category. It determines the relative values based on the amounts that it paid to fee-for-service providers to treat these major, severe, and chronic medical conditions under Parts A

and B of the Medicare Program. Higher relative values/weights are assigned to HCCs that include diagnoses with greater disease severity and greater costs associated with their treatment.

42. As previously stated, the HCC risk adjustment model is prospective and a beneficiary's risk score for a particular payment year is determined by his or her medical conditions during the previous year (*i.e.*, the date of service year). These medical conditions must be documented by a qualified healthcare provider (*e.g.*, a doctor, physician's assistant, etc. as defined by the CMS MA program) in the beneficiary's medical record during the previous year.

43. Each beneficiary's risk score is calculated anew for each payment year. For example, a beneficiary's risk score for payment year 2012 is determined by the diagnoses that his or her qualified healthcare providers documented in his or her medical records during face-to-face medical encounters during date of service year 2011.

44. MA Organizations obtain diagnosis data from the healthcare providers that treat the beneficiaries in their plans. Healthcare providers can transmit diagnosis codes to MA Organizations with claims for payment for services rendered, in encounter records reporting the services rendered, or by alternative means.

45. MA Organizations submit risk adjustment data, including diagnoses, to CMS using CMS' Risk Adjustment Processing System ("RAPS"). Each RAPS submission must include the following information: the Medicare beneficiary's identification number (called a "HIC number" or "HICN"); the date(s) of the medical encounter; the type of provider (physician or hospital); and the diagnosis code(s) reported by the provider for the encounter. Medical encounters include physician office visits, hospital outpatient visits, and hospital inpatient stays.

46. MA Organizations are entitled to risk adjustment payments based on the diagnosis codes that they submit to CMS only if the codes are from face-to-face medical encounters between the Medicare beneficiary and provider, the encounter occurred during the relevant date of service year, the provider was of a type and specialty acceptable for risk adjustment purposes, and at the time of the encounter, the provider documented the medical conditions identified by the diagnosis codes in the medical record based on acceptable documentation. In addition, codes should

be based on documented conditions that require or affect patient care treatment or management. *See* 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide ("2008 RA Participation Guide") at § 6.4.1.

47. Risk adjustment claims are true, and the resulting risk adjustment payments are valid, only to the extent that the diagnosis codes submitted by the MA Organizations are valid. The diagnoses must be coded according to the *International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting* ("ICD-9- CM" & "ICD-10-CM") and documented with sufficient clinical specificity. All diagnosis codes submitted by MA Organizations must be supported by medical record documentation. If the medical record is ambiguous, it cannot be relied on for diagnosis information for risk adjustment payments. *See* 2008 RA Participation Guide at § 7.2.4.1 (stating that risk adjustment claims and payments cannot be based on questionable diagnoses).

48. MAOs have a statutory obligation to report and return any overpayment received from the Government, 42 U.S.C. § 1320a-7k(d). Further, federal regulations are clear that MAOs like Kaiser are required to report and return both overpayments that they have identified and overpayments that they "should have determined through the exercise of reasonable diligence" were made by CMS. 42 C.F.R. 422.326(c). The law is clear that any overpayment retained after the statutory deadline of 60 days is an "obligation" for purposes of 31 U.S.C. § 3729. 42 U.S.C. § 1320a-7k(d)(4)(B) (defining overpayments); 42 C.F.R. 422.326(e).

B. Affordable Care Act ("ACA")

49. The Affordable Care Act sets up a program of risk adjustment in individual and group markets to lessen or eliminate the influence of risk selection on the premiums that plans charge. In the risk adjustment model utilized under the ACA, which is named the HHS-Hierarchical Condition Categories ("HHS-HCC") risk adjustment model, HHS utilizes criteria and methods similar to those utilized under the Medicare Advantage program, and adapts Medicare Advantage HCCs for use in the HHS-HCC model. The chief goal in the design of the HHS-HCC model is to assure that premiums reflect differences in benefits and plan efficiency. The HHS-HCC model uses

current year diagnoses and demographics to predict the current year's spending, as distinguished from the Medicare Advantage program, which uses the risk adjustment model to predict next year's spending. But in the end, the effect of risk adjustment on ACA premiums is similar to the impact of risk adjustment on capitated payments made under the Medicare Advantage program. Insurers like Kaiser receive more ACA premiums the more documented and coded conditions are submitted for their insureds.

50. Pursuant to the ACA, the United States contributes, through tax credits, to premiums paid by low-income individuals to private health insurance companies, including Kaiser, based upon a sliding scale calibrated to the poverty line. Accordingly, when premiums are artificially high due to documentation and coding fraud, both enrollees and the United States are harmed by the overcharges.

THE FACTS

I. KAISER AND ITS RELATED COMPANIES OVERDOCUMENT AND OVERCODE/UPCODE "HIGH-VALUE" HIERARCHICAL CONDITION CODES ("HCCS")

51. Ms. Bryant and Ms. Hernandez have witnessed Kaiser and its related companies engage in systematic fraud on the Medicare Advantage program, and other government programs including the ACA, for many years through teaching and implementing "HCC maximization techniques" to physicians and coding staff, resulting in systematic over-documenting, over-coding and upcoding of certain high value HCCs, as detailed below. The HCCs directly impact risk adjustment scores, meaning that the Government overpays Kaiser for its patient population which is not as sick as Kaiser reports.

52. Kaiser submitted a Risk Adjustment Attestation to the Medicare Program each year after the final risk adjustment submission deadline and knew that it was required to submit a truthful Risk Adjustment Attestation. Despite its obligations under Medicare law, Kaiser's documentation, coding and Risk Adjustment Attestations have been false.

A. Aortic Atherosclerosis ("AA")

(i) Clinical significance, documentation and coding convention

53. AA is sometimes referred to as "hardening of the arteries." It describes a thickening and loss of elasticity in the arterial wall. This condition is often an incidental finding in radiology and imaging reports and neither treated nor managed after being identified. It often has no impact on patient care or outcomes. Unless AA is related to signs, symptoms or conditions/diagnoses that necessitated the performance of the radiology and imaging test, treatment and management is actually directed toward the AA, or a follow-up office visit is ordered for treatment, it should not be reported/coded to Medicare.

54. For example, the American Hospital Association's ("AHA") Coding Clinic, the official clearing house for ICD-9-CM and ICD-10-CM/PCS coding guidance, publishes the following guidance for outpatient encounters, including emergency room visits: "It is inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test for a patient being seen in the emergency department (ED). The ED physician would need to clarify that the finding was clinically significant and related to the visit in order for it be coded." *See* Exhibit 1.

55. Official Coding and Reporting Guidelines applicable to inpatient encounters further confirm the standard:

> encounters for diagnostic tests that have been interpreted by a provider.

When it is coded, AA is currently assigned ICD-10-CM code 170.0 (Atherosclerosis of Aorta). Under ICD-9-CM, AA was assigned ICD-9-CM code 440.0 (Atherosclerosis of Aorta). The AA diagnosis is assigned to HCC 108; in 2016, Kaiser received approximately $2,260 for each HCC 108 code.

(ii) Kaiser's scheme

56. Labeled an "area of significant missed opportunity" by Kaiser's Medicare Finance Group and Kaiser's Permanente Medical Groups, Kaiser implemented an HCC initiative in 2011 to review and capture AA diagnoses in all clinic, emergency, outpatient surgery, and inpatient encounters, even when incidental to the encounter. In Kaiser's NCAL region, Kaiser subsidiary

TPMG trained its physicians to choose a diagnosis from Kaiser's proprietary, electronic diagnosis "pick list" to capture AA, even when it was merely an incidental finding.

57. Kaiser's TPMG senior clinician leaders took the position that AA is a "chronic, systemic condition" that is a permanent risk factor once diagnosed, and thus is properly codeable regardless of its actual significance or treatment. This interpretation, if accurate, would result in the AA diagnosis meeting the Official Coding and Reporting Guideline for the coding of a systemic condition without coding staff questioning it. Kaiser's NCAL TPMG region directed Regional Health Information Management ("Regional HIM") coding leaders to instruct and train to "always code" AA on the basis that it was supposedly a systemic condition and should always be coded. This direction and instruction ignored coding conventions and guidance, and internal feedback from Kaiser NCAL's Regional HIM, including Ms. Bryant and Ms. Hernandez who questioned whether this condition was truly systemic. This improper TPMG direction was eventually migrated to Kaiser's other regions as a "best practice."

58. Kaiser's NCAL Regional HIM, led by Ms. Bryant, remained uncomfortable with the TPMG instruction on AA. Ms. Bryant had numerous conversations with individuals within TPMG and others within Kaiser regarding her and her colleagues' concerns, and submitted a written inquiry to AHA Coding Clinic as to whether the diagnosis of AA is properly considered a chronic, systemic condition (similar to hypertension and diabetes mellitus) that is codeable on a routine basis even in the absence of treatment, management, and/or monitoring. The guidance received from AHA Coding Clinic subsequently rejected NCAL TPMG's clinical determination. But TPMG management exerted intimidation, pressure and other undermining techniques to silence Ms. Bryant and her Regional HIM staff.

59. To provide "documentation" that would constitute evidence of the clinical significance of AA and meet the Official Coding and Reporting Guidelines, Kaiser's NCAL TPMG region developed a "SMARTPHRASE" to automatically populate the medical record when AA was observed and/or diagnosed in radiology and imaging reports that would routinely, automatically, and falsely state that the diagnosis was significant, not incidental, and would require clinical follow-

up, often through the use of "addenda" added to the medical record long after the medical visit. This process was implemented so that the hospital coding staff would assign the ICD-9-CM code for AA, and the HCC for AA would be captured.

60. Ms. Bryant continued to bring her concerns to Kaiser's National Compliance Ethics & Integrity Office ("National Compliance Office" or "NCO") and finally, in August 2015, Kaiser NCO announced that a Kaiser Permanente ("KP") clinical review overruled NCAL TPMG's clinical determination that AA is a chronic, systemic condition that should always be coded. But three years had passed and hundreds of thousands of inaccurate, false codes entered before that belated direction was issued. There was no discussion of or action plan developed to address the inaccuracies of the past with the AA diagnosis and HCC capture.

61. Kaiser coded data reports from 2010-2016 shows that the increased AA diagnosis-capture scheme worked – AA diagnoses and coding increased four- and five-fold across all Kaiser regions over that period and spread to all patient populations and payers.

(iii) Chronology and evidence

62. In late 2011, members of Kaiser's National Compliance Office and NCAL Revenue Cycle teams for The Kaiser Foundation Health Plan and Hospitals ("NCAL KFHP") focused attention on the accurate coding of AA as a result of internal inquiries and requests for guidance. After an exchange of emails, members of these teams, including Ms. Bryant and Ms. Hernandez, drafted and published a memo to all Regional HIM Directors and hospital Coding Staff in March 2012 outlining the correct coding convention for AA. *See* Exhibit 2. The memo correctly stated that AA should not be coded except under certain limited conditions (see above).

63. TPMG Director Anne Cadwell, NCAL Revenue Cycle VP David Nyburg, and TPMG Physician Liaison Dr. David Bliss reacted unfavorably to this memo immediately. In calls with Ms. Bryant, they took the position that AA "is always significant and a risk factor so thus they will teach the MDs to document that so it will be coded." *See* Exhibit 3**.** Ms. Bryant noted that she was "troubled" by this approach in an email to Janet Franklin, Kaiser's Senior Compliance Practice Leader in its National Compliance Office. *Id.* Ms. Hernandez and other HIM coding

leaders shared Ms. Bryant's concern. No definitive guidance was provided nor action taken by Kaiser's National Compliance Office.

64. In 2012, TPMG trained its doctors to document AA as if it were always significant, and KFH hospital coding staff to always code AA, as directed by Dr. Bliss and other TPMG Directors (*e.g.*, Anne Cadwell, Karen Graham, and Erica Eastham). In a December 3, 2012 email, TPMG's Ms. Cadwell wrote to Ms. Bryant and Ms. Hernandez that she was concerned that Kaiser Hospital coding staff was not getting the communication about AA: "We need to get everyone on the same page that AA is **not** an incidental finding from a clinical perspective." *See* Exhibit 4 (emphasis in original). Ms. Bryant and Ms. Hernandez felt that they were being strongly pressured to violate coding guidelines and to participate in manipulating documentation and codes.

65. During a December 12, 2012 WebEx/call with TPMG, TPMG Director Ms. Cadwell told NCAL HIM Leadership that the NCAL region would develop and implement a "SMARTPHRASE" for its doctors to add to, or "addend," the patients' electronic files (*e.g.*, in their EPIC electronic health records, called "KP Health Connect") whenever AA was found on a radiology report in order to indicate its significance, even months after the encounter. It was requested that NCAL HIM leadership approve this documentation so that AA would be "always coded." *See* Exhibit 5 (WebEx meeting invitation).

66. The "SMARTPHRASE" developed by TPMG in Kaiser's NCAL region stated as follows: "Aortic Atherosclerosis noted on review of the radiology exam associated with chart review and this visit. Will follow longitudinally as an independent risk factor for CVD and CVA, with management per standard risk factor controls over time by PCP or appropriate specialist." *See* Exhibit 6 at REL0000061. This phrasing was developed in an attempt to satisfy the numerous concerns raised by NCAL HIM Leadership (*i.e.*, Ms. Bryant and Ms. Hernandez) that documentation of AA was required, including language of clinical significance, to pass audit and/or coding compliance testing. But it was clinically false and misleading. AA can be clinically insignificant and incidental and should not always be coded, but Kaiser was training its physicians to always document the clinical significance of the findings so as to cause coders to always code it

without question. In December 2012, NCAL HIM was still waiting for Kaiser's National Compliance Office to provide definitive guidance. In the meantime, Ms. Bryant and Ms. Hernandez made repeated but futile attempts to help TPMG leadership understand the compliant and appropriate documentation for the coding of AA.

67. By January 2013, Dr. Bliss, TPMG Director Ms. Cadwell and other senior management had fully overridden the coding memo issued in March 2012 by NCAL HIM Leadership. Summarizing Kaiser NCAL's new directive for coding AA in the hospital setting, Ms. Bryant emailed Kaiser's National Compliance personnel, including Ms. Franklin, as follows (copying Ms. Hernandez) to alert NCO as to the new direction in the NCAL region: "TPMG takes the position that once AA is present it never goes away and is then a lifelong risk factor …. We (NCAL) do believe that AA meets the criteria to be reportable and does impact care and decision making. To go further with this discussion I believe needs individual with greater clinical knowledge like physicians and would invite TPMG *i.e.* Dr. David Bliss) [sic] to discuss this further." *See* Exhibit 7. Kaiser's National Compliance Office did nothing to stop this new direction.

68. In fact, Ms. Bryant was required to be "supportive," "collaborative," and a "partner" with TPMG's direction for capturing the AA HCC by putting together an educational power point presentation with Dr. Bliss titled "Documentation and Coding Aortic Atherosclerosis Clarification," which they presented during a January 2013 WebEx conference call for NCAL Regional hospital coding staff and Clinical Documentation Integrity Staff (CDI). *See* Exhibit 8**.** The presentation identified AA as an "Area of significant missed opportunity."[1] *Id.* at REL0000069. The presentation adopted TPMG's and Dr. Bliss' position that AA is a "systemic disease" that should always be diagnosed, documented, and coded when identified in a radiology report, and should be added to Kaiser's "Always Code" List (which is a Kaiser National Compliance Office document).

[1] Two years earlier, in a September 2011 power point presentation entitled "Documentation and Coding Leads Meeting," TPMG used the same phrase for capturing AA – "Area of significant missed opportunity" – establishing that capturing the diagnosis had been a long-term focus in the Kaiser NCAL region. *See* Exhibit 9 at REL0000107.

69. Similar presentations were made throughout 2013, 2014 and 2015 to various Kaiser regional leadership audiences. TPMG's AA directive and smartphrase were migrated to Kaiser's other regions and adopted by Kaiser's other Permanente Medical Groups. For example, at Kaiser's Regional Reporting Group ("RRG") meetings, Kaiser regional leaders overseeing its Medicare Advantage programs presented on opportunities and techniques to capture high-yield HCCs, including AA, emulating NCAL TPMG. *See* Exhibit 10 at REL0000137. Similarly, Kaiser NCAL's Revenue Cycle Clinical Documentation Integrity/Improvement ("CDI") included vascular disease (including AA) as an HCC target, and an opportunity to query physicians based on radiology and imaging findings. *See* Exhibit 11 at REL0000179-80.

70. On behalf of NCAL HIM Regional Leadership, Ms. Bryant remained deeply concerned and continued to pursue direction and guidance from Janet Franklin of Kaiser's National Compliance Office, but received none. Moreover, Ms. Bryant and NCAL HIM Regional Leadership, including Ms. Hernandez, continued to question the new direction taken by TPMG leadership regarding AA diagnosis and coding. Due to her continued concern, Ms. Bryant went so far as to submit a question to AHA Coding Clinic, the recognized authority on ICD-9 and ICD-10 coding, on the issue in December 2012. *See* Exhibit 12**.**

71. Kaiser drafted queries to Coding Clinic at least two other times regarding the proper coding of AA (*see* Exhibit 13): In May 2013, Kaiser queried Coding Clinic regarding the status of AA as "a chronic systemic condition." *Id.* at REL0000189. In its May 16, 2013 response, Coding Clinic stated that if the impact of AA were unclear, the physician should be queried. *Id.* Over a year later, in approximately November 2014, Kaiser NCO's Janet D. Franklin, with the assistance of Ms. Bryant, drafted a detailed follow-up question to AHA Coding Clinic: Would AA "be considered a systemic condition that can be coded even in the absence of active intervention in the same way that other systemic diagnoses noted in Coding Clinic (*e.g.* COPD, CHF, Diabetes, Parkinson's Disease, hypertension) may be coded without additional documentation of evaluation, treatment, consideration, etc."? *Id.* at REL0000186-87. Ms. Franklin noted in the attached exhibit that her draft was subject to review by Dr. Simon Cohn, Kaiser's physician lead for The Medical

Group Federation and RRG, and other Kaiser staff. Ms. Bryant was later told by Nancy Anderson of Kaiser's NCO group that the question was never submitted to AHA Coding Clinic based upon a decision by Kaiser leadership, yet another Kaiser decision that caused Ms. Bryant and Ms. Hernandez significant concern.

72. In the meantime, while the Permanente Medical Groups in Kaiser's other regions were following TPMG's practice to always document and code AA, Kaiser's National Compliance Office was taking its time deciding whether that direction was proper. On July 23, 2014, TPMG approached Ms. Bryant and Ms. Hernandez to meet to discuss viewpoints regarding AA capture for Kaiser's National Compliance office. *See* Exhibit 14 (calling the long-delayed meeting "a high priority and time critical").

73. On July 31, 2014, a presentation was given to Kaiser's Coding Governance Group (CGG), which represents all Kaiser Regions, on the topic of AA capture for coding, taking the position that AA should be added to Kaiser's "Always Code List" as a chronic, systemic condition. *See* Exhibit 15 at REL0000220.

74. In 2015, Dr. Simon Cohn, the physician lead for Kaiser's Medical Group Foundation and RRG, requested that Ms. Bryant meet with him face-to-face, but did not provide the topic of the discussion in advance. During the meeting in Dr. Cohn's office, Dr. Cohn asked Ms. Bryant to summarize the events surrounding AA HCC capture at Kaiser, including the TPMG guidance and direction of Dr. Bliss and others, which she did. Dr. Cohn told Ms. Bryant that this issue was being further reviewed by the medical groups. Ms. Bryant told Dr. Cohn that it was not her place to question the clinical and medical interpretations of Dr. Bliss, so she accepted his direction but felt compelled to go to NCO for further and final advice. In the meantime, the improper coding of AA continued throughout Kaiser, with Kaiser physicians being instructed, trained, and prompted to add the HCC diagnosis during or even months after patient encounters through addenda to the medical records.

75. *Finally*, on August 4, 2015, Kaiser's National Compliance Office and Medical Group Federation completed its "clinical review" of TPMG's AA directive, requiring that

it be changed back to the way that Ms. Bryant, Ms. Hernandez and their colleagues in NCAL HIM stated it in 2011 and early 2012: "After having gone through clinical review, AA is not considered a systemic condition and will not appear on the final list of examples of systemic conditions. The clinician must do more than just list this condition. There must be documentation to show how it impacted the current encounter. It will be up to the region to decide if they want to query the provider about this condition when it is only listed. Without a query and additional documentation from the provider to show how it impacted the encounter, it cannot be coded." *See* Exhibit 16 at REL0000224. This information from NCO was shared with Kaiser Coding Leaders as well so that they would be informed and comply with the directive.

(iv) Impact of Kaiser's HCC AA "missed opportunity" directive

76. Kaiser's internal data establishes that its efforts to mine for AA succeeded in capturing and submitting an enormous increase of AA codes to Medicare and other payers, beginning with fewer than 600,000 AA codes captured and submitted in 2010 and culminating in over three million submitted in 2015. AA Dx ("Diagnosis") Frequency Report 2010-2016 (Source: Kaiser internal data aggregated by Ms. Bryant) *see* Exhibit 17 at REL0000226. Medicare claims for HCC 108 (Vascular Disease), the classification that includes AA diagnoses, were among the highest in number and revenue for Kaiser during 2014-2016. *See* Exhibit 18 at REL0000254. (Over 350,000 HCC 108 cases in 2014 submitted for almost $800 million in revenue).

77. In early 2016, Ms. Bryant discovered in the course of ICD-10-CM/PCS national coding quality monitoring and coding validation that Kaiser was still coding AA based upon it being a systemic condition, notwithstanding the August 2015 conclusion of Kaiser NCO rejecting AA as a "chronic, systemic condition." Ms. Bryant, who was at that time working in Kaiser's National Revenue Cycle group, shared this finding with Ms. Hernandez, who was also working for this group at the time. Both Ms. Bryant and Ms. Hernandez were disturbed and troubled. Ms. Bryant brought the AA findings to the attention of Janet D. Franklin and Nancy Anderson of Kaiser NCO. Ms. Bryant requested that the appropriate coding guidance be posted in the National Coding Bulletin Board for all Kaiser Regions to see. She also provided the appropriate

coding advice on AA to regional HIM leaders during leadership forum meetings and requested that each region disseminate the guidance to all appropriate staff and stakeholders, including Kaiser's medical groups.

78. In 2016, after Kaiser had started to pull back the directive, there were still almost two million AA codes submitted across payers. Exhibit 17. In just the first four months of 2016, Kaiser reported to Medicare Advantage over 300,000 cases of vascular disease (HCC 108), which includes the AA diagnosis codes, accounting for almost $700 million. Exhibit 18. Many Kaiser members now have the diagnosis of AA assigned to their clinical profiles incorrectly, potentially impacting patients' future insurance coverage and profile.

79. Ms. Bryant's and Ms. Hernandez believe and therefore allege that Kaiser has never gone back to validate the accuracy of AA documentation and coding for years prior to 2016, and has never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding AA. Moreover, they believe and therefore allege that there has been no specific AA validation of documentation and coding or discussion regarding rebilling or resubmission of corrected claims or data. Indeed, shortly before her retirement from Kaiser in October 2017, Ms. Bryant was asked by NCO's Nancy Andersen to join a coding workgroup to look at AA, as the Kaiser Medical Groups wanted to revisit the issue, *yet again*, of whether the condition is "systemic." Thus, Kaiser continues its efforts to avoid "missed opportunities" with this false documentation and coding.

B. Mechanical Ventilation Dependence Status ("Vent Dependence")

(i) Clinical significance, documentation and coding convention

80. The HCC for "dependence on respirator status" is HCC 82 (linked with ICD-9-CM code V46.11 (Dependence on respirator, status) and ICD-10-CM code Z99.11 (Dependence on respiratory ventilator status)). Dependence on respirator (or ventilator) status is a "status code" that is used when a patient requires long-term, continued ventilator support to breathe beyond the acute care phase. The status code is/was reported for both Medicare Advantage HCCs and HHS

HCCs (*e.g.*, Medicaid under the Affordable Care Act). In 2016, Kaiser received approximately $11,497 for each HCC 82.

81. On February 7, 2014, Coding Clinic stated in a specific response to Kaiser's inquiry – an inquiry initiated by Ms. Bryant with Ms. Hernandez's input – that "this code should be reported when the patient requires continued ventilator support for an unexpected period of time and not for the short-term acute phase of a condition." Coding Clinic further stated that "there is no time frame set on what constitutes ventilator dependency." *See* Exhibit 19.

82. In short, the HCC for vent dependence status should never be coded, and "respirator dependence," "ventilator dependence," "vent status," or similar terminology should never be documented in the medical record, if a patient is weaned from a ventilator during or at the end of an acute short-term stay in the hospital (of whatever length) and discharged home or to a post-acute-care facility without clinically requiring vent support. That does not constitute "vent dependence status." Rather, a patient is vent dependent only if the patient relies on the ventilation to live on a long-term basis *and not for the short-term acute phase of a condition.*

(ii) Kaiser's scheme

83. Kaiser's directives on vent dependence documentation and coding differ region by region, but were all similarly invalid, with regions establishing a "time frame"-based criteria for documenting vent dependence status after which the specific code assignment is permitted. For example, TPMG, the medical group in Kaiser's NCAL region, initially defined the time period as 12 hours or more but later changed it to 30 days or more on a ventilator before the status condition should be documented and then coded irrespective of discharge status or disposition. Kaiser's Southern California PMG only required 21 days as its time-frame criteria for documenting and coding this status.

84. These directives contravened AHA Coding Clinic's caution that there is no "set time frame" and that vent dependence should not be reported for the short-term acute phase of a condition. Kaiser, especially its Permanente Medical Groups, consciously ignores Coding Clinic's response, instead criticizing and rejecting Ms. Bryant's professional coding decision to seek input

from Coding Clinic in the first place, which led to Ms. Bryant being excluded from further coding discussions on this topic and others. By elevating set time periods over actual long-term dependence, Kaiser manipulated the system to over-document and over-code for vent dependence status. Any patient that is on a ventilator for a set period of time is assigned the status code by Kaiser, even if the patient's reliance is neither long-term nor continuous but instead arises from the acute phase of a condition or following a procedure.

85. Moreover, Kaiser ignored its own improper directives by coding for vent dependence status even when patients are on vents for just a few days, then discharged without the vent. Kaiser data shows high volumes of patients being coded for vent dependence status even after being discharged from the acute care hospital without a ventilator, and even for lengths of stay as short as one or two days across four hospital regions, and in the outpatient physician office/clinic setting after discharge.

(iii) Chronology and evidence

(A) October/November 2013

86. Ms. Hernandez and Ms. Bryant were first made aware of Kaiser's vent dependence status documentation and coding practices in the context of newborns that are placed on ventilators temporarily in the hospital before being discharged home. This came about due to the patient population impacting the Affordable Care Act, and questions were raised internally by Regional NCAL HIM leadership (Ms. Bryant, Ms. Hernandez and Dawna Toews) about whether V46.11 (vent dependence status) was appropriate in this circumstance. Ms. Bryant, Ms. Hernandez and Ms. Toews were extremely concerned with the direction that TPMG wanted to take with the V46.11 status code. The three of them discussed the situation and agreed that the status code should be infrequently assigned and coded; given the high number of such codes at Kaiser, it thus appeared that TPMG was focusing on capturing this status code inappropriately.

87. In a series of meetings and emails, chronicled contemporaneously by Ms. Hernandez (*see* Exhibit 20), Ms. Hernandez and Ms. Bryant investigated Kaiser's existing documentation and coding practices, researched the proper coding convention, reached out to

external clinical and coding experts and, on November 21, 2013, submitted email queries to AHA's Nelly Leon-Chisen, Director and Editor of Coding Clinic, and a separate email to Sue Bowman, American Health Information Management Association ("AHIMA") Senior Director of Coding Policy and Compliance. ("AHIMA," like AHA's Coding Clinic, is a neutral organization that can be queried for guidance by coding professionals.)

88. On November 22, 2013, AHIMA's Ms. Bowman responded by email as follows: "V46.11 is intended for 'dependence' on a ventilator – meaning long-term dependence (such as patients with spinal cord injuries or progressive neuromuscular diseases such as multiple sclerosis) – not for short-term use of a ventilator during an acute illness, following surgery, etc. So it seems unlikely that a newborn would be declared ventilator-dependent". *Id.* at REL0000262.

89. On November 25, 2013, Kaiser's NCAL HIM's Regional Coding Review Managers met onsite. All agreed that the vent dependence status code would not be appropriate for newborn initial clinic visits, follow-up clinic visits, or hospital short-term acute care visits, nor if the newborn was weaned and discharged home without ventilation. They concluded and insisted that Kaiser's hospital coding staff should follow and be compliant with official coding guidelines for the assignment of a respiratory/vent status code.

(B) December 2013

90. During a follow-up phone conference on December 3, 2013 attended by Ms. Hernandez and members of TPMG's Encounter Information Operations group ("EIO," a TPMG group that specifically focuses on the Medicare Advantage program and was led at the time by Director Anne Cadwell), the above coding guidance conclusion was rejected over Ms. Hernandez's objection and notwithstanding the references provided, including that Ms. Bryant had submitted an inquiry to AHA Coding Clinic. TPMG stated that it would move forward with capturing vent dependence status if a hospital newborn was placed on ventilation for at least 12 continuous hours,

even if the newborn was successfully weaned from the respirator/ventilator and discharged without a respirator/ventilator.

91. The December 3 directive was followed by a call to Ms. Hernandez on December 4, 2013 from TPMG Director Ms. Cadwell and Dr. Bliss, who focused not on Kaiser's invalid coding of vent dependence or references provided, but on why Coding Clinic was queried by Ms. Bryant in the first place. Ms. Hernandez was required to provide Ms. Bryant's cell phone number so that the TPMG EIO Directors could immediately contact Ms. Bryant once they learned that she was the one who submitted the Coding Clinic query. Dr. Bliss and Ms. Cadwell called Ms. Bryant to rebuke and chastise her for submitting a query to Coding Clinic without notifying TPMG. Both Ms. Hernandez and Ms. Bryant were in Dr. Bliss' "line of fire," and were very distressed. *See* Exhibit 21.

92. Ms. Hernandez and Ms. Bryant were told not to inquire outside Kaiser anymore on such issues without input and approval from Kaiser's Coding Governance Group (CGG). They were warned that outside inquiry would create risk for Kaiser. Once again, pressure and criticism were directed at Ms. Bryant and Ms. Hernandez for not agreeing to TPMG's approach to capturing this diagnosis.

93. On December 8, 2013, Ms. Hernandez was further instructed by TPMG Clinical Documentation Improvement ("CDI") Physician Director Dr. Shirley Cachola, to "use 'respirator dependence' for patients with tracheal intubation until the specifics are clarified by the coding clinic …. Not sure this meets compliance since it is not defined but this is how med. group wishes to proceed for now." Exhibit 22 at REL0000273. Ms. Bryant and Ms. Hernandez believed this instruction to be clear error and unethical, a sentiment echoed by their colleague in the Regional HIM group, Dawna Toews, who questioned how the company could proceed "when it is clearly out of compliance…. I am not inclined to continue working for a company that blatantly ignores guidelines I have promised to follow, and that put me in jeopardy of losing my professional licensing." *Id.* at REL0000269.

94. Ms. Bryant was directed by TPMG to quickly follow-up on the pending response from Coding Clinic on the newborn-specific issue of vent dependence coding. On December 6, 2013, Coding Clinic's Senior Coding Consultant Anita Rapier wrote via email to Ms. Bryant that "code V46.11 (respirator dependence status) is used to describe patients who have been dependent on mechanical ventilation over a period of time. It is not used for newborns who are placed on a vent for a short period." Exhibit 20 at REL0000267.

95. Ms. Bryant sent a follow-up email to Anita Rapier as follows: "Thus if a newborn was placed on a vent for 12 or even 20 hours and then at discharge is NO longer on the vent, we would not assign the V46.11 status code to that discharge/stay." AHA Coding Clinic's Senior Coding Consultant Ms. Rapier responded immediately: "Yes, that is my interpretation." *Id.* at REL0000266. Thus, Coding Clinic corroborated AHIMA's response and Ms. Bryant's and Ms. Hernandez's original conclusion. Coding Clinic's more formal February 7, 2014 response letter to Ms. Bryant, quoted above, confirmed its guidance. *See* Exhibit 19.

96. Contemporaneously, Ms. Bryant and Ms. Hernandez continued to have deep concern and investigated Kaiser's coding practices for vent dependence status both inside and outside of the newborn care context, including for patients in the Medicare Advantage program. They quickly confirmed that they were similar. TPMG in Kaiser's NCAL region required its CDI Physician Director Dr. Cachola, CDI Managers, Susan Ingerbretsen and Donna McIvor (under Dr. Bliss' leadership) to create an acceptable timeline for the capture of vent status code. In Diagnostic Guidelines published in November 2013, TPMG CDI established a "greater than 30 day" rule for vent dependence status: that is, if a patient is receiving respiratory support through intubation for more than 30 days, then vent dependence status should be documented and the code should be assigned, even if the patient is successfully weaned and discharged without a ventilator. Exhibit 23 (TPMG Neonatal Intensive Care Unit Diagnostic Guidelines), at REL0001005.

97. Similarly, in Kaiser's SCAL region, SCPMG's regional CDI program established a 21-day duration of care to constitute vent dependence. Exhibit 24 (HIX Neonatology Documentation and Coding 2014), at REL0001040.

98. The RRG meetings that Ms. Bryant attended often included the capture of specific HCCs, and ventilation status was included on numerous occasions. Kaiser promoted the documentation and capture of the respirator/ventilator dependence code (HCC 82) in education sessions and materials to Kaiser physicians throughout the Kaiser regions. In this way, Kaiser's improper practice for coding the ventilation status code was migrated systemically throughout the Kaiser regions and adopted by all of Kaiser's Permanente Medical Groups, notwithstanding the coding guidance from Coding Clinic and AHIMA.

(iv) Impact of Kaiser's vent dependence practices

99. Kaiser data compiled by Ms. Bryant through her national coding quality monitoring work establishes that the Vent Dependence status code is or was being captured frequently by Kaiser. Medicare Advantage and HHS-HCC payer data specifically indicated a high volume of these codes, particularly in Kaiser's NCAL and SCAL regions. *See* Exhibit 25 and Exhibit 18.

100. The coding data includes a high volume of cases in which patients were successfully weaned from ventilation and routinely discharged home or to self-care, including after just a day or two in the hospital. *See id.*; Exhibit 26 (showing NCAL vent dependence cases). In a December 2013 validation audit, Ms. Hernandez and her NCAL audit team concluded that 100% of a sample of TPMG vent dependence cases were invalid. See Exhibit 27.

101. Data from all Kaiser Regions confirms that the vent dependence coding volume skyrocketed across Kaiser. *See* Exhibit 28 (Kaiser data gathered by Ms. Bryant). *See also* Exhibit 18 (includes vent dependence (HCC 82) data submitted by Kaiser to the Medicare Advantage program from January, 2014 through April, 2016).

102. Kaiser cannot articulate or produce any clinical research, standards or evidence-based medical justification for coding vent dependence status once a patient has been ventilated and removed after a set number of days; for coding vent dependence status even when ventilation is used for far fewer days than the purported thresholds; or for setting different policies for determining ventilation dependence status within the various Kaiser regions.

103. Ms. Bryant and Ms. Hernandez further believe and therefore allege that Kaiser's proprietary, diagnoses electronic "pick list" was being utilized by Kaiser to easily and falsely capture this inaccurate status code in all clinical settings. Moreover, they believe and therefore allege that Kaiser has never gone back to validate the coding to identify incorrect codes, and has never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding vent dependence status. To their knowledge, there has been no validation or discussion for rebilling or resubmission of corrected claims or data.

II. "THE KAISER WAY" IGNORES ESTABLISHED PROCEDURE, INCENTIVIZES GREED, AND CULTIVATES FRAUD

104. At every level and across regions, Kaiser is driven by a corporate culture that demands and rewards financial success from its employees. Kaiser's senior management pushes relentlessly to increase Kaiser's revenue from risk adjustment. The risk adjustment practices described in this Complaint are attributable in large part to these demands and rewards. Ms. Bryant and Ms. Hernandez have witnessed Kaiser's profit-seeking and financial-gaming culture corrode its compliance function over many years, leading to the frauds described herein on the government and its Medicare and Medicaid programs.

A. Kaiser's policies and procedures

105. Kaiser consistently publishes and enforces internal company policies and procedures that contravene coding and diagnostic principles that are widely accepted and enforced within the broader coding community. To avoid detection, Kaiser sometimes labels its instructional documents as "Program Advisories" rather than "policies" in order to circumvent the implications of imposing an improper requirement. But these Advisories are not optional and are enforced like any other policy and procedure within Kaiser.

106. Many of Kaiser's proprietary policies regarding diagnosing and coding are intentionally constructed to be less restrictive than the norm in furtherance of the company's emphasis on profit over compliance. These departures from accepted policy and procedure lead directly to improper documentation, coding and overbilling. Kaiser's Permanente Medical Groups

and Kaiser's Medicare Finance Department initiate and lead this corporate culture, focusing on capturing higher reimbursement without any contravening focus on the avoidance of overbilling.

107. Kaiser's National Compliance Office is ineffective, apprehensive, and slow in investigating and responding to documentation and coding compliance issues. In addition, NCO coding leadership has openly admitted to Ms. Hernandez that the Permanente Medical Groups have significant control over chart audit selection, accuracy rates, documentation guidance, coding policy and practices, all to manipulate the capture of more HCC codes and to increase government payer reimbursement. Instead of turning to NCO, the Permanente Medical Groups asked "Medical Group Regional Compliance" staff for advice about who can be manipulated easily within the region to get the desired result (*e.g.*, more HCC target capture). When NCO completes an internal audit that shows inaccurate or misleading documentation or coding, NCO is pressured and intimidated by the relevant Regional PMG to change the audit's accuracy results.

108. On a system-wide basis, Kaiser has been reluctant to perform historical code correction and billing submission when a problem or issue has been identified that should be rebilled. The culture at Kaiser perpetuates a superiority, manipulation, and intimidation by physician medical group leaders and medical group management, resulting in an inability to challenge or present a different perspective, even when backed by express, unambiguous coding guidelines, standards or HIM coding expertise, without being chastised, threatened and ridiculed.

(i) Query templates

109. Coding professionals are permitted under AHIMA's Standards of Ethical Coding to query physicians/providers for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation. Querying physicians/providers is also permitted after billing (*e.g.*, retrospectively) if performed in a timely manner.

110. But these Standards, as well as AHIMA's Guidelines for Achieving a Compliant Query Practice and AHIMA's Managing an Effective Query Process Practice Brief,

forbid coding professionals and others (e.g., clinical staff, physicians, nursing staff, etc.) who query from "leading" providers to select a particular diagnosis. *See* Exhibit 29.

111. According to AHIMA's Managing an Effective Query Practice Brief, "Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption." Exhibit 30 at REL0000511.

112. In *Health Information Management Compliance: A Model Program for Healthcare Organizations,* AHIMA's Sue Bowman writes that "Communication tools between coding personnel and physicians, such as coding summary sheets, attestation forms, or coding clarification forms (*e.g.*, physician query forms), should never be used as a substitute for appropriate physician documentation in the health record."

113. Nevertheless, some of the Kaiser regions developed sets of query "templates" for clinical documentation improvement (CDI) staff for specific HCC diagnoses to use in concurrent querying of providers that do just that. These improper query templates were used in at least Kaiser's NCAL hospital CDI and Northwest CDI, and perhaps others. There is a cultural reluctance within NCO to give direction and/or require the Kaiser Regions to utilize the Kaiser standard query form language for coding and CDI.

114. The hospital coding staff also utilizes templated physician queries, but these query templates are reviewed and constructed to ensure non-leading language for a variety of diagnoses, regardless of payer type or reimbursement impact. Most of the query reviews of language utilized were under the oversight of Ms. Bryant and guidance of Ms. Hernandez, always utilizing, communicating, and applying the AHIMA direction, guidance and practice briefs.

115. KP NCAL and Northwest CDI query templates developed by TPMG and the Northwest PMG, respectively, many of which involve diagnoses directly linked to HCCs under the Medicare Advantage program and HHS-HCCs under the Affordable Care Act, are designed to be, and are in fact, leading. Through the queries, CDI staff introduce clinical indicators for specific HCC diagnoses to the providers, who in turn routinely follow the suggestion to add a reimbursable

diagnosis where none existed and should not have been added. In Kaiser's NCAL Region, the CDI queries are not made an official permanent part of the record while HIM coding queries are, thus obscuring the role of CDI and improper querying from review.

116. Although the role of CDI staff is to seek clarification from providers for documentation for specific clinical indicators, there has been inconsistent application of the Practice Brief Guidance at Kaiser. These queries are always, or almost always, directed toward an HCC diagnosis for maximizing reimbursement capture and not for overall quality documentation for all clinical situations, all payers, and all patients. In fact, Ms. Bryant recalls on several occasions a stated reluctance from Kaiser's Revenue Cycle leaders to look at documentation and coding both ways – *e.g.*, for both over- and under coding – on the basis that it is too costly and time consuming. Moreover, Kaiser's CDI program is not a "payer agnostic" approach. TPMG in Kaiser's NCAL Region, for example, limits its CDI focus to HCCs only and never expanded to examine severity of illness (SOI) and risk of mortality (ROM) to all patients and to all payers, notwithstanding Ms. Bryant's strong recommendations,

117. Examples of the leading query templates include Kaiser's templates for: obesity/extreme or morbid obesity; protein calorie malnutrition (mild/moderate/severe); pressure ulcer; neoplasm (history versus current); emphysema; depression; adrenal mass; aortic atherosclerosis; diabetes manifestations; neutropenia; sepsis/SIRS with organ dysfunction, and others. *See* Exhibit 31 (improper query templates from Kaiser's Northwest region, operated by the Northwest PMG); Exhibit 32 (TPMG CDI Tip Sheet).

118. Moreover, certain query templates in Kaiser's Northwest Region developed by the Northwest PMG include leading language introducing a diagnosis to the physician, and not including options of "unknown," "other," "clinically undetermined" or "unspecified." They contravene AHIMA's guidance on Achieving a Compliant Query Process, which states that "*Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record, recognizing that there may be only one reasonable option….Multiple choice query formats should also include additional options such as*

'clinically undetermined' and 'other' that would allow the provider to add free text. Additional options such as 'not clinically significant' and 'integral to' may be included on the query form if appropriate."

(ii) Inquiries to AHA Coding Clinic

119. As discussed above in the Vent Dependence Status section, Kaiser chastised and reprimanded Ms. Bryant, Ms. Hernandez and other HIM coding professionals for submitting coding questions directly to the American Hospital Association Central Office for Coding Clinic, a routine and standard of practice for coding professionals across the country. Ultimately, Kaiser instituted and mandated requirements for all AHA Coding Clinic questions, routing them through a rigorous review committee comprised primarily of non-coding professionals and many layers of approval process before submission.

120. Ms. Bryant was directed that any and all coding questions must go through Kaiser's own Coding Governance Group ("CGG"), a group that was and is composed of a majority of physicians and representatives from Kaiser's Permanente Medical Groups rather than coding professionals. In December 2013, Ms. Bryant was told by Kaiser TPMG's senior physician lead Dr. Bliss that she was "putting the organization at risk" by submitting questions directly to Coding Clinic, a sentiment echoed by TPMG Director Anne Cadwell on a call that also included many regional physicians and Revenue Cycle leaders. Ms. Bryant's expertise, professional knowledge and career-long practice of submitting questions to Coding Clinic were thus called into question. Ms. Bryant commented to the group that it was her duty and responsibility as a coding professional, and a standard of practice, to submit questions for coding clarification to AHA Coding Clinic without a committee review.

121. Ms. Bryant expressed concern on the December 2013 call that this internal group lacked coding expertise, and inserted a layer of bureaucracy in an area where Kaiser's National Coding group (led by Ms. Bryant) should have independence and the ability to send unattributed questions to Coding Clinic. Her protests and professional rationale were ignored.

122. Ms. Bryant reported back to Kaiser's NCAL HIM leadership, including Ms. Hernandez and Dawna Toews, regarding this new directive. Her staff was appalled with the outcome of the meeting and felt that their credentials were at risk due to being prohibited from following ethical coding practices to seek and comply with official coding guidelines. *See* Exhibit 22. Under extreme pressure, Ms. Bryant reluctantly complied with the CGG request and worked with NCO's Nancy Andersen to develop a coding questions workflow over the coming years (started in 2014 and finalized in 2015, currently still under revision in 2017).

123. The internal coding question workflow for submitting coding questions to Coding Clinic was discussed during a March/April 2015 conference call/meeting involving NCO's Diana Medal, Nancy Andersen, Ms. Bryant and Ms. Hernandez. The group specifically discussed the restrictive and controlling nature of the CGG directive and how the physician members of the CGG were extremely apprehensive of Ms. Bryant sending questions to Coding Clinic due to their concern that Coding Clinic's response might force Kaiser to change its HCC documentation and HCC capture practices.

124. NCO's Nancy Andersen mentioned that the CGG physician leader, Dr. Annette Guido, was behind the restriction that had been imposed and that she (Ms. Andersen) did not entirely agree with it, but that the physicians' directive had to be followed. Ms. Bryant stated her concerns with the CGG being composed mostly of physicians and not coding experts, a point with which Ms. Andersen agreed. On the same call, Ms. Hernandez discussed her concern that TPMG had been focusing on HCCs and had restricted her in the past from collaborating outside TPMG EIO (*i.e.*, with Ms. Bryant, Ms. Anderson and NCO), much less submit a question to Coding Clinic, and felt that TPMG feared that the Coding Clinic response or guidance would derail its capture efforts of HCC diagnoses. Ms. Andersen stated that she understood but "we have no choice." She stated that it was difficult to get the medical groups and CGG to understand the need to query AHA Coding Clinic directly and freely.

125. When Ms. Hernandez requested a copy of the recording of the conference call several days later, Ms. Medal stated via email that it had been deleted per the instructions of

Ms. Andersen. Ms. Bryant and Ms. Hernandez believe that the recording was deleted due to the fact that many comments were made during the call, including by NCO leadership, that were highly critical of CGG's and TPMG's leadership and practices.

B. Kaiser's emphasis on financial outcomes

126. At every level of the company, Kaiser emphasizes financial results over compliance and accuracy, bending the rules and utilizing gaming strategies to falsely engineer profits.

(i) CDI program and related activities.

127. In late 2009, Kaiser NCAL Revenue Cycle developed its "Clinical Documentation Improvement" program, which it called "Clinical Documentation Integrity" or "CDI," to ostensibly improve its clinical documentation of hospital inpatient medical encounters. This effort was followed by the SCAL and Northwest Regions in the hospital setting. In actuality, Kaiser's CDI programs strive only to improve clinical documentation insofar as it increases HCC capture and Medicare and HHS reimbursement.

128. AHIMA's guidance on CDI programs provides that they are required to address all payers, not just Medicare. In addition, CDI programs should not focus solely on reimbursement. In furtherance of this guidance, the original NCAL CDI program initially developed by Ms. Bryant in 2009 was designed to achieve a payer-agnostic focus by the end of a three-year plan. But Kaiser's CDI program, in practice, has diverged from Ms. Bryant's expertise and design and is definitively not "payer agnostic." It focuses almost exclusively on risk-adjusted payers, such as HHS under the ACA program and CMS under the Medicare Advantage program, and only on documentation impacting HCCs.

129. Ms. Bryant made several requests to expand Kaiser's CDI program to other payers and not to focus solely on HCC reimbursement, but was not successful. In approximately late 2010, Kaiser NCAL Revenue Cycle Vice President Dave Nyburg moved the CDI Program from Ms. Bryant's oversight to his direct oversight. Ms. Bryant believes that this move was made due to

ongoing TPMG discomfort with the direction she wanted to move the program and the pressure and resistance to Ms. Bryant's advice and guidance.

130. Moreover, in the past, Kaiser's CDI program conducted its concurrent documentation reviews by going into prior or old encounters and pulling diagnostic and clinical information to query physicians for the current encounter for HCC diagnosis capture. Again, this contravenes coding guidelines and AHIMA Standards of Ethical Coding under section 4.5: Coding professionals shall not "*Utilize health record documentation from or in other encounters to generate a provider query*." *See* Exhibit 29.

131. For example, Ms. Hernandez received multiple inquiries from CDI leadership and CDI nursing staff as to whether they may use old lab values, clinical indicators and documentation from previous encounters and apply these to send a query about a different, current encounter. Ms. Hernandez has repeatedly told CDI leadership staff that this is not appropriate. But the repeated nature of the inquiries gave rise to Ms. Hernandez's belief that the CDI program was routinely looking backwards; it was highly unlikely that the CDI leadership was getting to every instance and every CDI employee to provide Ms. Hernandez's guidance.

132. For many years, Kaiser's CDI program, especially in the NCAL region, has consistently expressed the value of its work in terms of additional dollars captured, not in improved quality of care, patient safety, severity of illness, improved mortality scores, compliant documentation, or outcomes.

133. For example, in a July 2010 NCAL presentation "CDI Prioritization for Roll Out," Kaiser's NCAL CDI group analyzed the results of an internal audit of inpatient "HCC underpayment." The presentation quantified the impact of the HCC codes that had been "recaptured" in the audit in terms of how much additional revenue that meant for the company. The presentation did not mention compliance or identify any HCC overpayment. *See* Exhibit 33.

134. In a Kaiser NCAL "CDI Program: Update" presentation in December 2011, the company emphasized in its Key Findings that the program had generated year-to-date 2011 revenue of "$27.80 million." *See* Exhibit 11. The presentation even quantified the "Top CDI

Queries" by HCC in terms of the "Revenue Impact" to the company. CDI Program Updates have followed the same format and included these same metrics for many years.

(ii) Kaiser's RRG meetings and Regional Competitions for Revenue/HCC Capture.

135. In approximately 2008-2009, Kaiser formed Regional Reporting Group ("RRG"), comprised of senior personnel from the Health Plan, Permanente Medical Groups and Revenue Cycle of each region with the focus of Medicare Advantage Finance Risk Adjustment. The RRG meetings were initially led by Dr. Simon Cohn until his retirement in 2015, after which the RRG was led by Dr. Annette Guido of Kaiser's Northwest Region, along with Hovannes Daniels, Kaiser's Medicare Finance VP under Kaiser's Health Plan.

136. The RRG meets regularly to share regional "best practices" on how to capture more HCC conditions, diagnoses, and codes, and thus to increase Kaiser revenue. This was and is the top focus of these high-level meetings. Other topics discussed are risk scores and Risk-Adjustment Data Validation (RADV) audits, regulatory changes, comparing regions to each other, and reviewing financial and HCC targets.

137. "Best practices" often contain improper and inaccurate querying, documentation, and coding practices. Certain HCC conditions and diagnoses are specifically targeted at the RRG meetings for their financial impact and discussed and compared with the other regions. Ms. Bryant recalls a RRG meeting where a regional physician leader made a presentation which contained inaccurate documentation and coding information. Ms. Bryant took her concerns about the presentation to Janet D. Franklin of Kaiser's NCO. Ms. Franklin agreed that Ms. Bryant was correct but said that that they could not say anything here at the RRG meeting in front of the Permanente Medical Groups. Ms. Bryant told Janet Franklin that she was concerned with that approach in that there was a large audience in many regions who would think that the presentation had correct information. Ms. Franklin agreed, but said that there was nothing that could be done.

138. Kaiser's various regions, including especially its NCAL (TPMG) and Southern California regions (SCPMG), compete with each other on which region manages to

capture the highest number of HCCs and improved risk scores. Monthly or Bi-monthly WebEx meetings and report outs are generated showing the results of the risk-adjustment metrics, as well as goals and targets for regional HCC capture over the next period. In addition, the regions compete in the third and fourth fiscal quarters each year as to their metrics on capturing chronic conditions and HCCs, and improving scores and revenue, metrics which are also discussed and presented at RGG meetings.

(iii) Employee and management bonuses.

139. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser's NCAL region, including TPMG, gives bonuses to employees and leadership near year-end that are tied to the overall financial goals and success of the Kaiser region. They therefore believe and allege from their experience working in TPMG that bonuses are related, directly or indirectly, to HCC and revenue capture.

(iv) Kaiser's regional medical groups dominate over Kaiser's compliance function.

140. In June 2013, Nancy Andersen, Kaiser's National Compliance manager, told Ms. Hernandez that the regional Permanente Medical Groups choose what and how to be audited. She told Ms. Hernandez that "she knows where the bodies are buried," but that the National Compliance Office has no power over the Permanente Medical Groups. This is exactly the opposite of how the compliance function should operate in a compliant organization. In 2016, Ms. Andersen confirmed to Ms. Bryant that Kaiser's Permanente Medical Groups continue to be "rabid for HCCs" and that Kaiser's NCO group has no power to focus the organization on compliance.

C. Kaiser improperly employs technology to further its HCC and revenue capture.

(i) Data mining.

141. In 2014-2015, Kaiser's TPMG EIO's "data mining" team, comprised largely of out-of-country doctors, used "algorithms" in the NCAL region to identify and capture possible missed HCCs to create "add files," referred to as "missed opportunities" by TPMG. Ms. Hernandez believes and therefore alleges that this practice had been going on for many years.

142. Also in 2014-2015, Ms. Hernandez witnessed TPMG utilizing foreign doctors, who were not licensed as physicians in the United States and may not have had current foreign licenses, to access the clinic encounters. The foreign doctors would send "Dear Doctor" notes via KP Health Connect to the primary care physician asking them to add to (addend) the medical records with HCC diagnoses based on their reviews and using their algorithms, often several months after the encounter.

143. This process was improper and led to HCC payment errors. For example, as part of an NCO audit in 2015, Ms. Hernandez found documentation of sepsis added onto a clinic encounter four months after the patient was seen, with no supporting documentation as to how the HCC diagnosis was determined (*e.g.*, no lab values, signs/symptoms, treatment, clinical indicators, etc.). When Ms. Hernandez shared with her director, Anne Cadwell (TPMG EIO Director), that Ms. Hernandez agreed with NCO's finding that sepsis was improperly coded, Ms. Hernandez was told by Ms. Cadwell "never to agree" with an NCO audit, and if the topic came up, to just say "thank you." Ms. Hernandez asked what to enter in the audit response, given that she agreed with the finding. Ms. Cadwell instructed Ms. Hernandez not to talk at the audit exit call and to only speak when Ms. Cadwell asked Ms. Hernandez to say something.

(ii) Improper Carry-Over From Prior Years.

144. In 2014-2015, Ms. Hernandez discovered that in Kaiser's NCAL TPMG region, Kaiser's "Business Intelligence Team" ("BIT") generated questionable "block" files and "add" files for resubmission to CMS based on algorithms. The addenda process they used may have improperly carried over HCCs from previous years to the current year without physician validation or a face-to-face encounter.

145. Ms. Hernandez was part of the TPMG EIO Director email distribution list where medical record diagnoses files were emailed to the directors asking for approval for "add" or "block" files, which Ms. Hernandez never approved. To Ms. Hernandez' knowledge, "add" (or "addenda") files were created based on algorithms run by the BIT team (*e.g.*, diabetes with manifestations, etc.), and automatically carried from the previous year to the current year's problem

list even where patients were not seen face-to-face as required under the Medicare Advantage program.

(iii) Computer Assisted Coding

146. Computer Assisted Coding (CAC) is a natural language processing technology utilized as a tool to assist the coding professional to confirm and select ICD and CPT codes based on words and language used in the medical record. CAC identifies wording and/or full sentences within the electronic health record which contains signs, symptoms, diagnoses and procedures for which a code may possibly be assigned once confirmed and validated by the coding professional. CAC was identified and implemented by Kaiser as a valuable tool and asset to increase coding productivity, coding accuracy, and HCC capture.

147. In approximately 2013, during the pilot phase of CAC implementation in Kaiser's NCAL region, Ms. Hernandez conducted auditing and validation of the resulting diagnoses and codes, along with Ms. Sheryl Roy (Regional NCAL HIM employee at the time). Ms. Hernandez and Ms. Roy determined that CAC was capturing and overcoding diagnoses with an overall poor accuracy rate (60% or less). They shared their findings with Ms. Bryant, who agreed with their concerns.

148. During a CAC quality assurance meeting, which was held via recorded webex, Ms. Bryant, Ms. Hernandez and Ms. Roy reported their audit findings and concerns to NCAL Revenue Cycle Charge Capture Manager, Gina Sandler, and Revenue Cycle Integrity Director, Diane Ott, who were members of Kaiser's CAC implementation team. Ms. Sandler typed meeting minutes during the call. Ms. Hernandez and Ms. Roy later discovered that the audit results and their concerns had been excluded from the meeting minutes. Moreover, they discovered that Ms. Sandler and Ms. Ott had manipulated the actual audit results to indicate a higher accuracy rate. Ms. Hernandez and Ms. Bryant believe and therefore allege that the audit results were manipulated and their concerns were ignored so as to avoid identification of any problems with CAC which might delay its full implementation at Kaiser. Ms. Bryant and Ms. Hernandez voiced their concerns to

NCAL Revenue Cycle Leadership and to Kaiser's NCO leadership (Ms. Anderson), but were ignored.

149. Ultimately, Kaiser's CAC implementation moved forward in 2014 on outpatient and inpatient encounters. After 18 months to two years of constant problems with CAC, the hospital coding and auditing staff expressed outrage with the continued inaccuracy and their mistrust of the CAC tool. These complaints resulted in NCAL Revenue Cycle Leadership finally discontinuing CAC in hospital outpatient encounters in 2016.

150. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser never went back to correct the many inaccurate codes generated by the Kaiser's flawed CAC processes.

D. The Kaiser Defendants Acted With Intent.

151. The Kaiser Defendants acted with intent in over-charging the United States and retaining and failing to return such overpayments. Kaiser's entire corporate culture is built around "mining for", "gaming" and "capturing" codes even when they are not validly supported or documented, training its physicians to over-diagnose and falsely document diagnoses, elevating its profits over its compliance function, and motivating employees through the setting of metrics and, upon information and belief, utilizing bonuses for successful code and revenue capture. The specific schemes described above engineered by Kaiser regarding aortic atherosclerosis, vent dependent status, and others evidence Kaiser's intentional, systematic efforts to circumvent proper documentation and coding practices and Medicare law. Moreover, although Kaiser has a National Compliance Office with hundreds of staff, there are huge holes and gaps in the effectiveness of its compliance program, which is subverted to the profit goals of Kaiser's medical groups.

E. Kaiser's Fraud Was and Is Material to the Government's Payment Decision

152. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, has paid money that it otherwise would not have paid. For example, CMS would have refused to make risk adjustment payments, in whole or in part, to the Kaiser Defendants if it had known that the Kaiser Defendants were falsifying documentation and coding as alleged in this

Complaint. The fraudulent diagnostic data and coding submitted by the Kaiser Defendants constituted a substantial portion of all of the diagnostic data and coding submitted by the Kaiser Defendants to the government. Given that diagnostic data and coding is the sole determinant in the calculation of any risk adjustment payment based on a beneficiary's health status, the government's payment decision necessarily would have been different had the government known that the data and coding were false.

153. Moreover, CMS makes reconciliation payments to the Kaiser Defendants based on the diagnostic data submitted. Those payments are adjusted to account for invalid diagnoses codes that providers such as Kaiser submit. If the Kaiser Defendants had complied with their obligation to delete invalid diagnoses from RAPS, Medicare would have processed the corrected data, recalculated the risk score for the beneficiaries, and the risk adjustment reconciliation payment system would have made the corresponding payment adjustment. But when the Kaiser Defendants did not delete invalid diagnoses from RAPS, Medicare paid for the invalid diagnoses as part of its final reconciliation payment to the Kaiser Defendants. If the Kaiser Defendants had corrected their invalid diagnoses, CMS would have processed the corrected data to produce accurate risk scores for beneficiaries, which necessarily would have changed the risk adjustment payments for those beneficiaries.

154. The risk adjustment attestations submitted by the Kaiser Defendants each year are a reminder to the Kaiser Defendants of their obligation to submit valid data and to promptly correct invalid data. They also have a direct impact on the government's risk adjustment payments. For example, if CMS knew that the Kaiser Defendants' attestations were false, CMS's risk adjustment payments would have changed in that CMS would have refused to make risk adjustment payments to the Kaiser Defendants, in whole or in part.

155. The materiality of the Kaiser Defendants' fraud is further established by the fact that the United States has filed suit against Kaiser in this case and against other managed care organizations over similar documentation and coding fraud as alleged herein.

FIRST CLAIM FOR RELIEF

False Claims Act: Presentation of False or Fraudulent Claims

U.S.C. § 3729(a)(1)(A) (formerly 31 U.S.C. § 3729(a)(1))

156. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 208 above as though they are fully set forth herein.

157. Defendants violated 31 U.S.C. § 3729(a)(1)(A) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. 3729(b)(1)) presented or caused to be presented a false or fraudulent claim for payment or approval. Specifically, Defendants knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the Medicare Program.

158. Defendants violated former 31 U.S.C. § 3729(a)(1) as follows: Defendants knowingly presented, or caused to be presented, to the United States a false or fraudulent claim for payment or approval. Specifically, Defendants knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the Medicare Program.

159. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

160. By virtue of the said false or fraudulent claim, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

SECOND CLAIM FOR RELIEF

False Claims Act: Making or Using False Records or Statements

U.S.C. § 3729(a)(1)(B) (formerly 31 U.S.C. § 3729(a)(2))

161. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 213 above as though they are fully set forth herein.

162. Defendants violated 31 U.S.C. § 3729(a)(1)(B) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation material to a false or fraudulent claim for risk adjustment payments from the Medicare Program.

163. Defendants violated former 31 U.S.C. § 3729(a)(2) as follows: Defendants knowingly made, used, or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the United States. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation to get a false or fraudulent claim for risk adjustment payments paid or approved by the Medicare Program.

164. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

165. By virtue of the said false record or statement, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

THIRD CLAIM FOR RELIEF

False Claims Act: Conspiracy

U.S.C. § 3729(a)(1)(C) (formerly 31 U.S.C. § 3729(a)(3))

166. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 218 above as though they are fully set forth herein.

167. Defendants violated 31 U.S.C. § 3729(a)(1)(C) as follows: Defendants conspired with one another to commit a violation of 31 U.S.C. § 3729(a)(1)(A), (B), and/or (G), as those violations are specifically alleged in Claims I, II, and IV of this Complaint.

168. Defendants violated former 31 U.S.C. § 3729(a)(3) as follows: Defendants conspired with one another to defraud the United States by getting a false or fraudulent claim allowed or paid. Specifically, Defendants conspired with one another to defraud the United States

by getting risk adjustment payments from the Medicare Program based on a false or fraudulent claim for risk adjustment payments and/or a false or fraudulent Risk Adjustment Attestation.

169. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

170. By virtue of the said conspiracy, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

FOURTH CLAIM FOR RELIEF

False Claims Act: Reverse False Claims

U.S.C. § 3729(a)(1)(G) (formerly 31 U.S.C. § 3729(a)(7))

171. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 223 above as though they are fully set forth herein.

172. Defendants violated 31 U.S.C. § 3729(a)(1)(G) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation material to an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program.

173. Defendants also violated 31 U.S.C. § 3729(a)(1)(G) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) concealed or improperly avoided or decreased an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly concealed or improperly avoided or decreased an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program.

174. Defendants violated former 31 U.S.C. § 3729(a)(7) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit

money or property to the United States. Specifically, Defendants knowingly made, used, or caused to be made or used, a false Risk Adjustment Attestation to conceal, avoid or decrease an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program.

175. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

176. By virtue of the said false record, statement, and other acts of concealment and improper avoidance, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

FIFTH CLAIM FOR RELIEF

False Claims Act: Relief From Retaliatory Actions Against Defendant TPMG

U.S.C. § 3730(h)

177. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 246 above as though they are fully set forth herein.

(a) 31 U.S.C. § 3730(h), Relief From Retaliatory Actions, provides:

(i) In general.— Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, or agent on behalf of the employee, contractor, or agent or associated others in furtherance of other efforts to stop 1 or more violations of this subchapter.

(ii) Relief.— Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs

and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection.

178. Ms. Hernandez was employed by the Kaiser Defendants from June 1995 through October 2015. From January 2000 forward, Ms. Hernandez's was employed in various coding leadership positions.

179. Ms. Hernandez received stellar employment reviews throughout her career with Kaiser until she was hired into Kaiser's TPMG organization. In her last year of Kaiser employment (October 2014 through October 2015), the only year that she worked at Kaiser's TPMG subsidiary, Ms. Hernandez was criticized for purported lack of communication and, at the same time, also reprimanded for communicating her concerns about TPMG's coding and auditing functions.

180. This review came after, and was the direct result of, Ms. Hernandez observing and reporting internally several of the coding errors and systemic fraud detailed herein committed at and by Kaiser and its affiliates, including TPMG.

181. The poor review was improper retribution for Ms. Hernandez's efforts to bring to the attention of leadership the deceptive and fraudulent practices within Kaiser. She was set up to be terminated for reporting what she observed even though she had been asked by TPMG leadership to stop looking for another job. Ms. Hernandez felt harassed, disrespected, and bullied. She was subjected to threats and intimidation by TPMG leadership.

182. In October 2015, in anticipation of being terminated, and due to Kaiser TPMG's intimidation and harassment, she resigned her position with Kaiser.

183. Ms. Hernandez engaged in protected activity by, among other things, reporting to multiple Kaiser supervisors her concerns that Kaiser was submitting illegal, unlawful and/or false claims to the Government in an effort to stop Kaiser from presenting or causing to be presented to the Government false or fraudulent claims for payment or approval, and from making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim.

184. Kaiser TPMG knew that Ms. Hernandez engaged in the above described protected activity.

185. Kaiser TPMG discharged, demoted, threatened, harassed, and otherwise discriminated against Ms. Hernandez as a result of her protected activities.

186. As a result of Kaiser's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

SIXTH CLAIM FOR RELIEF

Violation of Cal. Lab. Code § 1102.5, *et seq.* Against Defendant TPMG

187. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 256 above as though they are fully set forth herein.

188. In violation of Cal. Lab. Code § 1102.5, Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms. Hernandez for having opposed, resisted, and complained of the acts alleged herein.

189. Defendant TPMG retaliated against Ms. Hernandez for opposing and refusing to participate in Defendant's violations of state and federal statutes and/or rules and regulations. In contesting Defendant's violations, Ms. Hernandez was engaged in protected activity. Under Cal. Lab. Code § 1102.5, Defendant TPMG is prohibited from retaliation against Ms. Hernandez for opposing any practices forbidden or made unlawful under Cal. Lab. Code § 1102.5.

190. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms. Hernandez's rights, entitling her to an award of punitive damages.

191. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages,

including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

SEVENTH CLAIM FOR RELIEF

Violation of Cal. Lab. Code § 98.6 Against Defendant TPMG

192. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 261 above as though they are fully set forth herein.

193. In violation of Cal. Lab. Code § 98.6, Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms. Hernandez for having opposed, resisted, and complained of the acts alleged herein.

194. After Ms. Hernandez complained about and objected to Kaiser's practices detailed herein and in response to such complaints and objections, Defendant TPMG subjected her to ongoing retaliation, including but not limited to ostracism and the threat of termination.

195. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms. Hernandez's rights, entitling her to an award of punitive damages.

196. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

EIGHTH CLAIM FOR RELIEF

Violation of Fair Labor Standards Act Against Defendant TPMG

29 U.S.C. § 215

197. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 266 above as though they are fully set forth herein.

198. In violation of the Fair Labor and Standards Act of 1939 ("FLSA"), Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms.

Hernandez in constructively discharging her for having opposed, resisted, and complained of the acts alleged herein, including numerous violations of federal law and rules and regulations.

199. In making the above-described internal complaints, Ms. Hernandez was engaged in a protected activity under the FLSA. Defendant TPMG willfully continued to mask its violations after Ms. Hernandez apprised Defendant of the extent of Defendant's non-compliant practices. Ms. Hernandez subsequently suffered an adverse employment action when she was constructively discharged from her employment by Defendant in retaliation for making said complaints and refusing to accede to Defendant's masking of its unlawful practices.

200. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms. Hernandez's rights, entitling her to an award of punitive damages.

201. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

PRAYER

WHEREFORE, *qui tam* plaintiffs Gloryanne Bryant and Victoria M. Hernandez pray for judgment against Defendants as follows:

On Claims I, II, III, and IV (False Claims Act), against all Defendants jointly and severally:

- for the amount of the United States' damages, trebled as required by law, together with the maximum civil penalties allowed by law, costs, post-judgment interest, and such other and further relief as the Court may deem appropriate;
- for Relators to be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) of the Federal False Claims Act;
- for Relators to be awarded all costs of this action, including attorneys' fees and expenses;

- and for the United States and Relators to receive all such other relief as the Court deems just and proper.

Further, on Claims V, VI, VII, and VIII, Plaintiff-Relator Ms. Hernandez, on her own behalf, demands that judgment be entered in her favor and against Defendant The Permanente Medical Group, Inc. granting the following relief:

- An award of back pay with prejudgment interest;
- An award of front pay in lieu of reinstatement;
- An award of general damages to compensate Ms. Hernandez for the mental and emotional distress caused by Defendant TPMG's misconduct;
- An award of punitive damages to deter and punish Defendant TPMG;
- An award of double, treble, exemplary, and/or punitive damages pursuant to 31 U.S.C. § 3730(h)(2), the California Labor Code, and the FLSA;
- An award of attorneys' fees and costs pursuant to 31 U.S.C. § 3730(h)(2), the California Labor Code, and the FLSA; and
- An award of such other and further relief as this Court deems just and proper.

DEMAND FOR JURY TRIAL

Relators hereby demand a trial by jury as to all issues.

Dated: November 15, 2021

Respectfully submitted,

GLORYANNE BRYANT and
VICTORIA M. HERNANDEZ

By /s/ Roger A. Lewis

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Counsel for Plaintiffs-Relators

No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
VOLUME 4 of 9

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Attorneys for Plaintiffs and Appellants,
Marcia Stein and Rodolfo Bone

TAB 16

EXHIBIT 1

Incidental finding on radiology reports for outpatient encounter

ICD-9-CM Coding Clinic, **Third Quarter 2010** Pages: 8-9 Effective with discharges: October 1, 2010

Question:

We are requesting guidance on coding incidental findings found on radiology reports during outpatient encounters. For example, a patient is seen in the emergency department (ED) for chest pain and a computed tomography (CT) of the chest and abdomen are performed. The CT of the abdomen was performed to rule out any type of gastritisassociated chest pain. The impression on the CT is normal except for "single renal cyst." The cyst is not documented anywhere else on the ED record, nor does it appear to be related to the reason why the CT was initially performed.

Are we correct in interpreting existing guidelines and previous *Coding Clinic* advice that findings from x-rays performed on patients in the ED should not be coded except to gain greater specificity for an already diagnosed condition? Do you agree that it is the responsibility of the ED physician to document the relevance and pertinence of each diagnosis in his/her final impression? To us, this is different than the guidelines we follow for coding outpatient diagnostic tests when the patient presents to the ancillary department specifically for a particular test and interpretation. There is no other physician involved to 'coordinate' the care, treatment, and diagnosis of the patient like there is when the patient presents to the ED and gets these tests performed.

Answer:

It is inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test for a patient being seen in the emergency department (ED). The ED physician would need to clarify that the finding was clinically significant and related to the visit in order for it to be coded.

Outpatient chest x-ray (radiology) coding

ICD-10-CM/PCS Coding Clinic, **First Quarter ICD-10 2017** Page: 7 Effective with discharges: March 13, 2017

Related Information

Question:

The physician refers a patient for chest x-ray to outpatient radiology with a diagnosis of weakness and chronic myelogenous leukemia (CML). The radiology report demonstrated no acute disease and moderate hiatal hernia. For reporting purposes, which codes are appropriate for the facility to assign?

Answer:

The facility should assign code R53.1, Weakness, and code C92.10, Chronic myeloid leukemia, BCR/ ABL-positive, not having achieved remission, for this encounter. It is not appropriate to report code K44.9, Diaphragmatic hernia without obstruction or gangrene, for the hiatal hernia, because it is an incidental finding.

EXHIBIT 2

revenueCYCLE NORTHERN CALIFORNIA

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Date: March 1, 2012

To: NCAL HIM Directors, HIM Coding Staff

Cc: Regional Coding Review Managers
Gloryanne Bryant, NCAL Managing Director HIM
Dawna Toews, NCAL Regional Assoc. Director of Hospital Coding
Dexter D'Costa, NCAL Regional Director of CDI
Helena Rush, NCAL Regional Manager of CDI QA

From: Nancy J Andersen, Regional Director of Hospital Coding

Subject: Coding Aortic Atherosclerosis

One of the roles of Regional HIM is to assist with providing coding guidance to questions that occur repeatedly. Some concern has been raised to us by HIM coding staff regarding the coding of "aortic atherosclerosis" as a secondary diagnosis. This memo has been developed to provide guidance to the HIM coding staff in the correct assignment of aortic atherosclerosis as a secondary diagnosis.

Overview:
There have been recent discussions among HIM and CDI staff regarding the appropriate capture of aortic atherosclerosis as a secondary diagnosis. Input was sought from Janet D. Franklin of Kaiser's National Compliance Office (NCO). Based on a discussion held with NCO, Regional HIM and CDI QA leadership, the following criteria is to be used when determining whether or not to assign aortic atherosclerosis as a secondary diagnosis.

The determination as to whether or not aortic atherosclerosis (AA) documented on radiology reports should be considered an incidental finding is dependent upon the following:

- Was the purpose of the diagnostic radiology exam **specifically** to look for or diagnose AA? If the physician does not indicate the significance and/or relevance of the aortic atherosclerosis to the admission or encounter, it is considered an incidental finding and should not be coded. This is in keeping with AHA *Coding Clinic* advice which states incidental findings in a radiology report are not to be coded when they are unrelated to the sign, symptom, or condition that necessitated the performance of the test.

- If the AA is an incidental finding on the radiology report because the study was not performed specifically to look for AA, review the documentation to determine if any of the following is present:

  a. Treatment directed towards the AA such as medication prescribed?

  b. Required follow up documented by the physician?

  d. Other indication that the AA was evaluated by the physician beyond stating "the patient has AA"?

If none of the above conditions are met, the AA is considered an incidental finding and the physician should **not** be queried about it **nor should it be coded**. It is the responsibility of the physician to document the relevance and pertinence of each diagnosis in his/her documentation.

References:

AHA *Coding Clinic,* Third Quarter 2010, pages 8-9:

"It is inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test for a patient being seen in the emergency department (ED). The ED physician would need to clarify that the finding was clinically significant and related to the visit in order for it to be coded."

AHA *Coding Clinic,* Second Quarter 1990, pages 15 – 16:

> *Abnormal findings (laboratory, X-ray, pathologic, and other diagnostic results) are not coded and reported unless the physician indicates their clinical significance. If the findings are outside the normal range and the physician has ordered other tests to evaluate the condition or prescribed treatment, it is appropriate to ask the physician whether the diagnosis should be added.*

The coder should not arbitrarily add an additional diagnosis ….on the basis of an abnormal laboratory finding alone. To make a diagnosis on the basis of a single lab value or abnormal diagnostic finding is risky and carries the possibility of error. Is this from Coding Clinic or guidelines?

Action Required: Immediate distribution to all HIM coders and CDI QA staff

If you have any questions please contact me directly via email at: nancy.j.andersen@kp.org or via phone at 510 625-5674. Thank you.

EXHIBIT 3

Aortic Atherosclerosis - Confidential
Gloryanne H Bryant to: Janet D Franklin
Cc: Nancy J Andersen, Dawna M Toews
Default custom expiration date: 03/02/2015

03/09/2012 02:38 PM

Janet, I'm not sure I should even email you about this.....So now another question about this issue of Aortic Atherosclerosis.....hearing from Dr Bliss this afternoon ... he just told us that "aortic atherosclerosis" is always significant and a risk factor so thus they will teach the MDs to document that so it will be coded.

So the clinical documentation improvement (CDI) program will query for significance if it's not there.
Of course AA it's an HCC too.
I'm a little troubled by this approach and I believe Nancy is also.
Maybe we should ask Dr Bliss about the clinical studies that indicate ANY degree of aortic atherosclerosis puts the patient at risk?

Gloryanne Bryant, RHIA, CCS, CCDS
Certified ICD-10-CM/PCS Trainer
Regional Managing Director HIM
NCAL Revenue Cycle
Kaiser Foundation Health Plan Inc & Hospitals
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510 625-3980 (tel)
510 625-5701 (fax)
Admin Asst: Shirley Palmer #510 625 4945
email: Gloryanne.h.bryant@kp.org
Please visit the NCAL HIM resources, tools and information online at our wiki:
http://wiki.kp.org/wiki/x/fYDGBQ
BRING SAFETY TO WORK: Know the Basics; Look for Causes; Let Someone Know; Work Safely; and Ask For Help
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EXHIBIT 4

Re: Fw: phi -- addending aortic atherosclerosis

Gloryanne H Bryant to: Anne V Cadwell, Rebecca J Robinson 12/03/2012 03:36 PM

Cc: David Bliss, David L Nyburg, Diane Ott, Karen Graham, Sylvia Delacadena, Victoria M Hernandez

Default custom expiration date: 03/02/2015

Hi there, yes we can discuss this specific documentation and coding situation. Rebecca can you set up a mtg to discuss this. I believe this week is packed, so maybe early next week would work.

Gloryanne Bryant, RHIA, CCS, CDIP, CCDS
AHIMA Approved ICD-10-CM/PCS Trainer
Regional Managing Director HIM
NCAL Revenue Cycle
Kaiser Foundation Health Plan Inc & Hospitals
1800 Harrison St. 24th Floor, Oakland, CA 94612
510 625-3980 (tel)
510 625-5701 (fax)
email: Gloryanne.h.bryant@kp.org
Please visit the NCAL HIM resources, tools and information online at our wiki:
http://wiki.kp.org/wiki/x/fYDGBQ
BRING SAFETY TO WORK: Know the Basics; Look for Causes; Let Someone Know; Work Safely; and Ask For Help
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Anne V Cadwell Hi Gloryanne and Victoria It seems that we conti... 12/03/2012 11:45:50 AM

From: Anne V Cadwell/CA/KAIPERM
To: Gloryanne H Bryant/CA/KAIPERM, Victoria M Hernandez/CA/KAIPERM@KAIPERM
Cc: Sylvia Delacadena/CA/KAIPERM@Kaiperm, David Bliss/CA/KAIPERM@KAIPERM, Karen Graham/CA/KAIPERM@Kaiperm, David L Nyburg/CA/KAIPERM@KAIPERM, Diane Ott/PO/KAIPERM@Kaiperm
Date: 12/03/2012 11:45 AM
Subject: Fw: phi -- addending aortic atherosclerosis

Hi Gloryanne and Victoria

It seems that we continue to have communication issues at the local HIM level re Aortic Atherosclerosis. Do you think we could set up a call with all the local HIMS directors to discuss this? We are asking our physicians to do addendums to clarify any documentation. We do not want to wait until next year - as the HIMs person is suggestion below. We do want not want to perform retrospective reviews - we have worked very hard to get current on everything we do. We need to get everyone on the same page that AA is not an incidental finding from a clinical perspective. Can we set up a call this week?

I am arranging a call with the ED physician at GSAA - no need for you to call them.

Thanks - We really need to be aligned on this. If you have a better approach - let us know.

Anne V. Cadwell
Managing Director
The Permanente Medical Group
1950 Franklin St., 16th floor
Oakland, CA 94612
Office: 510-987-2774
Fax: 510-873-5244
Cell: 510-735-7561

Executive Assistant: Celina.M.Hodges 510-987-2771

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----- Forwarded by Anne V Cadwell/CA/KAIPERM on 12/03/2012 11:33 AM -----

From: Sylvia Delacadena/CA/KAIPERM
To: Anne V Cadwell/CA/KAIPERM@KAIPERM
Date: 12/03/2012 11:30 AM
Subject: Fw: phi -- addending aortic atherosclerosis

Here you go.....

Please advise.

Sylvia Delacadena |Manager, TPMG Business Services /Controller's Office |Office: 510.675.5544, Tie Line: 8.434.5544|Mobile: 510.427.3274

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----- Forwarded by Sylvia Delacadena/CA/KAIPERM on 12/03/2012 11:29 AM -----

From: Kamar F Braish/CA/KAIPERM
To: Christopher A Wan/CA/KAIPERM@Kaiperm
Cc: Sylvia Delacadena/CA/KAIPERM@Kaiperm, Jonathan Hall/CA/KAIPERM@KAIPERM, Ashley N Case/CA/KAIPERM@KAIPERM, Pam Grewal/CA/KAIPERM@Kaiperm, Phil Wald/CA/KAIPERM@KAIPERM, Lucy A Martinez, Scott Tafuri/CA/KAIPERM@KAIPERM, Merritt Quisumbing-Anderson/CA/KAIPERM@KAIPERM, Charles Thevnin/CA/KAIPERM
Date: 12/03/2012 09:14 AM
Subject: Re: phi -- addending aortic atherosclerosis

Hi Dr. Wan:

I agree with you so I checked with region and they confirmed that under Medicare Advantage reporting guidelines we can report HCC dx up for a year later, since MA works on a calendar year and not individual encounters, so that is allowed and that is why we can perform retrospective HCC capture. Moving forward this has to stop since we are sending bills and doing an HCC capture for Medicare so the government will be looking and comparing our data. This work should be guided by the TPMG CMS Auditors lead by Pam.

Sylvia: all additions have to be compliant and the below is not acceptable to Coding compliance. Please work with Pam before requesting physicians to add diagnosis.

I had Victoria regional coding review manager take a look at this case below and here is what she found:

After reviewing the record, no I would NOT code the 440.0 Aortic Atherosclerosis since it does not meet UHDDS definition of "other diagnosis." It appears to be an incidental finding from the radiology report and AA was not mentioned, treated or followed-up anywhere else throughout the record. In addition, the radiology report was not ordered specifically to look for AA. This would be in line with our instructions from the regional guidance memo on when to code Aortic Atherosclerosis. I'm attaching our guidance memo from March 2012 just for reference. Thanks, Kamar and let me know if I can help with anything else. Thanks.

[attachment "Coding+Guidance+Memo+-+Aortic+Atherosclerosis3.2012.pdf" deleted by Gloryanne H Bryant/CA/KAIPERM]

VICTORIA M. HERNANDEZ, RHIT, CCS, CRCR, AHIMA-Approved ICD-10-CM/PCS Trainer

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Christopher A Wan Kamar, I think we could use some guidance and... 12/01/2012 08:29:20 AM

EXHIBIT 5

Date: Wednesday, December 12, 2012
Time: 3:00 pm, Pacific Standard Time (San Francisco, GMT-08:00)
Meeting Number: 570 398 298
Meeting Password: Addending101

To start or join the online meeting

Go to
https://kponline.webex.com/kponline/j.php?ED=217792652&UID=494591302&PW=NMGY5NGViN2I0&RT=MiM0

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Access code:570 398 298

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Anne V Cadwell Hi Gloryanne and Victoria It seems that... 12/03/2012 11:45:50 AM

From: Anne V Cadwell/CA/KAIPERM
To: Gloryanne H Bryant/CA/KAIPERM, Victoria M Hernandez/CA/KAIPERM@KAIPERM
Cc: Sylvia Delacadena/CA/KAIPERM@Kaiperm, David Bliss/CA/KAIPERM@KAIPERM, Karen Graham/CA/KAIPERM@Kaiperm, David L Nyburg/CA/KAIPERM@KAIPERM, Diane Ott/PO/KAIPERM@Kaiperm

Date: 12/03/2012 11:45 AM
Subject: Fw: phi -- addending aortic atherosclerosis

Hi Gloryanne and Victoria

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Thanks - We really need to be aligned on this. If you have a better approach - let us know.

Anne V. Cadwell
Managing Director
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Cell: 510-735-7561

Executive Assistant: Celina.M.Hodges 510-987-2771

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----- Forwarded by Anne V Cadwell/CA/KAIPERM on 12/03/2012 11:33 AM -----

From: Sylvia Delacadena/CA/KAIPERM
To: Anne V Cadwell/CA/KAIPERM@KAIPERM
Date: 12/03/2012 11:30 AM
Subject: Fw: phi -- addending aortic atherosclerosis

Here you go.....

Please advise.

Sylvia Delacadena |Manager, TPMG Business Services /Controller's Office |Office: 510.675.5544, Tie Line: 8.434.5544|Mobile: 510.427.3274

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Date: 12/03/2012 11:30 AM
Subject: Fw: phi -- addending aortic atherosclerosis

Here you go.....

Please advise.

Sylvia Delacadena |Manager, TPMG Business Services /Controller's Office |Office: 510.675.5544, Tie Line: 8.434.5544|Mobile: 510.427.3274

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----- Forwarded by Sylvia Delacadena/CA/KAIPERM on 12/03/2012 11:29 AM -----

From: Kamar F Braish/CA/KAIPERM
To: Christopher A Wan/CA/KAIPERM@Kaiperm
Cc: Sylvia Delacadena/CA/KAIPERM@Kaiperm, Jonathan Hall/CA/KAIPERM@KAIPERM, Ashley N Case/CA/KAIPERM@KAIPERM, Pam Grewal/CA/KAIPERM@Kaiperm, Phil Wald/CA/KAIPERM@KAIPERM, Lucy A Martinez, Scott Tafuri/CA/KAIPERM@KAIPERM, Merritt Quisumbing-Anderson/CA/KAIPERM@KAIPERM, Charles Thevnin/CA/KAIPERM
Date: 12/03/2012 09:14 AM
Subject: Re: phi -- addending aortic atherosclerosis

Hi Dr. Wan:

I agree with you so I checked with region and they confirmed that under Medicare Advantage reporting guidelines we can report HCC dx up for a year later, since MA works on a calendar year and not individual encounters, so that is allowed and that is why we can perform retrospective HCC capture. Moving forward this has to stop since we are sending bills and doing an HCC capture for Medicare so the government will be looking and comparing our data. This work should be guided by the TPMG CMS Auditors lead by Pam.

Sylvia: all additions have to be compliant and the below is not acceptable to Coding compliance. Please work with Pam before requesting physicians to add diagnosis.

I had Victoria regional coding review manager take a look at this case below and here is what she found:

After reviewing the record, no I would NOT code the 440.0 Aortic Atherosclerosis since it does not meet UHDDS definition of "other diagnosis." It appears to be an incidental finding from the radiology report and AA was not mentioned, treated or followed-up anywhere else throughout the record. In addition, the radiology report was not ordered specifically to look for AA. This would be in line with our instructions from the regional guidance memo on when to code Aortic Atherosclerosis. I'm attaching our guidance memo from March 2012 just for reference. Thanks, Kamar and let me know if I can help with anything else. Thanks.

[attachment "Coding+Guidance+Memo+-+Aortic+Atherosclerosis3.2012.pdf" deleted by Gloryanne H Bryant/CA/KAIPERM]

VICTORIA M. HERNANDEZ, RHIT, CCS, CRCR, AHIMA-Approved ICD-10-CM/PCS Trainer

Kamar F. Braish, B. S., RHIT
HIM DIRECTOR
Greater Southern Alameda Service Area
27400 Hesperian Blvd. Hayward, CA 94545
Phone: 510-784-4242 Cell: 510-460-0852
Fax: 510-784-6219
Email: Kamar.F.Braish@kp.org

Staff Assistant: Desrinique Jordan
Phone: 510-784-4384
Tie-line: 8-430
Fax: 510-784-4884
Email: Desrinique.L.Jordan@kp.org

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Christopher A Wan Kamar, I think we could use some gui... 12/01/2012 08:29:20 AM

From: Christopher A Wan/CA/KAIPERM
To: Kamar F Braish/CA/KAIPERM@KAIPERM
Date: 12/01/2012 08:29 AM
Subject: phi -- addending aortic atherosclerosis

Kamar,

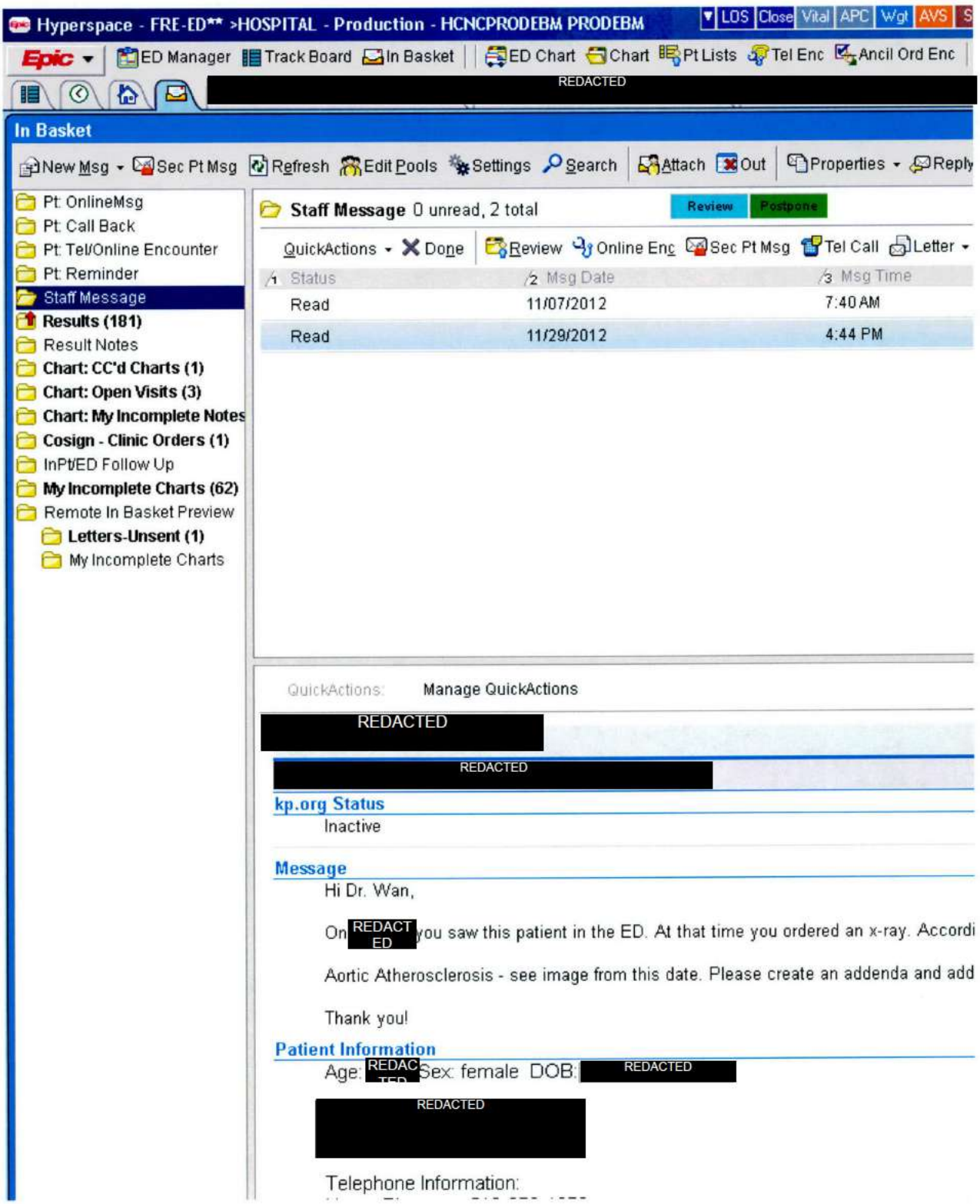
I think we could use some guidance and perhaps some clarity on these requests coming from coding -- do you know who could help us understand better?

In this case -- I'm being asked to add in a diagnosis on an ED chart from 3/2012 (about 8 months ago) for a diagnosis that we don't really make in the ER -- and one that doesn't even officially get read by the radiologist until after the patient has left.

What I'm looking for is some reassurance that this in no way would be considered fraud or inappropriate -- because of the length of time the information is entered, and simply also that it's not a diagnosis that we make in the ER, and the official readings that come from radiology won't come back for 1 or 2 days -- so the finding really has no impact on our ER care.

If I can get reassurance, I'm more than happy to enter the information -- but because of the concerns -- I'm sure I share this with many ER physicians.

If Joint Commission or Medicare came in to audit the cases and they saw this -- would they have any concerns or issues?


Hyperspace - FRE-ED** >HOSPITAL - Production - HCNCPRODEBM PRODEBM
LOS Close Vital APC Wgt AVS S
Epic
ED Manager Track Board In Basket ED Chart Chart Pt Lists Tel Enc Ancil Ord Enc
REDACTED
In Basket
New Msg Sec Pt Msg Refresh Edit Pools Settings Search Attach Out Properties Reply
Pt: OnlineMsg
Pt: Call Back
Pt: Tel/Online Encounter
Pt: Reminder
Staff Message
Results (181)
Result Notes
Chart: CC'd Charts (1)
Chart: Open Visits (3)
Chart: My Incomplete Notes
Cosign - Clinic Orders (1)
InPt/ED Follow Up
My Incomplete Charts (62)
Remote In Basket Preview
Letters-Unsent (1)
My Incomplete Charts
Staff Message 0 unread, 2 total
Review
Postpone
QuickActions Done Review Online Enc Sec Pt Msg Tel Call Letter
Status
Msg Date
Msg Time
Read
11/07/2012
7:40 AM
Read
11/29/2012
4:44 PM
QuickActions: Manage QuickActions
REDACTED
REDACTED
kp.org Status
Inactive
Message
Hi Dr. Wan,
On REDACTED you saw this patient in the ED. At that time you ordered an x-ray. Accordi
Aortic Atherosclerosis - see image from this date. Please create an addenda and add
Thank you!
Patient Information
Age: REDACTED Sex: female DOB: REDACTED
REDACTED
Telephone Information:

Just want to get your affirmation that this process is appropriate.

Chris

EXHIBIT 6

Gloryanne Bryant <gloryanneb@sbcglobal.net>
To
victoriamhernandez@yahoo.com
Apr 21 at 2:09 PM
TPMG
gloryanneb@sbcglobal.net

--- On Wed, 12/5/12, <Gloryanne.H.Bryant@kp.org> wrote:

> From: <Gloryanne.H.Bryant@kp.org>
> Subject: Fw: PLEASE APPROVE_NEW SMARTPHRASE FOR AORTIC ATHEROSCLEROSIS
> To: gloryanneb@sbcglobal.net
> Date: Wednesday, December 5, 2012, 12:05 PM
>
>
> Rebecca J Lange
>
> -----
> Original Message -----
>
> From: Rebecca J Lange
>
> Sent: 12/05/2012 10:36 AM
> PST
>
> To: Gloryanne Bryant; Roderick Madamba; Victoria Hernandez
>
> Cc: HIM Directors NCAL-KPNC
>
> Subject: Fw: PLEASE APPROVE_NEW
> SMARTPHRASE FOR AORTIC ATHEROSCLEROSIS
>
> Good morning,
>
>
>
>
> Is this a local, facility decision whether to approve and use "SMARTPHRASES"
> ? Will everyone implement this
> "Aortic Atherosclerosis" phrase ?
>
>>
> Thank you,
>
> Rebecca Lange, RHIA, CRCR, Director
>
>

>
> Health Information Management and Operator Services
> Kaiser Foundation Hospital San Francisco
> 2425 Geary Blvd, M110
> San Francisco, CA 94115
> Office: (415) 833-3823 Cell: (415) 243-6962
> Tie Line: 8-493-3823 Fax: (415) 833-3821
> Pager: (415) 201-3757
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>
>
> -----
> Forwarded by Rebecca J Lange/CA/KAIPERM on 12/05/2012 10:30
> AM -----
>
>
>
> From: Joel Cho/CA/KAIPERM
>
> To: Rebecca J Lange/CA/KAIPERM
>
> Date: 12/04/2012 10:13 PM
>
> Subject: FW: PLEASE APPROVE_NEW SMARTPHRASE FOR
> AORTIC ATHEROSCLEROSIS
>
>
>
>
>
>
> Rebecca,

> Please see below. What do you think?
>

> Joel

> Sent with Good (www.good.com)

> ----- Forwarded by

> Joel Cho/CA/KAIPERM on 12/04/2012 10:12:58
> PM-----
> -------- Original Message --------
>
>
>
> From : Erica E Eastham/CA/KAIPERM
>
> To : EIO Field Trainers-KPPO, EIO DQ Auditors-KPNC, CMS
> Proj Mgrs List-KPNC, Doc Code Phys Leads-KPNC
>
> Cc : EIO Mgt Team-KPNC-OAK
>
> Sent on : 12/04 10:01:39 PM PST
>
> Subject : PLEASE APPROVE_NEW SMARTPHRASE FOR AORTIC
> ATHEROSCLEROSIS
>
>
>
> Audience: EIO Field Trainers-KPPO, EIO DQ
> Auditors-KPNC, CMS Proj Mgrs List-KPNC, Doc Code Phys
> Leads-KPNC,
>
> Communication: Update on SmartPhrase
> addition
>
> Effective: 12/3/12
>
>
>
> Hello,
>
> I have great news!
> The SmartPhrase that was originally shared as a
> 'best practice' from the NVA is now available in the
> regional library of SmartPhrases for NCAL, making it
> accessible to all NCAL clinicians. Below are the
> details of the addition, the updated addenda job aid and a
> few screenshots to illustrate use and the wording.
>
>
> .
>
> Please contact me if you have any questions.
>
>
>

> (See attached file: Addenda Job Aid v5.doc)
>
> SmartPhrase Name: .AORTICATHEROSCLEROSIS
>
>> SmartPhrase Wording:
>
>
> Aortic Atherosclerosis noted on review of the radiology exam associated with chart
> review and this visit. Will follow longitudinally as an independent risk factor for CVD and CVA, with management per
> standard risk factor controls over time by PCP or appropriate specialist
>
> Thanks,
>
> Erica
>
>
> Erica E. Eastham, CCS-P
> AHIMA Approved ICD-10-CM/PCS Trainer
> Director, Documentation Quality Training
> The Permanente Medical Group, Inc.
> Encounter Information Operations
> 1950 Franklin St. Oakland, CA. 94612
> Desk line @ 1950 Franklin (510) 987-2419, tie 8-427
> Desk line @ 2829 Watt Ave (916) 979-3570
> Cell (510) 414-4774
> Assistant: Sharonda R Morris (510) 987-4452
>
>
>
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> Thank you.
>
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>

EXHIBIT 7

Re: Fw: Followup on Aortic Atherosclerosis - coding guidance nat'l
Gloryanne H Bryant to: Janet D Franklin 01/11/2013 02:52 PM
Cc: Nancy J Andersen, Victoria M Hernandez, Carolyn J Mar
Default custom expiration date: 03/02/2015

We've already addressed this internally in the region and had TPMG work with us on understanding the clinical significance of this condition.
TPMG takes the position that once AA is present it never goes away and is then a life long risk factor. In addition, the condition will continue to evolve without medical treatment or intervention, which could include, stop smoking, diet, eat healthy, decrease cholesterol, exercise, take aspirin, take prescribed meds ie statins, Thus the treatment could be any of these.
We looked at this criteria and definition and AA does meet these.

- Is always present, even though it may have been stabilized; (cannot be resolved, eradicated, or removed) AND
- By its very nature (because of its impact on the patient), requires that it be considered by the physician in evaluating the patient's chief complaint; AND
- The condition affects a major body system (and typically, more than one major body system)

We (NCAL) do believe that AA meets the criteria to be reportable and does impact care and decision making.

To go further with this discussion I believe needs individual with greater clinical knowledge like physicians and would invite TPMG ie Dr David Bliss) to discuss this further.

Gloryanne Bryant, RHIA, CCS, CDIP, CCDS
AHIMA Approved ICD-10-CM/PCS Trainer
Regional Managing Director HIM
NCAL Revenue Cycle
Kaiser Foundation Health Plan Inc & Hospitals
1800 Harrison St. 24th Floor, Oakland, CA 94612
510 625-3980 (tel)
510 625-5701 (fax)
email: Gloryanne.h.bryant@kp.org
Please visit the NCAL HIM resources, tools and information online at our wiki:
http://wiki.kp.org/wiki/x/fYDGBQ
BRING SAFETY TO WORK: Know the Basics; Look for Causes; Let Someone Know; Work Safely; and Ask For Help
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Janet D Franklin Hi Nancy, Per our phone conversation today, I a... 01/11/2013 02:34:49 PM

From: Janet D Franklin/PO/KAIPERM
To: Nancy J Andersen/CA/KAIPERM@KAIPERM
Cc: Gloryanne H Bryant/CA/KAIPERM@KAIPERM, Victoria M Hernandez/CA/KAIPERM@KAIPERM, Carolyn J Mar/PO/KAIPERM@KAIPERM
Date: 01/11/2013 02:34 PM
Subject: Re: Fw: Followup on Aortic Atherosclerosis - coding guidance nat'l

Hi Nancy,

Per our phone conversation today, I am responding to your e-mail below and adding additional comments related to the copy/paste function for radiology reports, Coding Clinic regarding incidental findings and dot phrases.

1. Systemic condition

I would find it had to qualify aortic atherosclerosis as meeting the definition of a systemic condition, particularly the requirement that by it's very nature, it requires the provider to consider it regardless of the reason for the encounter.

Definition

- Is always present, even though it may have been stabilized; (cannot be resolved, eradicated, or removed) AND
- By its very nature (because of its impact on the patient), requires that it be considered by the physician in evaluating the patient's chief complaint; AND
- The condition affects a major body system (and typically, more than one major body system)

2. Always Code List

It would be inappropriate to add this condition to the Always Code List. That list is to be referenced only after the following two questions has been answered by the coder, 1) Is it a systemic condition? If yes, the condition should be coded. If no then 2) Does the documentation support that the condition impacted the encounter? If yes, the condition should be coded. Only if the answer is no to both questions, would the coder reference the always code list. The always code list contains those conditions that KP feels should always be coded even when they do not impact the encounter. As such, the only diagnoses allowed to be on this list are those that have no financial impact. Otherwise, we would have a written document instructing coders to add codes that impact reimbursement for conditions that did not impact the encounter resulting in reimbursement to which KP is not entitled.

The last time I reviewed this list, we carefully checked to make sure that there were no conditions listed on the Always Code List where the codes would result in increased reimbursement, either from a DRG perspective or from an HCC perspective. Aortic atherosclerosis maps to both a CMS-HCC and an RxHCC resulting in additional reimbursement and cannot be added to this list.

3. Copy/paste

If the provider copy/pastes a radiology report into their note, the fact that the radiology report mentions a finding of aortic atherosclerosis is, on it's own, insufficient to code the condition for a couple of reasons

- Physicians will tell us that they copy/paste a note into a record because they agree with the findings. They also tell us that they copy/paste the report into their note to have it front of them as a reference, but the copy/paste activity does not imply their agreement with the diagnosis and because of that, they should not be required to assign a visit diagnosis (with resulting code) for the condition nor should they be dinged on an audit because their visit diagnosis did not accurately reflect the documentation in the copy/pasted note. Basically, we have a function where, without additional documentation, we cannot determine the intent/purpose of the use.

- If the finding of aortic atherosclerosis was incidental to the reason for the test (e.g. chest x-ray for pneumonia), then based on Coding Clinic guidelines, it cannot be coded unless the provider indicates the significance of the finding.

[redacted]

[redacted]

Thanks,

Janet (don't forget the) D Franklin

Janet D Franklin, RHIT, CCS, CCS-P, CHC
AHIMA Approved ICD-10-CM/PCS Trainer
Compliance Manager, Government Audit and Reimbursement
National Compliance, Ethics & Integrity Office
Office: 8-423-5735, 510-271-5735
Cell: 510-918-8125
Fax: 8-423-5039, 510-891-5039

Admin Assistant: Elizabeth Styles-Bartlett
8-423-6831, 510-271-6831

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Nancy J Andersen Hi Janet, I know we discussed this request previ... 12/19/2012 10:06:56 AM

From: Nancy J Andersen/CA/KAIPERM
To: Janet D Franklin/PO/KAIPERM@KAIPERM
Cc: Gloryanne H Bryant/CA/KAIPERM
Date: 12/19/2012 10:06 AM
Subject: Fw: Followup on Aortic Atherosclerosis - coding guidance nat'l

Hi Janet,

I know we discussed this request previously, however in researching atherosclerosis I am finding it described as a "systemic disease" and I'm wondering if aortic atherosclerosis should therefore also be considered a systemic disease. I also believe that atherosclerosis is considered a chronic condition; once a patient has it it doesn't go away (such as CAD).

Per AHA Coding Clinic:
"Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. This advice applies to inpatient coding."

I am unclear whether aortic atherosclerosis is in the same category those mentioned in Coding Clinic in terms of the affect this condition has on the patient for the rest of their life. Should we look for input from a physician champion such as Internal Medicine and/or Vascular Surgeon? I'd really like to put this question to bed once and for all.

Thanks,

Nancy J. Andersen, MS, RHIA, CCS, CRCR, AHIMA-Approved ICD-10-CM/PCS Trainer
Senior Compliance Manager, Care Delivery and Health Information Management
National Compliance, Ethics and Integrity Office
Kaiser Foundation Health Plan, Inc.
One Kaiser Plaza, 12th Floor
Oakland, CA 94612
Blackberry: 510-418-2455
nancy.j.andersen@kp.org

Embed a culture of compliance across the care delivery enterprise that inspires the highest level of ethics and integrity

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From:	Gloryanne H Bryant/CA/KAIPERM
To:	Nancy J Andersen/CA/KAIPERM@KAIPERM
Cc:	Victoria M Hernandez/CA/KAIPERM@KAIPERM
Date:	12/14/2012 05:30 AM
Subject:	Followup on Aortic Atherosclerosis - coding guidance nat'l

Nancy in followup on the NCAL call relating to the documentation and capture of Dx Aortic Atherosclerosis, we'd like to bring this issue to the coding governance and consideration of inclusion in the "always" code list. We do understand that AA may not be systemic but still would like some guidance. thank you.

Gloryanne Bryant, RHIA, CCS, CDIP, CCDS
AHIMA Approved ICD-10-CM/PCS Trainer
Regional Managing Director HIM
NCAL Revenue Cycle
Kaiser Foundation Health Plan Inc & Hospitals
1800 Harrison St. 24th Floor, Oakland, CA 94612
510 625-3980 (tel)
510 625-5701 (fax)
email: Gloryanne.h.bryant@kp.org
Please visit the NCAL HIM resources, tools and information online at our wiki:
http://wiki.kp.org/wiki/x/fYDGBQ
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EXHIBIT 8

AA presentation

Sherry A Davis to: Gloryanne H Bryant, Victoria M Hernandez 01/10/2013 12:44 PM

Default custom expiration date: 03/02/2015

History: This message has been replied to.

Here's my copy of the presentation with my notes. Also, I tried to capture all the questions and answers on the last page.

Documentation & Coding Aortic Atheroscl 1.2013 final.pdf

Sherry A. Davis, RHIA
Interim Regional Director of Hospital Coding

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1800 Harrison St. 24th Fl, Oakland, CA 94612
E-mail Sherry A. Davis
revenueCYCLE

510-625-3031
8-428-3031 tie line
510-625-5696 fax

Visit Revenue Cycle Wiki

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Documentation and Coding Aortic Atherosclerosis Clarification

Conference Call

January 2013

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Case: 22-15862, 11/21/2022, ID: 12593323, DktEntry: 10-5, Page 33 of 233

Background

TPMG has been working on identifying (diagnosing) Aortic Atherosclerosis as part of early detection and quality of care.

Failure to capture and document chronic conditions will adversely affect our ability to care for our members.

Diagnosing "Aortic Atherosclerosis" is good patient care.

Case: 22-15862, 11/21/2022, ID: 12593323, DktEntry: 10-5, Page 34 of 233

Physician Training: Diagnosis specificity- Aortic Atherosclerosis

Area of significant missed opportunity

Be sure to add the Aortic Atherosclerosis diagnosis to an encounter when reviewing imaging. Due to the high incident of missed opportunity, the below process has been implemented.

Review and Capture Process Radiologist documents calcification in Aorta in Impression

Treating or Ordering Physician Captures Diagnosis

- Reviews Radiology Impression Note
- Addends an ED visit and adds Aortic Atherosclerosis diagnosis

Case: 22-15862, 11/21/2022, ID: 12593323, DktEntry: 10-5, Page 35 of 233

New Approved Dot Phrase to Help

Aortic Atherosclerosis

Aortic Atherosclerosis noted on review of the radiologist exam associated with chart reviewed this visit. Will follow longitudinally as an independent risk factor for CVD and CVA, with management per standard risk factor controls over time by PCP or appropriate specialist.

Case: 22-15862, 11/21/2022, ID: 12593323, DktEntry: 10-5, Page 36 of 233

PRE-PROCEDURE ASSESSMENT

Unspecified Hemorrhage of GI Tract

Lxxxx M Bxxxx is a xx YO male

The past and present medical history of this patient were reviewed on 9/9/2099, including past relevant consultation notes. Results of relevant diagnostic tests were examined. The patient's past anesthesia experience was reviewed.... Medications being taken currently as well as medication allergies were also reviewed.

Last Oral Intake: 6 pm

Physical Exam:

A physical exam was performed on 1/3/2012. Vital signs were reviewed, and pertinent exam findings are as follows.....

Procedural Sedation Plan: IV versed and fentanyl

Intended Level of Sedation: II (Moderate/Conscious Sedation)

Informed consent regarding .....

Additional / Pertinent Clinical or Lab Data: No significant findings ....

ASA Rating: 2

Will proceed as planned.

Current Medical History:

DM2 w Diabetic CKD3

Hyperlipidemia

Hyperthyroidism

Hypertension

GERD

Migrane

Aortic Atherosclerosis

I have confirmed with the patient and/or the medical record the presence of the above diagnoses, and the diagnoses are followed by his or her PCP or appropriate specialist.

PAUL T KEFALIDES MD

For outpatient procedures (GI/PMR), are there specific documentation guidelines to provide the MD's as a way to capture conditions that can be coded by HIMS per coding guidelines?

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Page 5

Case: 22-15862, 11/21/2022, ID: 12593323, DktEntry: 10-5, Page 37 of 233

Clinical Aspects: Arteriosclerosis/Atherosclerosis

Clinical Definition:

Arteriosclerosis is a general term for several disorders that cause thickening and loss of elasticity in the arterial wall.

- Atherosclerosis, is the most common form of this disorder and is the most serious because it causes coronary artery disease (CAD) and cerebrovascular disease.
- Sometimes referred to as: "Hardening of the arteries"

Case: 22-15862, 11/21/2022, ID: 12593323, DktEntry: 10-5, Page 38 of 233

Clinical Aspects: Etiology of Atherosclerosis

- Atherosclerotic plaque- a collection of lipids, cholesterol, inflammatory cells, smooth muscle cells, connective tissue, thrombi, and Calcium deposits.
  - Stable plaque grow slowly or remain static until they may cause stenosis or occlusion
  - Unstable plaque cause thrombosis, occlusion, and infarction
- All stages of atherosclerosis are considered an inflammatory response to injury particularly the endothelial.
- Specific areas of the arterial tree are affected more than others due to turbulent blood flow.
- Atherosclerosis is a chronic disease
- Note: Atherosclerosis is one of the major causes of abdominal aortic aneurysm.

Case: 22-15862, 11/21/2022, ID: 12593323, DktEntry: 10-5, Page 39 of 233

Clinical Aspects: Risk Factors for Atherosclerosis

- Dyslipidemia (high LDL, low HDL): high cholesterol
- Diabetes
- Smoking
- Obesity
- Metabolic Syndrome (abdominal obesity, along with at least 2 of the following: dyslipidemia, hypertension, insulin resistance)
- Hyperinsulinemia
- Prothrombotic states
- Hypertension
- Renal insufficiency
- Systemic infections
- Age
- Family history
- Sedentary lifestyle

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Clinical Aspects: Atherosclerosis Signs & Symptoms (Dr. Bliss)

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Coding and Reporting

(Gloryanne)

CODING OF SECONDARY CONDITIONS

General Information

The guidelines for the coding of secondary diagnoses have been clarified in order to ensure consistency in accurately assigning appropriate secondary diagnosis codes.

Per CODING CLINIC, the definition for "other diagnoses" includes additional conditions that affect patient care in terms of requiring:

clinical evaluation; or
therapeutic treatment; or
diagnostic procedures; or
extended length of hospital stay; or
increased nursing care and/or monitoring

Systemic diseases (e.g., diabetes mellitus, hypertension, Parkinson's disease – see List A) are always coded, even in the absence of documented active intervention since these types of conditions meet one or more of the elements of the definition given above. (Coding Clinic, Second Quarter, 1990, page 14.)

Note: you only need one of the criteria for "other diagnosis" reporting.

revenueCYCLE

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Coding and Reporting

AHA Coding Clinic

Systemic diseases (e.g., diabetes mellitus, hypertension, Parkinson's disease) are always coded, even in the absence of documented active intervention since these types of conditions meet one or more of the elements of the definition given above. (Coding Clinic, Second Quarter, 1990, page 14.)

Note: e.g. means example, thus is list is only an example of systemic diseases

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Coding and Reporting

AHA Coding Clinic 3rd Qtr- 2007

Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded. This advice applies to inpatient coding.

For outpatient encounters/visits, chronic conditions that require or affect patient care treatment or management should be coded.

The Official Guidelines for Coding and Reporting for Outpatient Services, state, "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions(s).

"Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist." This information was previously published in *Coding Clinic*, Fourth Quarter 2006, pages 236-240.

Conversely, conditions that do not require or affect patient care, treatment or management are not reported

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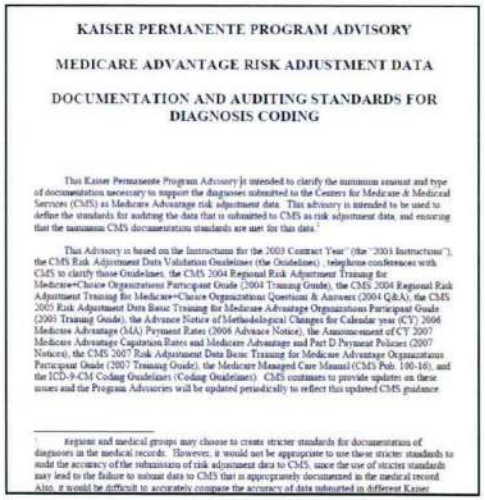
Kaiser Permanente MA Documentation and Coding Guidance

- According to the Coding Guidelines, certain diagnoses such as hypertension, Parkinson's disease, and diabetes mellitus are example of systemic diseases that should be coded, even in the absence of documented active interventions. [Coding Clinic, Second Quarter, 1990, p.14].
- Based on these Coding Guidelines, Kaiser has developed the following Coding and Documentation Guideline for coding of such systemic diseases for Kaiser Foundation Hospitals, referred to as the "Always Code" Guideline.



KAISER PERMANENTE PROGRAM ADVISORY

MEDICARE ADVANTAGE RISK ADJUSTMENT DATA

DOCUMENTATION AND AUDITING STANDARDS FOR DIAGNOSIS CODING

This Kaiser Permanente Program Advisory is intended to clarify the minimum amount and type of documentation necessary to support the diagnoses submitted to the Centers for Medicare & Medicaid Services (CMS) as Medicare Advantage risk adjustment data. This advisory is intended to be used to define the standards for auditing the data that is submitted to CMS as risk adjustment data, and ensuring that the minimum CMS documentation standards are met for this data.[1]

This Advisory is based on the Instructions for the 2003 Contract Year" (the "2003 Instructions"), the CMS Risk Adjustment Data Validation Guidelines (the Guidelines), telephone conferences with CMS to clarify those Guidelines, the CMS 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations Participant Guide (2004 Training Guide), the CMS 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations Questions & Answers (2004 Q&A), the CMS 2005 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide (2005 Training Guide), the Advance Notice of Methodological Changes for Calendar year (CY) 2006 Medicare Advantage (MA) Payment Rates (2006 Advance Notice), the Announcement of CY 2007 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies (2007 Notice), the CMS 2007 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide (2007 Training Guide), the Medicare Managed Care Manual (CMS Pub. 100-16), and the ICD-9-CM Coding Guidelines (Coding Guidelines). CMS continues to provide updates on these issues and the Program Advisories will be updated periodically to reflect this updated CMS guidance.

[1] Regions and medical groups may choose to create stricter standards for documentation of diagnoses in the medical records. However, it would not be appropriate to use these stricter standards to audit the accuracy of the submission of risk adjustment data to CMS, since the use of stricter standards may lead to the failure to submit data to CMS that is appropriately documented in the medical record. Also, it would be difficult to accurately compare the accuracy of data submitted in different Kaiser

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KP MA: Documentation and Coding Reportable Systemic Conditions (con't)

Systemic diseases . . . are always coded, even in the absence of documented active intervention

Systemic conditions always to be coded include, but are not limited to, the following:

AIDS
Lupus
Atherosclerosis
Multiple sclerosis
Collagen vascular disease
Parkinson's Disease
Diabetes mellitus
Renal Failure, Chronic
Hypertension
Rheumatoid Arthritis

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Kaiser Permanente MA: Documentation and Coding (con't)

The following statements further define the acceptability of the submission of "systemic conditions."

A diagnosis will always be coded and is acceptable for submission to CMS as risk adjustment data, even in the absence of expressly documented active treatment, evaluation, or intervention by the physician, if the condition meets all four of the following criteria:

1) The condition is always present, even though it may have been stabilized; AND

2) By its very nature (because of its impact on the patient), the condition must be considered by the physician in evaluating the patient's chief complaint; AND

3) The condition affects a major body system (and, typically, more than one major body system), which include the following:

- **(A) Cardiovascular;** AND/OR
- (B) Respiratory: AND/OR
- (C) Gastrointestinal; AND/OR
- (D) Renal; AND/OR
- (E) Hematologic/Lymphatic/Immunologic; AND/OR
- (F) Neurologic; AND/OR
- (G) Psychiatric; AND

4) The physician indicates that he/she considered the diagnosis by documenting the diagnosis in the medical record for the encounter.

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Kaiser Permanente "Always Code List"

Systemic Conditions - List A Examples of systemic conditions always to be coded include, but are not limited to, the following:

AIDS
Asthma, chronic obstructive
Atherosclerosis, generalized
Bronchitis, chronic obstructive
Collagen vascular disease
COPD
Diabetes mellitus
Emphysema
Hypertension
Systemic lupus erythematosus
Multiple sclerosis
Parkinson's disease
Peripheral vascular disease
Chronic kidney disease
Rheumatoid arthritis

*Note: Attending physician confirmation of clinical significance of all radiology findings is required for inpatients per Coding Clinic.

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Summary

- **Physician focus on diagnosing and documenting "Aortic Atherosclerosis"**
- **Secondary Diagnosis reporting criteria**
  - Only need one of the criteria to report dx
- **Coding Guidelines regarding Chronic Systemic Conditions**
- **KP MA Guidelines on Chronic Systemic Conditions & reporting criteria**
- **KP Always Code List**
- **Documenting and Coding "Aortic Atherosclerosis" is good patient care**

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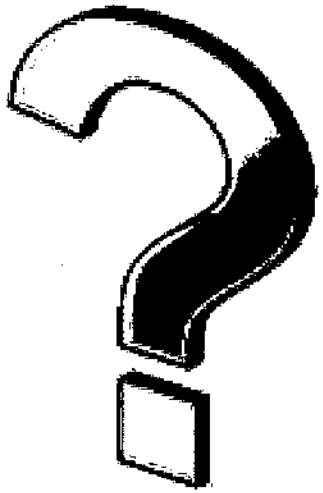
Questions



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Thank you

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EXHIBIT 9

Documentation and Coding Leads Meeting

September 13, 2011

ER-551

Agenda

- Welcome & Introductions
- Seeing Patients, Maintaining Diagnoses, Data Mining & NLP
- HCCs Increased Capture
  - Diabetes Specificity
  - CKD
  - Vascular Disease: Aortic Atherosclerosis
  - Protein Calorie Malnutrition
  - Other Dx Capture Issues: Vertebral Fracture; Dementia
- Demo Medicare Advantage eCode tool
- E/M: Level of Service Coding Completion (hard stop)
  - Scope, Training & Reports
- Celebration

2011 GOALS

- ✓ Refresh 99% Diagnoses
- ✓ Address 99% 2010 Data Mining & NLP Conditions

Includes all inpatient, outpatient and claims-based face-to-face encounters with a qualified CMS provider

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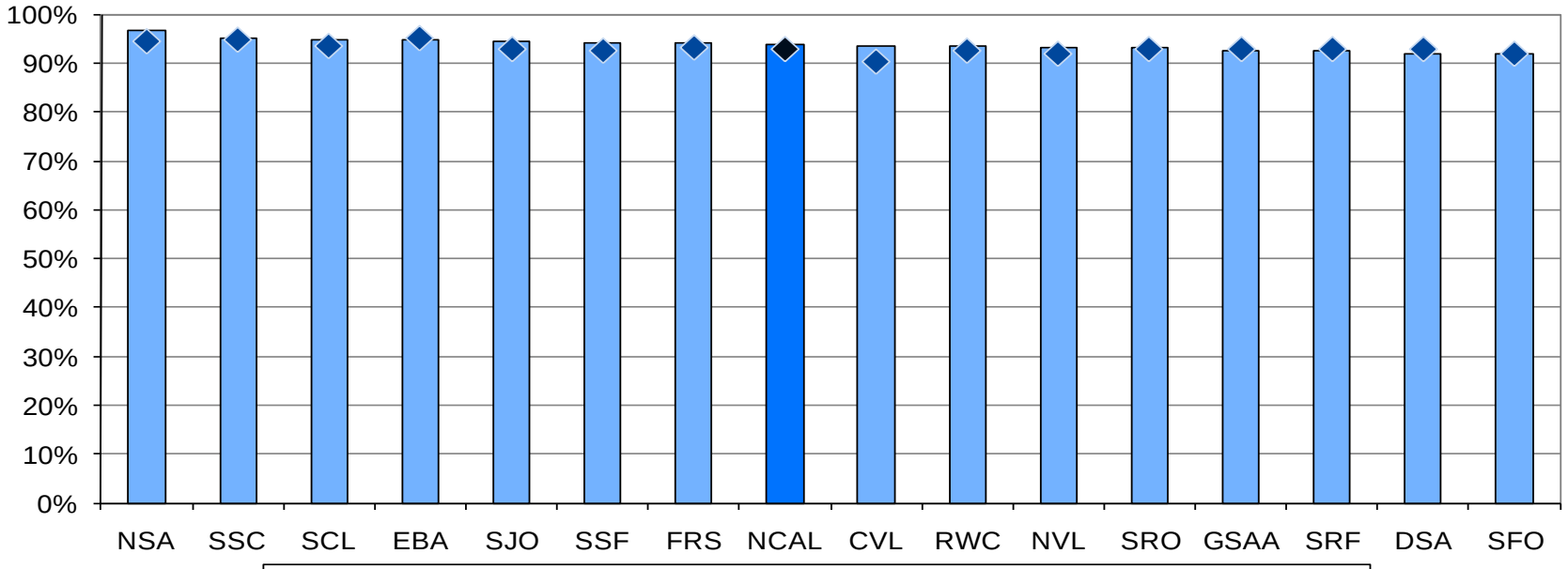
Seeing Patients

SEEING PATIENTS WITH A CHRONIC CONDITION OR DATA MINING PROMPT
YTD 2011 / 2010 COMPARISON
Pre Period: January 1, 2008 through December 31, 2010
Post Period: January 1, 2011 through August 31, 2011 Update



	NSA	SSC	SCL	EBA	SJO	SSF	FRS	NCAL	CVL	RWC	NVL	SRO	GSAA	SRF	DSA	SFO
MA Members With a Chronic Dx in Pre-Period OR Data Mining Prompt	21,548	16,188	29,420	25,501	17,701	14,358	16,189	334,546	18,389	11,259	52,940	16,441	21,974	16,306	40,360	15,972
MA Members With a Chronic Dx in Pre-Period OR Data Mining Prompt NOT SEEN YTD	677	776	1,503	1,331	948	815	962	20,976	1,171	741	3,603	1,121	1,593	1,200	3,225	1,310
Total % Seen YTD 2011	96.9%	95.2%	94.9%	94.8%	94.6%	94.3%	94.1%	93.7%	93.6%	93.4%	93.2%	93.2%	92.8%	92.6%	92.0%	91.8%
Total % Seen YTD 2010	94.6%	94.8%	93.5%	95.3%	92.9%	92.5%	93.2%	93.0%	90.5%	92.6%	91.8%	92.9%	93.1%	92.8%	92.8%	92.1%

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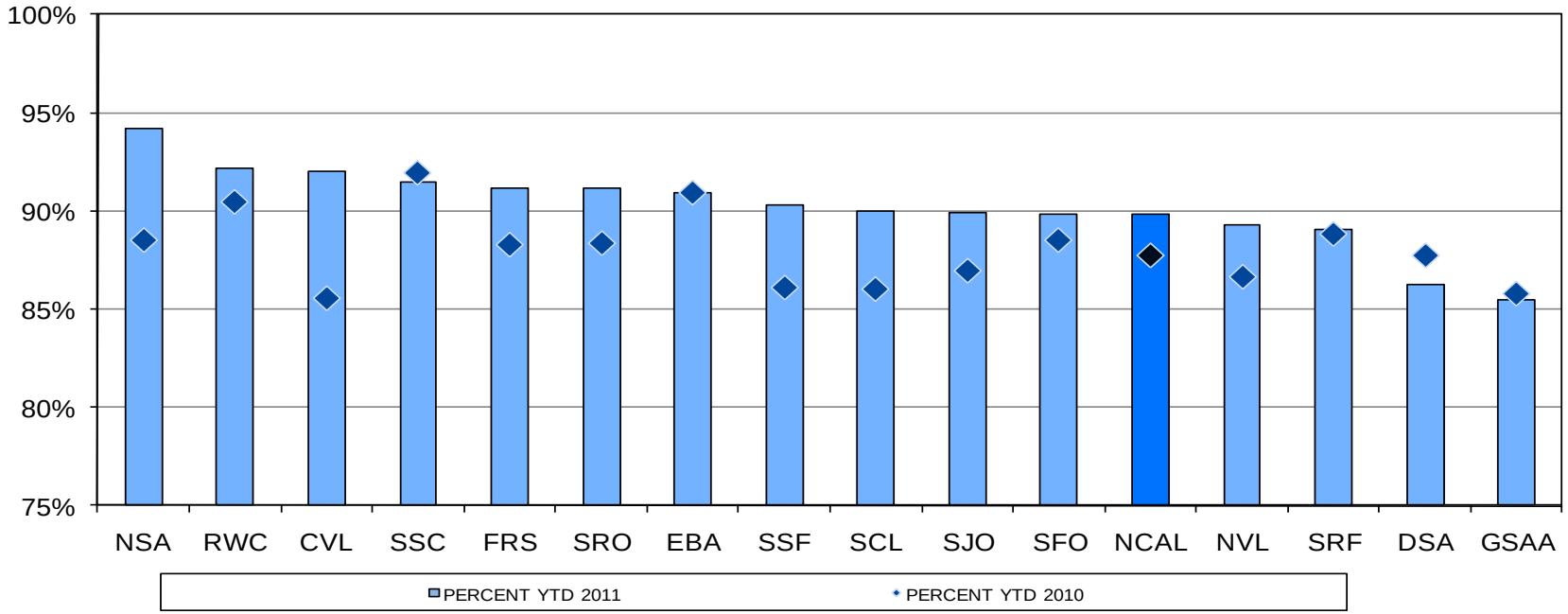
Maintaining Diagnoses

MAINTAINING ACCURATE & UP-TO-DATE DIAGNOSES
REFRESHED CHRONIC DIAGNOSES - YTD 2010 / 2011 COMPARISON
Pre Period: January 1, 2008 through December 31, 2010
Post Period: January 1, 2011 through August 31, 2011



	NSA	RWC	CVL	SSC	FRS	SRO	EBA	SSF	SCL	SJO	SFO	NCAL	NVL	SRF	DSA	GSAA
TOTAL CHRONIC CMS HCC PRE PERIOD	65,986	30,371	56,536	48,992	48,384	44,886	70,923	42,172	82,657	50,769	43,840	952,413	149,406	42,563	109,324	65,604
TOTAL CHRONIC CMS HCC POST PERIOD	62,150	27,996	52,020	44,825	44,111	40,916	64,486	38,089	74,367	45,636	39,395	855,739	133,460	37,913	94,315	56,060
PERCENT YTD 2011	94.2%	92.2%	92.0%	91.5%	91.2%	91.2%	90.9%	90.3%	90.0%	89.9%	89.9%	89.8%	89.3%	89.1%	86.3%	85.5%
PERCENT YTD 2010	88.5%	90.5%	85.6%	91.9%	88.3%	88.3%	91.0%	86.1%	86.0%	87.0%	88.5%	87.8%	86.6%	88.8%	87.8%	85.8%

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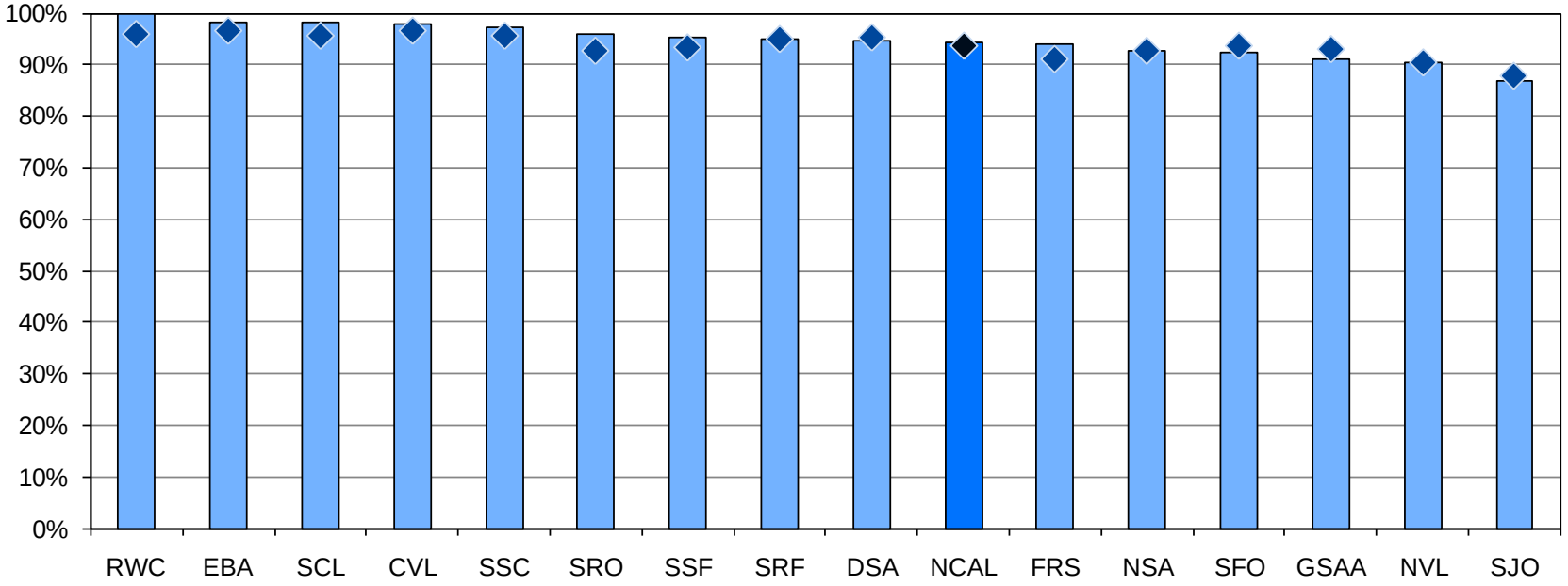
ER-555

REL0000090

Maintaining Diagnoses - ESRD

ESRD MEMBERS - MAINTAINING ACCURATE & UP-TO-DATE DIAGNOSES
REFRESHED CHRONIC DIAGNOSES - YTD 2010 / 2011 COMPARISON
Pre Period: January 1, 2008 through December 31, 2010
Post Period: January 1, 2011 through August 31, 2011



	RWC	EBA	SCL	CVL	SSC	SRO	SSF	SRF	DSA	NCAL	FRS	NSA	SFO	GSAA	NVL	SJO
TOTAL CHRONIC CMS HCC PRE PERIOD	298	1,830	1,414	1,047	1,333	469	794	300	1,820	17,103	575	1,332	1,097	1,510	2,127	1,157
TOTAL CHRONIC CMS HCC POST PERIOD	298	1,798	1,388	1,026	1,296	450	757	285	1,722	16,116	541	1,236	1,013	1,376	1,924	1,006
PERCENT YTD 2011	100.0%	98.3%	98.2%	98.0%	97.2%	95.9%	95.3%	95.0%	94.6%	94.2%	94.1%	92.8%	92.3%	91.1%	90.5%	86.9%
PERCENT YTD 2010	96.1%	96.7%	95.6%	96.5%	95.7%	92.7%	93.2%	94.9%	95.2%	93.6%	91.0%	92.8%	93.7%	93.0%	90.4%	88.0%

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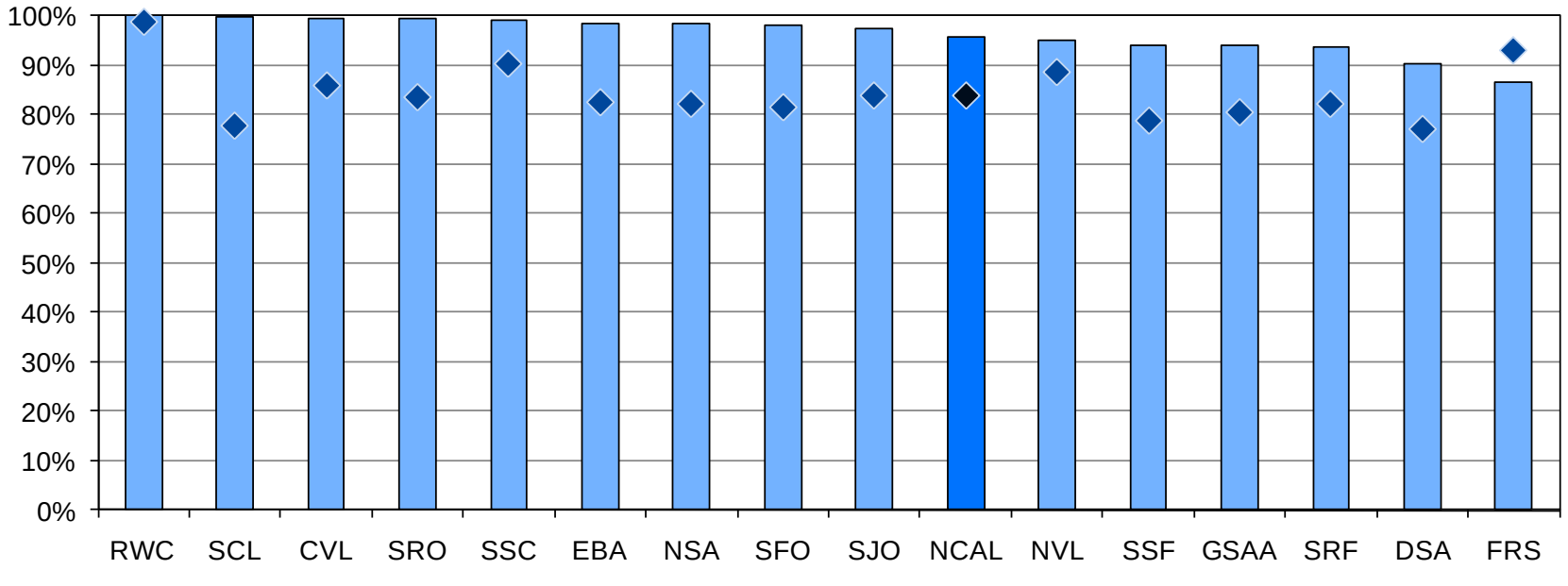
ER-556

REL0000091

Maintaining Diagnoses - SNF

SNF MEMBERS - MAINTAINING ACCURATE & UP-TO-DATE DIAGNOSES
REFRESHED CHRONIC DIAGNOSES - YTD 2010 / 2011 COMPARISON
Pre Period: January 1, 2008 through December 31, 2010
Post Period: January 1, 2011 through August 31, 2011



	RWC	SCL	CVL	SRO	SSC	EBA	NSA	SFO	SJO	NCAL	NVL	SSF	GSAA	SRF	DSA	FRS
TOTAL CHRONIC CMS HCC PRE PERIOD	143	1,088	546	342	514	1,086	493	251	423	9,896	1,928	291	744	599	803	645
TOTAL CHRONIC CMS HCC POST PERIOD	143	1,087	544	340	509	1,071	485	246	412	9,488	1,831	274	700	562	726	558
PERCENT YTD 2011	100.0%	99.9%	99.6%	99.4%	99.0%	98.6%	98.4%	98.0%	97.4%	95.9%	95.0%	94.2%	94.1%	93.8%	90.4%	86.5%
PERCENT YTD 2010	98.9%	77.8%	85.8%	83.7%	90.3%	82.5%	82.0%	81.4%	84.0%	83.9%	88.8%	78.9%	80.6%	82.3%	77.1%	93.1%

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Data Mining by Medical Center

Data Mining Facility Report - By Medical Center - Data Extracted 9/4/2011

DM Condition: (ALL)

Data Mining Condition:	(Multiple Items)

MEDICAL CENTER	DATA MINING DIAGNOSES RELEASED	DATA MINING Dx ASSIGNED	DATA MINING Dx STOP PROMPT	TOTAL ADDRESSED	% ASSIGNED	% STOP PROMPT	% ADDRESSED	REMAINING DATA MINING DIAGNOSES	% OF REMAINING DATA MINING DIAGNOSES
(CVL) Central Valley	519	366	40	406	90.1%	9.9%	78.2%	113	21.8%
(DSA) Diablo Service Area	961	543	141	684	79.4%	20.6%	71.2%	277	28.8%
(EBA) East Bay Area	683	386	146	532	72.6%	27.4%	77.9%	151	22.1%
(FRS) Fresno	463	247	93	340	72.6%	27.4%	73.4%	123	26.6%
(GSAA) Greater Southern Alameda Area	581	267	201	468	57.1%	42.9%	80.6%	113	19.4%
(NSA) Napa Solano Area	750	425	112	537	79.1%	20.9%	71.6%	213	28.4%
(NVL) North Valley	1,572	908	95	1,003	90.5%	9.5%	63.8%	569	36.2%
(RWC) Redwood City	218	122	31	153	79.7%	20.3%	70.2%	65	29.8%
(SCL) Santa Clara	231	160	25	185	86.5%	13.5%	80.1%	46	19.9%
(SFO) San Francisco	281	151	70	221	68.3%	31.7%	78.6%	60	21.4%
(SJO) San Jose	116	88	3	91	96.7%	3.3%	78.4%	25	21.6%
(SRF) San Rafael	314	148	55	203	72.9%	27.1%	64.6%	111	35.4%
(SRO) Santa Rosa	321	164	75	239	68.6%	31.4%	74.5%	82	25.5%
(SSC) South Sacramento	441	285	91	376	75.8%	24.2%	85.3%	65	14.7%
(SSF) South San Francisco	204	140	21	161	87.0%	13.0%	78.9%	43	21.1%
NCAL Region	**7,655**	**4,400**	**1,199**	**5,599**	**78.6%**	**21.4%**	**73.1%**	**2,056**	**26.9%**

COLUMN	COLUMN HEADING DESCRIPTION
Released Data Mining Diagnoses	Released for facilities to work on.
Total Addressed	Sum of members assigned and members with Stop Prompt (by Providers).
% Assigned	Number of members assigned divided by Total Addressed.
% Stop Prompt	Number of members with Stop Prompt (by Providers) divided by Total Addressed.
% Addressed	Total Addressed divided by Released members with data mining condition.
Remaining Data Mining Diagnoses	Released members with Data Mining condition minus the number addressed year to date.
% Remaining Data Mining Diagnoses	Number of remaining members divided by total number of Released members with data mining condition.

Notes:

YTD % OF DATA-MINING'S POSSIBLE CHRONIC CMS HCC ADDRESSED BY FACILITY
FOR ALL M+C MEMBERS (LESS ESRD & HOSPICE). DM DX MAY BE ADDRESSED IN ALL DEPTS.
DM DX RELEASED IN PERIOD = 1/1/2011 TO 09/04/2011
DM DX STOP-PROMPT PERIOD = 1/1/2011 TO 09/04/2011

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Data Mining by Condition

Data Mining Facility Report - By Condition - Data Extracted 9/4/2011

LMC Id: (ALL)

Facility Id: (ALL)

License Medical Center:	NCAL Region	Facility Name:	All Facilities

DATA MINING CONDITION	DATA MINING DIAGNOSES RELEASED	DATA MINING Dx ASSIGNED	DATA MINING Dx STOP PROMPT	TOTAL ADDRESSED	% ASSIGNED	% STOP PROMPT	% ADDRESSED	REMAINING DATA MINING DIAGNOSES	% OF REMAINING DATA MINING DIAGNOSES
AMPUTATIONS	8	4	-	4	100.0%	0.0%	50.0%	4	50.0%
CACHEXIA (ROUND 2)	413	161	97	258	62.4%	37.6%	62.5%	155	37.5%
CHRONIC KIDNEY DISEASE	1,074	722	87	809	89.2%	10.8%	75.3%	265	24.7%
CHRONIC RESPIRATORY FAILURE	864	472	192	664	71.1%	28.9%	76.9%	200	23.1%
CONSIDER MAJOR DEPRESSION	689	256	171	427	60.0%	40.0%	62.0%	262	38.0%
DM W/ DIABETIC ERECTILE DYSFUNCTION	351	230	34	264	87.1%	12.9%	75.2%	87	24.8%
DM W/ DIABETIC PERIPHERAL NEUROPATHY	378	150	140	290	51.7%	48.3%	76.7%	88	23.3%
DM W/ DIABETIC PVD	107	46	26	72	63.9%	36.1%	67.3%	35	32.7%
DM 2 W/ LO HDL & HI TRIGLYCERIDES D/T DM DIABETIC DYSLIPIDEMIA	596	420	32	452	92.9%	7.1%	75.8%	144	24.2%
DM W/ DIABETIC CKD	1,212	690	166	856	80.6%	19.4%	70.6%	356	29.4%
DM2 W/ DIABETIC NEPHROPATHY, MICROALBUNURIA	1,234	820	127	947	86.6%	13.4%	76.7%	287	23.3%
HEART FAILURE	23	15	7	22	68.2%	31.8%	95.7%	1	4.3%
HX OF MI/STABLE ANGINA	400	238	55	293	81.2%	18.8%	73.3%	107	26.8%
OSTOMY	31	27	-	27	100.0%	0.0%	87.1%	4	12.9%
PANCREATITIS	16	5	6	11	45.5%	54.5%	68.8%	5	31.3%
PERIPHERAL VASCULAR DISEASE	206	109	49	158	69.0%	31.0%	76.7%	48	23.3%
SEIZURE	49	32	9	41	78.0%	22.0%	83.7%	8	16.3%
TRACHEOSTOMY	4	3	1	4	75.0%	25.0%	100.0%	-	0.0%
TOTAL ALL COND	**7,655**	**4,400**	**1,199**	**5,599**	**78.6%**	**21.4%**	**73.1%**	**2,056**	**26.9%**
CACHEXIA (ROUND 1)	3,008	1,430	1,578	3,008	47.5%	52.5%	100.0%	-	0.0%
CONSIDER AORTIC ATHEROSCLEROSIS	4,413	165	12	177	93.2%	6.8%	4.0%	4,236	96.0%

COLUMN	COLUMN HEADING DESCRIPTION
Released Data Mining Diagnoses	Released for facilities to work on.
Total Addressed	Sum of members assigned and members with Stop Prompt (by Providers).
% Assigned	Number of members assigned divided by Total Addressed.
% Stop Prompt	Number of members with Stop Prompt (by Providers) divided by Total Addressed.
% Addressed	Total Addressed divided by Released members with data mining condition.
Remaining Data Mining Diagnoses	Released members with Data Mining condition minus the number addressed year to date.
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Notes:

YTD % OF DATA-MINING'S POSSIBLE CHRONIC CMS HCC ADDRESSED BY FACILITY
FOR ALL M+C MEMBERS (LESS ESRD & HOSPICE). DM DX MAY BE ADDRESSED IN ALL DEPTS.
DM DX RELEASED IN PERIOD = 1/1/2011 TO 09/04/2011

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Natural Language Process Findings

- All NCal clinic NLP findings being reviewed by TPMG physicians (2010 dates of service)

- Potential Diagnoses, once verified by physician reviewer, will be
  1) added to Data Mining (as was 2009 dates of service)
  2) submitted to CMS for 2011 revenue year

- Total Volume clinically reviewed (2010 dos) - 1,822
  - Potential positive findings approximately 70% to date
- Last year (2009 dos) Total Volume clinically reviewed – 2,198
  - 70% recommended for Dx Capture

Diabetes

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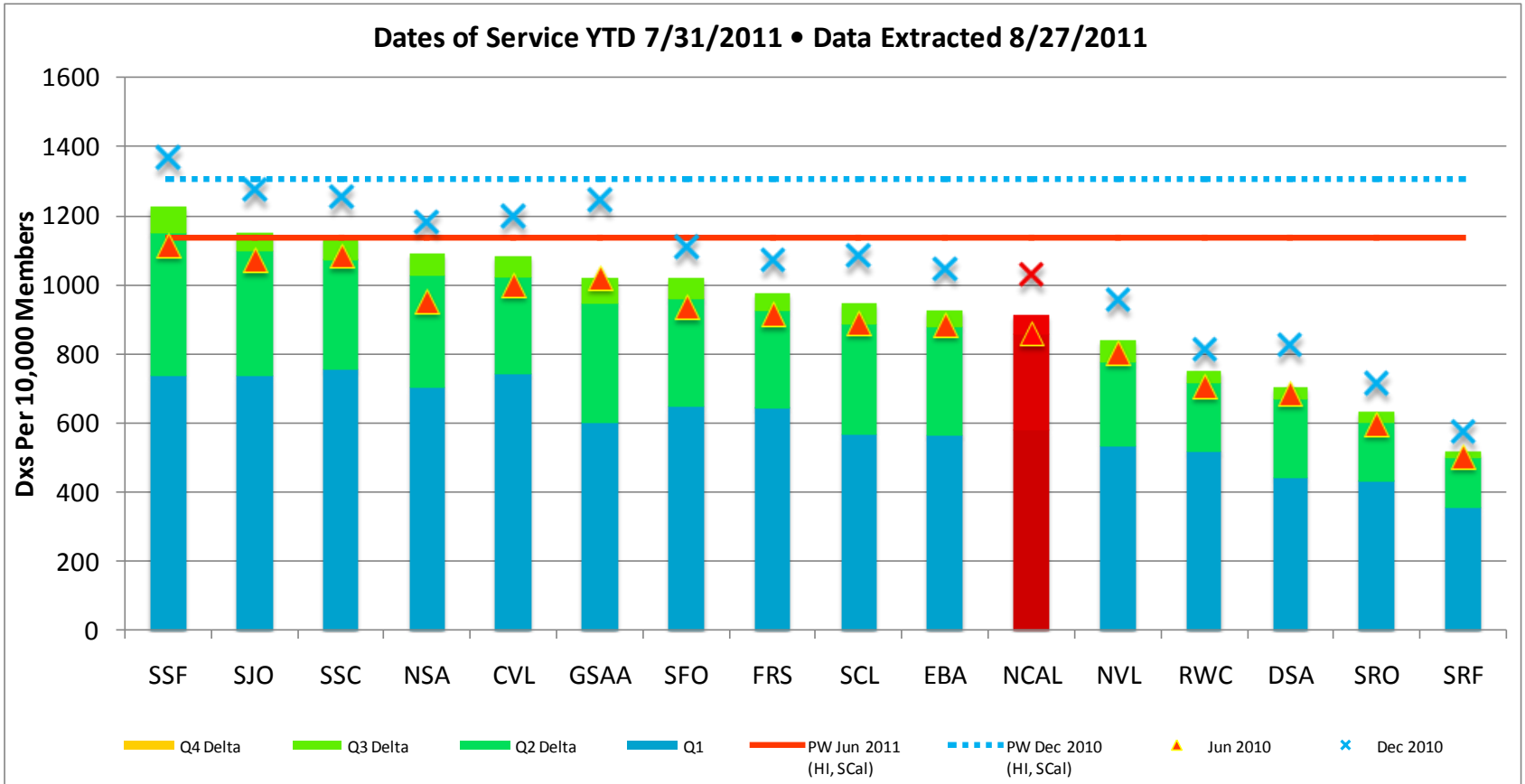
HCC 15: Diabetes w/ Renal or Peripheral Circulatory Manifestation

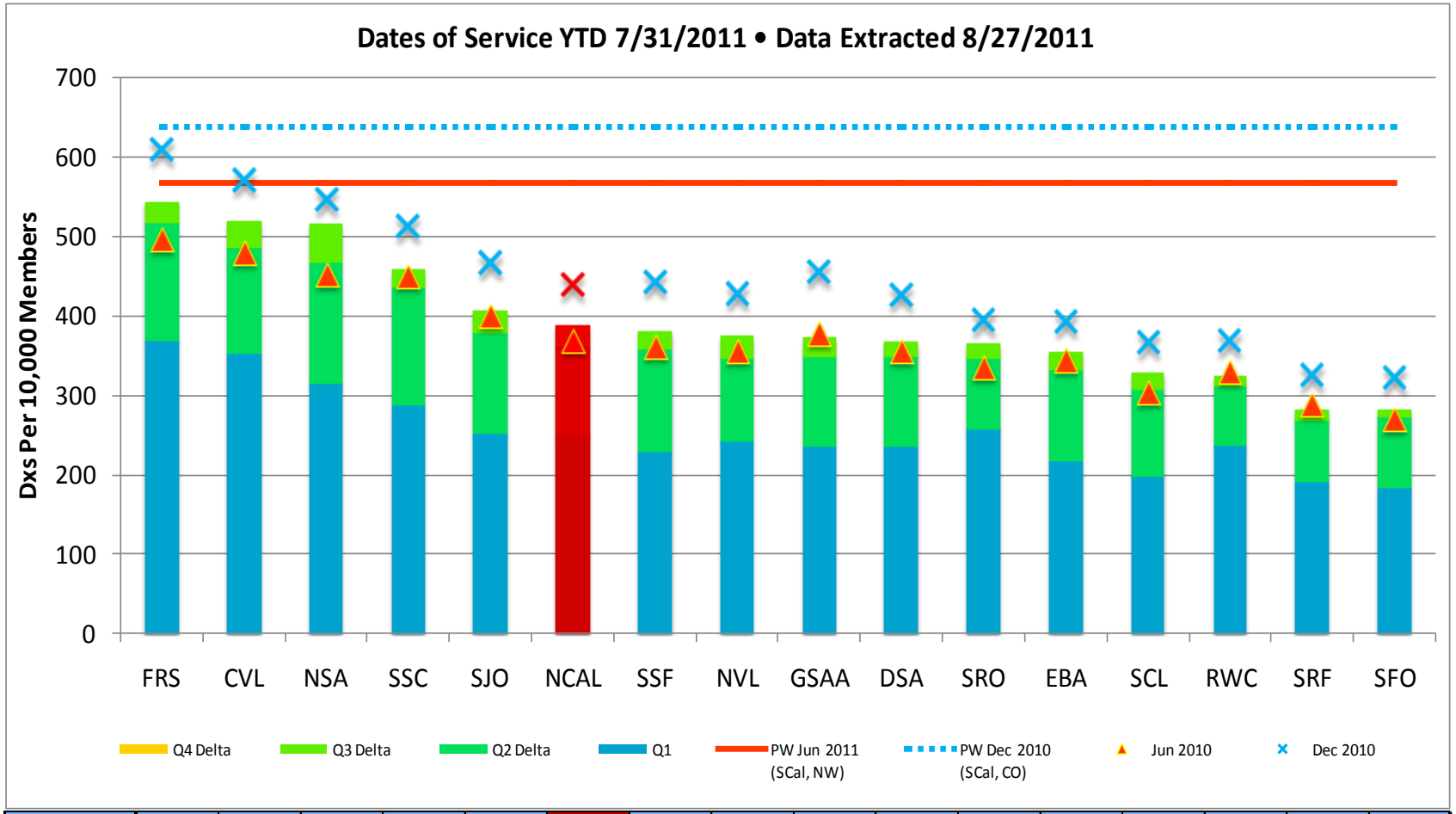


HCC15	SSF	SJO	SSC	NSA	CVL	GSAA	SFO	FRS	SCL	EBA	NCAL	NVL	RWC	DSA	SRO	SRF
Jul 2011	1,227	1,149	1,137	1,090	1,080	1,019	1,017	975	947	925	911	840	749	705	629	517
Jul 2010	1,117	1,073	1,085	952	1,002	1,020	936	917	892	886	861	805	706	685	596	502
Jul 2009	1,082	1,038	902	884	987	969	823	822	829	743	768	654	669	575	526	421

ER-562

REL0000097

HCC 16: Diabetes w/ Neurologic or Other Specified Manifestation



HCC16	FRS	CVL	NSA	SSC	SJO	NCAL	SSF	NVL	GSAA	DSA	SRO	EBA	SCL	RWC	SRF	SFO
Jul 2011	544	519	516	458	406	387	381	375	373	368	365	355	328	324	282	282
Jul 2010	498	481	453	452	401	369	363	356	379	356	336	345	304	329	289	270
Jul 2009	428	379	379	360	355	303	330	273	324	283	277	271	247	283	238	250

Increased Capture of Diabetes Specificity

Issue: Expected increase in the capture of Diabetes HCC 15 and/or HCC 16 from implementation of Diabetes Questionnaire has not occurred.

Discussion

- Have all Med Ctrs implemented Questionnaire?
- What are obstacles to implementation?
- How can obstacles been overcome?
- Are physicians aware of need to capture the higher specificity of Diabetes?

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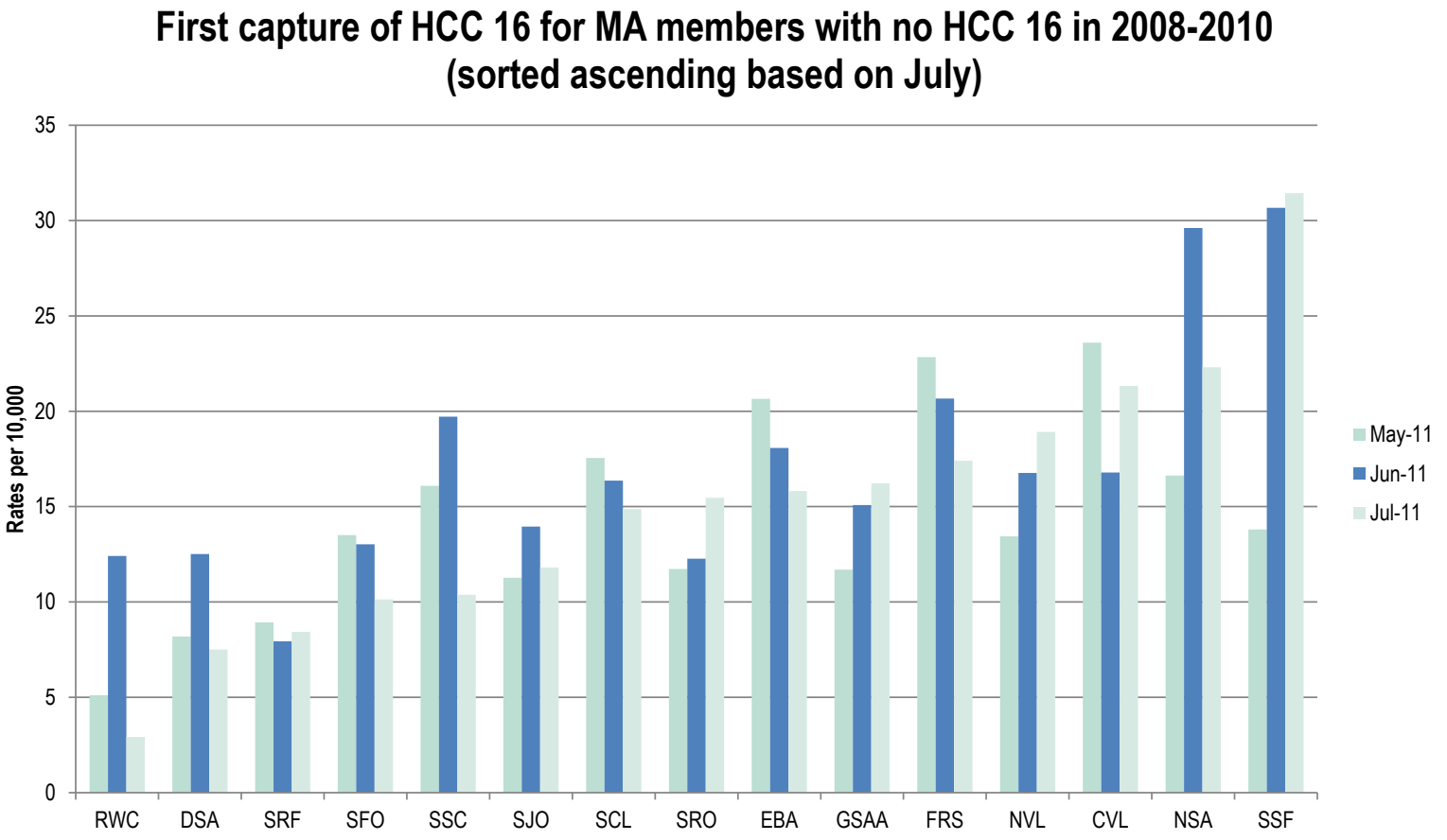
HCC 16 - May, June, July 2011



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ER-565

REL0000100

CKD

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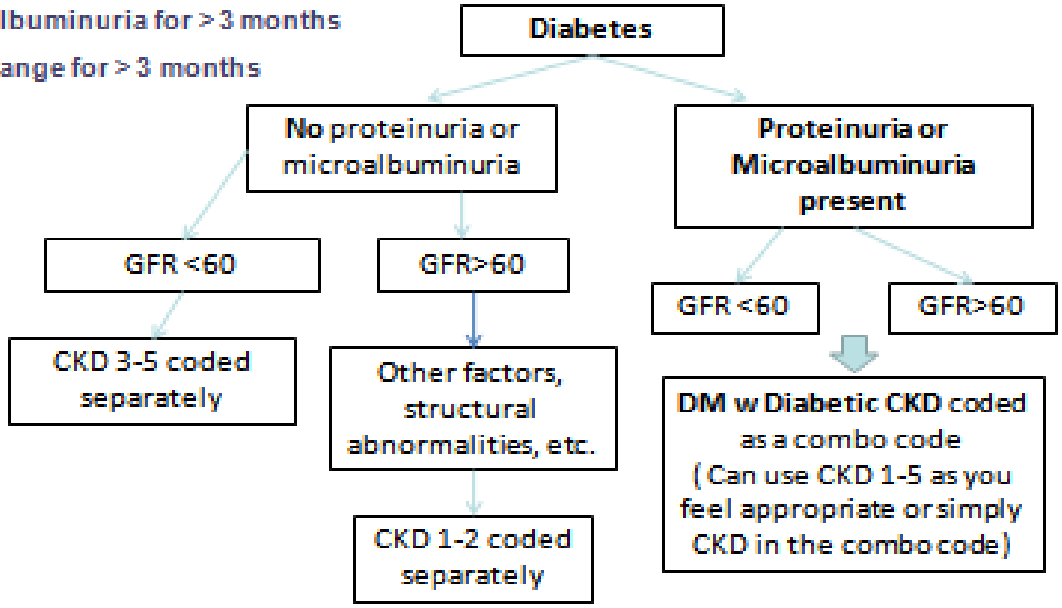
Revised CKD Algorithm

*Nephrology Dept. in Agreement

Diabetic CKD – Algorithm*

- Proteinuria is defined as a protein/creatinine ratio greater than 0.2 for > 3 months, or an abnormal 24-hour urine protein result for > 3 months.
- Abnormal Microalbuminuria for > 3 months
- Abnormal GFRs range for > 3 months



2

*No longer need to factor in retinopathy in the decision

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REL0000102

Ncal – Only Region Using HCC 132 - Nephritis

HCCs by Region

RATS Extract date: 8/20/2011

Data Period : 1/1/2011 - 07/31/2011

Region	Category	Description	Count	Members	Rate per 10,000 in Region
CO	HCC132	Nephritis	190	69,488	27
GA	HCC132	Nephritis	45	15,294	29
HI	HCC132	Nephritis	25	23,891	10
MA	HCC132	Nephritis	24	40,703	6
NC	HCC132	Nephritis	7,724	385,149	201
NW	HCC132	Nephritis	160	56,178	28
OH	HCC132	Nephritis	222	18,267	122
SC	HCC132	Nephritis	172	362,383	5

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Vascular Disease

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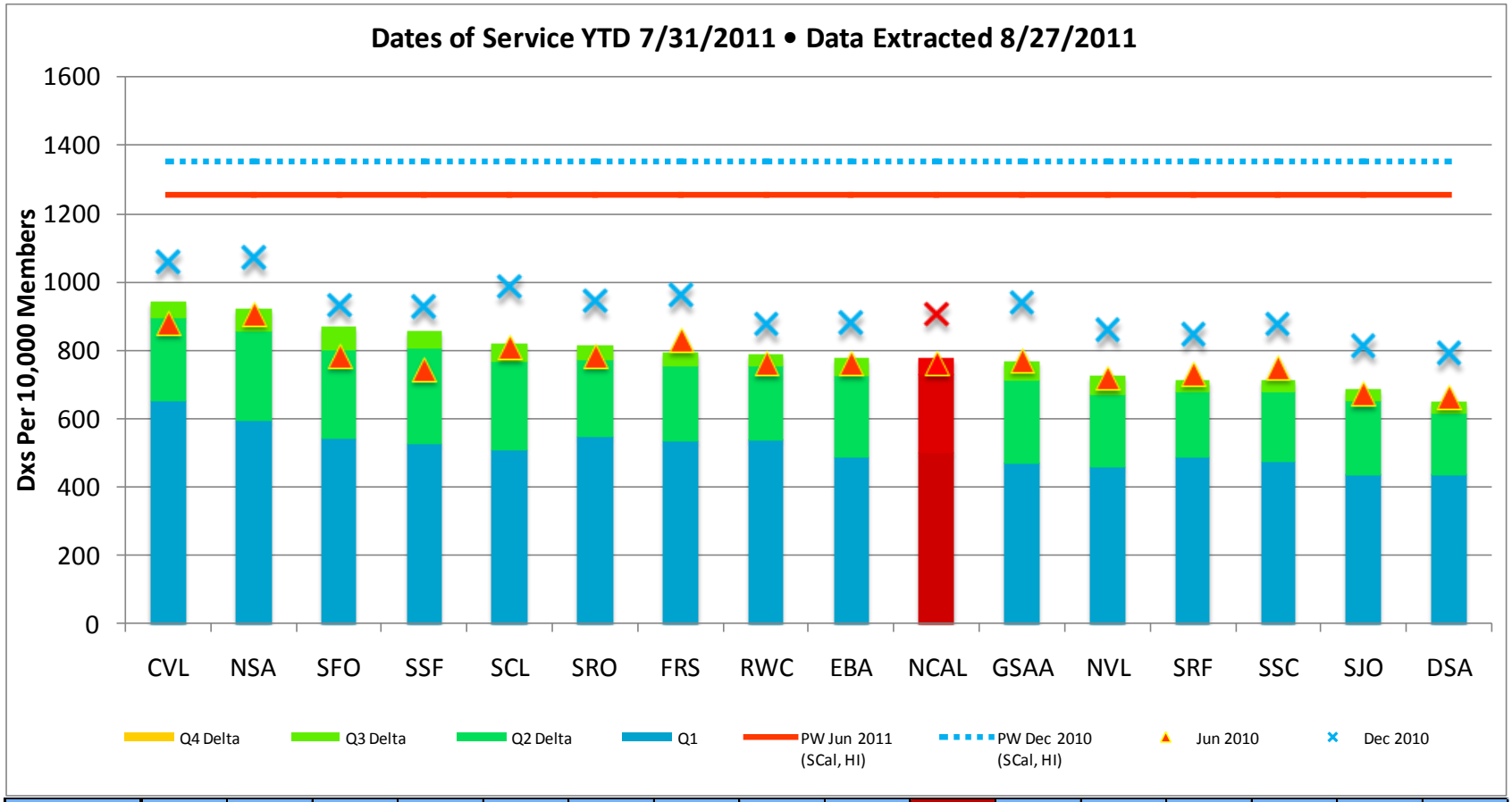
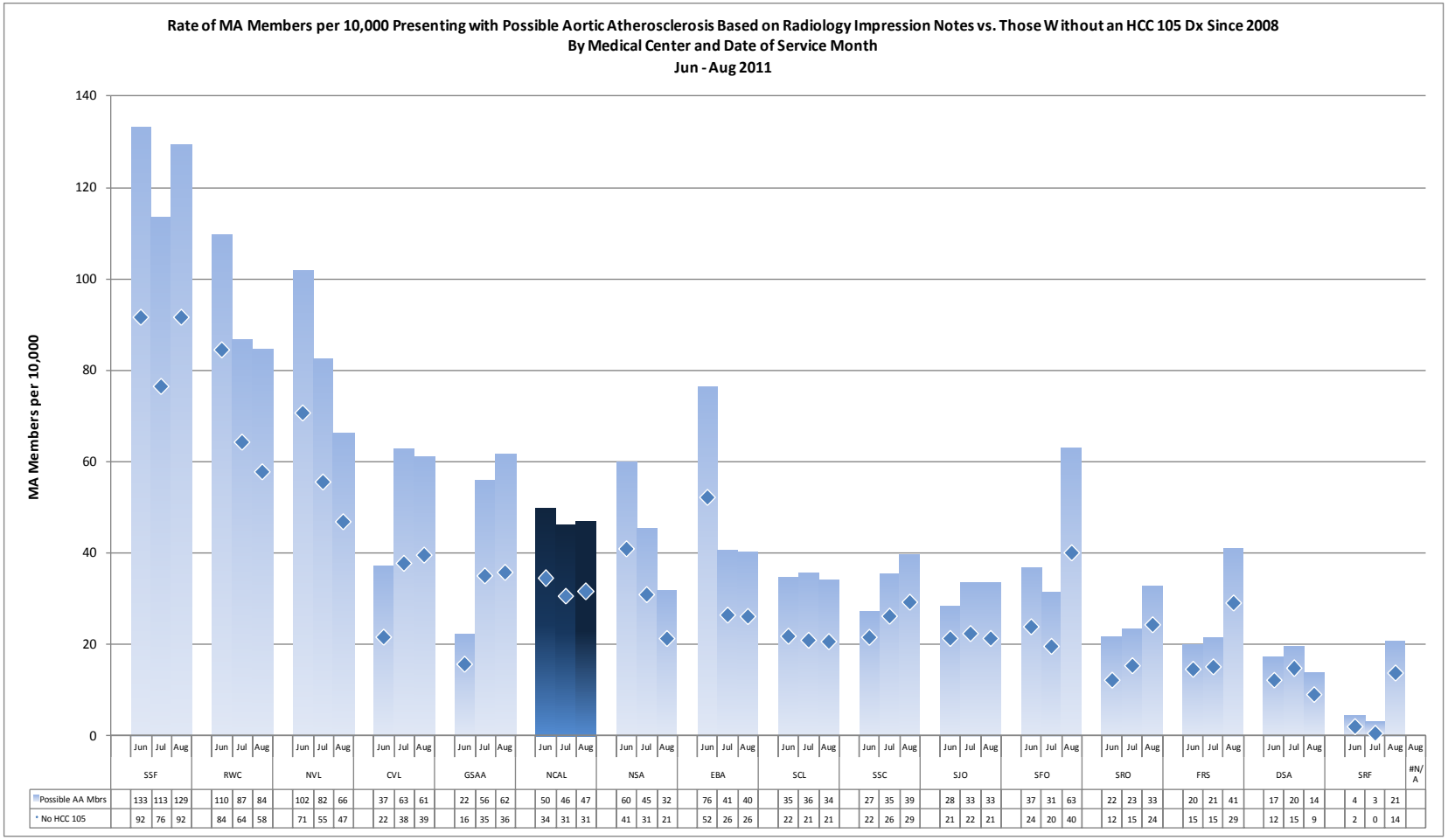
HCC 105: Vascular Disease



HCC105	CVL	NSA	SFO	SSF	SCL	SRO	FRS	RWC	EBA	NCAL	GSAA	NVL	SRF	SSC	SJO	DSA
Jul 2011	941	921	868	856	819	812	795	790	777	775	767	723	712	711	686	650
Jul 2010	883	908	784	746	811	783	833	763	763	764	772	719	733	749	673	665
Jul 2009	805	777	674	624	696	643	684	666	666	658	727	600	595	619	649	568

Aortic Atherosclerosis



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REL0000106

Vascular Disease – Capture of Aortic Atherosclerosis

Area of significant missed opportunity

Review and Capture Process

- **Assure Radiologist** documents calcification in Aorta
- **Qtrly, Text parsing** locates records with potential diagnoses
- **Regional Clinical Team** reviews to ensure potential exists for diagnosis of Aortic Calcification
  - Dx Prompts now on MDP as Data Mining
  - Tracked separately / not added to Data Mining denominator
- **Treating Physician Captures Dx**
  - Reviews Radiology Impression Note
  - Evaluates and make diagnosis in Visit Note or Addendum or Stop Prompts, as appropriate

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REL0000107

Aortic Atherosclerosis (cont.)

Issues for Clarification

- **PHASE Program** – Patient no longer automatically entered into PHASE, as of September, 2011
- Physician decides whether to add patient to PHASE

Trainer and Physician Lead

- Assure Radiologist captures impression
- Remind Physicians to review Radiology Impression Notes
- Co-lead Training at Medicine Dept. meetings

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NCAL vs SCAL Vascular Disease Capture Rates

HCC 105	Rates / 10 k
NCAL	775
SCAL	1332

Dates of Service YTD 6/30/2011 ~ Data Extracted 8/27/2011

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Protein Calorie Malnutrition

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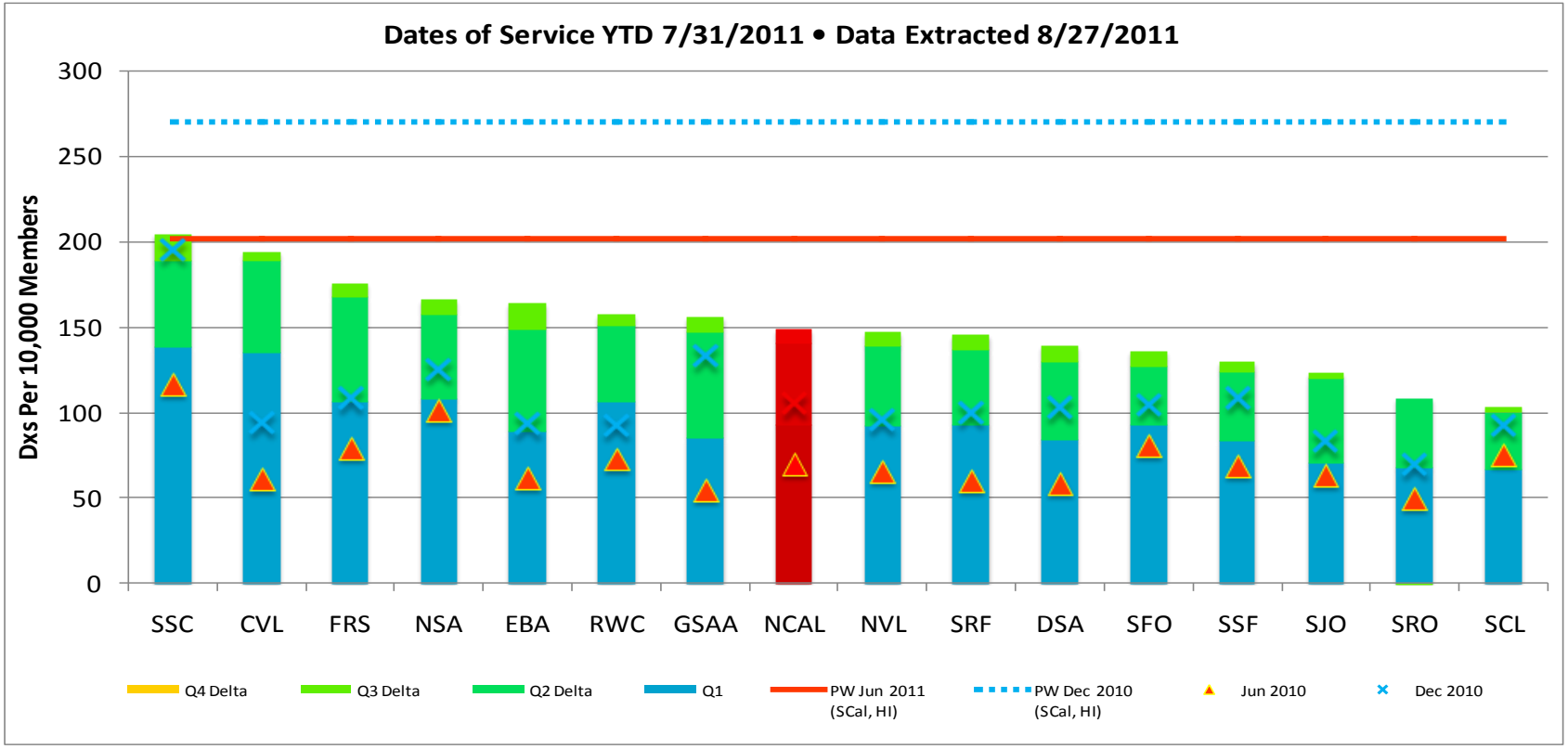
HCC 21: Cachexia / Protein-Calorie Malnutrition



HCC21	SSC	CVL	FRS	NSA	EBA	RWC	GSAA	NCAL	NVL	SRF	DSA	SFO	SSF	SJO	SRO	SCL
Jul 2011	204	194	176	166	164	158	156	149	147	145	139	136	130	124	106	104
Jul 2010	117	61	79	102	62	73	55	70	66	60	59	81	69	64	50	75
Jul 2009	70	37	62	75	54	49	29	49	44	66	34	54	58	54	36	46

Protein Calorie Malnutrition

Actions Needed

- Coordinate local Med Ctr Work Group to monitor diagnosis capture process and metrics
  - Include: Registered Dietitian, Wound Care Nurse, CDI Physician Champion, Trainer
  - Monitor available metrics (RD and CDI Reports)
  - End-to-End reporting is being developed

- Continue Repeat Training
  - Inpatient
  - Ambulatory – continue to emphasize Cachexia

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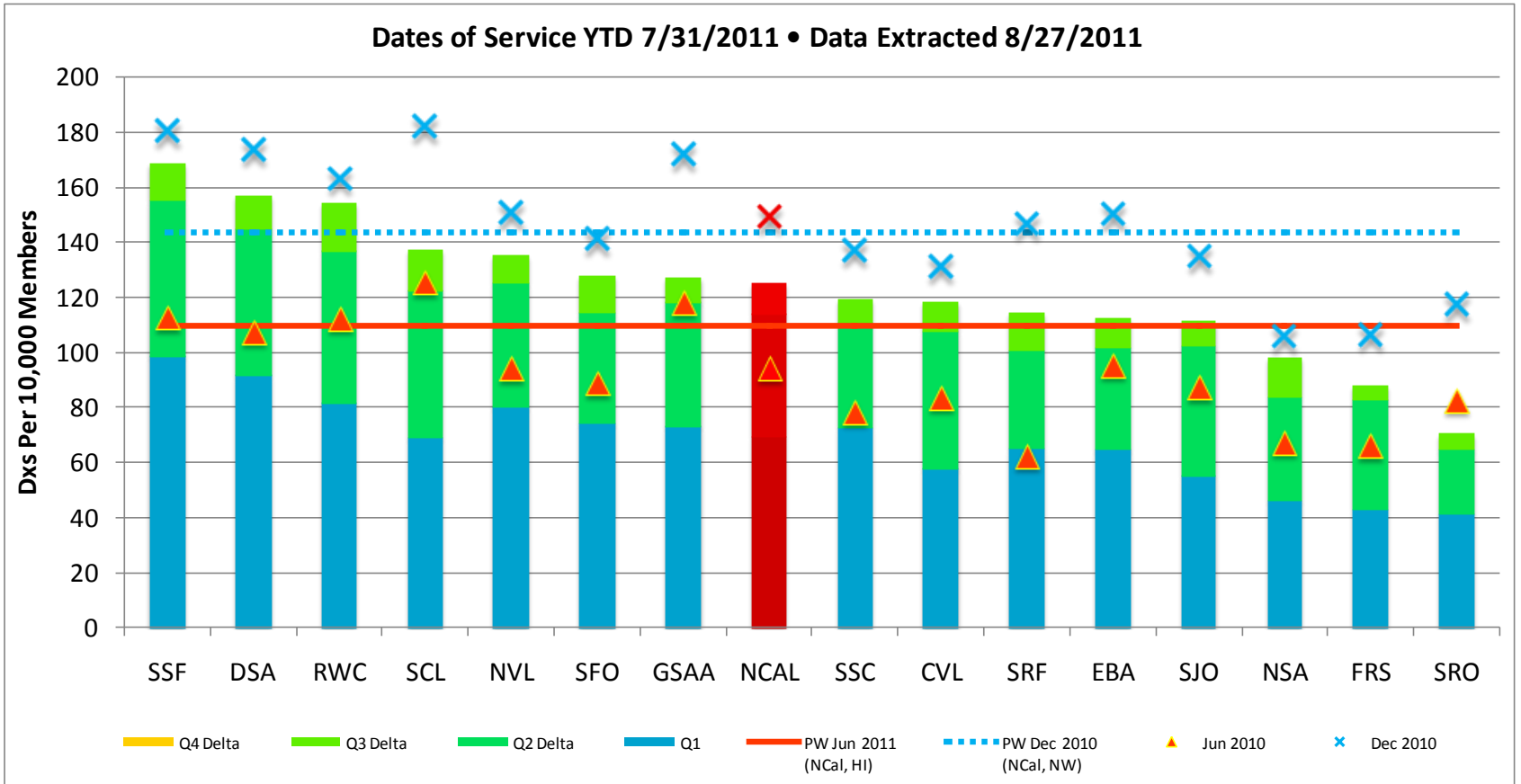
HCC 2: Septicemia/Shock



HCC2	SSF	DSA	RWC	SCL	NVL	SFO	GSAA	NCAL	SSC	CVL	SRF	EBA	SJO	NSA	FRS	SRO
Jul 2011	169	157	154	137	135	128	127	125	119	118	115	112	111	98	88	70
Jul 2010	113	108	113	126	94	89	118	94	78	84	63	95	88	67	66	83
Jul 2009	67	58	61	79	40	46	64	54	52	41	47	52	60	56	59	74

Other HCC Clarification

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Vertebral Fracture

Diagnosis Clarification

- Chronic when on
  - long-term calcitonin
  - analgesic
  - or referral for evaluation of vertebralplasty

Dementia – Memory Clinics

Expect CMS to add back for 2012 dates of service

- Important to Develop / Enhance Memory Clinics to
  - Assist with making diagnosis of Dementia w/ Complications
  - Assure quality treatment and follow up for patient and care of family members

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Demonstration of Medicare Advantage Tracking Tool (eCode)

ERIC WANG, M.D. – North Valley Physician Lead

Joel Weiner, Dir. EIO Business Intelligence Team

Aileen Abrenilla, Manager BIT

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BREAK TIME

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ER-583

REL0000118

Encounter Coding Strategy

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Encounter Coding Strategy

- **Effective October 19th most encounters will require an E/M, Time-based LOS or Procedure Only Code**
  - Beginning January 1, 2012, CMS will require that organizations submit full claims data (the same data required for a Fee-for-Service patient) for each encounter with an MA patient.
  - Important components of claims data are E/M, Time-based LOS or Procedure Only codes
  - Without encounter codes, we could lose significant revenue
  - This should not be a problem for most of our clinicians because these codes are currently being assigned to more than 75% of all visits, not just those for which the BPA has fired. Many clinicians are already coding 100% of all their visits.
- **Hard Stop triggered by combination of Encounter & Provider Types**

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Required Provider Types for E/M, Time-based LOS and Procedure Only Codes

- **Provider Types to be Included in Phase 1 – October 19th**
  - Physicians – part-time and pool
  - Podiatrists
  - Physician Assistants
  - Nurse Practitioners *
  - Optometrists *
  - Maxillofacial Surgeons

  * Pending further leadership discussions
- **Provider Types to be Included in Phase 2 (BPA will continue to fire on billable encounters **) - date to be determined**
  - Psychologists **
  - LCSWs **
  - Continuum of Care Providers
  - Allied Health Professionals who provide 'incident to' services – RN, Marriage Family Therapists, etc..
  - Residents in the Ambulatory setting to be evaluated prior to Phase 2

**Note if Phase 2 is implemented after January 1, 2012 , the BPA will expanded to MA billable encounters

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Required Encounter Types for E/M, LOS and Procedure Only Codes

- **Encounter Types to be Included in Phase 1 – October 19th**
  - Office Visits
  - Office Visit - Workers Comp and Workers Comp MH/BH
  - Office Visit - Chemical Dependency
  - Office Visit - MH/BH
  - Office Visit - Adolescent
  - Confidential Visit – Adult, Adolescent
  - Pre-Op Visit
- **Encounter Types to be Included in Phase 2 – date to be determined**
  - Office Visit – OB
  - CLIN DOC (e.g. for Rad Onc)
  - Continuum of Care
  - Allied Health
- **TAVs will continue to be Excluded**

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Clarifications for Coding

- **Consults** – Designation is no longer recognized by CMS and is already removed as an option in KPHC. These will be coded using the standard E/M codes for office visits (99201-99215).

- **New vs Established** – No longer requires provider selection. Now identified by KPHC via EPIC functionality or Revenue Cycle edits

- **Preventive Codes** – Option has been added as a 'drop down' selection in KPHC making codes easier to find in provider workflow.

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Clarification for Coding (cont)

- **Procedure Only Visits**
  - Use “PROCEDURE ONLY” - formally labeled as “NO LOS REQUIRED”

- **Global Services** - Bundling of charges will be managed by Revenue Cycle; Providers will not need to know global period

- **Modifiers –** Providers no longer required to capture Modifiers; Modifiers will no longer be available for selection - with exception of Modifier 57 Decision for Surgery. Will be captured/assigned in Revenue Cycle edits

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E/M Training and Reporting

- **Training**
  - Updated Materials Available
  - Training Priority based on Provider / Dept. Coding Completion Reports
  - Collaboration with KPHC Site Support
  - Documentation & Coding Lead Role
    - Assure that all Providers have received Leadership Message regarding Hard Stop
    - Support Trainers in getting time on Dept or Module meetings for training
- **Reporting**
  - Monthly encounter closure reports will be sent to PIC's, by department and provider, to monitor encounters not meeting the 48 hour closure requirement

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CELEBRATION TIME !!!

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APPENDIX

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Cancer Accuracy Rates and Volumes

LMC	Jan 2010 Dates of Service			Jul 2011 Dates of Service		
	Accuracy Rate	Dxs Evaluated	Dxs Loaded	Accuracy Rate	Dxs Evaluated	Dxs Loaded
CVL	64.2%	695	950	91.6%	476	523
DSA	72.4%	1,055	1,768	92.2%	1,004	1,030
EBA	74.6%	485	790	89.9%	605	617
FRS	66.9%	507	707	94.5%	398	402
GSAA	73.2%	497	938	94.4%	591	612
NSA	65.6%	497	716	89.6%	537	553
NVL	73.1%	1,744	2,391	89.8%	1,214	1,347
RWC	77.8%	406	607	91.7%	288	313
SCL	74.1%	902	1,419	90.8%	885	926
SFO	77.3%	392	641	93.7%	398	403
SJO	72.2%	353	621	88.5%	321	337
SRF	71.2%	559	785	89.2%	351	380
SRO	78.1%	543	692	89.7%	359	375
SSC	68.4%	471	650	94.1%	372	419
SSF	81.0%	567	840	95.6%	432	539
NCAL	72.6%	9,673	14,515	91.5%	8,231	8,770

CVA Accuracy Rates and Volumes

LMC	Jan 2010 Dates of Service			Jul 2011 Dates of Service		
	Accuracy Rate	Dxs Evaluated	Dxs Loaded	Accuracy Rate	Dxs Evaluated	Dxs Loaded
CVL	5.1%	39	44	9.1%	11	14
DSA	14.7%	95	98	53.3%	15	17
EBA	31.9%	47	50	25.0%	20	23
FRS	20.0%	30	34	55.6%	9	12
GSAA	45.7%	35	39	21.4%	14	16
NSA	28.9%	45	46	71.4%	7	10
NVL	23.5%	98	103	35.0%	20	24
RWC	11.8%	34	37	66.7%	3	3
SCL	5.9%	85	90	16.7%	12	12
SFO	28.6%	28	31	50.0%	6	8
SJO	25.9%	27	31	60.0%	5	6
SRF	21.9%	32	33	14.3%	7	10
SRO	20.5%	44	50	14.3%	7	10
SSC	17.0%	47	49	75.0%	4	11
SSF	48.3%	29	32	50.0%	2	9
NCAL	21.1%	715	767	35.2%	142	185

FX Accuracy Rates and Volumes

LMC	Jan 2010 Dates of Service			Jul 2011 Dates of Service		
	Accuracy Rate	Dxs Evaluated	Dxs Loaded	Accuracy Rate	Dxs Evaluated	Dxs Loaded
CVL	2.1%	47	53	38.9%	18	28
DSA	9.3%	86	94	30.6%	36	41
EBA	18.3%	71	72	44.4%	27	30
FRS	29.3%	41	42	28.6%	14	16
GSAA	17.8%	45	59	57.9%	19	19
NSA	10.0%	50	52	66.7%	12	12
NVL	19.9%	156	162	64.9%	37	45
RWC	16.1%	31	32	83.3%	12	14
SCL	16.5%	79	88	42.5%	40	45
SFO	14.6%	48	50	80.0%	15	16
SJO	21.7%	46	47	54.5%	11	12
SRF	10.5%	57	57	100.0%	1	4
SRO	13.5%	52	52	28.6%	14	18
SSC	17.9%	28	28	60.0%	5	9
SSF	11.4%	44	44	60.0%	5	8
NCAL	15.4%	881	932	50.0%	266	317

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EXHIBIT 10

June 16th, 2015 RRG WebEx

Time (PT)		RRG Agenda Topic	Discussion Leader
12:00pm	12:05pm	Introductions, Agenda Review, & Announcements	Simon Cohn, MD Hovannes Daniels Cindy Love
12:05pm	12:25pm	ICD-10 Update	Dr. Tom Hartman Ed Kho
12:25pm	12:35pm	ACA Analytics Status	Sandra Lopez
12:35pm	12:55pm	ACA Submission Status	Christy Lu
12:55pm	1:10pm	2014-2015 Risk Score Update	Leanne Powell
1:10pm	1:25pm	Comparison of RATS to Encounter Data	Jialin Gu
1:25pm	1:30pm	Wrap-up and Upcoming Events	Simon Cohn, MD Hovannes Daniels Cindy Love

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ICD-10 Update

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Part II : ICD-10 Readiness for Risk Adjustment
Risk Adjustment Analytical review

June 16, 2015

Tom Hartman, M.D.

Edward Kho

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Overview

What are the preparation plans for ICD10?

Two major efforts:

a) Risk Score Impact:
   - Assess impact of ICD9 to ICD10 to no HCC?
     - Fine tune ICD9 to ICD10 to EDG terms mapping

b) ICD10 Monitoring
   - Develop plan:
     - Identify reporting of volume/errors
     - Establish teams to triage ICD10 issues
     - Identify relevant Risk Adjustment metrics (existing & new) to spot ICD10 related deficiencies

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Risk Score Impact Analysis

Conduct Analysis

Focus of work with CMT/RA Analytics:

ICD9 to ICD10

Groupings	ICD9 count	ICD10 count
icd9 to icd10 do map to (ICD10) HCC	2,926	10,904
icd9 to icd10 do not map to (ICD10) HCC	8,961	54,529
icd9 to icd10	10,888	65,434

ICD9 to ICD10 to EDG terms

Groupings	ICD9 count	EDG Term count
icd9 to icd10 /w EDG terms	10,888	184,769
icd9 to icd10 do not map to (ICD10) HCC with EDG terms	8,961	156,706
icd9 to icd10 do not map to (ICD10) HCC with EDG terms /w freq	182	861

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Risk Score Impact Analysis (2)

Conduct Analysis

Common icd9 to idc10 to no HCC labeled "OK":

- Combo code and other code in HCC
- Subsequent or Sequela diagnosis
- Non-Medicare related Diagnosis

Group	examine	ok	Total ICD9 cohorts
Group 1: >500	12	41	53
Group 2: 200-499	5	13	18
Group 3 : 100-199	3	19	22
Group 4 : <100	39	50	89
Total ICD9 cohorts	**59**	**123**	**182**

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REL0000136

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Coder and Physician Modeler Review and Analysis (2)

Investigate ICD9 to ICD10 and how it relates to HCC

Example 1: Vascular Disease

icd9 code	EDG CID	EDG Display Name	icd10 code	ICD10 Descriptions	ICD9 HCC	ICD10 HCC	ICD9 Frequency
440.20	121141070	Atherosclerosis of right leg	I70.201	ATHEROSCLEROSIS	108	108	1,219
440.20	121141071	Atherosclerosis of left leg	I70.202	ATHEROSCLEROSIS	108	108	1,219
440.20	121141072	Atherosclerosis of bilat legs	I70.203	ATHEROSCLEROSIS	108	108	1,219
440.20	121141330	Right brachiocephalic artery stenosis	I70.8	ATHEROSCLEROSIS	108	no hcc	1,219
440.20	121141331	Left brachiocephalic artery stenosis	I70.8	ATHEROSCLEROSIS	108	no hcc	1,219

- Verify ICD9 to ICD10 coding
- Check for other available EDG terms to get us HCC 108

Result: Good news ! Coders re-map to I70.208: Unspecified atherosclerosis of native arteries of extremities, other extremity

- ICD10 I70.208 maps to HCC108

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ER-603

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Coder and Physician Modeler Review and Analysis

Investigate ICD9 to ICD10 and how it relates to HCC

a) Verify coding: Validate ICD9 to ICD10 ✓
b) Conduct Coder review ✓
c) Physician CMT Modeler review
   a) Do we need to add or edit terms in EDG file?
   b) Consider other what other ICD10 to get to HCC?
   c) Do we need to change EDG term to map to HCC?

Group sets	icd9 code	EDG terms
Set 1 : >500	12	40
Set 2: 200-499	5	25
Set 3: 100-199	3	8
Set 4: <100	39	82
Total:	59	155

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ER-604

REL0000138

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Benefits

Benefits to this exercise:

1) Fine tune EDG Term describing ICD9 to ICD10
2) With Coding corrections and EDG terminology review – mitigate ICD9 to ICD10 to no HCC mapping
3) Potential to improve use of ICD10 Diagnosis calculator

Example: Major Depressive Disorder

Display Name	ICD9	ICD10	Total KP Encounters over 2 years
MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE	296.3	F33.9	1,579,054
MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, MODERATE	296.32	F33.1	433,088
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE	**296.2**	**F32.9**	**343,435**
MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, IN FULL REMISSION	296.36	F33.42	263,308
MAJOR DEPRESSIVE DISORDER RECURRENT EPISODE, IN PARTIAL REMISSION	296.35	F33.41	171,897
MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, MILD	296.31	F33.0	136,895
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, MODERATE	296.22	F32.1	106,732
MAJOR DEPRESSIVE DISORDER, RECURRENT EPISODE, SEVERE	296.33	F33.2	97,352
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE, IN FULL REMISSION	296.26	F32.5	63,530

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Benefits (2)

Display Name	ICD9 code	ICD10 code	Total KP use over 2 years
DEPRESSION, UNSPECIFIED	311	**F32.9**	619,919
MAJOR DEPRESSIVE DISORDER, SINGLE EPISODE	296.2	**F32.9**	343,435
DEPRESSIVE DISORDER	311	**F32.9**	137,783
MOOD DISORDER WITH DEPRESSIVE FEATURE	296.2	**F32.9**	25,379
SENILE DEMENTIA WITH DEPRESSION	290.21	F03.90, **F32.9**	2,482
REACTIVE DEPRESSION	300.4	**F32.9**	2,223
MULTI INFARCT DEMENTIA WITH DEPRESSION	290.43, 437.0	F01.50, **F32.9**	125
PRESENILE DEMENTIA WITH DEPRESSION	290.13	F03.90, **F32.9**	119

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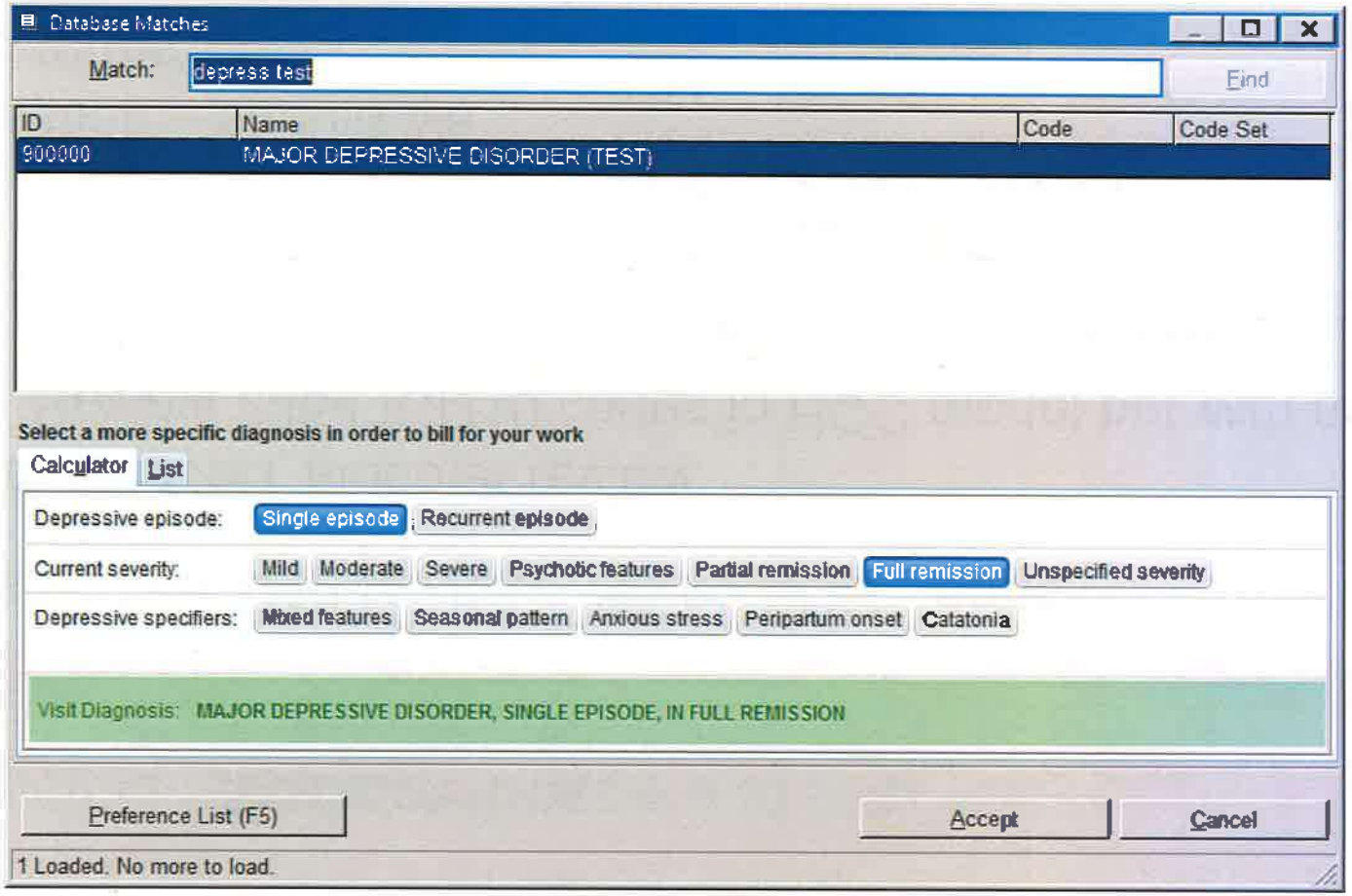
Proposed Major Depression Calculator



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Physician Modeler Review and Analysis

Investigate ICD10 to HCC with no EDG Terms

- Physician CMT Modeler review:
  - Review 2364 ICD10 codes in HCC model but with no current EDG term

Examples:

icd10_code	description
C40.80	Malignant neoplasm of overlapping sites of bone and articular cartilage of unspecified limb
C40.90	Malignant neoplasm of unspecified bones and articular cartilage of unspecified limb
C69.20	Malignant neoplasm of unspecified retina
D68.8	Other specified coagulation defects
D70.8	Other neutropenia
D83.8	Other common variable immunodeficiencies
E08.311	Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
F33.40	Major depressive disorder, recurrent, in remission, unspecified
S98.149A	Partial traumatic amputation of one unspecified lesser toe, initial encounter
Z89.419	Acquired absence of unspecified great toe

Question – should we add terms?

Many codes on the list are related to "unspecified" laterality

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ER-608

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Timing

Risk Score Impact Timing – ETA July 2015

	Start	End	Deliverable	Participants
Data analysis	7-May	13-May	Integrate i9 to i10 to i9/hcc and i10 /hcc	Edward Kho & Ken Nelson
Mapping Review	14-May	1-Jun	Review and assess i9 to i10 to no i10/hcc	Dr T Hartman & Edward Kho
Coder and Physician modeler Review	5-Jun	17-Jun	Conduct deeper review of i9 to i10 to no i10/hcc	Dr T Hartman & coder team
CMT release date	18-Jun	21-Jul	change to master file (7/18) and regional production (07/21)	Dr T Hartman and team
Data analysis	21-Jul	24-Jul	re-run analysis and assess risk score impact	Rita Barsoum, Ken Nelson & Edward Kho

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Timing (2)

ICD10 Monitoring – ETA Aug 2015

	Start	End	Deliverable	Participants
Data extract - Clarity	15-Jun	19-Jun	Pull Claims data extract with ICD9/ICD10 for Reporting team.	Andy A./Julie Q.
Identify reports to monitor Volume/Rejections	22-Jun	26-Jun	identify all KPMETA and rejection reports. Establish access to claim level detail.	Risk Adjustment Work group
Identify reports to monitor Risk Adjustment Metrics	22-Jun	26-Jun	identify all existing Risk Adjustment reporting - Risk scores, HCC, PMPM to monitor completeness.	Risk Adjustment Work group
Adjust reporting requirementts	29-Jun	3-Jul	Define existing or produce new metrics.	Ed K., Ken N., Gary B., Jialin G., Julie Q.
Produce pro-forma report deck	6-Jun	3-Aug	Establish reporting deck to monitor pre vs post cutover	Ed K., Ken N., Gary B., Jialin G., Julie Q.

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ACA Analytics Status

- Identifying New ACA Members with Conditions
- ACA Benchmark Comparison (Understanding our Membership)
- Understanding ACA Enrollment Patterns / Analysis of Churn

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Identifying New ACA Members with Conditions

- Background
  - Use vendor database to supply condition information on new-to-KP and existing members. Implement an "overlap" test run of membership to the vendor database to determine fit of our membership to vendor's financial/insurance oriented data.
- Status Update
  - KP had contracted with MIB to conduct a pilot study
  - MIB has discontinued this product offering to new clients
  - MIB database no longer an option for KP
- Next Steps
  - Evaluating new vendor solutions
    - The Milliman AlertRx system is a tool for payers to optimize their risk adjustment revenue by instantly identifying potential HCCs for members as well as proactively identifying and enrolling high cost members into case management (CM) or disease management (DM) programs.

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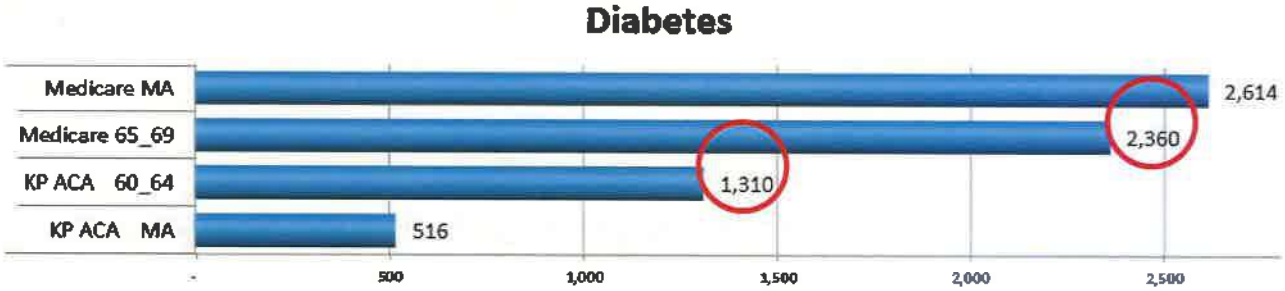
ACA Benchmark Comparison (Understanding our Membership)

- **Background**
  - How do ACA HCC rates per 10K compare to Medicare populations, and Wakely benchmarks when the ACA model is run on each population?
    - Closely examine the ACA 60-64 year olds with the Medicare 65-69 year olds

- **Status Update**
  - Preliminary analysis complete: Medicare membership run through ACA model.

- **Next Steps**
  - Exec. Brief (July)
  - All ACA HCCs
  - Regional View



program wide results, 2014 data, 03/21/15 extract, silver coefficients

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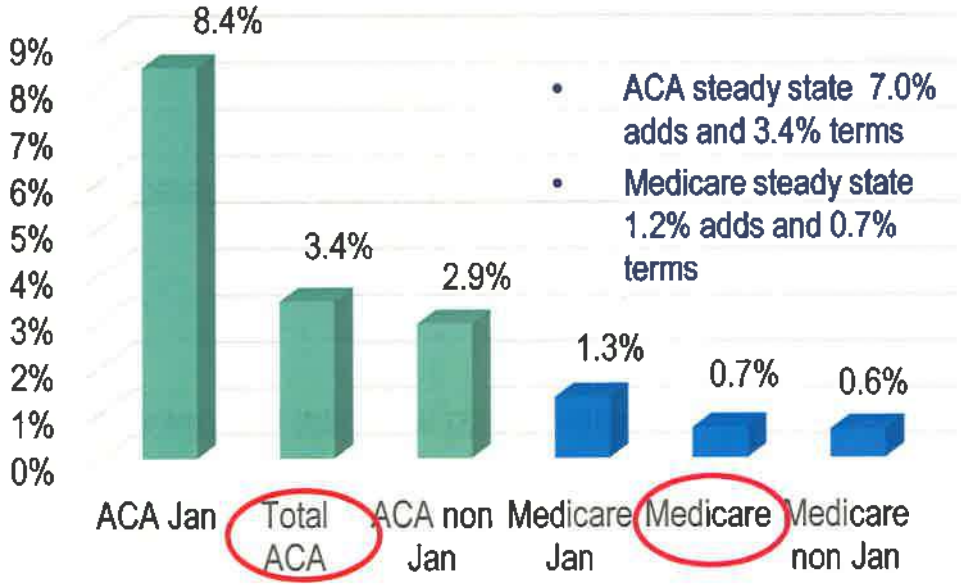
Understanding ACA Enrollment Patterns / Analysis of Churn

- **Background**
  - Understanding differences in enrollment, disenrollment, and stable enrollment.
    - How sticky are the ACA members compared to Medicare?

- **Status Update**
  - Adds/Terms calculations performed at regional level
  - Analysis underway

- **Next Steps**
  - Executive Brief (July)
  - Regional Views with Highlights



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ACA Submission Status

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ACA Submission Status

HHS Update:

- HHS closed submissions on 5/15
  - Currently in 'Blackout' period, meaning no 2015 data can be sent to the Edge Server
  - CMS will reopen submissions for 2015 data at a later date (expected late June / early July)
  - Supplemental Submissions
    - Over 18K supplemental diagnoses submitted
  - Enhancements and break fixes underway during transition from project to operations, planned through August. Analysis underway of data submission results.

	Accepted Claims	Rejected Claims	Percentage Rejected
Medical	5,318,055	39,676	0.75%
Pharmacy	3,554,660	2,040	0.06%

Risk Score Accuracy and Completeness:

Future Enhancements

- EDGE Server team continues enhancements and Phase 2 development initiatives to expand system functionality
  - Includes Automation, Standardization of Production and Operations, Enhancements for Efficiency

Reporting

- Comprehensive analytic reporting capability still in definition
- Scope evaluation in progress to define requirements. Targeting multiphase approach.
- Expanded operational reporting functionality continuing to roll out

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Formal Discrepancy Reporting – Final

- CMS has established a process to file discrepancies that Issuers find in CMS RA/RI reports
  - Team filed final discrepancies with CMS on 6/1/15
- Per CMS guidance and request, project focused on evaluating CMS calculations in seven RA/RI reports
  - Comparison analysis of detailed report lines, identifying where KP calculation differs from CMS calculation
  - Deep dive analysis to understand drivers of discrepancies
  - KP files discrepancy reports to CMS for their review; CMS determines if reports have errors and should be remediated
- In process
  - Waiting for CMS response on discrepancies
  - Reviewing / debriefing the project for standardizing the process, and plan for future

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Formal Discrepancy Reporting – Findings

Results:

Report	Content	Results
RACSD report	RA Claims Selection detail	-10.9M claim lines match at the claims header level - **Only 158** claims lines present on CMS but not on KP
RARSD report	RA Risk Score detail	-1.1M records. - **99.92%** match between KP report and CMS report
RIDE report	RI Enrollee detail	- Difference between CMS calculation and KP calculation is **~13K.**
RATEE report	RA Transfer Elements	-No significant differences identified from RATEE report. i) Plan liability risk score difference: the average difference is **-0.0002** ii) Allowable rating factor difference: the average difference is **-0.0004** iii) Plan's age adjusted average premium difference: the average difference is **0.0536**
RISR report	RI summary	- Completed. **No variance**
RACSS report	RA Claims summary	- Completed. **No variance**
RARSS report	RA Risk Score summary	- Difference identified from RARSS report is derived from the difference identified from RARSD report. There is no financial impact of this report.

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Reinsurance Recovery Estimates

- Submission completed for 2014

Regions	Est. As of 12/31/2014	Current Est.	Diff to Dec 2014
California	$186	$192	$6
Colorado	$19	$22	$2
Georgia	$5	$6	$1
Hawaii	$4	$4	$0
MidAtlantic	$5	$6	$1
Northwest	$9	$10	$1
Totals	**$228**	**$240**	**$12**

Notes: - $ in Million

- Current Est. is KP's calculation based on CMS run as of 5/15/2015.

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2014-2015 Risk Score Update

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2014 Risk Score is above budget program-wide

Medicare

2013 and 2014 scores calculated under the 2015 payment blend (67%/33%)

- Most regions are already above budget.
  - Regions are now focusing on retroactive initiatives (data mining, NLP, chart reviews) for 2014 data. The CMS deadline for submission of 2014 encounters is January 31, 2016. Please work with your regional submission team to determine internal KP submission deadline.

2014 Part C Risk Scores for 2015 MA Revenues

	2013 Actual	2014 Score 4/18/2015 Extract	2014 Score 5/23/2015 Extract	2014 v 2013	2014 Budget	Variance	Remaining Initiatives for 2014 Encounters
Colorado**	1.1451	1.1735	1.1581	0.0130	1.1808	-0.0227	NLP
Georgia	0.9855	1.0577	1.0536	0.0681	1.0512	Above Budget	
Hawaii	1.0382	1.0594	1.0601	0.0218	1.0590	Above Budget	NLP
Northern California	1.1604	1.1834	1.1830	0.0226	1.1761	Above Budget	NLP; External claims review; Inpatient Dec-Jan crossover review
Northwest	1.0954	1.1187	1.1187	0.0233	1.1142	Above Budget	NLP
Southern California	1.1414	1.1658	1.1654	0.0240	1.1505	Above Budget	NLP
MA Regions*	**1.1415**	**1.1662**	**1.1658**	**0.0243**	**1.1571**	**Above Budget**	
Mid-Atlantic	0.9277	0.9653	0.9654	0.0378	NA	NA	

Updated 05-23-2015

* The MA Regions risk score is an average of the regional risk scores, weighted by proportion of membership

** Colorado 2014 score is from 5/30/15 extract

2014 data are not final. Final submission deadline is January 31, 2016

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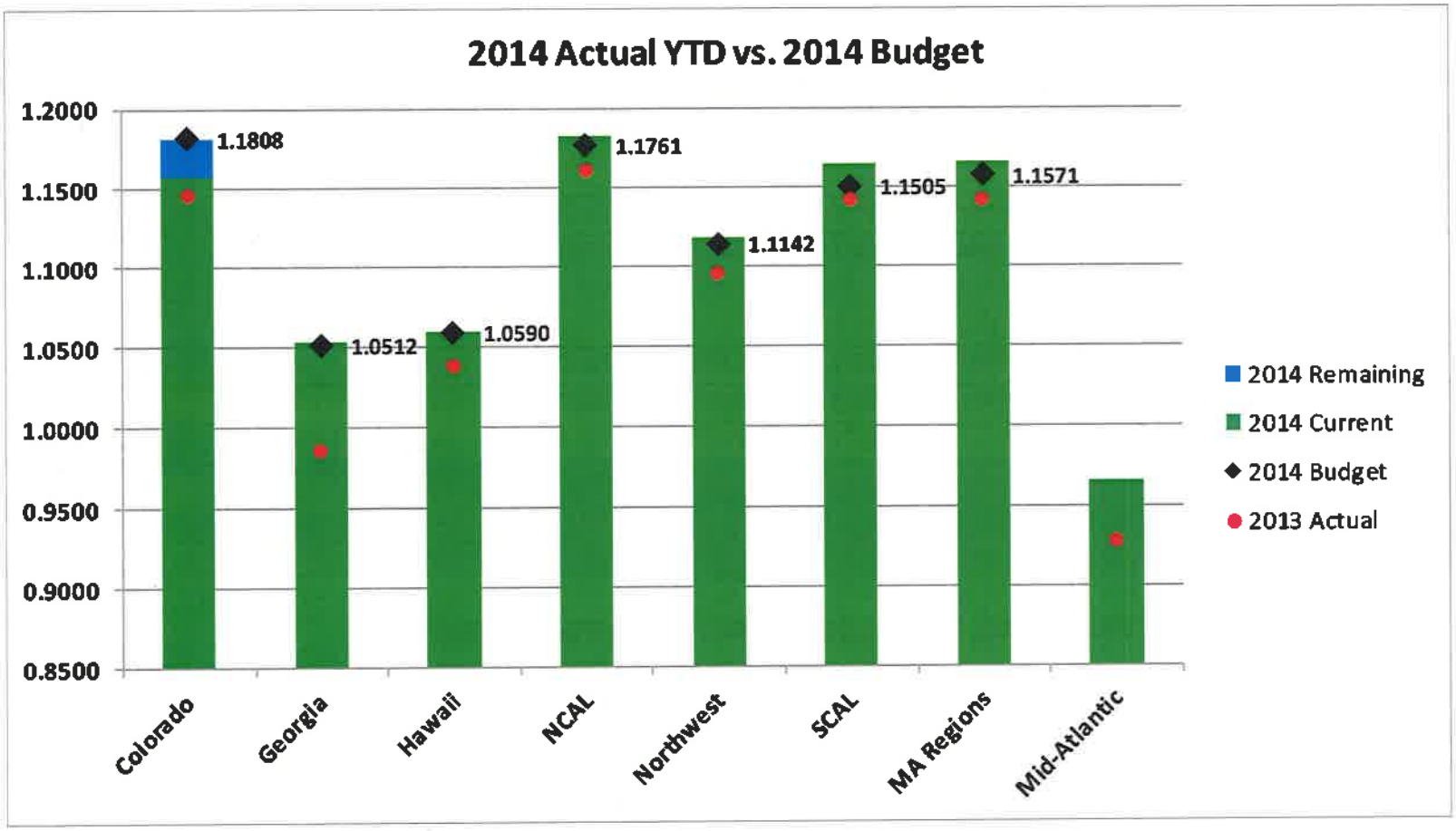
2014 Risk Score Improvement Targets by Region

Medicare

2013 and 2014 scores calculated under the 2015 payment blend (67%/33%)



2014 data are not final. Final submission deadline is January 31, 2016.

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2015 Program-wide YTD Risk Score

Medicare

This slide shows 2014 and 2015 scores under the 2014 model, which CMS will use for 2016 payments.

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC
2014	0.6394	0.7402	0.8195	0.8800	0.9305	0.9713	1.0049	1.0357	1.0628	1.0847	1.1047	1.1205
2015	0.6482	0.7534	0.8361	0.8871								
Change	0.0088	0.0133	0.0165	0.0071								
Trajectory	0.6409	0.7419	0.8214	0.8821	0.9327	0.9736	1.0072	1.0381	1.0653	1.0872	1.1073	1.1231
Target												1.1231
Target Increase												0.0026

Through March dates of service, risk score is ahead of last year by 1.6 points. Current target is for a 0.26 point increase over year end 2014 score.

2014 data are not final. Final submission deadline is January 31, 2016.

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2015 Risk Score Improvement by Refresh Type

Medicare

This slide shows 2014 and 2015 scores under the 2014 model, which CMS will use for 2016 payments.

2015 Program-wide MA risk score YTD is above prior year by 1.6 points

- Higher than last year in most Regions
- Annual target is for a 0.3 point increase program-wide

YTD 2015 Risk Score Compared to Same Months of 2014
By Refresh Type

	DOS Thru Date	Chronic Refresh	New HCCs	Other (1)	2015 YTD vs. 2014 Same Months	2015 Annual Budget Imprvm't (2)
Colorado	Mar	0.0171	0.0054	0.0014	0.0239	0.0196
Georgia	Mar	0.0405	0.0100	0.0094	0.0599	0.0369
Hawaii	Mar	(0.0090)	(0.0080)	(0.0036)	(0.0206)	0.0008
Mid-Atlantic	Mar	(0.0063)	0.0108	(0.0008)	0.0037	NA
Northern California	Mar	0.0138	(0.0003)	0.0040	0.0175	0.0033
Northwest	Mar	0.0239	(0.0012)	0.0030	0.0257	0.0197
Southern California	Mar	0.0102	(0.0035)	0.0089	0.0156	(0.0007)
MA Regions	Mar	0.0132	(0.0020)	0.0053	0.0165	0.0030

Updated 05-23-2015
(1) Including non-chronic refresh, refresh of HCCs for new-to-KP members, and demographics.
(2) Improvement compared to current 2014 scores.

2014 data are not final. Final submission deadline is January 31, 2016.

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2015 Metrics

Medicare

This slide shows 2014 and 2015 metrics under the 2014 model, which CMS will use for 2016 payments.

- 2015 performance is mixed
- More than 73% of the members have already been seen

2015 Metrics (2014 CMS Model)

Region	Access - % Mems w/RATS Enc			Prevalence - % Mems w/HCC			Complexity - HCCs/1000 Mems		
	2014	2015	YOY	2014	2015	YOY	2014	2015	YOY
Colorado	70.9%	72.0%	1.1%	40.3%	42.1%	1.8%	1,083	1,121	38
Georgia	77.9%	78.9%	1.0%	48.3%	52.6%	4.3%	1,049	1,247	197
Hawaii	78.6%	77.1%	-1.5%	44.9%	41.7%	-3.2%	978	883	(95)
Mid-Atlantic	74.1%	68.9%	-5.2%	42.6%	40.0%	-2.5%	879	867	(13)
Northern California	71.0%	69.7%	-1.3%	49.2%	49.0%	-0.1%	1,253	1,281	27
Northwest	73.9%	74.4%	0.5%	45.6%	47.4%	1.8%	1,125	1,195	70
Southern California	76.9%	76.0%	-1.0%	51.7%	51.9%	0.1%	1,228	1,250	22
MA Regions	**73.9%**	**73.1%**	**-0.8%**	**49.2%**	**49.4%**	**0.3%**	**1,212**	**1,240**	**28**

05-23-2015 RATS extract. Continuous members only.

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ACA Risk Score Summary – March 2015

- Existing Member year-to-date scores are higher than last month by 1.86 points program-wide.
  - Declines in some regions may be due to high proportions of 2015 existing members joining KP in 2014, a cohort who has shown to have lower scores than those who were members with KP before 2014.

ACA Risk Score Summary - March 2015 YTD					
	Risk Score				
Region	2015 YTD Existing	2014 YTD Existing	2015 vs. 2014 YOY	2015 YTD New	2015 YTD All Members
CO	0.7428	0.7585	(0.0157)	0.6789	0.7330
GA	0.9072	0.9259	(0.0187)	0.6472	0.8469
HI	0.7348	0.7683	(0.0335)	0.5504	0.7104
MA	0.7479	0.7534	(0.0055)	0.5643	0.6529
NCAL	0.7524	0.7268	0.0256	0.6199	0.7320
NW	0.9122	0.8473	0.0649	0.8265	0.9021
SCAL	0.7508	0.7327	0.0181	0.5797	0.7122
PW	0.7592	0.7406	0.0186	0.6003	0.7262

Risk scores are based on 5/11/2015 data extract.
Risk scores are based on silver metal plan coefficients.
Risk scores do not account for ACA enrollment impact (non-ACA dx capture, ACA mbr month weights)

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ACA Performance Metrics Summary – March 2015

- Members Seen has been updated to reflect only HHS eligible encounters based on the CPT filtering logic of the HHS Model.
- Members Seen (42.10%) and Members with HCC (11.62%) are both lower compared to Medicare, meaning fewer ACA members come in for a visit and fewer of those ACA members with a visit result in an HCC.

ACA Performance Metrics Summary - March 2015 YTD					
	Members Seen	Mbrs w HCC	Membership Volume		
Region	2015 YTD Members Seen	2015 YTD Members with an HCC	2015 YTD Total	Existing Member %	New Member %
CO	33.55%	8.46%	95,336	84.8%	15.2%
GA	42.46%	12.81%	30,126	76.8%	23.2%
HI	40.22%	7.77%	31,160	86.8%	13.2%
MA	37.93%	9.41%	107,707	48.3%	51.7%
NCAL	41.06%	12.59%	561,985	84.6%	15.4%
NW	43.28%	11.98%	38,577	88.2%	11.8%
SCAL	46.43%	11.77%	428,418	77.4%	22.6%
PW	**42.10%**	**11.62%**	**1,293,309**	**79.2%**	**20.8%**

Note:

- Metrics are based on 5/11/2015 data extract.

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RA Risk Score Summary (Medicare, ACA, CALPERS)

Through March/April

Summary of Key Risk Score Performance Metrics												
	Medicare Risk Score				ACA Risk Score				CalPERS Risk Score			
Region	2014 YTD Continuous	2015 YTD Continuous	2015 vs. 2014 YOY	2014 YE Continuous	2014 YTD Existing	2015 YTD Existing	2015 vs. 2014 YOY	2015 YTD All Members	2014 YTD Existing	2015 YTD Existing	2015 vs. 2014 YOY	2015 YTD All Members
Period	3/2014	3/2015	Change	12/2014	3/2014	3/2015	Change	3/2015	4/2014	4/2015	Change	4/2015
CO	0.7504	0.7743	0.0239	0.8342	0.7585	0.7428	(0.0157)	0.7330				
GA	0.7312	0.7911	0.0599	0.8465	0.9259	0.9072	(0.0187)	0.8469				
HI	0.7389	0.7183	(0.0206)	0.7632	0.7683	0.7348	(0.0335)	0.7104				
MA	0.6850	0.6888	0.0037	0.7297	0.7534	0.7479	(0.0055)	0.6529				
NCAL	0.8406	0.8581	0.0175	0.9112	0.7268	0.7524	0.0256	0.7320	0.9553	1.0191	0.0638	0.9976
NW	0.7860	0.8117	0.0257	0.8674	0.8473	0.9122	0.0649	0.9021				
SCAL	0.8232	0.8388	0.0156	0.8855	0.7327	0.7508	0.0181	0.7122	0.9394	0.9793	0.0399	0.9583
PW	0.8195	0.8361	0.0165	0.8871	0.7406	0.7592	0.0186	0.7262				
	Extract Date: 5/23/2015				Extract Date: 5/11/2015				Extract Date: 5/11/2015			

*** Risk Scores should not be compared between RA Programs. HHS Model used for ACA and CalPERS risk scores. CMS model used for Medicare risk scores. Models are different and yield different results***

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Comparison of RATS to Encounter Data

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Comparison of RATS to Encounter Data

Project Objective

- Compare RATS data with encounter data to identify data gaps on encounter level; research for root causes; and close encounter data submission gaps to achieve completeness of encounter data submission for payment neutrality.

Increased Urgency – CMS has Initiated Migration to rely on EDS for Risk Adjustment Payment

- CMS will use 2014 diagnoses from both RAPS and EDS to calculate risk score for 2015 payment. Use of 2014 EDS will be reflected in the final risk score calculation, in July 2016. Encounter data is to be used together with RAPS and FFS data with no weight applied to any source.

- CMS will calculate risk score using 90% of risk scores based on RAPS and 10% risk scores based on EDS for payment year 2016 (2015 DOS)

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Comparison of RATS to Encounter Data

Risk and Remediation –

- EDS submission gap could have relevant diagnoses linked to unique HCC resulting in loss revenue for payment year 2016.

- We have developed Supplemental Diagnosis Submission (SDS) to capture relevant diagnose accepted by CMS in RATS submission but no in EDS submission. However, SDS has its limitation –

Internal/External	Dx in EDS	Encounters in EDS	SDS Coverage
Internal	Missing	Found	Use EDS encounter information + Missing Dx
Internal	Missing	Missing	Use default value for encounter information + missing Dx
External	Missing	Found	Use EDS encounter information + Missing Dx
External	Missing	Missing	Out of Scope – Risk of loss revenue not covered by SDS

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Comparison of RATS to Encounter Data

Challenges –

- RATS and EDS are two different submission flow from different sources. Matching the data, as well as root cause analysis is challenging.

- Discrepancies could be results of
  - Missing matching keys
  - True data gaps

Current Status and Call for Action –

- Discrepancies have been identified

- Need collaboration between Regional teams (Rev Cycle and Claims) and Decision Support teams –
  - To perform root cause analysis on discrepancies – pull examples to research discrepancies to identify patterns; code and flag in the discrepant claim population; repeat the root cause analysis cycle to understand drivers for all discrepancies;
  - For identified root causes, to determine priority and collaborate for solutions to close the data submission gaps

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UPCOMING 2015 EVENTS

RRG Events

- 07/21/2015 – RRG WebEx
- 08/18/2015 – RRG WebEx
- 09/15/2015 – RRG WebEx

Other Events

- 6/30 – Final 2014 ACA Data Submission Report

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EXHIBIT 11

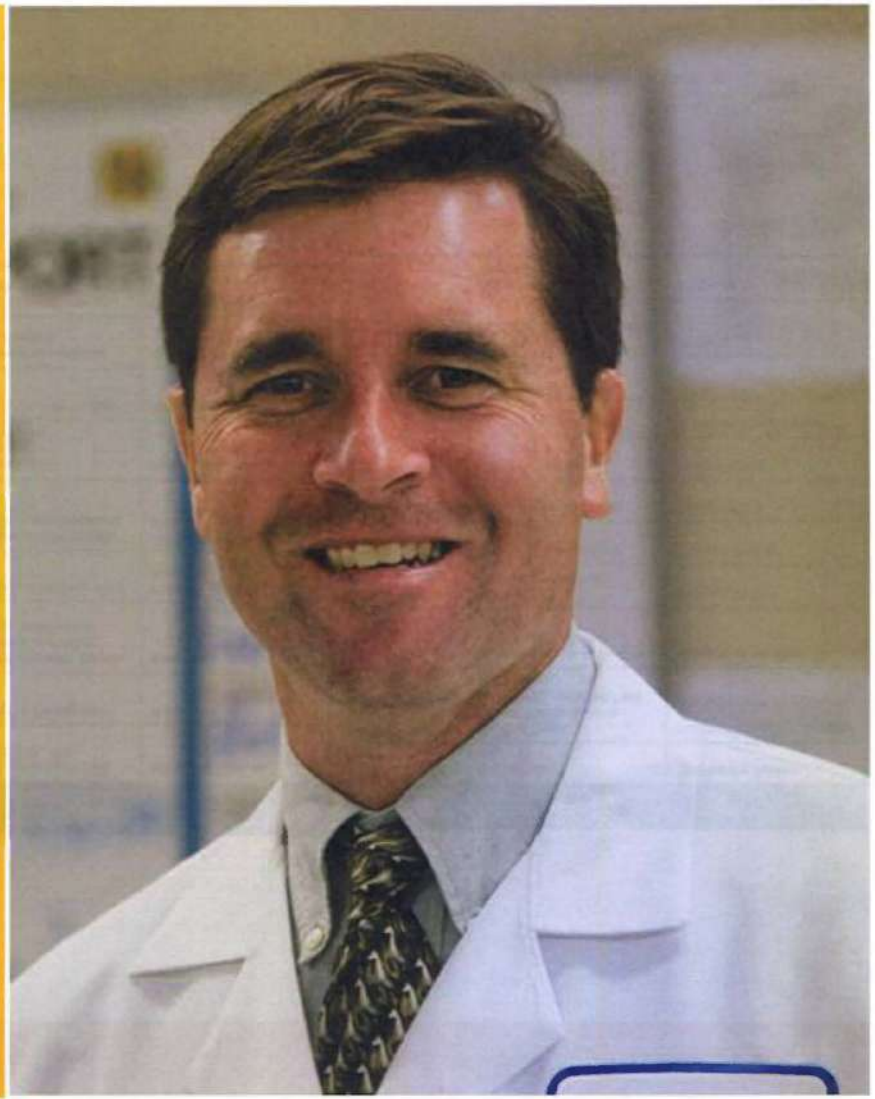
NORTHERN CALIFORNIA

Clinical Documentation Integrity (CDI) Program: Update

Dexter D'Costa, MBBS, MHA, CRCR
Regional Director, CDI

Helena Rush, RHIA, RHIT, CPC, CPC-H
QA Manager, CDI

HIM Peer Group Meeting
December 14, 2011



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revenueCYCLE

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NORTHERN CALIFORNIA

CDI – Current Scope

CURRENT SCOPE (Phase 1)

- **Medicare Advantage population**
- **Specific Physician Groups**
  - HBS (Hospital-based Specialists)
  - Intensivists (select facilities)
- **20 Hierarchical Condition Categories (HCC) diagnoses**

	HCC	Condition	Body System / Disease Group
1	2	Sepsis (w/ pneumonia), SIRS, shock, UTI	Infectious Disease
2	7	Metastatic Cancer (all)	Neoplasm
3	10	Cancer: Prostate, Breast, Colorectal and other cancers and tumors	Neoplasm
4	15	Diabetes w / CKD or PVD	Endocrine / Nutrition & Metabolic
5	16	Diabetes w / Neuropathy and other manifestations	Endocrine / Nutrition & Metabolic
6	21	Protein Calorie Malnutrition (type/degree)	Nutrition & Metabolic
7	79	Respiratory Failure (all)	Respiratory System
8	105	PVD (with and without Complication)	Vascular System
9	131	Renal Failure/disease (include dialysis status)	Renal / Urinary system

	HCC	Condition	Body System / Disease Group
10	111, 112	Pneumonia *	Respiratory System
11	80,81, 82, 83, 92	Cardiac (heart failure*/shock, cardiac arrhythmia, acute MI,* old MI, angina)	Cardiac/Circulatory System
12	148, 149	Pressure ulcers (Cellulitis and all other chronic ulcers)	Disease of the Skin
13	75, 95, 96	Stroke* / CVA / Hemorrhage (coma)	Nervous System
14	100	Stroke* / CVA residual deficit	Nervous System
15	154, 155	Head Injuries (Trauma)	Trauma/Injury
16	157	Vertebral Fractures (Trauma)	Trauma/Injury
17	158	Hip Fractures (Trauma)	Musculoskeletal System
18	161	Traumatic Amputation (include status)	Injury
19	176	Artificial Opening feeding/Ostomies (status)	2nd Dx
20	177	Amputation Status and Complications	2nd Dx

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VH00372

ER-636

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NORTHERN CALIFORNIA

CDI Roll-Out

2009 – 1 facility, 2010 – 5 facilities, 2011 – 15 facilities

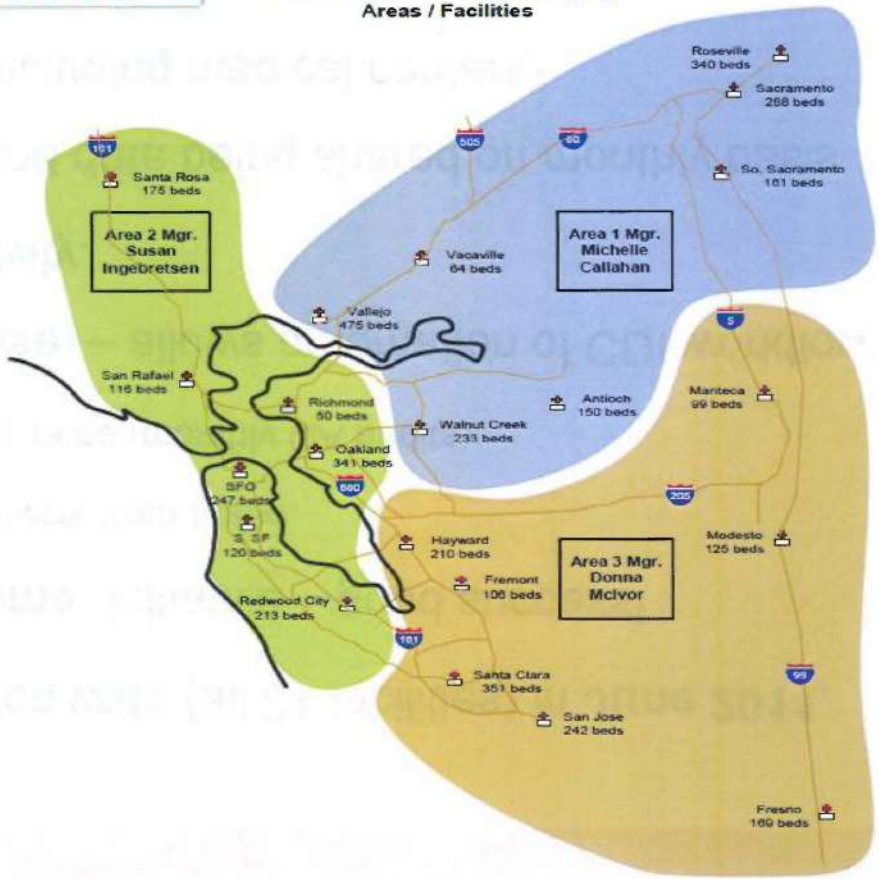
CDI Roll-Out: NCAL Region

- South Sacramento: 12/2009
- South San Francisco: 10/04/2010
- Antioch: 11/29/2010
- Walnut Creek: 11/29/2010
- Roseville: 11/29/2010
- Sacramento: 11/29/2010
- Vallejo: 1/24/2011
- Vacaville: 1/24/2011
- Oakland: 2/14/2011
- Richmond: 2/14/2011
- San Francisco: 2/14/2011
- Redwood City: 2/14/2011
- Santa Rosa: 3/28/2011
- San Rafael: 4/11/2011
- Fremont: 4/25/2011
- Hayward: 4/25/2011
- San Jose: 5/9/2011
- Santa Clara: 5/9/2011
- Fresno: 6/6/2011
- Modesto: 6/6/2011
- Manteca: 6/6/2011

revenueCYCLE

Northern California
Clinical Documentation Integrity
Areas / Facilities

October 27, 2011



CDI Area Managers & Facilities Covered

Area 1 Mgr. – Michelle Callahan – Facilities: Antioch, Roseville, Sacramento, So. Sacramento, Vacaville, Vallejo, Walnut Creek

Area 2 Mgr. – Susan Ingebretsen – Facilities: Oakland, Redwood City, Richmond, San Francisco, San Rafael, Santa Rosa, So. San Francisco

Area 3 Mgr. – Donna McIvor – Facilities: Fremont, Fresno, Hayward, Manteca, Modesto, San Jose, Santa Clara

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CDI Milestones: 2011

- CDI Roll-out completed region wide (all 21 facilities) in **June 2011**.
- CDI Nurses "**Work from Home**" initiative – good success!
  - 30 out of 35 CDI staff (85.7%) work from home.
  - High Review & Query accuracy rates (monthly QA audits).
- **CDI Tool** developed (in-house) – allows automation of CDI workflow and enhanced staff productivity.
- **CDI Dashboard** validated and data being shared on monthly basis with KP NCAL leadership (including medical centers).

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NORTHERN CALIFORNIA

CDI Workflow

Medical Center CDI Leads

- **Physician Champion** – CDI medical leadership for the facility and regional CDI team
- **Regional CDI Manager** – Facility point of contact for all CDI operations

CDI Staff

- **Clinical Documentation Integrity Senior Consultants (CDISC)**
  - Clinical background - RN
  - 1-2 per medical center – remotely located/census driven
  - Performs concurrent reviews in HealthConnect to identify gaps in physician documentation.
  - Work remotely from home with queries sent via ***Dear Doctor Notes***
- **Clinical Documentation Integrity Consultants (CDIC)**
  - Inpatient coding background - CCS, RHIA, RHIT
  - Performs concurrent quality audits of CDISC work
  - Provides education to CDISC staff and ensures compliant queries

Physician documentation (accurately clarified via CDI queries)

↓

Accurate coding of HCC diagnoses (by HIM coders)

↓

Better clinical outcomes reporting (Medicare Risk Scores)

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NORTHERN CALIFORNIA

Physician Engagement & Education

PHYSICIAN ENGAGEMENT:

- **Monthly Phone Call with Physician Champion and CDI Leadership** to discuss data, develop plans for improvement, prepare for facility meeting.
- **Monthly In-Person HBS physician meetings** to share outcomes/receive feedback. CDI nurses attend HBS meetings.
- **Quarterly Physician Champion Meetings** (at Oakland) set up to facilitate sharing of "Best Practices".

PHYSICIAN FEEDBACK/EDUCATION:

- **CDI Query Escalation processes established at Medical Center**
  - ✓ Page - Phone Call - Weekly Reports (recently automated in CDI Tool)
- **CDI team working in collaboration with TPMG Physician Trainers**
  - ✓ EIO trainers invited to attend CDI HBS Meetings (and incorporate education sessions)
- **Physician-specific reports shared**
  - ✓ CDI sharing data with EIO data quality trainers on monthly basis.
  - ✓ Reports provide individual physician-specific data to identify improvement opportunities

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NORTHERN CALIFORNIA

HIM (Health Information Management) Partnership

- **GOAL: Ensure accurate capture of all HCC dx (based on CDI queries to physicians) reflected in coding.**

- **FINDINGS:** Reasons for "CDI-HIM GAP"
  - **Manual (and time intensive) process** for CDI QA staff to validate dx in KP Health Connect
  - **Lack of data** to identify cases needing CDI-HIM reconciliation
  - **No established process/timelines** for escalating cases to CDI-HIM leadership

- **PROCESS IMPROVEMENT:**
  - **Automated coding validation** in CDI Tool – May 2011
  - **Coding reconciliation process** with CDI QA and Regional HIM for "Agreed But Not Coded Dx" – May-June 2011
  - **Query communication** (Account Note) process in KPHC between CDI RNs and HIM coders – August 2011

- **OUTCOME:** Reduced "Agreed but Not Coded" CDI-HIM Gap to **1 - 4 %**

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NORTHERN CALIFORNIA

CDI UPDATE: October 2011

CDI Dashboard Facility: 21 NCAL KP hospitals Year: 2011

	Metrics	Target	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	YTD
1	Overall Medicare Advantage CMI		1.58	1.61	1.58	1.69	1.67	1.67	1.65	1.69	1.67	1.72	1.65
2	Overall CDI Medicare Advantage CMI		1.55	1.57	1.64	1.64	1.63	1.64	1.63	1.67	1.65	1.7	1.63
3	# of Charts with Queries		667	608	768	854	849	1,010	978	975	968	1,250	8,927
		>30%	47%	38%	35%	36%	30%	32%	31%	30%	31%	38%	34%
4	# of Total Physician Queries		933	846	1,064	1,171	1,087	1,324	1,287	1,257	1,239	1,768	11,976
5	QUERY RESPONSE RATE		686	610	797	941	904	1,098	1,109	1,127	1,113	1,618	10,003
		>90%	74%	72%	75%	80%	83%	83%	86%	90%	90%	92%	84%
6	QUERY AGREE RATE		393	347	489	546	617	738	743	809	830	1,180	6,692
		>80%	57%	57%	61%	58%	68%	67%	67%	72%	75%	73%	67%
7	CODED BY HIM		379	345	481	543	609	724	729	798	810	1,098	6,516
		100%	96%	99%	98%	99%	99%	98%	98%	99%	98%	93%	97%
8	VALID HCCs		307	297	417	454	510	590	585	629	621	892	5,302
9	REVENUE IMPACT		$1,659,006	$1,554,105	$2,175,995	$2,436,074	$2,769,664	$3,166,611	$3,071,676	$3,363,463	$3,297,033	$4,314,520	$27,808,145

Report Run Date: 11/22/2011

KEY FINDINGS:

- Query Response Rate (Oct 2011) = 92% → Last 3 months: Query Response Rate met 90% target for NCAL region.
- Query Agree Rate (Oct 2011) = 73%
- Revenue Impact (Oct 2011) = $ 4.31 million
- YTD 2011 = $ 27.80 million

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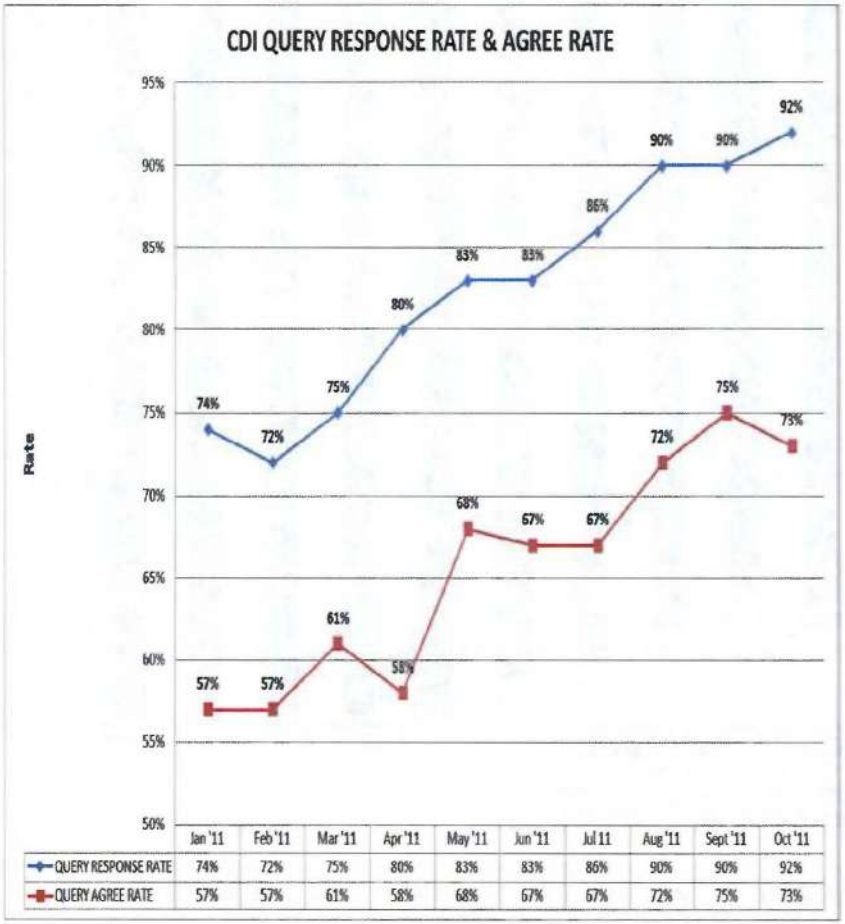
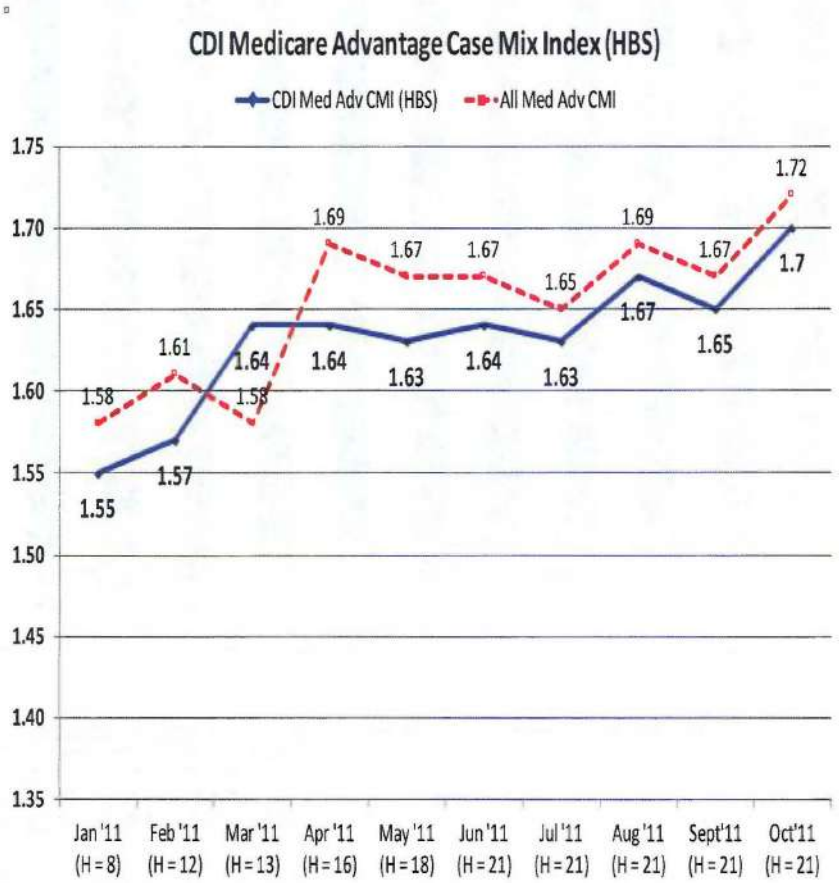
NORTHERN CALIFORNIA

CDI Metrics 2011: Trends & Impact



	Jan '11	Feb '11	Mar '11	Apr '11	May '11	Jun '11	Jul 11	Aug '11	Sept '11	Oct '11
QUERY RESPONSE RATE	74%	72%	75%	80%	83%	83%	86%	90%	90%	92%
QUERY AGREE RATE	57%	57%	61%	58%	68%	67%	67%	72%	75%	73%

Source: CDI Tool



Source: Finance & Reporting

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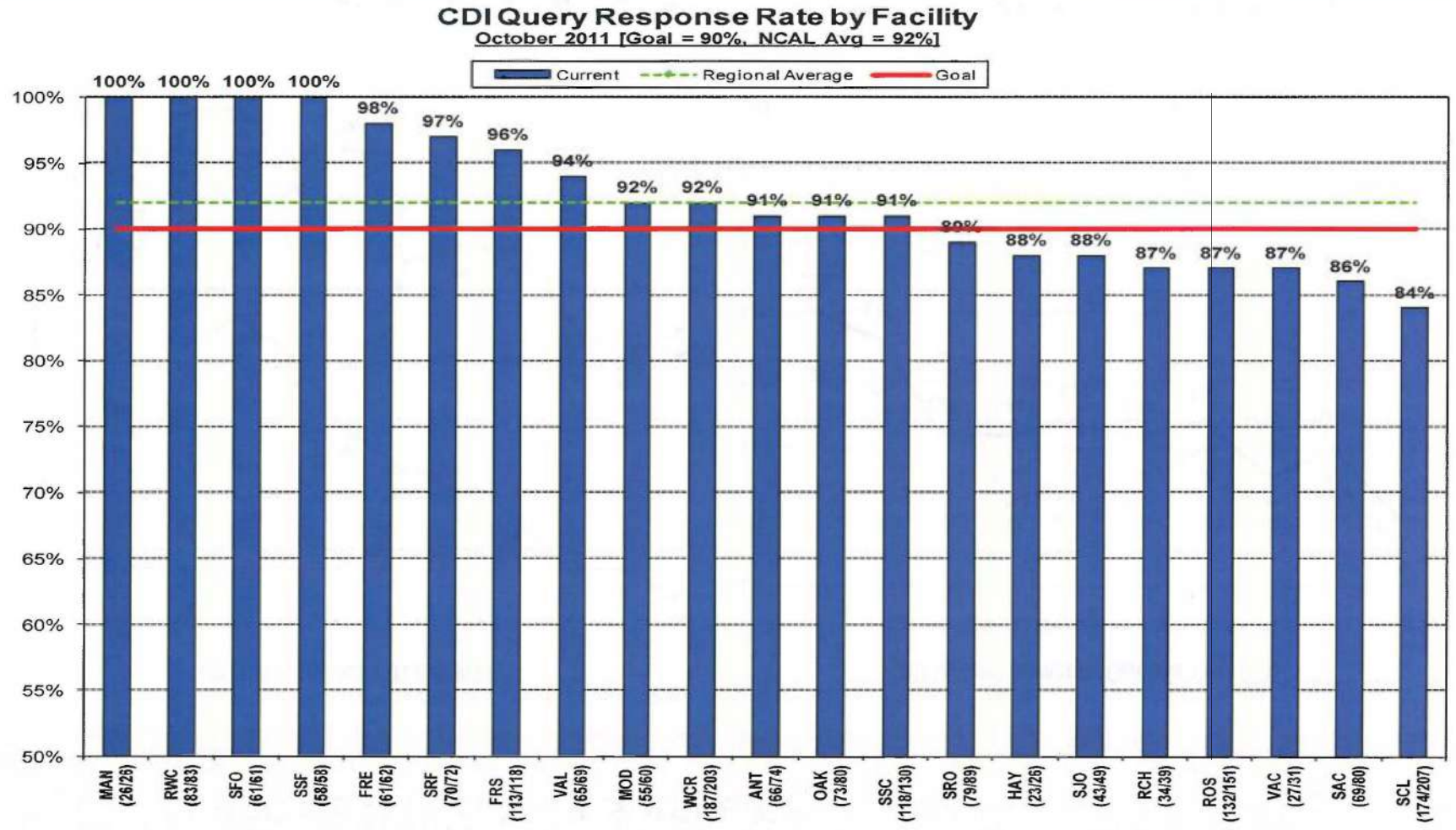
NORTHERN CALIFORNIA

Query Response Rate (Oct 2011):

➔ 13 facilities (61.9%) are at or above 90% target. (Last Month - 12 facilities were at or above 90% target.)



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Report Run Time: 11/22/2011 @4:20pm

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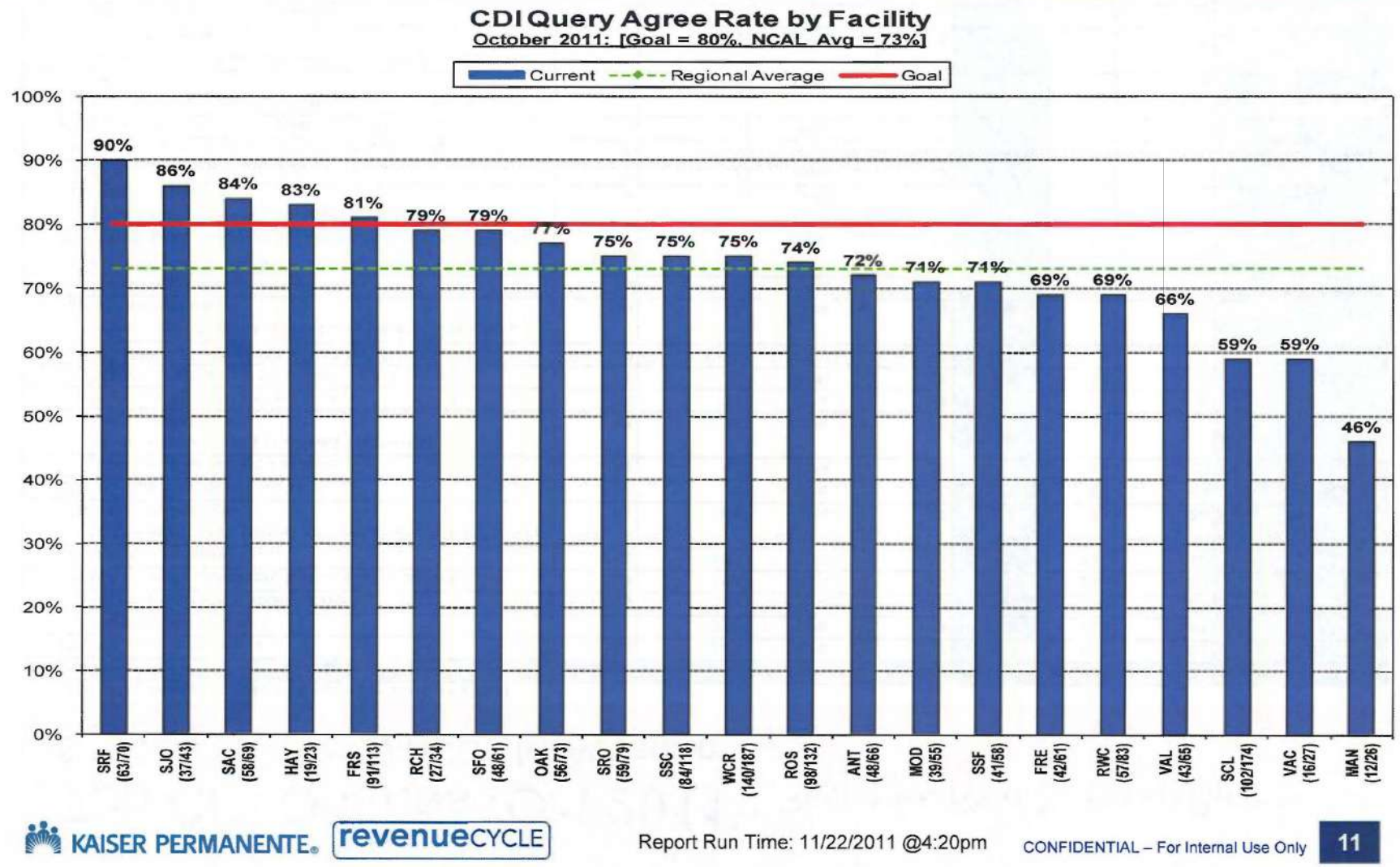
Query Agree Rate (Oct 2011):

➔ Agree Rate: 5 facilities (23.8%) are at or above 80% target. (Last Month – 7 facilities were at or above 80% target.)



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NORTHERN CALIFORNIA

Top CDI Queries (Oct 2011): Response Rate %, Agree Rate % & Revenue Impact by HCC - NCAL region

CDI HCC Analysis - NCAL Region (October 2011)

HCC Id	HCC Name	Queried	Responded	RESPONSE %	Agreed	AGREE %	Coded	Valid HCC	REVENUE IMPACT
105	Vascular Disease	386	347	90%	252	73%	225	201	$516,258
2	Septicemia/Shock	272	259	95%	173	67%	167	143	$882,188
21	Protein-Calorie Malnutrition	265	251	95%	238	95%	230	187	$1,301,066
79	Cardio-Respiratory Failure and Shock	213	194	91%	149	77%	136	100	$469,798
131	Renal Failure	212	183	86%	141	77%	131	110	$329,021
15	Diabetes with Renal or Peripheral Circulatory Manifestation	81	69	85%	47	68%	43	26	$107,355
148	Decubitus Ulcer of Skin	81	76	94%	56	74%	54	43	$402,978
80	Congestive Heart Failure	64	61	95%	26	43%	25	20	$66,650
111	Aspiration and Specified Bacterial Pneumonias	37	36	97%	15	42%	14	12	$68,568
100	Hemiplegia/Hemiparesis	25	21	84%	13	62%	11	8	$28,415
149	Chronic Ulcer of Skin Except Decubitus	21	20	95%	13	65%	12	6	$21,897
75	Coma Brain Compression/Anoxic Damage	19	18	95%	10	56%	9	6	$20,239
82	Unstable Angina and Other Acute Ischemic Heart Disease	19	18	95%	9	50%	7	7	$16,158
92	Specified Heart Arrhythmias	18	15	83%	6	40%	5	3	$7,144
157	Vertebral Fractures without Spinal Cord Injury	18	17	94%	12	71%	11	7	$25,205
16	Diabetes with Neurologic or Other Specified Manifestation	9	8	89%	7	88%	7	3	$9,949
81	Acute Myocardial Infarction	7	6	86%	2	33%	2	2	$5,836
83	Angina Pectoris/Old Myocardial Infarction	5	5	100%	2	40%	2	2	$3,966
104	Vascular Disease with Complications	4	3	75%	3	100%	2	1	$4,958
112	Pneumococcal Pneumonia Emphysema Lung Abscess	3	3	100%	3	100%	2	2	$4,048
10	Breast Prostate Colorectal and Other Cancers and Tumors	3	3	100%	1	33%	1	1	$1,691
158	Hip Fracture/Dislocation	2	1	50%	0	0%	0	0	$0
7	Metastatic Cancer and Acute Leukemia	2	2	100%	1	50%	1	1	$18,499
176	Artificial Openings for Feeding or Elimination	1	1	100%	0	0%	0	0	$0
95	Cerebral Hemorrhage	1	1	100%	1	100%	1	1	$2,633
	Total:	**1,768**	**1,618**	92%	**1,180**	73%	**1,098**	**892**	**$4,314,520**

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Report Run Time: 11/22/2011 @4:20pm

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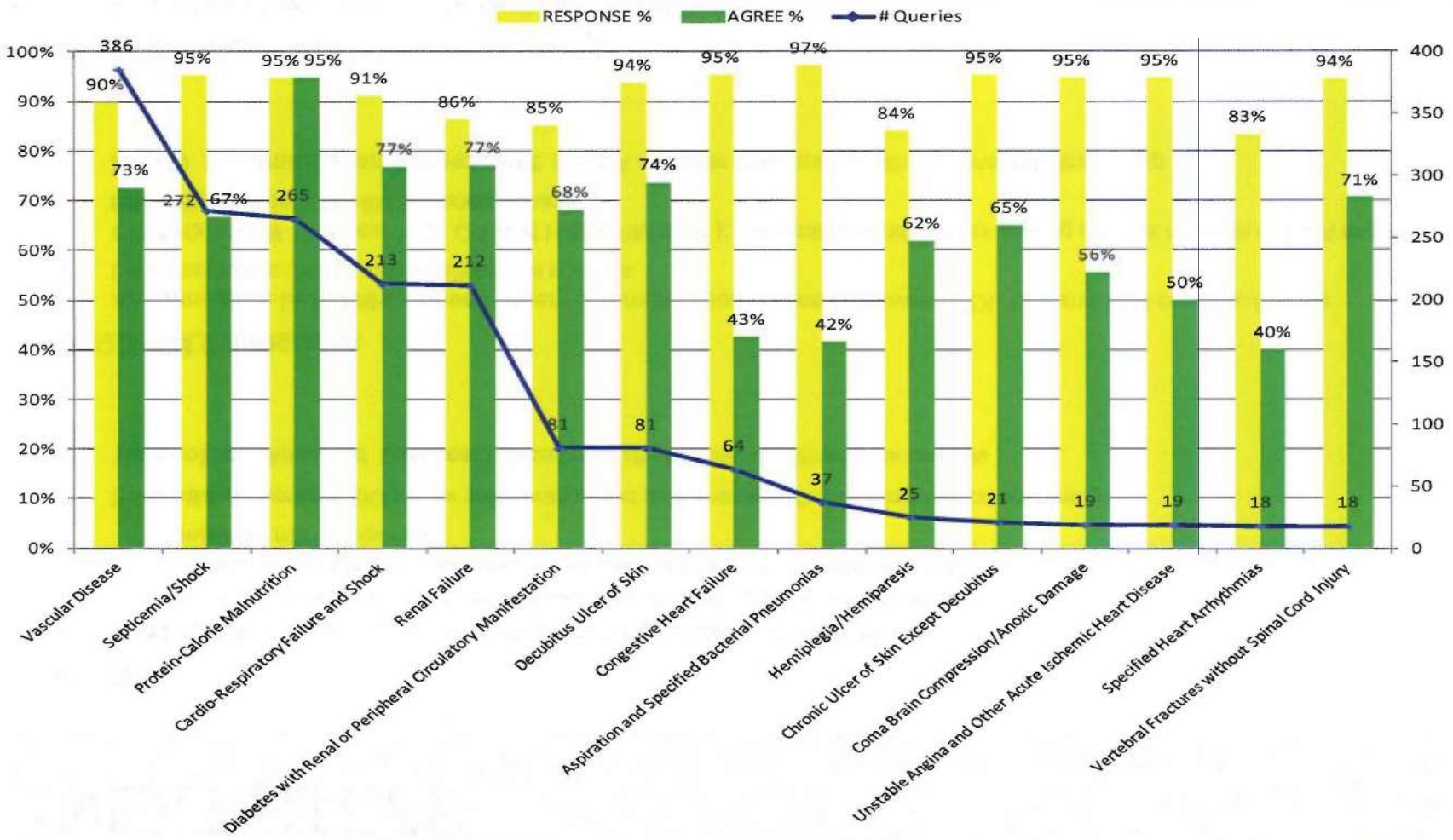
VH00382

NORTHERN CALIFORNIA

Top 15 CDI Queries (Oct 2011): Response Rate %, Agree Rate % by HCC - NCAL region



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NEXT STEPS:

#1. CDI:

- **PHYSICIAN:** Perform detailed Query Response/Agree Rate analysis by HCCs.
  - Focus on Queries with low "query rate" (if missed query opportunity) e.g. Aortic Atherosclerosis
  - Focus on Queries with "low" agree rates (if MD education needed) e.g. Coma, Hemiplegia, CHF
  - Intensivists (ICU) engagement
- **Education:** Increase EIO trainer collaboration and data sharing with CDI (documentation trends).
- **Technology:** Advanced Dashboard Reporting – allow further drill-down/data analysis

#2. CDI-HIM Collaboration

- **Account Note in HealthConnect** - query communication process (between CDI RNs and HIM coders): Provide trends/outcomes data to measure/evaluate success.
- **CRM Hand-Off** (between CDI QA and HIM CRM staff): Streamline workflow/data sharing process between CDI QA and HIM CRM staff on "CDI-HIM Variance" cases.
- **ICD-10 Documentation Assessment**: CDI QA manager collaborating with Regional HIM leadership.

#3. CDI PHASE 2: Year 2012

- **New HCCs** - Morbid Obesity, Dementia with complications
- **Additional Physician Specialties** - General Surgery [work in progress!!!]
- ***Linkage to Quality and HIM initiatives*** – *Hospital-Acquired Conditions (HACs), Present-on-Admission (POA)*

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QUESTIONS

- **Dexter D'Costa MBBS, MHA, CRCR**
  Regional Director, CDI
  Office: 510-625-5350
  Cell: 510-301-0323
  Email: Dexter.G.Dcosta@kp.org

- **Helena Rush, RHIA, RHIT, CPC, CPC-H**
  AHIMA Certified ICD-10-CM-PCS Trainer
  Regional QA Manager, CDI
  Office: (510) 625-5652
  Cell: (510) 381-7633
  Email: Helena.C.Rush@kp.org

Visit us at CDI Wiki: https://wiki.kp.org/wiki/x/uQRqCQ

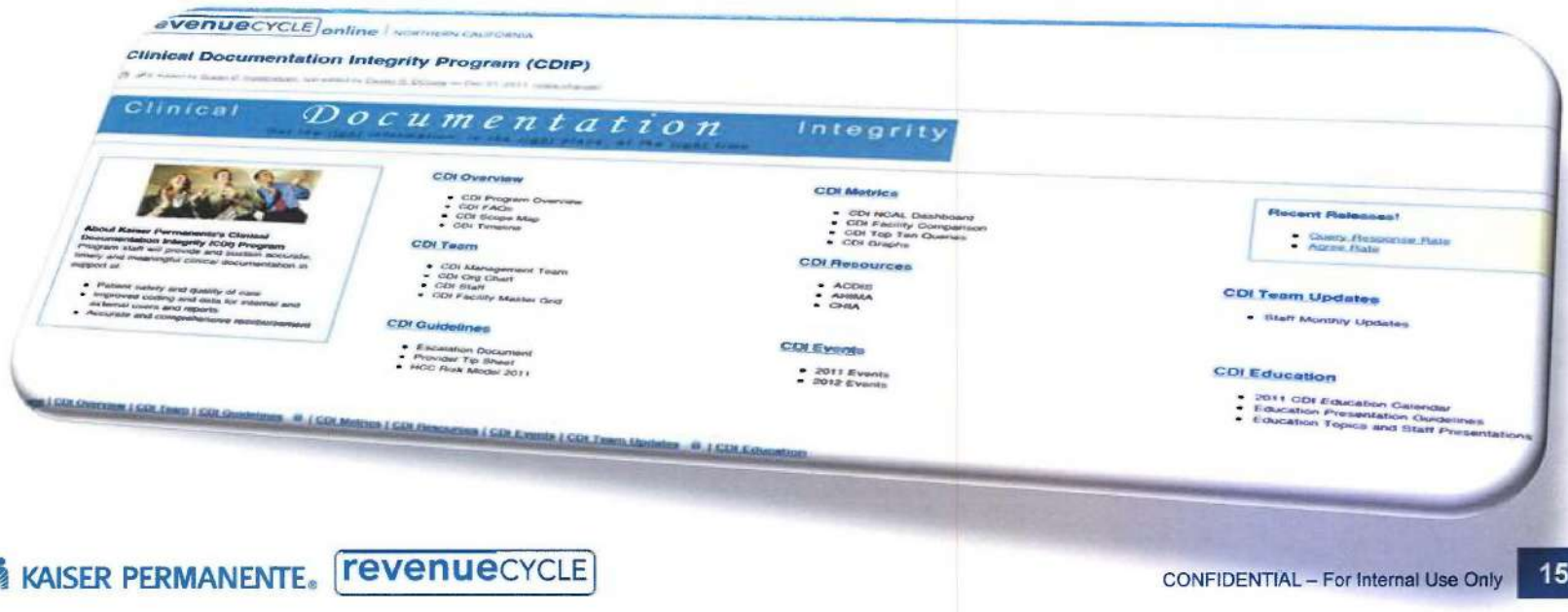

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EXHIBIT 12

AHA Coding Clinic for ICD-9-CM

Request for Coding Advice

Please formulate and submit your specific question regarding ICD-9-CM coding. Only one question may be submitted per request. Include pertinent documentation along with your request that will assist the Central Office in determining the appropriate diagnosis and/or procedure code assignment(s). The health record
Documentation may include copies of the discharge summary, history and physical examination, consultation report, progress notes and operative and pathology reports (if applicable). Other relevant information such as nursing or physician notes should be presented in a typed format. Questions submitted without the supporting
health record documentation may be returned unanswered.

In accordance with HIPAA requirements, remove all identifying information (i.e., hospital name, patient name, birth date, social security number and provider identifiers) from copies of the medical record documentation. Any request not complying with HIPAA will be returned unanswered.

Complete the form below and mail it along with your supporting documents to:

Central Office on ICD-9-CM
Coding Advice
American Hospital Association
155 North Wacker Drive, Suite 400
Chicago, IL 60606
You may also fax the question and documentation to: 312/278-0838 or 312/422-4583

Request for Coding Advice
Date: 12/30/2012
Name: Gloryanne Bryant
Department: Regional HIM
Facility: Kaiser Permanente Rev Cycle
HIM
Address: 1800 Harrison St., #24
City: Oakland State: CA Zip Code: 94612
Phone Number 510 625 3980 Email Address
gloryanne.h.bryant@kp.org
Question:
Many physicians believe that the diagnosis/condition of Aortic Atherosclerosis is a Chronic Systemic Condition. We had our physicians provide education about this condition and this included risk factors with AA:

Dyslipidemia (high LDL, low HDL): high cholesterol
☐ Diabetes ☐ Smoking ☐ Obesity
☐ Metabolic Syndrome (abdominal obesity, along with at least 2 of the following: dyslipidemia, hypertension, insulin resistance)

- ☐ Hyperinsulinemia
- ☐ Hypertension
- ☐ Systemic infections
- ☐ Sedentary lifestyle
- ☐ Prothrombotic states
- ☐ Renal insufficiency
- ☐ Age
- ☐ Family history

Thus, like COPD or Diabetes Mellitus, CAD, Lupus, should we code Aortic Atherosclerosis condition when documented, either outpatient or inpatient record similar to COPD? Thank you.

EXHIBIT 13

Coding Clinic question re Aortic Atherosclerosis

Janet D Franklin to: Nancy J Andersen, Diana Medal, Gloryanne H Bryant, Joan M Guilford 08/25/2014 02:17 PM

Default custom expiration date: 08/25/2015

Attached is a draft copy of the letter to Coding Clinic for you to submit for further review to Simon and other stakeholders (Anne V Cadwell, Steven Olson, Treska T Francis, James M Taylor)

Aortic Atherosclerosis Packet for Coding Clinic, Draft 1.pdf

Thanks,

Janet (don't forget the) D Franklin

Janet D Franklin, RHIT, CCS, CCS-P, CHC
AHIMA Approved ICD-10-CM/PCS Trainer
Compliance Manager, Government Audit and Reimbursement
National Compliance, Ethics & Integrity Office
Office: 8-423-5735, 510-271-5735
Fax: 8-423-5039, 510-891-5039

Admin Assistant: Elizabeth Styles
8-423-6831, 510-271-6831

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Central Office on ICD-10-CM
American Hospital Association

Request for Coding Advice

Question: We would like to ask Coding Clinic for clarification as to whether a diagnosis of aortic atherosclerosis would be considered a systemic condition that can be coded even in the absence of active intervention in the same way that other systemic diagnoses noted in Coding Clinic (e.g. COPD, CHF, Diabetes, Parkinson's Disease, hypertension) may be coded without additional documentation of evaluation, treatment, consideration; etc.

This issue has come to light primarily in review of the documentation and coding of physician office encounters

An earlier request for coding advice was made regarding the status of this diagnosis as a systemic condition and the response from Coding Clinic was that if the impact were unclear, the physician should be queried. Please see attached response Ref#50001447.213

Some interpreted this advice to mean that aortic atherosclerosis would not be considered a systemic condition, because if it were, it would not be necessary to query the physician. Others felt that this meant if the physician considered the condition to be systemic; it could be coded with just listing the condition as one of the patient's conditions with no documentation as to impact of the condition on the encounter. For instance, a patient may come in to see a provider to have a dog bite treated. All physician documentation is related to the dog bite. No mention of aortic atherosclerosis is made anywhere in the encounter note, yet the physician assigns it as a visit diagnoses which in our electronic record results in the code being submitted for the encounter, or it may be listed in the problem list and brought down as a visit diagnosis, again without any further documentation elsewhere in the note, similar to the capture of COPD.

Another example may be where the physician copies and pastes in a previous radiology report which notes minimal aortic atherosclerosis as one of several observations. It may be a recent report or an older report. Again, no other mention of the condition is made but the diagnosis is captured as an encounter diagnosis and the code reported.

Related to this question is the clarification of the documentation required to support the coding of the diagnosis of aortic atherosclerosis if, in fact, it is not considered a systemic condition. Some providers feel that the fact that the patient's hypertension was evaluated supported assigning a visit diagnosis of aortic atherosclerosis resulting in the submission of the related code. In some cases the aortic atherosclerosis is listed in the problem list, and the provider, while not mentioning the aortic atherosclerosis, does document information related to the patient's hypercholesterolemia and/or hyperlipidemia and the treatment for those conditions and considers this to be sufficient documentation to assign a visit diagnosis of aortic atherosclerosis resulting in submission of the related code.

We have two examples attached for your consideration. We would appreciate your review and opinion. As this is an issue where providers are generating the encounter note and documenting the visit

diagnosis which results in a code being submitted, this is not a query issue, but one of education for both our providers and coding auditors.

Thank you,

Janet Franklin, RHIT, CCS, CCS-P, CHC
Compliance Manager
National Compliance, Ethics & Integrity Office
Kaiser Permanente

Previous Coding Clinic Response

Ref #50001447.213

Central Office on
ICD-9-CM

American Hospital Association
155 N. Wacker Drive, Suite 400
Chicago, IL 60606-1725
312-422-3366
312-278-0838

May 16, 2013

Gloryanne Bryant
Regional HIM
Kaiser Permanente
1800 Harrison St., #24
Oakland, CA 94612

Dear Ms. Bryant,

This letter is in response to your request for clarification if it is appropriate to report aortic atherosclerosis as a chronic systemic condition.

When a patient has a chronic systemic condition that affects the patient the rest of his/her life, it is appropriate to assign a code for that condition.

As stated in *Coding Clinic* 3rd Quarter, 2007, Pages 13-14; "Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded." This advice applies to inpatient coding.

For outpatient encounters/visits, chronic conditions that require or affect patient care treatment or management should be coded. The Official Guidelines for Coding and Reporting for Outpatient Services, state, "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions(s). Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. Conversely, conditions that do not require or affect patient care, treatment or management are not reported."

If the coder is unclear whether a specific condition meets the definition of a chronic or secondary diagnosis, it is appropriate to query the provider for clarification. Please see *Coding Clinic*, Second Quarter 2000 Pages: 20-21.

I trust this information will be of assistance to you.

Sincerely,

Diane Komar

Diane Komar, RHIT
Coding Consultant
Ref. #50001447.213

AHA CENTRAL OFFICE
An American Hospital Association Service

American Hospital Association

This coding information is being provided specifically to you based on the facts and details you provided. The American Hospital Association has used its best efforts to provide accurate coding advice, but this advice should not be construed as providing clinical advice, dictating reimbursement policy, or a substitution for the judgment of a practitioner. This information is provided for individual reference only. Any reprint or distribution of all or part of this correspondence, without the express written consent of the American Hospital Association's Central Office on ICD-9-CM, is strictly prohibited.

Example Case 1

Office Visit

1/9/2013 Office Visit **Patient Name** | MRN:

Visit and Patient Information

Encounter Information

Date & Time	Provider	Department	Encounter #	Center
1/9/2013	XXX, MD	REDACTED		REDACTED

Encounter

Closed by XXX, MDon 1/9/13 at 6:19 PM

Diagnoses

TROCHANTERIC BURSITIS	- Primary	726.5
ATHEROSCLEROSIS AORTA		440.0

There are no scans attached to this encounter.

Future Appointments

View Future Appointments

After Visit Summary

After Visit Summary

Patient History

Patient History

History as of Encounter Date

Orders and Medications

Medication Administration Report for Patient Name

All administrations
No administration data available

Medications Reviewed

User	Date and Time
Name, RN [Z320811] **Meds**	2/6/2014

Comments as of 2/21/2005

took no pills today

Visit Summary

Default Flowsheet Data (all recorded)

Encounter Vitals

	01/09/13 1425
Enc Vitals	
BP	114/66 mmHg -JS
Pulse	88 -JS
Resp	18 -JS
Temp	97.6 °F (36.4 °C) -JS
Temp src	Tympanic -JS
SpO2	95 % -JS

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key		
Initials	Name	Effective Dates

Default Flowsheet Data (all recorded)

Additional Vitals

	01/09/13 1425
Cuff Size/Location	
Cuff Size	
BP Location	
Respiratory Vitals	
Activity	
SpO2	95 % -JS
O2 Method	
Pulse	88 -JS
Resp	18 -JS
Peak Flow	
Quality of Peak Flow	
Orthostatic Vitals	
Lying Heart Rate	
Lying BP	
Sitting Heart Rate	
Sitting BP	
Standing Heart Rate	
Standing BP	
Four Limb BP	
Four Limb Blood Pressure?	

(r) = User Recd, (t) = User Taken, (c) = User Cosigned

User Key		
Initials	Name	Effective Dates

All Flowsheet Templates (all recorded)

Encounter Vitals Flowsheet

Progress Notes

XXX, MD at 1/21/2013 8:29 AM

Status: Signed

Atherosclerosis of the aorta is added to diagnoses- 7/19/06 ct abd - "Minimal atherosclerotic calcification is shown in the aorta, but there is no aneurysm,dissection or rupture."

Electronically signed by XXX, MD at 1/21/2013 8:29 AM

XXX, MD at 1/9/2013 6:19 PM

Status: Signed

Pt presents with c/o knee and hip pain. He will have increased pain with prolonged standing or walking. He will increased pain at night which makes it more difficult to sleep. He has not had any distinct injury to the leg. Pain has now been present for the past 1 1/2 weeks. He has been using heat and some menthol topically. He has taken some pain pills that he had left over but these were not particularly helpful.

He states he used oxycodone from an old prescription.

He states he stopped all of his diabetes medications for several months, is now just taking cinnamon and some other over the counter supplements. He feels his blood sugar have been adequately controlled without medications- he has not taken these for months, he is not sure exactly when he stopped these. He has had home blood sugars < 150 consistently - he states 110 yesterday, 131 this morning when he checked.

OBJECTIVE: NAD. Vitals as above.
LLE- hip ROM is normal and he does not have significant discomfort with int/ext rotation or axial loading of the hip. He is tender to palpation around the greater trochanter and this is area of concern- palpation does reproduce his symptoms. He has some tenderness extending to the ITB as well, no tenderness around the L knee and no knee erythema/swelling.

ASSESSMENT: See dx.

PLAN:
1. Trochanteric bursitis handout is provided. We discussed cross-stretching, hamstring stretching, piriformis stretching. Ice to greater trochanter- avoid heat. Consider cortisone injection if symptoms are not improving.
2. As above, he has d/c his diabetes medications against my advice. He does not at this point want to restart these medications. He has had blood work drawn this morning and further consideration will be made after test results are available.

Electronically signed by XXX, MD at 1/9/2013 6:19 PM

Transcription

Transcription

Reason for Visit

LEG PROBLEM

Patient Instructions

Use **ice, not heat**, on the area of discomfort on your leg.

Anti-inflammatories like advil, aleve, and high dose aspirin should be avoiding as they can elevate the blood pressure, damage the kidneys, and cause stomach irritation/ulcers. **Tylenol is a safe choice for pain relief.**

You can take tylenol up to 1000mg 3 times per day for pain. The maximum dose of tylenol is 3000mg per 24 hours.

Trochanteric Bursitis: Exercises

Your Care Instructions

Here are some examples of typical rehabilitation exercises for your condition. Start each exercise slowly.

Ease off the exercise if you start to have pain.

Your doctor or physical therapist will tell you when you can start these exercises and which ones will work best for you.

How to do the exercises

Hamstring wall stretch

1. Lie on your back in a doorway, with your good leg through the open door.
2. Slide your affected leg up the wall to straighten your knee. You should feel a gentle stretch down the back of your leg.
   - Do not arch your back.
   - Do not bend either knee.
   - Keep one heel touching the floor and the other heel touching the wall. Do not point your toes.
1. Hold the stretch for at least 1 minute to begin. Then try to lengthen the time you hold the stretch to as long as 6 minutes.
2. Repeat 2 to 4 times.

If you do not have a place to do this exercise in a doorway, there is another way to do it:

1. Lie on your back, and bend the knee of your affected leg.
2. Loop a towel under the ball and toes of that foot, and hold the ends of the towel in your hands.
3. Straighten your knee, and slowly pull back on the towel. You should feel a gentle stretch down the back of your leg.
4. Hold the stretch for 15 to 30 seconds. Or even better, hold the stretch for 1 minute if you can.
5. Repeat 2 to 4 times.

Straight-leg raises to the outside

1. Lie on your side, with your affected leg on top.
2. Tighten the front thigh muscles of your top leg to keep your knee straight.
3. Keep your hip and your leg straight in line with the rest of your body, and keep your knee pointing forward. Do not drop your hip back.
4. Lift your top leg straight up toward the ceiling, about 12 inches off the floor. Hold for about 6 seconds, then slowly lower your leg.
5. Repeat 8 to 12 times.

Clamshell

1. Lie on your side, with your affected leg on top and your head propped on a pillow. Keep your feet and knees together and your knees bent.
2. Raise your top knee, but keep your feet together. Do not let your hips roll back. Your legs should open up like a clamshell.
3. Hold for 6 seconds.
4. Slowly lower your knee back down. Rest for 10 seconds.
5. Repeat 8 to 12 times.

Standing quadriceps stretch

1. If you are not steady on your feet, hold on to a chair, counter, or wall. You can also lie on your stomach or your side to do this exercise.
2. Bend the knee of the leg you want to stretch, and reach behind you to grab the front of your foot or ankle with the hand on the same side. For example, if you are stretching your right leg, use your right hand.
3. Keeping your knees next to each other, pull your foot toward your buttock until you feel a gentle stretch across the front of your hip and down the front of your thigh. Your knee should be pointed directly to the ground, and not out to the side.
4. Hold the stretch for 15 to 30 seconds.
5. Repeat 2 to 4 times.

Piriformis stretch

1. Lie on your back with your legs straight.

2. Lift your affected leg and bend your knee. With your opposite hand, reach across your body, and then gently pull your knee toward your opposite shoulder.
3. Hold the stretch for 15 to 30 seconds.
4. Repeat 2 to 4 times.

Double knee-to-chest

1. Lie on your back with your knees bent and your feet flat on the floor. You can put a small pillow under your head and neck if it is more comfortable.
2. Bring both knees to your chest.
3. Keep your lower back pressed to the floor. Hold for 15 to 30 seconds.
4. Relax, and lower your knees to the starting position.
5. Repeat 2 to 4 times.

Follow-up care is a key part of your treatment and safety. Be sure to make and go to all appointments, and call your doctor if you are having problems. It's also a good idea to know your test results and keep a list of the medicines you take.

Where can you learn more?

Go to http://www.kp.org

Enter **N503** in the search box to learn more about **"Trochanteric Bursitis: Exercises."**

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Content Version: 9.4.94723; Last Revised: January 26, 2012

Level of Service

OUTPT EST LEVEL 3 [99213B]

Allergies

Reviewed On: **12/3/2012** By:

Allergies as of 1/9/2013

Allergen	Noted	Type	Reactions
Lisinopril	10/03/2008	Intolerance	Other
Cough			
No Latex Allergy	01/26/2005		
Smoke	02/21/2005		
bronchial spasma			

Current Medications

Current Medications Report (as of 01/09/13)

User Access Log

Opened By

User	Instant	Changed From	Changed To
Name (Lpn) **User**	01/09/13 1425	Appointment	Office Visit

Access Log

User Access Log for Encounter

Appointment Information

Previous Visit

12/3/2012 9:20 AM	Department REDACTED	Encounter # REDACTED

Electronically Signed: Charting

Date and Time	Name
Wed Jan 9, 2013 6:19 PM	XXX, MD

KPCO DIVERSITY QUESTIONNAIRE

Question	Answer
INTERPRETER?	**No [2]**
LANG SPOKEN	**English [22]**
LANG WRITTEN	**English [20]**
ETHNICITY	**Unknown [9]**
RACE	**Unknown - Patient Refusal or Acknowledgment of Race [64]**

BILLING QUERY

Create In Basket Message

MEDICARE QUERY

Create In Basket Message

Encounter Medications as of 1/9/2013

Outpatient Medications

	Quantity	Refills	Start	End
LEVOTHYROXINE 50 MCG ORAL TAB (Discontinued)	90	0/2	12/10/2012	7/31/2013
Sig : TAKE ONE TABLET ORALLY ONCE DAILY FOR THYROID REPLACEMENT Route: Oral Reason for Discontinue: Continue Therapy				
HYDROCHLOROTHIAZIDE 25 MG ORAL TAB (Discontinued)	90	1/1	9/14/2012	7/31/2013
Sig : TAKE ONE TABLET ORALLY EVERY DAY FOR BLOOD PRESSURE (DUE FOR APPT BY 1/2013!!!) Route: (none) Reason for Discontinue: Other Reason				
SIMVASTATIN 40 MG ORAL TAB	90	PRN	2/8/2012	2/7/2013
Sig : TAKE ONE TABLET ORALLY EVERY DAY FOR CHOLESTEROL Route: (none)				
ONE TOUCH ULTRA TEST MISC STRIPS	100	PRN	2/7/2012	2/6/2013
Sig : USE AS DIRECTED Route: Miscell. (Med.Supl.;Non-Drugs)				
OMEPRAZOLE 20 MG ORAL CPDR SR CAP	180	PRN	1/31/2012	1/30/2013
Sig : TAKE ONE CAPSULE ORALLY ONE TO TWO TIMES A DAY FOR ACID REFLUX Route: (none)				
ONE TOUCH DELICA LANCETS MISC MISC	100	PRN	1/31/2012	1/30/2013
Sig : USE AS DIRECTED FOR DIABETES Route: Miscell. (Med.Supl.;Non-Drugs)				
TERAZOSIN 1 MG ORAL CAP (Discontinued)	180	PRN	1/31/2012	1/30/2013
Sig : TAKE TWO CAPSULES ORALLY AT BEDTIME FOR BENIGN PROSTATIC HYPERTROPHY Route: (none) Reason for Discontinue: Continue Therapy				
GLIPIZIDE 10 MG ORAL TAB (Discontinued)	30	PRN	1/31/2012	1/15/2013
Sig : TAKE ONE-HALF TABLET ORALLY TWICE DAILY FOR DIABETES Route: Oral Reason for Discontinue: Discontinue Prescription				
LOSARTAN 25 MG ORAL TAB (Discontinued)	90	PRN	1/31/2012	1/30/2013
Sig : TAKE ONE TABLET ORALLY EVERY DAY FOR BLOOD PRESSURE AND KIDNEY PROTECTION Route: (none) Reason for Discontinue: Replaced by Pharmacy				
METFORMIN 1000 MG ORAL TAB (Discontinued)	180	PRN	1/31/2012	1/15/2013
Sig : TAKE ONE TABLET ORALLY TWICE DAILY FOR DIABETES Route: Oral Comment: Pharmacy- please make sure patient is aware that tablets have changed from 500 to 1000mg tabs. Reason for Discontinue: Discontinue Prescription				
TRIAMCINOLONE ACETONIDE 0.1 % TOP OINT	45	0.69/2	1/31/2011	1/31/2012
Sig : APPLY TO AFFECTED AREA A THIN LAYER TWICE DAILY Route: Topical Class: Fill Later				
PROAIR HFA 90 MCG/ACTUATION INHL HFAA	8.5	0/0	9/7/2010	10/7/2010
Sig : INHALE TWO PUFFS EVERY FOUR TO SIX HOURS AS NEEDED FOR WHEEZING AND COUGH Route: Inhalation Class: Fill Later				
CHOLECALCIFEROL (VITAMIN D3) 1000 UNIT	100	PRN	6/9/2010	

REDACTED

ORAL TAB
Sig : Take 1 tab once daily for vitamin D deficiency.
Route: Oral

DOXEPIN 10 MG ORAL CAP	60	0.33/1	8/13/2009	8/13/2010

Sig : TAKE ONE CAPSULE ORALLY EVERY NIGHT AT BEDTIME FOR SLEEP AND ITCHING
Route: Oral
Class: Fill Later

ASPIRIN 81 MG ORAL CHEW TAB	36	PRN	8/13/2009

Sig : CHEW 1 TAB PO ONCE DAILY FOR PREVENTION OF HEART ATTACK AND STROKE
Route: Oral
Class: Fill Later

OMEGA-3 FISH OIL 1,000 MG-5 UNIT CAP	90	PRN	5/13/2006

Sig : TAKE AS DIRECTED
Route: Oral
Class: OTC

VITAMIN E 400 UNIT CAP	100	0/0	5/13/2006

Sig : Pt is taking 1 capsule once daily
Route: Oral
Class: OTC

Inpatient Medications

	Dose	Frequency	Start	End
VICODIN 5-500 mg 2 Tab (Hydrocodone-Acetaminophen)	2 Tab	EVERY 4 HOURS AS NEEDED	2/25/2005 0542	(none)

Route: Oral
Admin Dose: 2 Tab

PERCOCET 5-325 mg 1 Tab (Oxycodone-Acetaminophen)	1 Tab	EVERY 3 HOURS AS NEEDED	2/25/2005 0542	(none)

Route: Oral
Admin Dose: 1 Tab

PERCOCET 5-325 mg 2 Tab (Oxycodone-Acetaminophen)	2 Tab	EVERY 3 HOURS AS NEEDED	2/25/2005 0542	(none)

Route: Oral
Admin Dose: 2 Tab

ER-667
VH00089

REL0000198

Example Case 2

Encounter Date: 06/24/2013

Office Visit

6/24/2013 Office Visit **Patient Name | MRN:**

Visit Summary

Encounter Information

Date & Time	Provider	Department	Encounter #	Center
6/24/2013 2:10 PM	XXX (M.D.)			REDACTED

Reason for Visit

NUMBNESS

Diagnoses

MAJOR DEPRESSION, RECURRENT	- Primary	296.30
PERIPHERAL NEUROPATHY		356.9
ATHEROSCLEROSIS AORTA		440.0
CKD STAGE 3 (GFR 30-59)		585.3
HYPERLIPIDEMIA		272.4
HTN		401.9
GERD (GASTROESOPHAGEAL REFLUX DISEASE)		530.81
H PYLORI INFECTION		041.86

After Visit Summary

After Visit Summary

Vitals - Last Recorded

BP	Pulse	Temp	Resp	Ht	Wt
118/65	62	97 °F (36.1 °C)	17	5' 4.5"	200 lb (90.719 kg)

BMI	Sp02
33.81 kg/m2	99%

ALCOHOL SCREENING

How many times in the past three months have you had four or more drinks containing alcohol in a day?: 0
On average, how many days a week do you have an alcoholic drink?: 0
On a typical drinking day, how many drinks do you have?: 1

EXERCISE VITALS

06/24/2013	08/22/2012	04/27/2012	01/03/2012
40 minutes	140 minutes	140 minutes	Not addressed

All Flowsheet Data (all recorded)

Encounter Vitals

	06/24/13 1409
Enc Vitals	
BP	118/65 mmHg
Pulse	62
Resp	17
Temp	97 °F (36.1 °C)
SpO2	99 %
Weight	200 lb (90.719 kg)
Height	5' 4.5"

Not recorded

Visit Notes

MA Name, MA Mon Jun 24, 2013 2:10 PM
Preventative Health Prompts reviewed with patient
Domestic Violence screening done

ER-669
VH00091

REL0000200

Progress Notes

XXX (M.D.) at 6/24/2013 4:54 PM

Status: Signed

Clinical Progress Note:
Patient presents with a chief complaint of NUMBNESS

HPI: (Patient name) is a 77 Y , who presents for

DEPRESSION, MAJOR, RECURRENT (primary encounter diagnosis)
NEUROPATHY, PERIPHERAL
ATHEROSCLEROSIS AORTA
CKD STAGE 3 (GFR 30-59)
HYPERLIPIDEMIA
HYPERTENSION
GERD
Note: stable with her medications now.
Still has this tingling at her bilaterally fingers and toes since 05. No injury. Worry about diabetes mellitus. Wants to check lab.
Have reviewed lab from last year. No diabetes mellitus.

HELICOBACTER PYLORI INFECTION
Note: treated before. Needs check stool test.

I have reviewed (Patient)
medical history with no changes 6/24/2013 and social history with no changes 6/24/2013

Current Outpatient Prescriptions:
Lisinopril-Hydrochlorothiazide (PRINZIDE/ZESTORETIC) 20-12.5 mg Oral Tab, Take 1 tablet orally 2 times a day (Due for fasting lab and follow up with Primary Care Doctor before next refill)
Sertraline (ZOLOFT) 100 mg Oral Tab, Take 1 tablet orally daily

Review system: Review system: Review of Systems - History obtained from the patient
General ROS: negative for - chills or fever
Psychological ROS: negative for - anxiety, disorientation, hallucinations, hostility or irritability
Respiratory ROS: no cough, shortness of breath, or wheezing
Cardiovascular ROS: no chest pain or dyspnea on exertion
Gastrointestinal ROS: no abdominal pain,
Musculoskeletal ROS: negative for - gait disturbance, joint pain, joint stiffness, joint swelling, muscle pain or muscular weakness
Neurological ROS: no TIA or stroke symptoms

Physical Examination:
BP 118/65 | Pulse 62 | Temp 97 °F (36.1 °C) | Resp 17 | Ht 5' 4.5" | Wt 200 lb (90.719 kg) | BMI 33.80 kg/m2 | SpO2 99% General appearance - vital signs reviewed and alert, well appearing, and in no distress
Mental status - alert, oriented to person, place, and time
Respiratory - clear to auscultation, no wheezes, rales or rhonchi, symmetric air entry
Cardiovascular - normal rate and regular rhythm, normal S1, S2, no murmurs,

Bilaterally hands and feet-- Range of motion and muscle strength and sensation are within normal limits. Skin color is within normal limits. Peripheral pulse are within normal limits.
Negative for tinel's and phalet's sign

Data Reviewed:

WBC	6.2	08/22/2012
HCT	43.4	08/22/2012

HGB	14.0	08/22/2012
PLT	187	08/22/2012
CHOL	185	04/17/2012
HDL	44	04/17/2012
LDL CALC	117	04/17/2012
TRIG	121	04/17/2012
ALT	15	08/22/2012
AST	17	08/22/2012
BUN	16	08/22/2012
CREAT	1.08	08/22/2012
GFR-AFRAM	60	08/22/2012
GFR NONAFR AMER	49	08/22/2012
GFR-NONAFRAM	>60	07/14/2011
K	4.3	04/17/2012
NA	142	04/17/2012
TSH	1.14	04/17/2012
GLUC FAST	82	04/17/2012
HGBA1C %	5.9	08/22/2012
ESTIMATED AVERAGE GLUCOSE	123	08/22/2012

Assessment & Plan:
DEPRESSION, MAJOR, RECURRENT (primary encounter diagnosis)
NEUROPATHY, PERIPHERAL
ATHEROSCLEROSIS AORTA
CKD STAGE 3 (GFR 30-59)
HYPERLIPIDEMIA
HYPERTENSION
GERD
Note: most likely still her neuropathy since 05. Monitor. Repeat lab to rule/out diabetes mellitus.

HELICOBACTER PYLORI INFECTION
Note: check stool test.
Plan: HELICOBACTER PYLORI ANTIGEN, STOOL

As needed follow up if not well after the medications or early if worse the patient's symptoms. Understood the instructions well today. The patient is happy with the plan. The patient is satisfied with the care getting today.

Patient understands that it is the patients responsiiblility to call for questions or follow-up appointments for all reasons including routine health maintenance visits appropriate for patient's ages.

The patient may call me or e-mail me if the patient has any questions. My phone number is . For any medical information you can check my website at http://www.permanente.net/doctor

Electronically signed by XXX, MD

Scans

Encounter-Level Documents:

There are no encounter-level documents.

Encounter Date: 06/24/2013

Order-Level Documents:

There are no order-level documents.

Patient-Level Documents:

There are no patient-level documents.

Instructions and Follow-Up

Patient Instructions

None

Future Appointments

None

Misc Information

Level of Service

OUTPT EST LEVEL 4 [99214B]

Encounter Status

Closed by XXX, M.D.) on 6/24/13 at 4:54 PM

Electronically signed by:

Signed	Title	Date	Time
XXX	MEDICAL DOCTOR	Jun 24, 2013	16:54:51

Re: Revision to Draft Question to AHA Coding Clinic on AA

Gloryanne H Bryant to: Nancy J Andersen 11/17/2014 05:41 AM
Cc: Diana Medal, Janet D Franklin
Default custom expiration date: 11/17/2015

Good morning, I'm fine with the letter and revisions.

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS
AHIMA Approved ICD-10-CM/PCS Trainer
"I Support ICD-10 Implementation in 2015"
National Director Coding Quality, Education, Systems and Support
National Revenue Cycle
Kaiser Foundation Health Plan Inc & Hospitals
1 Kaiser Plaza- 15th floor, Office #1543, Oakland, CA 94612
510 267-7559 (tel)
510 267-7606 (fax)
email: Gloryanne.h.bryant@kp.org
kp.org.thrive
http://insidekp.kp.org/finance/revenuecycle
National Coding Quality Wiki Site: https://wiki.kp.org/wiki/display/coding/HOME

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Nancy J Andersen Hi Janet, I had received feedback from Simon a... 11/16/2014 10:23:49 PM

From: Nancy J Andersen/CA/KAIPERM
To: Janet D Franklin/PO/KAIPERM@KAIPERM
Cc: Gloryanne H Bryant/CA/KAIPERM@KAIPERM, Diana Medal/PO/KAIPERM@KAIPERM
Date: 11/16/2014 10:23 PM
Subject: Revision to Draft Question to AHA Coding Clinic on AA

Hi Janet,

I had received feedback from Simon a while ago regarding your initial draft of the AA question for Coding Clinic. He did not want any reference made to "copy and paste". I have made a few minor revisions to your original letter; please take a look and let me know if you agree with the revisions.

Gloryanne and Diana - please also review the revisions and provide feedback, thanks!

[attachment "Aortic Atherosclerosis Packet for Coding Clinic, Draft 2.pdf" deleted by Gloryanne H Bryant/CA/KAIPERM]

Nancy J. Andersen, MS, RHIA, CCS, AHIMA-Approved ICD-10-CM/PCS Trainer
Senior Compliance Manager, Care Delivery and Health Information Management Compliance
National Compliance, Ethics and Integrity Office
Kaiser Foundation Health Plan, Inc.
Cellphone: 510-418-2455
nancy.j.andersen@kp.org

"I Support ICD 10 Adoption and implementation in 2015"

Embed a culture of compliance across the care delivery enterprise that inspires the highest level of ethics and integrity

Kaiser Permanente does the right thing by promoting ethics in decision making and integrity in all actions.

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EXHIBIT 14

NCAL

High Priority / Time Critical Meeting: Discuss Viewpoints and Prepare Response from NCAL to NCO on Capture of AA ICD4400.

Marcus Lee to: Mitchell M Law 07/23/2014 12:38 PM

Cc: Sue Muscarella, Lindy A Petersen, Gloryanne H Bryant, Nancy J Andersen, Danielle Sheetenhelm, Dawna M Toews, Amy S Kane

Default custom expiration date: 07/23/2015

History: This message has been replied to and forwarded.

Hi Mitch,

Please schedule a high priority and time critical meeting early next week with the following:

Subject: Discuss Viewpoints and Prepare Response from NCAL to NCO on Capture of AA ICD4400.

Victoria Hernandez (key)
GloryAnne Bryant (key)
Nancy Andersen (key)
Lindy Petersen (key)
Marcus Lee (key)
Sue Muscarella (would like key members to meet if she cannot attend)
Danielle Sheetenhelm
Dawna Toes
Amy S Kane

Web ex is good.

Attendees - please let me know if you have any questions!

Thanks everyone for trying to make this meeting happen.

Marc

Marcus Lee
Director, Auditing and Coding Services
The Permanente Medical Group, Inc.
Encounter Information Operations
1950 Franklin St., 7th Floor
Oakland, CA. 94612
office: (510) 987-2668 / 8-427-2668
cell: (510) 363-6647
marcus.lee@kp.org

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EXHIBIT 15

Coding Governance Group (CGG)

DRAFT
V10

July 31, 2014
11:00 – 12:30 PST
Agenda Packet

Case: 22-15862, 11/21/2022, ID: 12593323, DktEntry: 10-5, Page 180 of 233

REVIEW0014444
VH00100

DRAFT

Coding Governance Group Meeting Agenda

Time	Item	Facilitator
11:00	Call to Order Announcements & Introductions Review of Apr. Minutes	Simon Cohn Tammi Keating
11:10	Follow up: CGG Charter	Simon Cohn Tammi Keating
11:20	Documentation and Coding Committees: Relationship of other documentation and coding forums to CGG	Nancy Andersen
11:35	Follow up: Coding Question Process Flowchart	Nancy Andersen
11:55	NCO Telehealth Documentation and Coding Reference Document	Nancy Andersen
12:05	Request to add Aortic Atherosclerosis to KP Always Code List as a Chronic Condition	Nancy Andersen Gloryanne Bryant
12:25	Wrap Up; Future Agenda Topics; Action Items for Next Meeting	Simon Cohn Tammi Keating

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VH00101

Request to Add Aortic Atherosclerosis to KP Always Code List

Background:

- AA Dx is a HCC: reimbursement impact
- Recent NCO Probe audit designated coding of AA as Chr. Systemic as an error

Recommendation:

- Request Aortic Atherosclerosis Dx be included in the KP Chronic Systemic Condition – Inpatient Always Code List
- Allow for Hospital OP reporting as well

Request

- CGG and NCO support recommendations

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Information to Substantiate the Request

- Current KP *Always Code List* and process for inclusion
- Clinical rationale (NCAL)
- Coding Rules
- Documentation & MA requirements
- Coding Clinic guidelines and response to question

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KP Hospital Inpatient *Always Code List* (con't)

- Based on Coding Guidelines, Kaiser has developed the Documentation and Coding Guideline for coding of such systemic diseases for Kaiser Foundation Hospitals, referred to as the "Always Code List" Guideline.

Systemic Conditions - List A Examples of Systemic conditions always to be coded include, but are not limited to, the following:
• AIDS • Asthma, chronic obstructive • Atherosclerosis, generalized • Bronchitis, chronic obstructive • Collagen vascular disease • COPD • Diabetes mellitus • Emphysema • Hypertension • Systemic lupus erythematosus • Multiple sclerosis • Parkinson's disease • Peripheral vascular disease • Chronic kidney disease • Rheumatoid arthritis • ***Note: Attending physician confirmation of clinical significance of all radiology findings is required for inpatients per Coding Clinic.**

The following table includes a list of secondary conditions that Kaiser has determined will always be coded, even though the conditions may not impact the patient's current stay. These conditions are pertinent to Kaiser's patient-mix data and conduction of health care studies. **Coding of other secondary conditions is left to the discretion of each facility. Each facility must develop a written guideline regarding the coding of any additional conditions.**

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KP Inpatient *Always Code List*

- A flow chart was developed within the Always Code List to assist in determining if a secondary condition should be coded.
- Flowchart steps:
  - 1. Determine if the condition is a systemic one. If so, code it.
  - 2. If not systemic, did it impact the patient's care as defined above? If so, code it.
  - 3. If it is not systemic and does not impact the patient's current care, is it on Kaiser's list of V codes always to be coded? If so, code it.
  - 4. If it does not meet any of these criteria, it is **not** to be coded.
- Coding of other secondary conditions is left to the discretion of each facility. Each facility must develop a written guideline regarding the coding of any additional conditions.
- The list was developed to include only conditions that do NOT have an impact on reimbursement.

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Coding: UHDDS Definition of Secondary Diagnosis Reporting

- Those conditions that affect the episode of hospital care in terms of any of the following:
  - Clinical evaluation
  - Therapeutic treatment
  - Further evaluation by diagnostic studies, procedures, or consultation
  - Extended length of hospital stay
  - Increased nursing care and/or other monitoring

Note: For inpatient coding, you only need to meet <u>one</u> of the criteria for "other diagnosis" reporting.

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VH00106

KP Criteria for MA Risk Adjustment Diagnosis Reporting

- A diagnosis will always be coded and is acceptable for submission to CMS as risk adjustment data, even in the absence of expressly documented active treatment, evaluation, or intervention by the physician, if the condition meets all four of the following criteria:
- 1) The condition is always present, even though it may have been stabilized; AND
- 2) By its very nature (because of its impact on the patient), the condition must be considered by the physician in evaluating the patient's chief complaint; AND
- 3) The condition affects a major body system (and, typically, more than one major body system), which include the following:

Cardiovascular; AND/OR	Hematologic/Lymphatic/Immunologic; AND/OR
Respiratory: AND/OR	Neurologic; AND/OR
Gastrointestinal; AND/OR	Psychiatric; AND
Renal; AND/OR	

- 4) The physician indicates that he/she considered the diagnosis by documenting the diagnosis in the medical record for the encounter.

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VH00107

Coding: AHA *Coding Clinic* Guidelines on Chronic Systemic Conditions

- AHA *Coding Clinic* definition of other/secondary diagnoses:
  - Inpatient Coding - Conditions that affect patient care in terms of requiring:
    - Clinical evaluation; or therapeutic treatment; or diagnostic procedures; or extended length of hospital stay; or increased nursing care and/or monitoring.
    - Systemic diseases are always coded, even in the absence of documented active intervention since these types of conditions meet one or more of the elements of the definition given above. (AHA Coding Clinic, Second Quarter, 1990, page 14).
  - Outpatient Coding:
    - Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care, treatment, or management. Do not code conditions that were previously treated and no longer exist. However, history codes (V10-V19) may be used as secondary codes if the historical condition or family history has an impact on current care or influences treatment.
    - Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
    - Incidental findings on outpatient radiology reports: It is inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test . . . The . . . physician would need to clarify that the finding was clinically significant and related to the visit in order for it to be coded. (AHA Coding Clinic, Third Quarter 2010, pages 8-9).

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VH00108

Question Submitted to AHA Coding Clinic

Many physicians believe that the diagnosis/condition of Aortic Atherosclerosis is a Chronic Systemic Condition. We had our physicians provide education about this condition and this included risk factors with AA:

- Dyslipidemia (high LDL, low HDL): high cholesterol
- Diabetes
- Smoking
- Obesity
- Metabolic Syndrome (abdominal obesity, along with at least 2 of the following: dyslipidemia, hypertension, insulin resistance)

- Hyperinsulinemia
- Prothrombotic states
- Hypertension
- Renal insufficiency
- Systemic infections
- Age
- Family history
- Sedentary lifestyle

Thus, like COPD or Diabetes Mellitus, CAD, Lupus, should we code Aortic Atherosclerosis condition when documented, either outpatient or inpatient record similar to COPD? Thank you.

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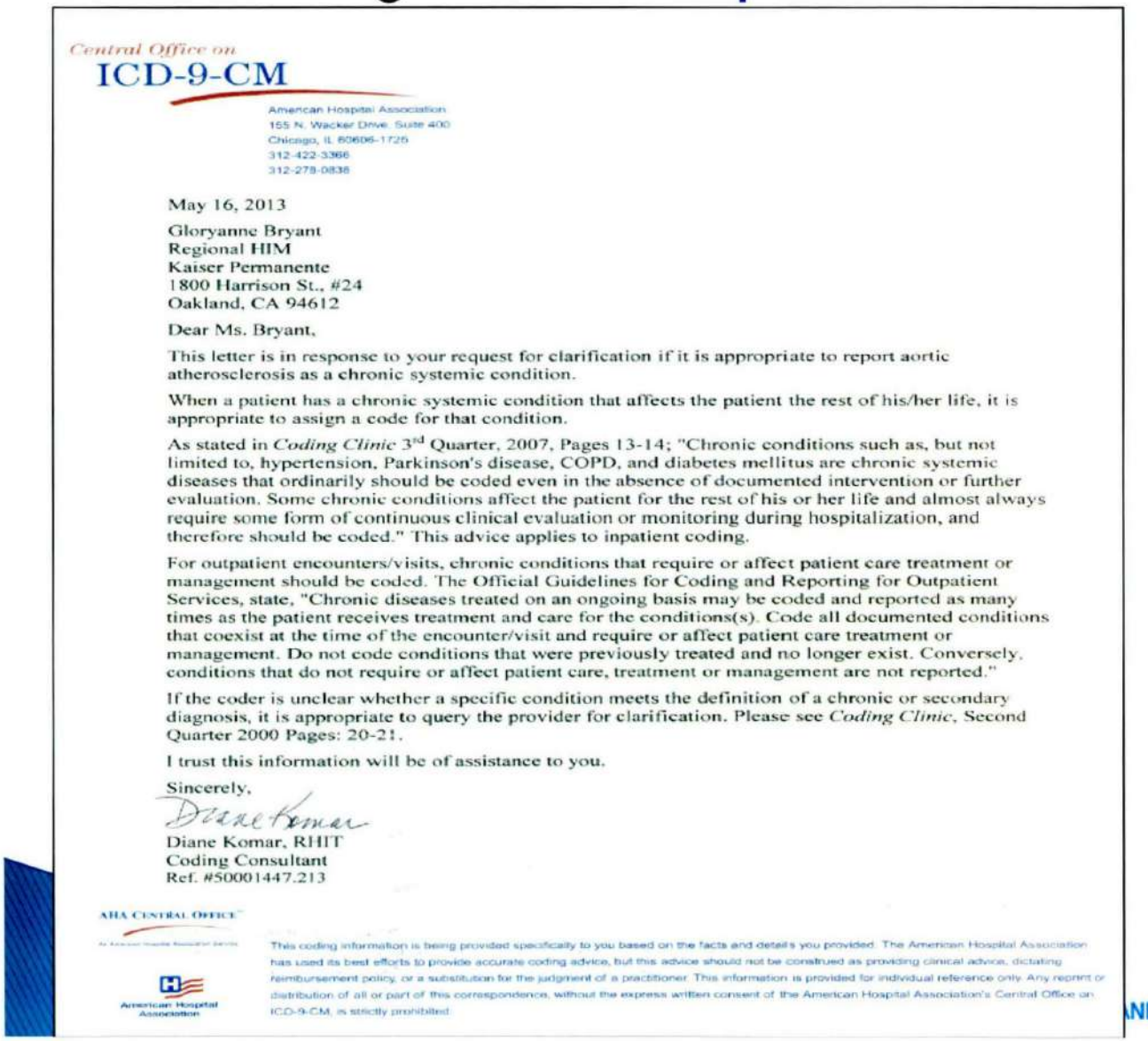
VH00109

REL0000216

AHA *Coding Clinic* Response



Central Office on
ICD-9-CM

American Hospital Association
155 N. Wacker Drive, Suite 400
Chicago, IL 60606-1726
312-422-3366
312-278-0838

May 16, 2013

Gloryanne Bryant
Regional HIM
Kaiser Permanente
1800 Harrison St., #24
Oakland, CA 94612

Dear Ms. Bryant,

This letter is in response to your request for clarification if it is appropriate to report aortic atherosclerosis as a chronic systemic condition.

When a patient has a chronic systemic condition that affects the patient the rest of his/her life, it is appropriate to assign a code for that condition.

As stated in *Coding Clinic* 3rd Quarter, 2007, Pages 13-14; "Chronic conditions such as, but not limited to, hypertension, Parkinson's disease, COPD, and diabetes mellitus are chronic systemic diseases that ordinarily should be coded even in the absence of documented intervention or further evaluation. Some chronic conditions affect the patient for the rest of his or her life and almost always require some form of continuous clinical evaluation or monitoring during hospitalization, and therefore should be coded." This advice applies to inpatient coding.

For outpatient encounters/visits, chronic conditions that require or affect patient care treatment or management should be coded. The Official Guidelines for Coding and Reporting for Outpatient Services, state, "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the conditions(s). Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. Conversely, conditions that do not require or affect patient care, treatment or management are not reported."

If the coder is unclear whether a specific condition meets the definition of a chronic or secondary diagnosis, it is appropriate to query the provider for clarification. Please see *Coding Clinic*, Second Quarter 2000 Pages: 20-21.

I trust this information will be of assistance to you.

Sincerely,

Diane Komar

Diane Komar, RHIT
Coding Consultant
Ref. #50001447.213

AHA CENTRAL OFFICE

American Hospital Association

This coding information is being provided specifically to you based on the facts and details you provided. The American Hospital Association has used its best efforts to provide accurate coding advice, but this advice should not be construed as providing clinical advice, dictating reimbursement policy, or a substitution for the judgment of a practitioner. This information is provided for individual reference only. Any reprint or distribution of all or part of this correspondence, without the express written consent of the American Hospital Association's Central Office on ICD-9-CM, is strictly prohibited.

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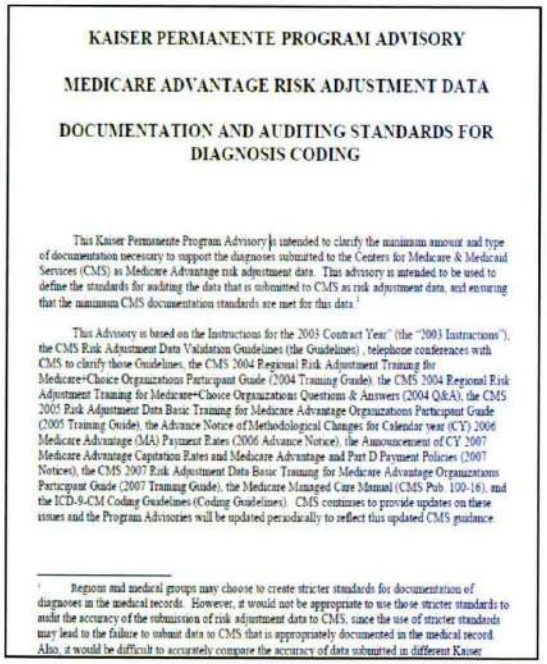
KP MA: Documentation and Coding Reportable Systemic Conditions (con't)

- Systemic conditions always to be coded include, but are not limited to, the following:
  - AIDS
  - Lupus
  - Atherosclerosis, generalized
  - Multiple sclerosis
  - Collagen vascular disease
  - Parkinson's Disease
  - Diabetes mellitus
  - Renal Failure, Chronic
  - Hypertension
  - Rheumatoid Arthritis



KAISER PERMANENTE PROGRAM ADVISORY

MEDICARE ADVANTAGE RISK ADJUSTMENT DATA

DOCUMENTATION AND AUDITING STANDARDS FOR DIAGNOSIS CODING

This Kaiser Permanente Program Advisory is intended to clarify the minimum amount and type of documentation necessary to support the diagnoses submitted to the Centers for Medicare & Medicaid Services (CMS) as Medicare Advantage risk adjustment data. This advisory is intended to be used to define the standards for auditing the data that is submitted to CMS as risk adjustment data, and ensuring that the minimum CMS documentation standards are met for this data.[1]

This Advisory is based on the Instructions for the 2003 Contract Year" (the "2003 Instructions"), the CMS Risk Adjustment Data Validation Guidelines (the Guidelines) , telephone conferences with CMS to clarify those Guidelines, the CMS 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations Participant Guide (2004 Training Guide), the CMS 2004 Regional Risk Adjustment Training for Medicare+Choice Organizations Questions & Answers (2004 Q&A), the CMS 2005 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide (2005 Training Guide), the Advance Notice of Methodological Changes for Calendar year (CY) 2006 Medicare Advantage (MA) Payment Rates (2006 Advance Notice), the Announcement of CY 2007 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies (2007 Notices), the CMS 2007 Risk Adjustment Data Basic Training for Medicare Advantage Organizations Participant Guide (2007 Training Guide), the Medicare Managed Care Manual (CMS Pub. 100-16), and the ICD-9-CM Coding Guidelines (Coding Guidelines). CMS continues to provide updates on these issues and the Program Advisories will be updated periodically to reflect this updated CMS guidance.

[1] Regions and medical groups may choose to create stricter standards for documentation of diagnoses in the medical records. However, it would not be appropriate to use those stricter standards to audit the accuracy of the submission of risk adjustment data to CMS, since the use of stricter standards may lead to the failure to submit data to CMS that is appropriately documented in the medical record. Also, it would be difficult to accurately compare the accuracy of data submitted in different Kaiser

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VH00111

Inpatient Documentation

- Currently inpatient documentation of AA requires the physician to document the clinical significance when the condition is noted on a radiology report (e.g. CT, Chest X-ray).

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Discussion

- The diagnosis of aortic atherosclerosis has potential financial impact to the organization.
- NCO does not currently recognize aortic atherosclerosis as a chronic, systemic condition.
- Regional Request: Aortic Atherosclerosis Dx be included in the KP Chronic Systemic Condition – Always Code Lis and allow for Hospital OP reporting as well.

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Potential CGG Determinations

- Accept original Coding Clinic answer which requires a query if impact is not discernable.
  - Coding Clinic response appears to negate AA as a systemic condition as queries are never required for impact of systemic conditions
  - Cannot be added to the "Always Code" list as this list includes those conditions that are to be always be coded even though they do NOT impact the encounter.
- Recommend second question to Coding Clinic with more detail, scenarios, and pro and con perspectives of coding the provided scenarios without the need to query.
  - NCO to send a second question to AHA Coding Clinic with more detail, examples of documentation of aortic atherosclerosis currently found in KPHC inpatient and physician office settings of care (redacted phi) and pro and con perspectives of coding the provided examples in the absence of the ability to query.
  - Request clarification on the question of whether this condition is considered a chronic, systemic condition.
  - NCO will base the decision of adding this condition to the KP Always Code List on the response received from AHA Coding Clinic.
  - If a decision is made to add the condition to the KP Always Code List, add to the "Systemic Condition" list. This action will be communicated to each region and PMG.

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VH00114

Appendix

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EXHIBIT 16

To: Nancy J Andersen/CA/KAIPERM@KAIPERM
Cc: Janet D Franklin/PO/KAIPERM@KAIPERM, Rizalyn A Andrews/CA/KAIPERM@KAIPERM
Date: 04/08/2016 10:23 AM
Subject: Re: Followup Question regarding AA documentation etc.

Do you want me to draft the question since we already have the answer?
I'm worried because we found in the ICD-10 assmt AA being coded when it should not have.

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS
AHIMA Approved ICD-10-CM/PCS Trainer
National Director Coding Quality, Education, Systems and Support
National Revenue Cycle
Kaiser Foundation Health Plan Inc & Hospitals
1 Kaiser Plaza- 15th floor, Office #1543, Oakland, CA 94612
510 267-7559 (tel)
510 267-7606 (fax)
email: Gloryanne.h.bryant@kp.org
kp.org.thrive
http://insidekp.kp.org/finance/revenuecycle
National Coding Quality Wiki Site: https://wiki.kp.org/wiki/display/coding/HOME

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Nancy J Andersen I agree it should be posted in the coding bulletin... 04/08/2016 10:18:25 AM

From: Nancy J Andersen/CA/KAIPERM
To: Gloryanne H Bryant/CA/KAIPERM@KAIPERM
Cc: Janet D Franklin/PO/KAIPERM@KAIPERM, Rizalyn A Andrews/CA/KAIPERM@KAIPERM
Date: 04/08/2016 10:18 AM
Subject: Re: Followup Question regarding AA documentation etc.

I agree it should be posted in the coding bulletin board for reference by all regions.

Nancy J. Andersen, MS, RHIA, CCS, AHIMA-Approved ICD-10-CM/PCS Trainer
Senior Compliance Manager, Government Audit and Reimbursement
National Compliance, Ethics and Integrity Office
Kaiser Foundation Health Plan, Inc.

510-418-2455
nancy.j.andersen@kp.org
NCO Care Delivery HIM SharePoint Site:
https://sites.sp.kp.org/teams/cdc2/cdc3/SitePages/Home.aspx

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Gloryanne H Bryant Hi, This coding is still coming up and SCAL did... 04/08/2016 09:34:42 AM

From: Gloryanne H Bryant/CA/KAIPERM
To: Janet D Franklin/PO/KAIPERM@KAIPERM
Cc: Nancy J Andersen/CA/KAIPERM@KAIPERM, Rizalyn A Andrews/CA/KAIPERM@KAIPERM
Date: 04/08/2016 09:34 AM

Subject: Re: Followup Question regarding AA documentation etc.

Hi, This coding is still coming up and SCAL did not know about the guidance from August (below) that this is not a systemic condition, we'd like to request that we post this on the National Bulletin Board, can that be done?.

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS
AHIMA Approved ICD-10-CM/PCS Trainer
National Director Coding Quality, Education, Systems and Support
National Revenue Cycle
Kaiser Foundation Health Plan Inc & Hospitals
1 Kaiser Plaza- 15th floor, Office #1543, Oakland, CA 94612
510 267-7559 (tel)
510 267-7606 (fax)
email: Gloryanne.h.bryant@kp.org
kp.org.thrive
http://insidekp.kp.org/finance/revenuecycle
National Coding Quality Wiki Site: https://wiki.kp.org/wiki/display/coding/HOME

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Janet D Franklin Hi Gloryanne, After having gone through clinicia... 08/04/2015 03:04:25 PM

From: Janet D Franklin/PO/KAIPERM
To: Gloryanne H Bryant/CA/KAIPERM
Cc: Nancy J Andersen/CA/KAIPERM@KAIPERM, Rizalyn A Andrews/CA/KAIPERM@KAIPERM, Simon Cohn/PO/KAIPERM@KAIPERM
Date: 08/04/2015 03:04 PM
Subject: Re: Followup Question regarding AA documentation etc.

Hi Gloryanne,

After having gone through clinician review, AA is not considered a systemic condition and will not appear on the final list of examples of systemic conditions. The clinician must do more than just list this condition. There must be documentation to show how it impacted the current encounter. It will be up to the region to decide if they want to query the provider about this condition when it is only listed. Without a query and additional documentation from the provider to show how it impacted the encounter, it cannot be coded.

Thanks,

Janet (don't forget the) D Franklin

Janet D Franklin, RHIT, CCS, CCS-P, CHC
AHIMA Approved ICD-10-CM/PCS Trainer
Compliance Manager, Government Audit and Reimbursement
National Compliance, Ethics & Integrity Office
Office: 8-423-5735, 510-271-5735
Fax: 8-423-5039, 510-891-5039

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Gloryanne H Bryant Good morning, In the past year + there has bee... 08/04/2015 05:50:51 AM

EXHIBIT 17

Aortic Atherosclerosis Dx Freq Report 2010-2016

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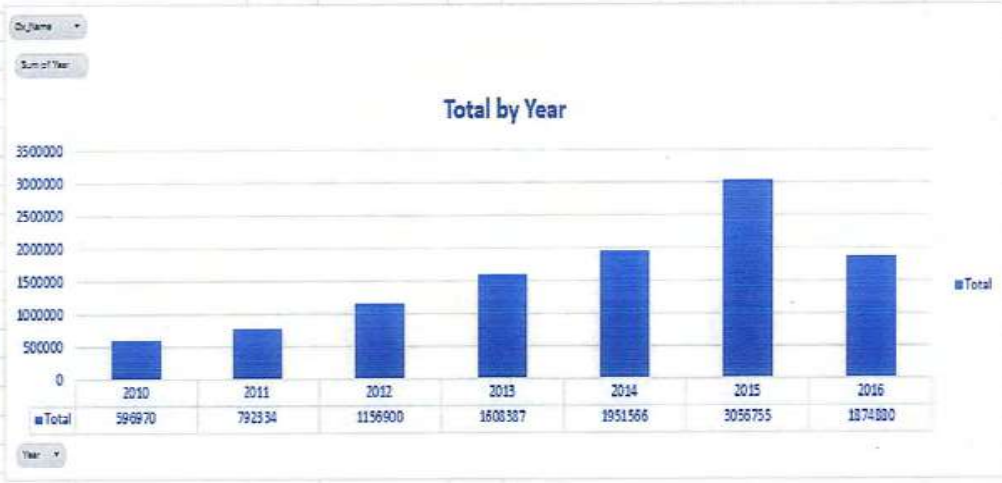
ALL REGIONS

ALL REGIONS

Total by Year

Dx_Name	(All)

Row Labels	Sum of Year
2010	596970
2011	792334
2012	1156900
2013	1608387
2014	1951566
2015	3056755
2016	1874880
Grand Total	11037792



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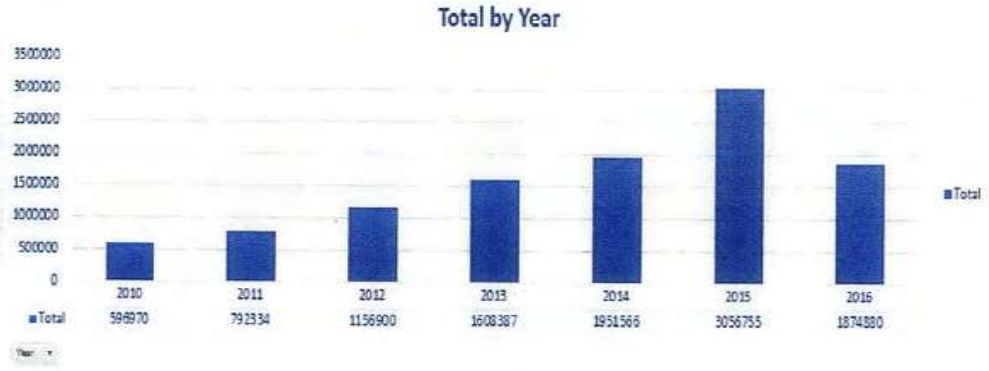
ALL REGIONS

ALL REGIONS

Total by Year

Dx_Name	(All)

Row Labels	Sum of Year
2010	596970
2011	792334
2012	1156900
2013	1608387
2014	1951566
2015	3056755
2016	1874880
Grand Total	**11037792**



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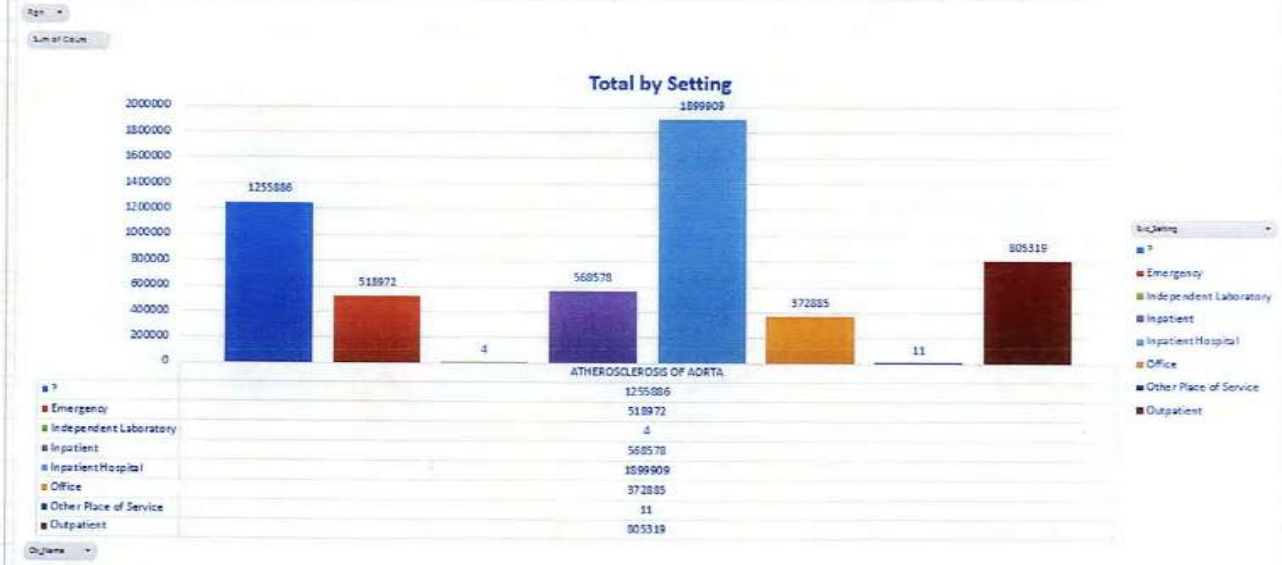
Total by Setting ALL REGIONS

Rgn (All)

Sum of Count	Column La							
Row Labels	?	Emergency	Independent Laboratory	Inpatient	Inpatient Hospital	Office	Other Place of Service	Outpatient	Grand Total
ATHEROSCLEROSIS OF AORTA	1255886	518972	4	568578	1899909	4E+05	11	805319	5421564
Grand Total	1255886	518972	4	568578	1899909	4E+05	11	805319	5421564



Total

Row Labels	Sum of Count
ATHEROSCLEROSIS OF AORTA	5421564
Grand Total	5421564

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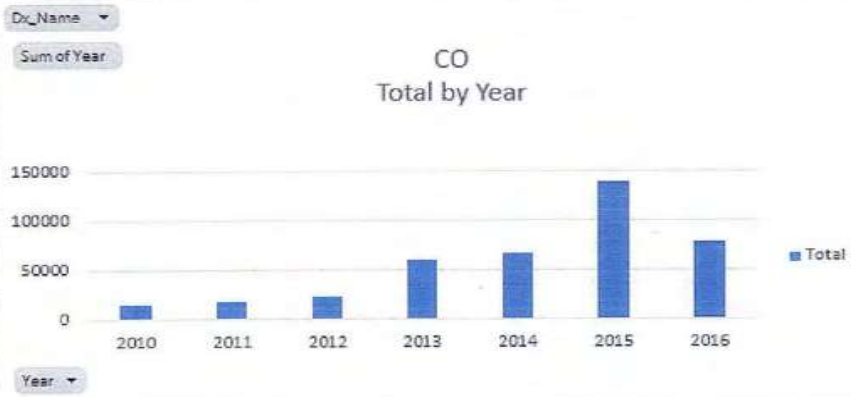
CO Region

Dx_Name	(All)
Row Labels	**Sum of Year**
2010	16080
2011	18099
2012	24144
2013	60390
2014	66462
2015	139035
2016	78624
Grand Total	**402834**



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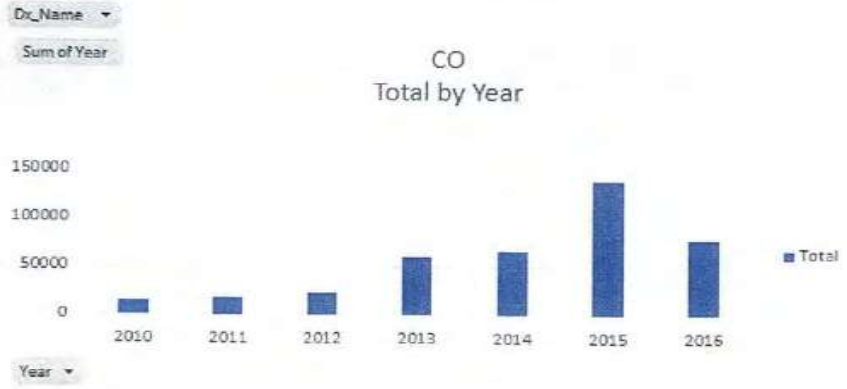
CO Region

Dx_Name	(All)

Row Labels	Sum of Year
2010	16080
2011	18099
2012	24144
2013	60390
2014	66462
2015	139035
2016	78624
Grand Total	**402834**



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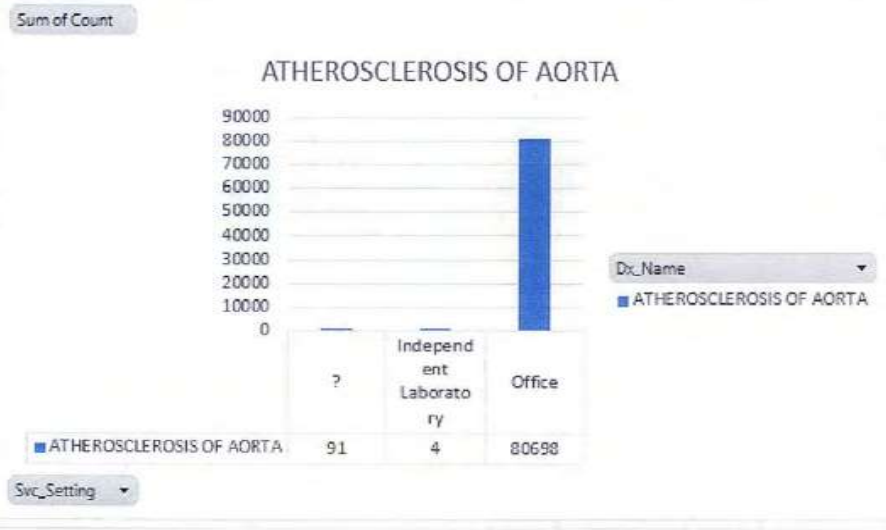
CO Region (cont.)

Sum of Count	Column Labels	
Row Labels	ATHEROSCLEROSIS OF AORTA	Grand Total
?	91	91
Independent Laboratory	4	4
Office	80698	80698
Grand Total	**80793**	**80793**



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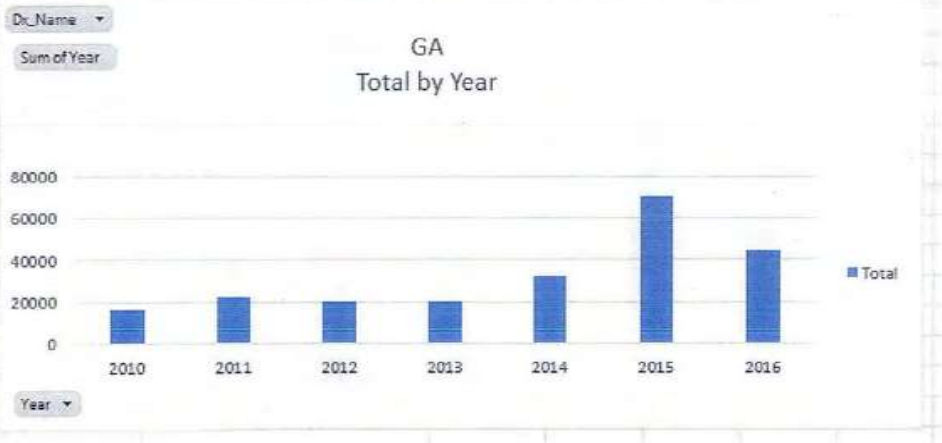
GA Region

Dx_Name	(All)
Row Labels	Sum of Year
2010	16080
2011	22121
2012	20120
2013	20130
2014	32224
2015	70525
2016	44352
Grand Total	225552



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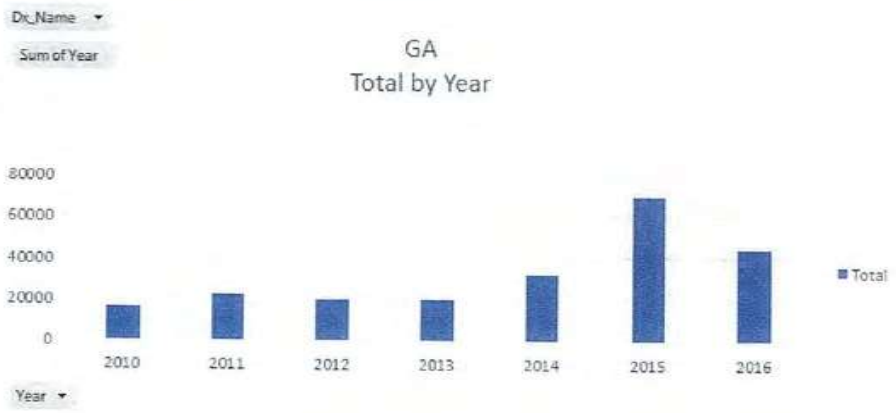
GA Region

Dx_Name	(All)

Row Labels	Sum of Year
2010	16080
2011	22121
2012	20120
2013	20130
2014	32224
2015	70525
2016	44352
Grand Total	225552



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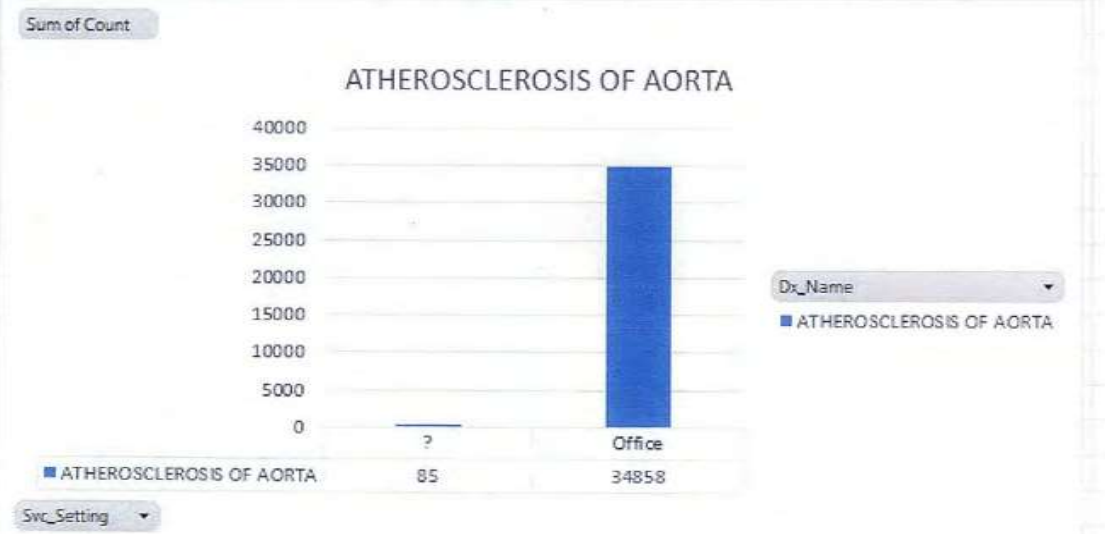
GA Region (cont.)

Sum of Count	Column Labels	
Row Labels	ATHEROSCLEROSIS OF AORTA	Grand Total
?	85	85
Office	34858	34858
Grand Total	**34943**	**34943**



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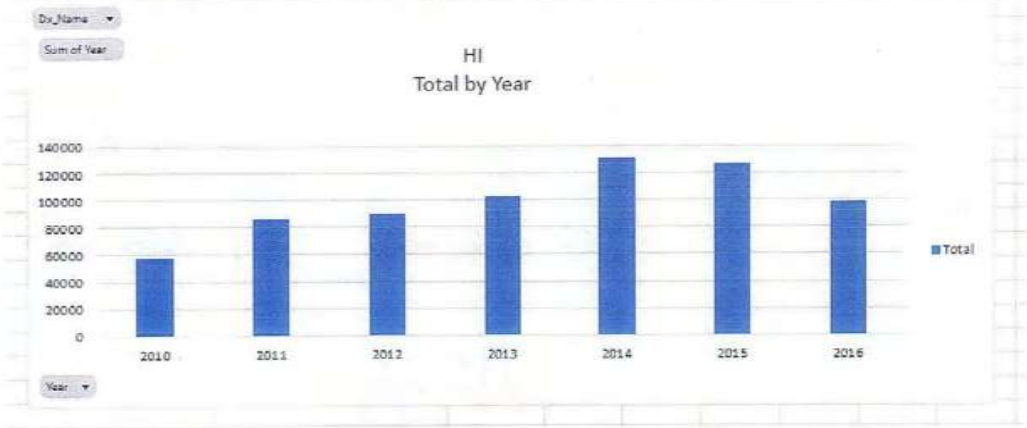
HI Region

Dx_Name	(All)
Row Labels	Sum of Year
2010	58290
2011	86473
2012	90540
2013	102668
2014	130910
2015	126945
2016	98784
Grand Total	694605



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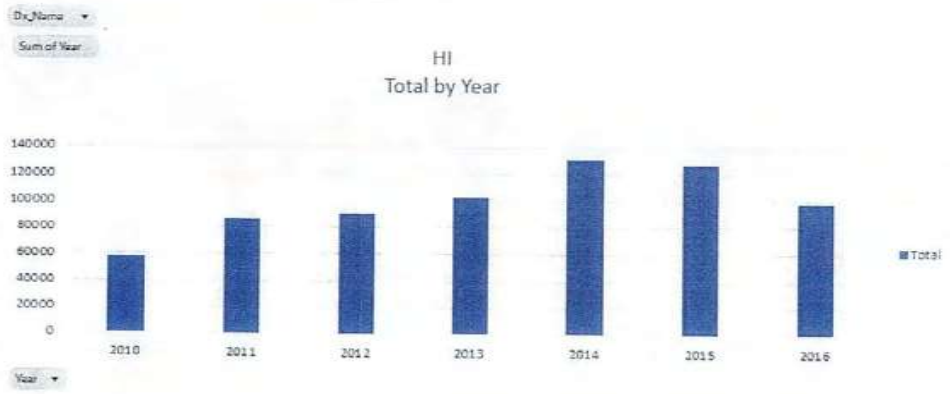
HI Region

Dx_Name	(All)

Row Labels	Sum of Year
2010	58290
2011	86473
2012	90540
2013	102663
2014	130910
2015	126945
2016	98784
Grand Total	694605



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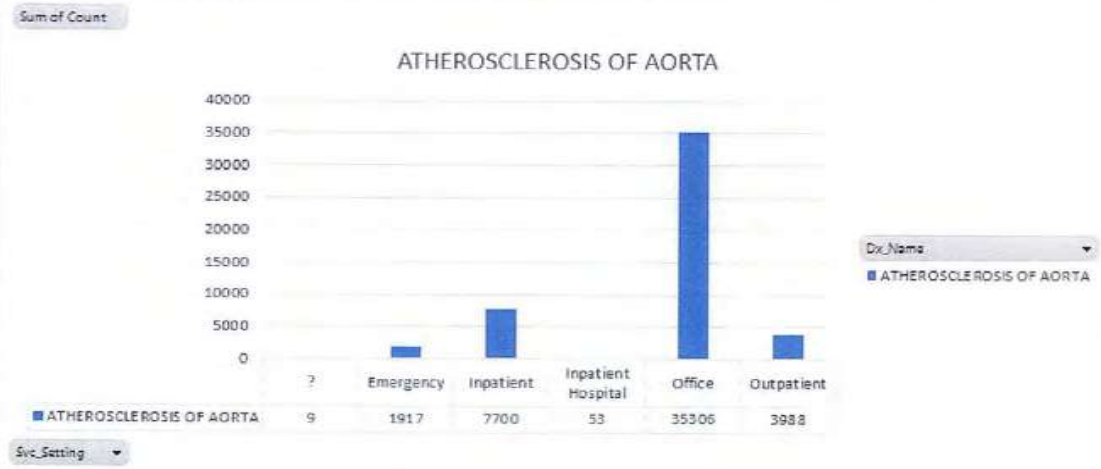
HI Region (cont.)

Sum of Count	Column Labels	
Row Labels	ATHEROSCLEROSIS OF AORTA	Grand Total
?	9	9
Emergency	1917	1917
Inpatient	7700	7700
Inpatient Hospital	53	53
Office	35306	35306
Outpatient	3988	3988
Grand Total	**48973**	**48973**



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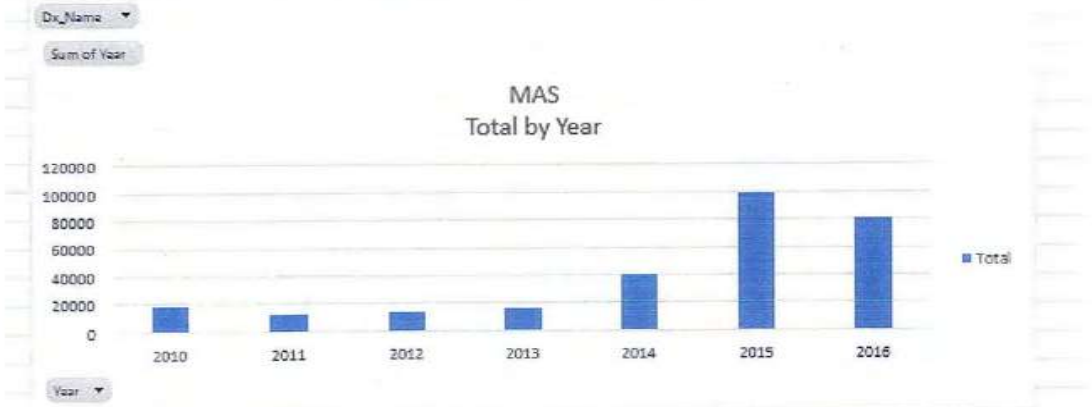
MAS Region

Dx_Name	(All)

Row Labels	Sum of Year
2010	18090
2011	12066
2012	14084
2013	16104
2014	40280
2015	98735
2016	80640
Grand Total	279999



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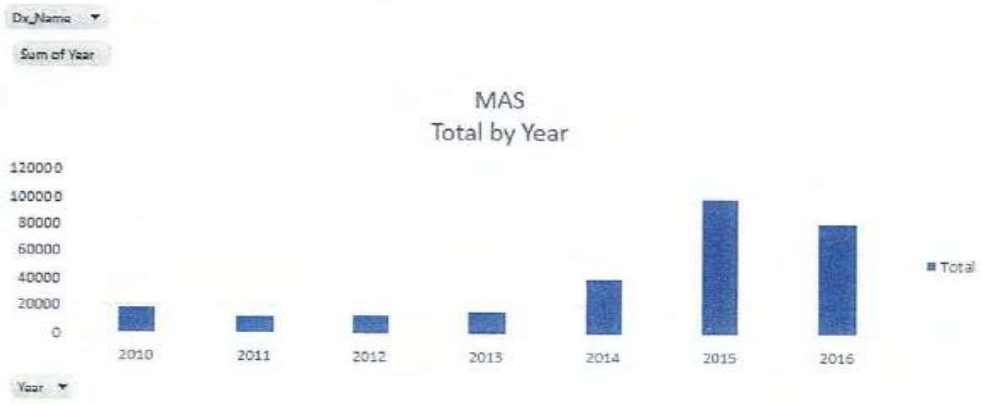
MAS Region

Dx_Name	(All)

Row Labels	Sum of Year
2010	18090
2011	12066
2012	14084
2013	16104
2014	40280
2015	98735
2016	80640
Grand Total	**279999**



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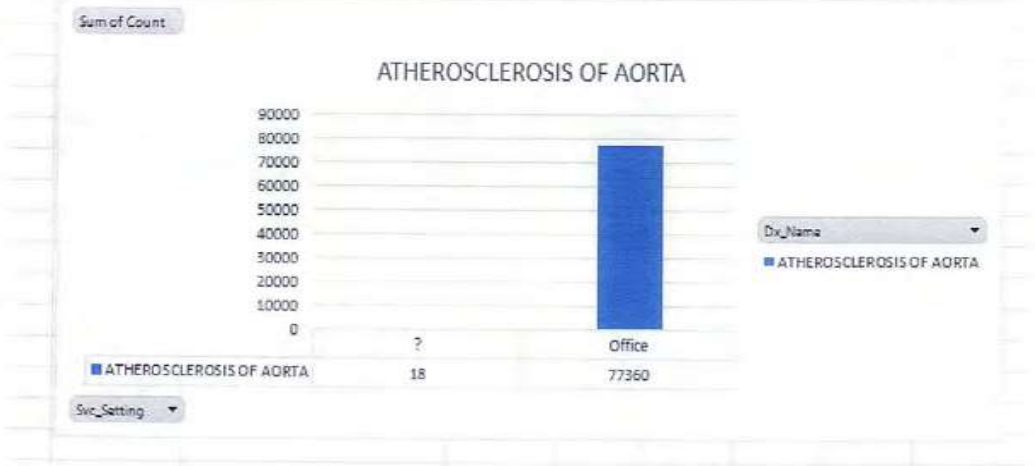
MAS Region (cont.)

Sum of Count	Column Labels	
Row Labels	ATHEROSCLEROSIS OF AORTA	Grand Total
?	18	18
Office	77360	77360
Grand Total	**77378**	**77378**



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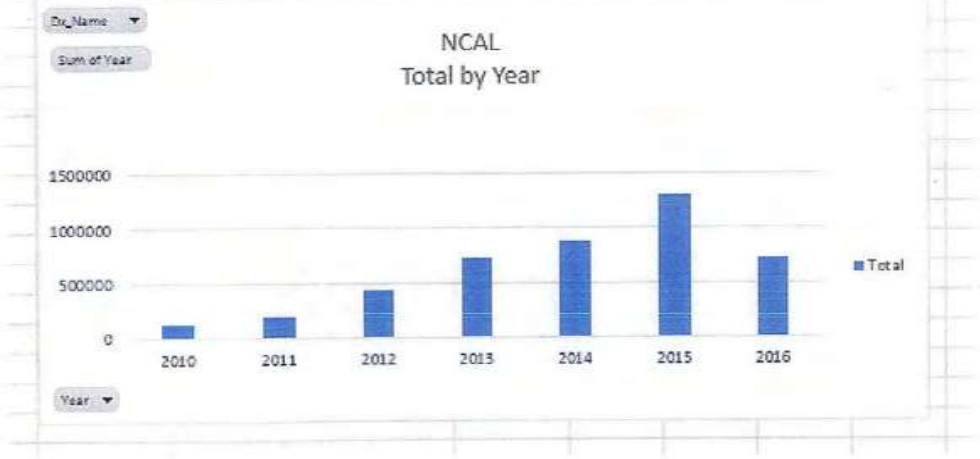
NCAL Region

Dx_Name	(All)
Row Labels	Sum of Year
2010	124620
2011	199089
2012	434592
2013	728706
2014	872062
2015	1301690
2016	725760
Grand Total	4386519



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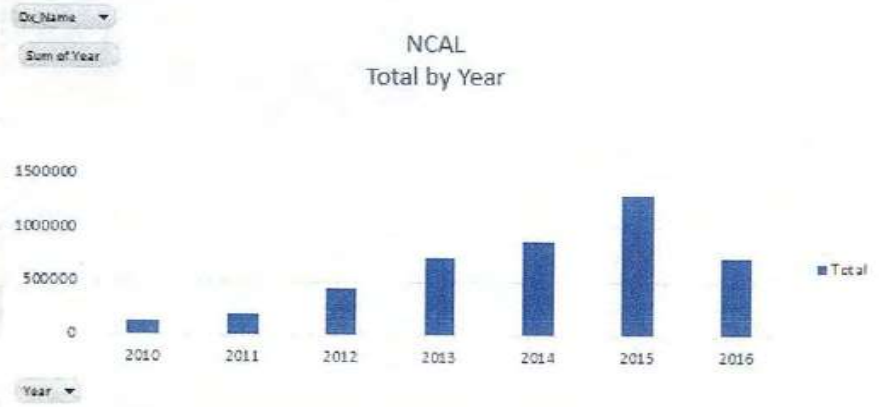
NCAL Region

Dx_Name (All)

Row Labels	Sum of Year
2010	124620
2011	199089
2012	434592
2013	728706
2014	872062
2015	1301690
2016	725760
Grand Total	**4386519**



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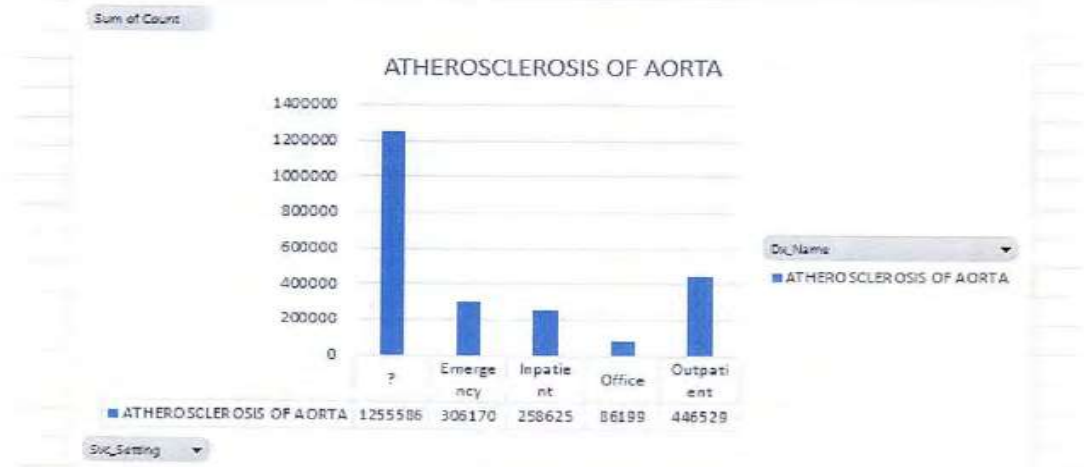
NCAL Region (cont.)

Sum of Count	Column Labels	
Row Labels	ATHEROSCLEROSIS OF AORTA	Grand Total
?	1255586	1255586
Emergency	306170	306170
Inpatient	258625	258625
Office	86199	86199
Outpatient	446529	446529
Grand Total	**2353109**	**2353109**



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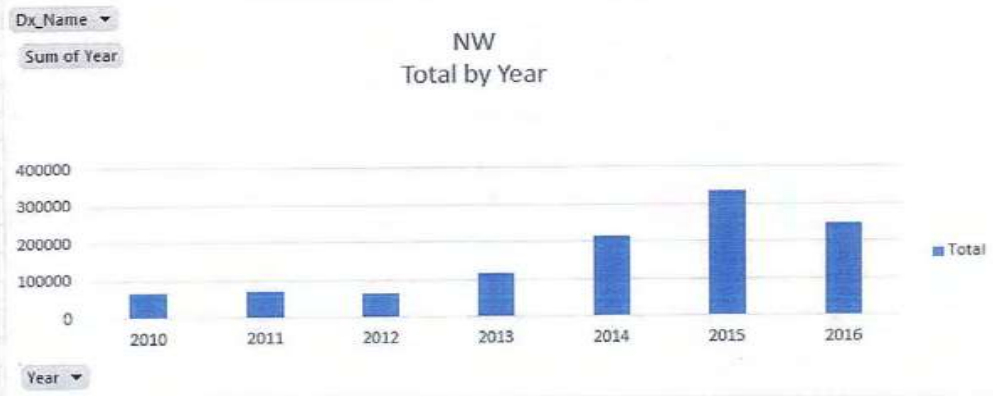
NW Region

Dx_Name	(All)
Row Labels	**Sum of Year**
2010	68340
2011	72396
2012	62372
2013	116754
2014	213484
2015	336505
2016	247968
Grand Total	**1117819**



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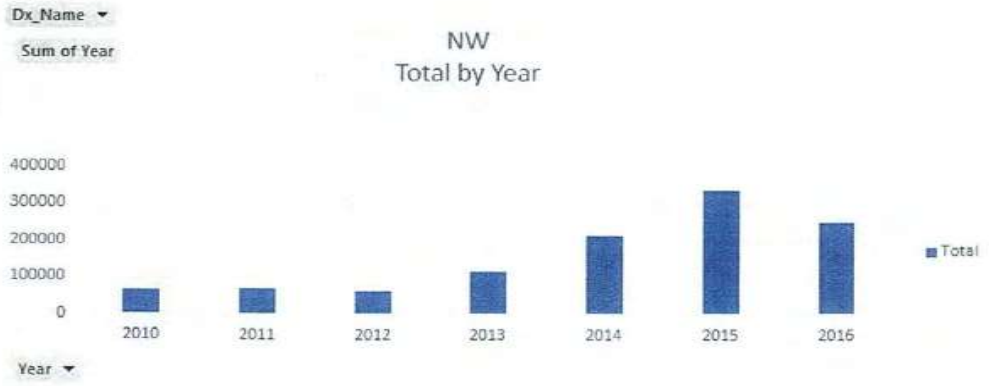
NW Region

Dx_Name	(All)

Row Labels	Sum of Year
2010	68340
2011	72396
2012	62372
2013	116754
2014	213484
2015	336505
2016	247968
Grand Total	**1117819**



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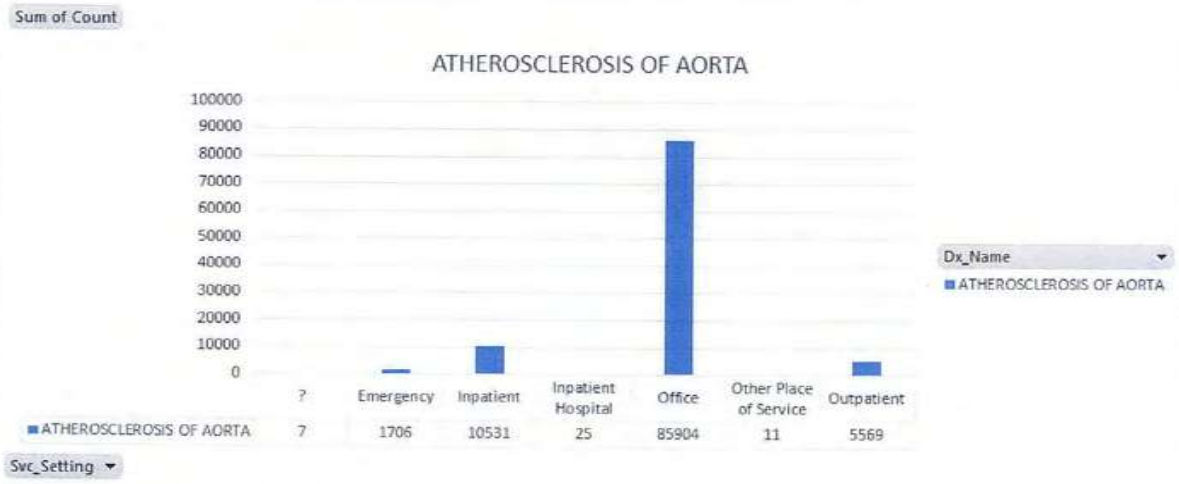
NW Region (cont.)

Sum of Count	Column Labels	
Row Labels	ATHEROSCLEROSIS OF AORTA	Grand Total
?	7	7
Emergency	1706	1706
Inpatient	10531	10531
Inpatient Hospital	25	25
Office	85904	85904
Other Place of Service	11	11
Outpatient	5569	5569
Grand Total	**103753**	**103753**



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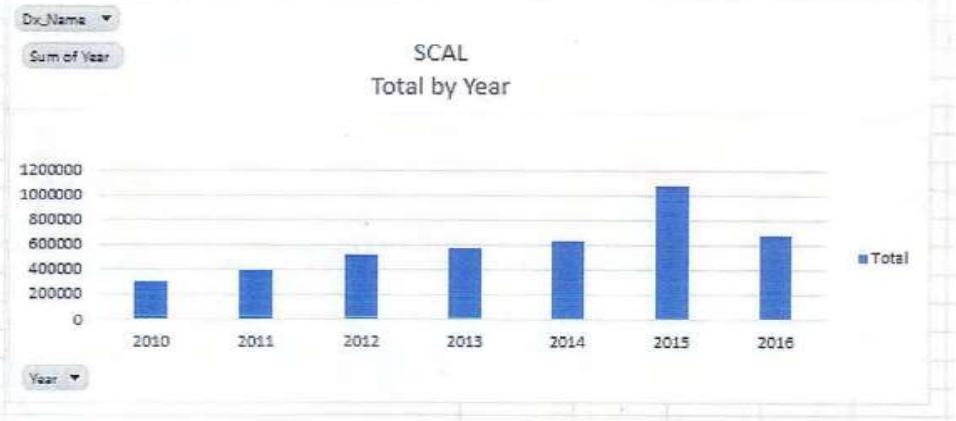
SCAL Region

Dx_Name	(All)
Row Labels	**Sum of Year**
2010	313560
2011	394156
2012	525132
2013	579744
2014	636424
2015	1082055
2016	679392
Grand Total	4210463



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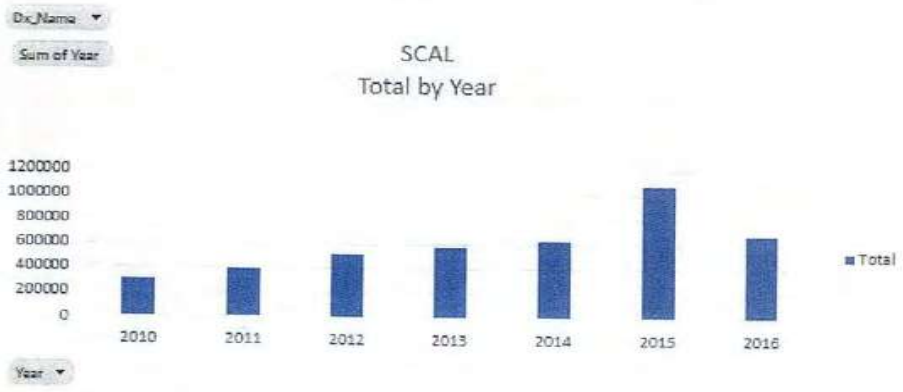
SCAL Region

Dx_Name	(All)

Row Labels	Sum of Year
2010	313560
2011	394156
2012	525132
2013	579744
2014	636424
2015	1082055
2016	679392
Grand Total	**4210463**



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SCAL Region (cont.)

Sum of Count	Column Labels	
Row Labels	ATHEROSCLEROSIS OF AORTA	Grand Total
?	108	108
Emergency	209179	209179
Inpatient	291722	291722
Inpatient Hospit	1899831	1899831
Office	49920	49920
Outpatient	349233	349233
Grand Total	**2799993**	**2799993**

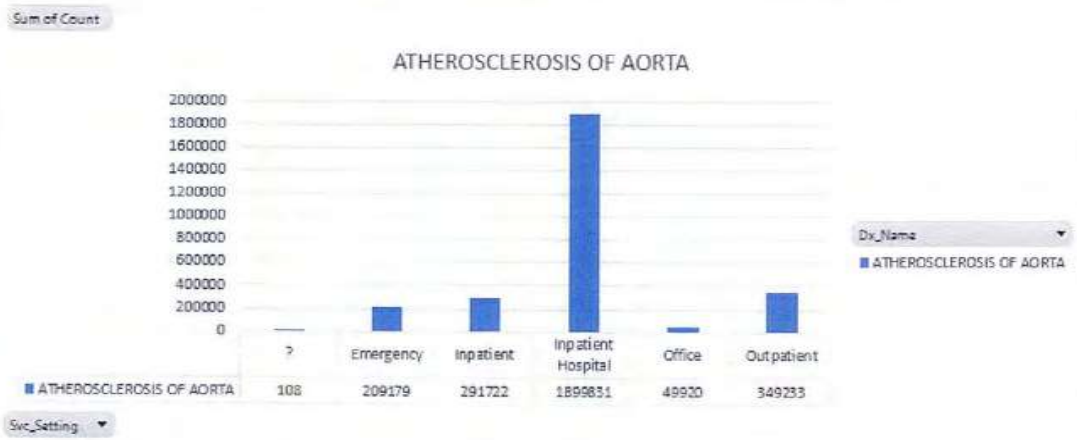

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EXHIBIT 18

_MA Regions HCC Rates and Weight (Part C - 2014 Model)
As of May 21, 2016 extract

Select Region: _MA Regions
Select DOS Period: CY2014

Average $$ per HCC	Average HCC per Member	PMPM Rate for Risk Score of 1.0	Continuous KP MA Members	Total Risk Score	Number of HCC's per Point
2,734	1.78	626.78	1,073,703	1.1189	29,540

		Impact on Revenues			Impact on Score			
Condition Category	Description	Annual $ Weights	Number of Unique Cases	Estimated Revenue Contribution	HCC Coefficient	Risk Score Contribution	Number of Cases per 10K Members	New HCC for PY2014?
HCC1	HIV/AIDS	3,535	2,884	10,195	0.470	0.001	26.9	-
HCC2	Septicemia, Sepsis, Systemic Inflammatory Respo	4,024	23,543	94,736	0.535	0.012	219.3	-
HCC6	Opportunistic Infections	3,309	2,026	6,705	0.440	0.001	18.9	-
HCC8	Metastatic Cancer and Acute Leukemia	18,683	10,754	200,919	2.484	0.025	100.2	-
HCC9	Lung and Other Severe Cancers	7,318	6,081	44,503	0.973	0.006	56.6	-
HCC10	Lymphoma and Other Cancers	5,054	13,813	69,816	0.672	0.009	128.6	-
HCC11	Colorectal, Bladder, and Other Cancers	2,384	6,786	16,180	0.317	0.002	63.2	-
HCC12	Breast, Prostate, and Other Cancers and Tumors	1,158	37,088	42,959	0.154	0.005	345.4	-
HCC17	Diabetes with Acute Complications	2,768	888	2,458	0.368	0.000	8.3	-
HCC18	Diabetes with Chronic Complications	2,768	221,354	612,681	0.368	0.076	2061.6	-
HCC19	Diabetes without Complication	888	52,574	46,661	0.118	0.006	489.7	-
HCC21	Protein-Calorie Malnutrition	5,363	30,075	161,285	0.713	0.020	280.1	-
HCC22	Morbid Obesity	2,745	115,356	316,688	0.365	0.039	1074.4	New
HCC23	Other Significant Endocrine and Metabolic Disorde	1,843	37,033	68,242	0.245	0.008	344.9	New
HCC27	End-Stage Liver Disease	6,942	3,480	24,159	0.923	0.003	32.4	-
HCC28	Cirrhosis of Liver	3,001	5,022	15,071	0.399	0.002	46.8	-
HCC29	Chronic Hepatitis	1,888	9,683	18,280	0.251	0.002	90.2	-
HCC33	Intestinal Obstruction/Perforation	2,332	9,528	22,216	0.310	0.003	88.7	-
HCC34	Chronic Pancreatitis	2,151	1,767	3,801	0.286	0.000	16.5	-
HCC35	Inflammatory Bowel Disease	2,271	8,655	19,660	0.302	0.002	80.6	-
HCC39	Bone/Joint/Muscle Infections/Necrosis	3,746	5,036	18,863	0.498	0.002	46.9	-
HCC40	Rheumatoid Arthritis and Inflammatory Connective	2,813	46,534	130,900	0.374	0.016	433.4	-
HCC46	Severe Hematological Disorders	8,544	2,951	25,214	1.136	0.003	27.5	-
HCC47	Disorders of Immunity	3,919	7,555	29,605	0.521	0.004	70.4	-
HCC48	Coagulation Defects and Other Specified Hematol	1,895	54,682	103,644	0.252	0.013	509.3	New
HCC54	Drug/Alcohol Psychosis	3,159	3,910	12,352	0.420	0.002	36.4	-
HCC55	Drug/Alcohol Dependence	3,159	19,587	61,875	0.420	0.008	182.4	-
HCC57	Schizophrenia	3,685	6,423	23,672	0.490	0.003	59.8	-
HCC58	Major Depressive, Bipolar, and Paranoid Disorders	2,482	153,809	381,764	0.330	0.047	1432.5	-
HCC70	Quadriplegia	9,281	1,074	9,968	1.234	0.001	10.0	-
HCC71	Paraplegia	7,913	1,890	14,955	1.052	0.002	17.6	-
HCC72	Spinal Cord Disorders/Injuries	3,828	4,108	15,727	0.509	0.002	38.3	-
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Ne	7,206	457	3,293	0.958	0.000	4.3	-
HCC74	Cerebral Palsy	338	1,473	499	0.045	0.000	13.7	-
HCC75	Myasthenia Gravis/Myoneural Disorders and Guilla	3,069	6,004	18,425	0.408	0.002	55.9	-
HCC76	Muscular Dystrophy	4,250	472	2,006	0.565	0.000	4.4	-
HCC77	Multiple Sclerosis	4,182	4,449	18,605	0.556	0.002	41.4	-
HCC78	Parkinsons and Huntingtons Diseases	5,197	13,317	69,212	0.691	0.009	124.0	-
HCC79	Seizure Disorders and Convulsions	2,136	19,612	41,893	0.284	0.005	182.7	-
HCC80	Coma, Brain Compression/Anoxic Damage	4,287	2,080	8,917	0.570	0.001	19.4	-
HCC82	Respirator Dependence/Tracheostomy Status	11,433	1,379	15,765	1.520	0.002	12.8	-
HCC83	Respiratory Arrest	6,032	114	688	0.802	0.000	1.1	-
HCC84	Cardio-Respiratory Failure and Shock	2,475	32,316	79,967	0.329	0.010	301.0	-
HCC85	Congestive Heart Failure	2,768	86,946	240,656	0.368	0.030	809.8	-
HCC86	Acute Myocardial Infarction	2,068	6,917	14,307	0.275	0.002	64.4	-
HCC87	Unstable Angina and Other Acute Ischemic Heart D	1,941	8,006	15,536	0.258	0.002	74.6	-
HCC88	Angina Pectoris	1,061	44,593	47,292	0.141	0.006	415.3	-
HCC96	Specified Heart Arrhythmias	2,219	127,024	281,843	0.295	0.035	1183.0	-
HCC99	Cerebral Hemorrhage	2,550	3,038	7,746	0.339	0.001	28.3	-
HCC100	Ischemic or Unspecified Stroke	2,384	9,282	22,131	0.317	0.003	86.4	-
HCC103	Hemiplegia/Hemiparesis	4,370	19,795	86,503	0.581	0.011	184.4	-
HCC104	Monoplegia, Other Paralytic Syndromes	2,978	987	2,940	0.396	0.000	9.2	-
HCC106	Atherosclerosis of the Extremities with Ulceration o	10,628	1,581	16,802	1.413	0.002	14.7	-
HCC107	Vascular Disease with Complications	3,084	10,787	33,265	0.410	0.004	100.5	-
HCC108	Vascular Disease	2,249	352,963	793,778	0.299	0.098	3287.3	-
HCC110	Cystic Fibrosis	3,136	39	122	0.417	0.000	0.4	-
HCC111	Chronic Obstructive Pulmonary Disease	2,602	95,086	247,452	0.346	0.031	885.6	-
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders	2,061	14,265	29,398	0.274	0.004	132.9	New
HCC114	Aspiration and Specified Bacterial Pneumonias	5,054	4,511	22,800	0.672	0.003	42.0	-
HCC115	Pneumococcal Pneumonia, Empyema, Lung Absc	1,504	1,814	2,729	0.200	0.000	16.9	-
HCC122	Proliferative Diabetic Retinopathy and Vitreous He	1,527	11,001	16,797	0.203	0.002	102.5	-
HCC124	Exudative Macular Degeneration	2,520	16,061	40,468	0.335	0.005	149.6	New
HCC134	Dialysis Status	3,580	2,042	7,311	0.476	0.001	19.0	-
HCC135	Acute Renal Failure	3,580	25,170	90,113	0.476	0.011	234.4	-
HCC136	Chronic Kidney Disease (Stage 5)	1,685	1,049	1,767	0.224	0.000	9.8	-
HCC137	Chronic Kidney Disease, Severe (Stage 4)	1,685	10,595	17,850	0.224	0.002	98.7	-
HCC157	Pressure Ulcer of Skin with Necrosis Through to M	18,713	629	11,771	2.488	0.001	5.9	-
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Los	10,064	2,003	20,157	1.338	0.002	18.7	-
HCC161	Chronic Ulcer of Skin, Except Pressure	4,031	13,825	55,735	0.536	0.007	128.8	-
HCC162	Severe Skin Burn or Condition	3,091	53	164	0.411	0.000	0.5	-
HCC166	Severe Head Injury	4,287	53	227	0.570	0.000	0.5	-
HCC167	Major Head Injury	1,226	4,355	5,339	0.163	0.001	40.6	-
HCC169	Vertebral Fractures without Spinal Cord Injury	3,738	8,587	32,099	0.497	0.004	80.0	-
HCC170	Hip Fracture/Dislocation	3,355	7,360	24,689	0.446	0.003	68.5	-
HCC173	Traumatic Amputations and Complications	1,993	2,595	5,172	0.265	0.001	24.2	-
HCC176	Complications of Specified Implanted Device or Gr	4,257	9,385	39,953	0.566	0.005	87.4	-
HCC186	Major Organ Transplant or Replacement Status	6,702	2,029	13,597	0.891	0.002	18.9	-
HCC188	Artificial Openings for Feeding or Elimination	4,896	8,457	41,409	0.651	0.005	78.8	-
HCC189	Amputation Status, Lower Limb/Amputation Compl	5,859	6,648	38,952	0.779	0.005	61.9	-
HCC190	Disabled, Opportunistic Infections	3,392	180	611	0.451	0.000	1.7	-
HCC191	Disabled, Chronic Pancreatitis	4,122	316	1,302	0.548	0.000	2.9	-
HCC192	Disabled, Severe Hematological Disorders	10,131	238	2,411	1.347	0.000	2.2	-
HCC193	Disabled, Drug/Alcohol Psychosis	2,490	969	2,412	0.331	0.000	9.0	-
HCC194	Disabled, Drug/Alcohol Dependence	0	4,863	0	0.000	0.000	45.3	-

ER-724

_MA Regions HCC Rates and Weight (Part C - 2014 Model)
As of May 21, 2016 extract

Select Region _MA Regions
Select DOS Period CY2014

Average $$ per HCC	Average HCC per Member	PMPM Rate for Risk Score of 1.0	Continuous KP MA Members	Total Risk Score	Number of HCC's per Point
2,734	1.78	626.78	1,073,703	1.1189	29,540

		Impact on Revenues			Impact on Score			
Condition Category	Description	Annual $ Weights	Number of Unique Cases	Estimated Revenue Contribution	HCC Coefficient	Risk Score Contribution	Number of Cases per 10K Members	New HCC for PY2014?
HCC195	Disabled, Cystic Fibrosis	18,164	24	436	2.415	0.000	0.2	-
HCC196	Disabled, Complications of Specified Implanted De	3,783	798	3,019	0.503	0.000	7.4	-
HCC197	Cancer*Immune Disorders	7,123	2,904	20,685	0.947	0.003	27.0	-
HCC198	Congestive Heart Failure*Chronic Obstructive Puln	1,948	22,416	43,667	0.259	0.005	208.8	-
HCC199	Congestive Heart Failure*Renal Disease	2,384	15,382	36,675	0.317	0.005	143.3	-
HCC200	Chronic Obstructive Pulmonary Disease*Cardiores	3,430	18,157	62,274	0.456	0.008	169.1	-
HCC201	Diabetes*Congestive Heart Failure	1,369	36,767	50,330	0.182	0.006	342.4	-
HCC202	Sepsis*Cardiorespiratory Failure	1,610	7,798	12,552	0.214	0.002	72.6	-
HCC203	MALE, AGE 0-34	910	2,067	1,881	0.121	0.000	19.3	-
HCC204	MALE, AGE 35-44	933	3,068	2,861	0.124	0.000	28.6	-
HCC205	MALE, AGE 45-54	1,361	7,048	9,595	0.181	0.001	65.6	-
HCC206	MALE, AGE 55-59	2,023	7,056	14,276	0.269	0.002	65.7	-
HCC207	MALE, AGE 60-64	2,339	10,753	25,153	0.311	0.003	100.1	-
HCC208	MALE, AGE 65-69	2,166	117,575	254,687	0.288	0.032	1095.0	-
HCC209	MALE, AGE 70-74	2,678	122,214	327,243	0.356	0.041	1138.2	-
HCC210	MALE, AGE 75-79	3,324	89,424	297,287	0.442	0.037	832.9	-
HCC211	MALE, AGE 80-84	4,084	61,180	249,867	0.543	0.031	569.8	-
HCC212	MALE, AGE 85-89	5,137	32,234	165,590	0.683	0.021	300.2	-
HCC213	MALE, AGE 90-94	6,378	12,525	79,886	0.848	0.010	116.7	-
HCC214	MALE, AGE 95+	7,732	2,649	20,482	1.028	0.003	24.7	-
HCC215	FEMALE, AGE 0-34	1,482	1,810	2,682	0.197	0.000	16.9	-
HCC216	FEMALE, AGE 35-44	1,542	3,549	5,472	0.205	0.001	33.1	-
HCC217	FEMALE, AGE 45-54	1,978	8,234	16,288	0.263	0.002	76.7	-
HCC218	FEMALE, AGE 55-59	2,452	8,557	20,982	0.326	0.003	79.7	-
HCC219	FEMALE, AGE 60-64	2,948	12,688	37,409	0.392	0.005	118.2	-
HCC220	FEMALE, AGE 65-69	2,166	152,039	329,341	0.288	0.041	1416.0	-
HCC221	FEMALE, AGE 70-74	2,617	149,421	391,102	0.348	0.048	1391.6	-
HCC222	FEMALE, AGE 75-79	3,287	110,049	361,715	0.437	0.045	1024.9	-
HCC223	FEMALE, AGE 80-84	4,054	78,407	317,865	0.539	0.039	730.2	-
HCC224	FEMALE, AGE 85-89	5,092	49,406	251,575	0.677	0.031	460.1	-
HCC225	FEMALE, AGE 90-94	6,130	24,414	149,656	0.815	0.019	227.4	-
HCC226	FEMALE, AGE 95+	6,318	7,336	46,349	0.840	0.006	68.3	-
HCC227	MEDICAID FEMALE, DISABLED	639	14,550	9,302	0.085	0.001	135.5	-
HCC228	MEDICAID FEMALE, AGED	1,136	46,344	52,634	0.151	0.007	431.6	-
HCC229	MEDICAID MALE, DISABLED	647	11,513	7,447	0.086	0.001	107.2	-
HCC230	MEDICAID MALE, AGED	1,331	21,781	28,997	0.177	0.004	202.9	-
HCC231	ORIGINALLY-DISABLED FEMALE	1,798	37,252	66,965	0.239	0.008	346.9	-
HCC232	ORIGINALLY-DISABLED MALE	1,226	33,748	41,375	0.163	0.005	314.3	-

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_MA Regions HCC Rates and Weight (Part C - 2014 Model)
As of May 21, 2016 extract

Select Region: _MA Regions
Select DOS Period: CY2015

Average $$ per HCC	Average HCC per Member	PMPM Rate for Risk Score of 1.0	Continuous KP MA Members	Total Risk Score	Number of HCC's per Point
2,741	1.84	630.32	1,145,502	1.1391	31,616

		Impact on Revenues			Impact on Score			
Condition Category	Description	Annual $ Weights	Number of Unique Cases	Estimated Revenue Contribution	HCC Coefficient	Risk Score Contribution	Number of Cases per 10K Members	New HCC for PY2014?
HCC1	HIV/AIDS	3,555	3,141	11,166	0.470	0.001	27.4	-
HCC2	Septicemia, Sepsis, Systemic Inflammatory Respo	4,047	26,066	105,481	0.535	0.012	227.6	-
HCC6	Opportunistic Infections	3,328	2,047	6,813	0.440	0.001	17.9	-
HCC8	Metastatic Cancer and Acute Leukemia	18,789	12,181	228,865	2.484	0.026	106.3	-
HCC9	Lung and Other Severe Cancers	7,360	6,653	48,964	0.973	0.006	58.1	-
HCC10	Lymphoma and Other Cancers	5,083	15,029	76,391	0.672	0.009	131.2	-
HCC11	Colorectal, Bladder, and Other Cancers	2,398	7,497	17,976	0.317	0.002	65.4	-
HCC12	Breast, Prostate, and Other Cancers and Tumors	1,165	41,466	48,301	0.154	0.006	362.0	-
HCC17	Diabetes with Acute Complications	2,784	1,010	2,811	0.368	0.000	8.8	-
HCC18	Diabetes with Chronic Complications	2,784	241,900	673,331	0.368	0.078	2111.7	-
HCC19	Diabetes without Complication	893	56,817	50,711	0.118	0.006	496.0	-
HCC21	Protein-Calorie Malnutrition	5,393	30,270	163,248	0.713	0.019	264.3	-
HCC22	Morbid Obesity	2,761	128,921	355,927	0.365	0.041	1125.5	New
HCC23	Other Significant Endocrine and Metabolic Disorde	1,853	43,339	80,314	0.245	0.009	378.3	New
HCC27	End-Stage Liver Disease	6,981	3,940	27,507	0.923	0.003	34.4	-
HCC28	Cirrhosis of Liver	3,018	5,844	17,637	0.399	0.002	51.0	-
HCC29	Chronic Hepatitis	1,899	10,622	20,166	0.251	0.002	92.7	-
HCC33	Intestinal Obstruction/Perforation	2,345	9,531	22,348	0.310	0.003	83.2	-
HCC34	Chronic Pancreatitis	2,163	2,007	4,342	0.286	0.001	17.5	-
HCC35	Inflammatory Bowel Disease	2,284	9,323	21,296	0.302	0.002	81.4	-
HCC39	Bone/Joint/Muscle Infections/Necrosis	3,767	5,368	20,220	0.498	0.002	46.9	-
HCC40	Rheumatoid Arthritis and Inflammatory Connective	2,829	52,648	148,936	0.374	0.017	459.6	-
HCC46	Severe Hematological Disorders	8,593	3,011	25,872	1.136	0.003	26.3	-
HCC47	Disorders of Immunity	3,941	9,586	37,776	0.521	0.004	83.7	-
HCC48	Coagulation Defects and Other Specified Hematol	1,906	66,396	126,557	0.252	0.015	579.6	New
HCC54	Drug/Alcohol Psychosis	3,177	3,194	10,147	0.420	0.001	27.9	-
HCC55	Drug/Alcohol Dependence	3,177	20,333	64,595	0.420	0.007	177.5	-
HCC57	Schizophrenia	3,706	6,922	25,655	0.490	0.003	60.4	-
HCC58	Major Depressive, Bipolar, and Paranoid Disorders	2,496	165,695	413,588	0.330	0.048	1446.5	-
HCC70	Quadriplegia	9,334	1,145	10,687	1.234	0.001	10.0	-
HCC71	Paraplegia	7,957	2,013	16,018	1.052	0.002	17.6	-
HCC72	Spinal Cord Disorders/Injuries	3,850	4,414	16,994	0.509	0.002	38.5	-
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Ne	7,246	501	3,630	0.958	0.000	4.4	-
HCC74	Cerebral Palsy	340	1,625	553	0.045	0.000	14.2	-
HCC75	Myasthenia Gravis/Myoneural Disorders and Guilla	3,086	5,952	18,368	0.408	0.002	52.0	-
HCC76	Muscular Dystrophy	4,274	484	2,068	0.565	0.000	4.2	-
HCC77	Multiple Sclerosis	4,206	4,686	19,707	0.556	0.002	40.9	-
HCC78	Parkinsons and Huntingtons Diseases	5,227	14,223	74,339	0.691	0.009	124.2	-
HCC79	Seizure Disorders and Convulsions	2,148	21,059	45,238	0.284	0.005	183.8	-
HCC80	Coma, Brain Compression/Anoxic Damage	4,311	2,388	10,296	0.570	0.001	20.8	-
HCC82	Respirator Dependence/Tracheostomy Status	11,497	1,355	15,579	1.520	0.002	11.8	-
HCC83	Respiratory Arrest	6,066	122	740	0.802	0.000	1.1	-
HCC84	Cardio-Respiratory Failure and Shock	2,489	36,388	90,552	0.329	0.010	317.7	-
HCC85	Congestive Heart Failure	2,784	91,763	255,423	0.368	0.029	801.1	-
HCC86	Acute Myocardial Infarction	2,080	7,894	16,420	0.275	0.002	68.9	-
HCC87	Unstable Angina and Other Acute Ischemic Heart D	1,951	9,340	18,227	0.258	0.002	81.5	-
HCC88	Angina Pectoris	1,067	44,088	47,020	0.141	0.005	384.9	-
HCC96	Specified Heart Arrhythmias	2,231	135,963	303,381	0.295	0.035	1186.9	-
HCC99	Cerebral Hemorrhage	2,564	3,479	8,921	0.339	0.001	30.4	-
HCC100	Ischemic or Unspecified Stroke	2,398	9,971	23,908	0.317	0.003	87.0	-
HCC103	Hemiplegia/Hemiparesis	4,395	20,859	91,667	0.581	0.011	182.1	-
HCC104	Monoplegia, Other Paralytic Syndromes	2,995	1,084	3,247	0.396	0.000	9.5	-
HCC106	Atherosclerosis of the Extremities with Ulceration o	10,688	1,675	17,902	1.413	0.002	14.6	-
HCC107	Vascular Disease with Complications	3,101	11,884	36,855	0.410	0.004	103.7	-
HCC108	Vascular Disease	2,262	412,566	933,060	0.299	0.108	3601.6	-
HCC110	Cystic Fibrosis	3,154	46	145	0.417	0.000	0.4	-
HCC111	Chronic Obstructive Pulmonary Disease	2,617	100,093	261,954	0.346	0.030	873.8	-
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders	2,073	16,664	34,536	0.274	0.004	145.5	New
HCC114	Aspiration and Specified Bacterial Pneumonias	5,083	4,883	24,820	0.672	0.003	42.6	-
HCC115	Pneumococcal Pneumonia, Empyema, Lung Absc	1,513	2,033	3,075	0.200	0.000	17.7	-
HCC122	Proliferative Diabetic Retinopathy and Vitreous He	1,535	11,313	17,371	0.203	0.002	98.8	-
HCC124	Exudative Macular Degeneration	2,534	18,479	46,824	0.335	0.005	161.3	New
HCC134	Dialysis Status	3,600	2,034	7,323	0.476	0.001	17.8	-
HCC135	Acute Renal Failure	3,600	27,755	99,929	0.476	0.012	242.3	-
HCC136	Chronic Kidney Disease (Stage 5)	1,694	1,052	1,782	0.224	0.000	9.2	-
HCC137	Chronic Kidney Disease, Severe (Stage 4)	1,694	10,793	18,287	0.224	0.002	94.2	-
HCC157	Pressure Ulcer of Skin with Necrosis Through to M	18,819	712	13,399	2.488	0.002	6.2	-
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Los	10,120	2,127	21,526	1.338	0.002	18.6	-
HCC161	Chronic Ulcer of Skin, Except Pressure	4,054	15,048	61,008	0.536	0.007	131.4	-
HCC162	Severe Skin Burn or Condition	3,109	75	233	0.411	0.000	0.7	-
HCC166	Severe Head Injury	4,311	48	207	0.570	0.000	0.4	-
HCC167	Major Head Injury	1,233	4,709	5,806	0.163	0.001	41.1	-
HCC169	Vertebral Fractures without Spinal Cord Injury	3,759	8,385	31,521	0.497	0.004	73.2	-
HCC170	Hip Fracture/Dislocation	3,373	7,781	26,249	0.446	0.003	67.9	-
HCC173	Traumatic Amputations and Complications	2,004	2,648	5,308	0.265	0.001	23.1	-
HCC176	Complications of Specified Implanted Device or Gr	4,281	9,722	41,621	0.566	0.005	84.9	-
HCC186	Major Organ Transplant or Replacement Status	6,739	2,328	15,689	0.891	0.002	20.3	-
HCC188	Artificial Openings for Feeding or Elimination	4,924	8,842	43,539	0.651	0.005	77.2	-
HCC189	Amputation Status, Lower Limb/Amputation Compl	5,892	7,057	41,582	0.779	0.005	61.6	-
HCC190	Disabled, Opportunistic Infections	3,411	187	638	0.451	0.000	1.6	-
HCC191	Disabled, Chronic Pancreatitis	4,145	373	1,546	0.548	0.000	3.3	-
HCC192	Disabled, Severe Hematological Disorders	10,189	250	2,547	1.347	0.000	2.2	-
HCC193	Disabled, Drug/Alcohol Psychosis	2,504	889	2,226	0.331	0.000	7.8	-
HCC194	Disabled, Drug/Alcohol Dependence	0	4,979	0	0.000	0.000	43.5	-

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_MA Regions HCC Rates and Weight (Part C - 2014 Model)

As of May 21, 2016 extract

Select Region _MA Regions

Select DOS Period CY2015

Average $$ per HCC	Average HCC per Member	PMPM Rate for Risk Score of 1.0	Continuous KP MA Members	Total Risk Score	Number of HCC's per Point
2,741	1.84	630.32	1,145,502	1.1391	31,616

		Impact on Revenues			Impact on Score			
Condition Category	Description	Annual $ Weights	Number of Unique Cases	Estimated Revenue Contribution	HCC Coefficient	Risk Score Contribution	Number of Cases per 10K Members	New HCC for PY2014?
HCC195	Disabled, Cystic Fibrosis	18,267	26	475	2.415	0.000	0.2	-
HCC196	Disabled, Complications of Specified Implanted De	3,805	848	3,226	0.503	0.000	7.4	-
HCC197	Cancer*Immune Disorders	7,163	3,833	27,456	0.947	0.003	33.5	-
HCC198	Congestive Heart Failure*Chronic Obstructive Puln	1,959	23,374	45,791	0.259	0.005	204.1	-
HCC199	Congestive Heart Failure*Renal Disease	2,398	16,502	39,568	0.317	0.005	144.1	-
HCC200	Chronic Obstructive Pulmonary Disease*Cardiores	3,449	19,839	68,427	0.456	0.008	173.2	-
HCC201	Diabetes*Congestive Heart Failure	1,377	39,468	54,333	0.182	0.006	344.5	-
HCC202	Sepsis*Cardiorespiratory Failure	1,619	9,201	14,893	0.214	0.002	80.3	-
HCC203	MALE, AGE 0-34	915	2,193	2,007	0.121	0.000	19.1	-
HCC204	MALE, AGE 35-44	938	3,301	3,096	0.124	0.000	28.8	-
HCC205	MALE, AGE 45-54	1,369	7,395	10,124	0.181	0.001	64.6	-
HCC206	MALE, AGE 55-59	2,035	7,481	15,221	0.269	0.002	65.3	-
HCC207	MALE, AGE 60-64	2,352	11,622	27,339	0.311	0.003	101.5	-
HCC208	MALE, AGE 65-69	2,178	128,744	280,456	0.288	0.032	1123.9	-
HCC209	MALE, AGE 70-74	2,693	130,474	351,333	0.356	0.041	1139.0	-
HCC210	MALE, AGE 75-79	3,343	94,174	314,846	0.442	0.036	822.1	-
HCC211	MALE, AGE 80-84	4,107	63,841	262,207	0.543	0.030	557.3	-
HCC212	MALE, AGE 85-89	5,166	34,721	179,373	0.683	0.021	303.1	-
HCC213	MALE, AGE 90-94	6,414	13,148	84,334	0.848	0.010	114.8	-
HCC214	MALE, AGE 95+	7,776	2,952	22,954	1.028	0.003	25.8	-
HCC215	FEMALE, AGE 0-34	1,490	1,890	2,816	0.197	0.000	16.5	-
HCC216	FEMALE, AGE 35-44	1,551	3,757	5,826	0.205	0.001	32.8	-
HCC217	FEMALE, AGE 45-54	1,989	8,443	16,796	0.263	0.002	73.7	-
HCC218	FEMALE, AGE 55-59	2,466	9,121	22,491	0.326	0.003	79.6	-
HCC219	FEMALE, AGE 60-64	2,965	13,856	41,084	0.392	0.005	121.0	-
HCC220	FEMALE, AGE 65-69	2,178	166,109	361,852	0.288	0.042	1450.1	-
HCC221	FEMALE, AGE 70-74	2,632	160,083	421,376	0.348	0.049	1397.5	-
HCC222	FEMALE, AGE 75-79	3,305	115,179	380,715	0.437	0.044	1005.5	-
HCC223	FEMALE, AGE 80-84	4,077	81,829	333,611	0.539	0.039	714.4	-
HCC224	FEMALE, AGE 85-89	5,121	51,455	263,488	0.677	0.030	449.2	-
HCC225	FEMALE, AGE 90-94	6,165	25,647	158,103	0.815	0.018	223.9	-
HCC226	FEMALE, AGE 95+	6,354	8,087	51,382	0.840	0.006	70.6	-
HCC227	MEDICAID FEMALE, DISABLED	643	16,731	10,757	0.085	0.001	146.1	-
HCC228	MEDICAID FEMALE, AGED	1,142	53,521	61,129	0.151	0.007	467.2	-
HCC229	MEDICAID MALE, DISABLED	650	13,316	8,662	0.086	0.001	116.2	-
HCC230	MEDICAID MALE, AGED	1,339	26,758	35,824	0.177	0.004	233.6	-
HCC231	ORIGINALLY-DISABLED FEMALE	1,808	40,466	73,153	0.239	0.008	353.3	-
HCC232	ORIGINALLY-DISABLED MALE	1,233	36,611	45,138	0.163	0.005	319.6	-

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_MA Regions HCC Rates and Weight (Part C - 2014 Model)
As of May 21, 2016 extract

Select Region: _MA Regions
Select DOS Period: YTD 2016-04

Average $$ per HCC	Average HCC per Member	PMPM Rate for Risk Score of 1.0	Continuous KP MA Members	Total Risk Score	Number of HCC's per Point
2,721	1.19	630.32	1,261,910	0.8902	35,083

		Impact on Revenues			Impact on Score			
Condition Category	Description	Annual $ Weights	Number of Unique Cases	Estimated Revenue Contribution	HCC Coefficient	Risk Score Contribution	Number of Cases per 10K Members	New HCC for PY2014?
HCC1	HIV/AIDS	3,555	2,847	10,121	0.470	0.001	22.6	-
HCC2	Septicemia, Sepsis, Systemic Inflammatory Respo	4,047	10,976	44,416	0.535	0.005	87.0	-
HCC6	Opportunistic Infections	3,328	1,317	4,383	0.440	0.000	10.4	-
HCC8	Metastatic Cancer and Acute Leukemia	18,789	10,615	199,442	2.484	0.021	84.1	-
HCC9	Lung and Other Severe Cancers	7,360	5,827	42,885	0.973	0.004	46.2	-
HCC10	Lymphoma and Other Cancers	5,083	12,394	62,998	0.672	0.007	98.2	-
HCC11	Colorectal, Bladder, and Other Cancers	2,398	5,233	12,547	0.317	0.001	41.5	-
HCC12	Breast, Prostate, and Other Cancers and Tumors	1,165	30,239	35,224	0.154	0.004	239.6	-
HCC17	Diabetes with Acute Complications	2,784	411	1,144	0.368	0.000	3.3	-
HCC18	Diabetes with Chronic Complications	2,784	183,688	511,297	0.368	0.054	1455.6	-
HCC19	Diabetes without Complication	893	53,322	47,592	0.118	0.005	422.5	-
HCC21	Protein-Calorie Malnutrition	5,393	18,117	97,706	0.713	0.010	143.6	-
HCC22	Morbid Obesity	2,761	91,016	251,279	0.365	0.026	721.3	New
HCC23	Other Significant Endocrine and Metabolic Disorde	1,853	32,654	60,513	0.245	0.006	258.8	New
HCC27	End-Stage Liver Disease	6,981	2,859	19,960	0.923	0.002	22.7	-
HCC28	Cirrhosis of Liver	3,018	4,859	14,664	0.399	0.002	38.5	-
HCC29	Chronic Hepatitis	1,899	7,965	15,122	0.251	0.002	63.1	-
HCC33	Intestinal Obstruction/Perforation	2,345	3,544	8,310	0.310	0.001	28.1	-
HCC34	Chronic Pancreatitis	2,163	1,394	3,016	0.286	0.000	11.0	-
HCC35	Inflammatory Bowel Disease	2,284	6,710	15,328	0.302	0.002	53.2	-
HCC39	Bone/Joint/Muscle Infections/Necrosis	3,767	2,887	10,875	0.498	0.001	22.9	-
HCC40	Rheumatoid Arthritis and Inflammatory Connective	2,829	34,479	97,537	0.374	0.010	273.2	-
HCC46	Severe Hematological Disorders	8,593	2,166	18,612	1.136	0.002	17.2	-
HCC47	Disorders of Immunity	3,941	5,963	23,499	0.521	0.002	47.3	-
HCC48	Coagulation Defects and Other Specified Hematol	1,906	44,530	84,879	0.252	0.009	352.9	New
HCC54	Drug/Alcohol Psychosis	3,177	306	972	0.420	0.000	2.4	-
HCC55	Drug/Alcohol Dependence	3,177	13,568	43,103	0.420	0.005	107.5	-
HCC57	Schizophrenia	3,706	5,535	20,514	0.490	0.002	43.9	-
HCC58	Major Depressive, Bipolar, and Paranoid Disorders	2,496	122,121	304,824	0.330	0.032	967.7	-
HCC70	Quadriplegia	9,334	767	7,159	1.234	0.001	6.1	-
HCC71	Paraplegia	7,957	1,413	11,244	1.052	0.001	11.2	-
HCC72	Spinal Cord Disorders/Injuries	3,850	2,990	11,512	0.509	0.001	23.7	-
HCC73	Amyotrophic Lateral Sclerosis and Other Motor Ne	7,246	402	2,913	0.958	0.000	3.2	-
HCC74	Cerebral Palsy	340	1,106	376	0.045	0.000	8.8	-
HCC75	Myasthenia Gravis/Myoneural Disorders and Guilla	3,086	4,534	13,992	0.408	0.001	35.9	-
HCC76	Muscular Dystrophy	4,274	341	1,457	0.565	0.000	2.7	-
HCC77	Multiple Sclerosis	4,206	3,450	14,509	0.556	0.002	27.3	-
HCC78	Parkinsons and Huntingtons Diseases	5,227	11,594	60,598	0.691	0.006	91.9	-
HCC79	Seizure Disorders and Convulsions	2,148	14,636	31,440	0.284	0.003	116.0	-
HCC80	Coma, Brain Compression/Anoxic Damage	4,311	1,085	4,678	0.570	0.000	8.6	-
HCC82	Respirator Dependence/Tracheostomy Status	11,497	804	9,244	1.520	0.001	6.4	-
HCC83	Respiratory Arrest	6,066	37	224	0.802	0.000	0.3	-
HCC84	Cardio-Respiratory Failure and Shock	2,489	22,875	56,925	0.329	0.006	181.3	-
HCC85	Congestive Heart Failure	2,784	68,087	189,521	0.368	0.020	539.6	-
HCC86	Acute Myocardial Infarction	2,080	3,271	6,804	0.275	0.001	25.9	-
HCC87	Unstable Angina and Other Acute Ischemic Heart D	1,951	3,934	7,677	0.258	0.001	31.2	-
HCC88	Angina Pectoris	1,067	31,168	33,241	0.141	0.003	247.0	-
HCC96	Specified Heart Arrhythmias	2,231	101,966	227,521	0.295	0.024	808.0	-
HCC99	Cerebral Hemorrhage	2,564	1,422	3,646	0.339	0.000	11.3	-
HCC100	Ischemic or Unspecified Stroke	2,398	4,394	10,536	0.317	0.001	34.8	-
HCC103	Hemiplegia/Hemiparesis	4,395	14,708	64,636	0.581	0.007	116.6	-
HCC104	Monoplegia, Other Paralytic Syndromes	2,995	656	1,965	0.396	0.000	5.2	-
HCC106	Atherosclerosis of the Extremities with Ulceration o	10,688	975	10,421	1.413	0.001	7.7	-
HCC107	Vascular Disease with Complications	3,101	6,253	19,392	0.410	0.002	49.6	-
HCC108	Vascular Disease	2,262	304,447	688,538	0.299	0.072	2412.6	-
HCC110	Cystic Fibrosis	3,154	35	110	0.417	0.000	0.3	-
HCC111	Chronic Obstructive Pulmonary Disease	2,617	72,568	189,918	0.346	0.020	575.1	-
HCC112	Fibrosis of Lung and Other Chronic Lung Disorders	2,073	12,114	25,106	0.274	0.003	96.0	New
HCC114	Aspiration and Specified Bacterial Pneumonias	5,083	2,085	10,598	0.672	0.001	16.5	-
HCC115	Pneumococcal Pneumonia, Empyema, Lung Absc	1,513	1,026	1,552	0.200	0.000	8.1	-
HCC122	Proliferative Diabetic Retinopathy and Vitreous He	1,535	8,094	12,428	0.203	0.001	64.1	-
HCC124	Exudative Macular Degeneration	2,534	15,695	39,770	0.335	0.004	124.4	New
HCC134	Dialysis Status	3,600	1,585	5,707	0.476	0.001	12.6	-
HCC135	Acute Renal Failure	3,600	12,369	44,533	0.476	0.005	98.0	-
HCC136	Chronic Kidney Disease (Stage 5)	1,694	907	1,537	0.224	0.000	7.2	-
HCC137	Chronic Kidney Disease, Severe (Stage 4)	1,694	9,440	15,994	0.224	0.002	74.8	-
HCC157	Pressure Ulcer of Skin with Necrosis Through to M	18,819	429	8,073	2.488	0.001	3.4	-
HCC158	Pressure Ulcer of Skin with Full Thickness Skin Los	10,120	1,118	11,315	1.338	0.001	8.9	-
HCC161	Chronic Ulcer of Skin, Except Pressure	4,054	8,709	35,308	0.536	0.004	69.0	-
HCC162	Severe Skin Burn or Condition	3,109	48	149	0.411	0.000	0.4	-
HCC166	Severe Head Injury	4,311	5	22	0.570	0.000	0.0	-
HCC167	Major Head Injury	1,233	1,806	2,227	0.163	0.000	14.3	-
HCC169	Vertebral Fractures without Spinal Cord Injury	3,759	2,645	9,943	0.497	0.001	21.0	-
HCC170	Hip Fracture/Dislocation	3,373	2,777	9,368	0.446	0.001	22.0	-
HCC173	Traumatic Amputations and Complications	2,004	463	928	0.265	0.000	3.7	-
HCC176	Complications of Specified Implanted Device or Gr	4,281	3,744	16,029	0.566	0.002	29.7	-
HCC186	Major Organ Transplant or Replacement Status	6,739	2,081	14,025	0.891	0.001	16.5	-
HCC188	Artificial Openings for Feeding or Elimination	4,924	6,094	30,007	0.651	0.003	48.3	-
HCC189	Amputation Status, Lower Limb/Amputation Compl	5,892	5,728	33,751	0.779	0.004	45.4	-
HCC190	Disabled, Opportunistic Infections	3,411	93	317	0.451	0.000	0.7	-
HCC191	Disabled, Chronic Pancreatitis	4,145	254	1,053	0.548	0.000	2.0	-
HCC192	Disabled, Severe Hematological Disorders	10,189	176	1,793	1.347	0.000	1.4	-
HCC193	Disabled, Drug/Alcohol Psychosis	2,504	67	168	0.331	0.000	0.5	-
HCC194	Disabled, Drug/Alcohol Dependence	0	3,519	0	0.000	0.000	27.9	-

ER-728

_MA Regions HCC Rates and Weight (Part C - 2014 Model)
As of May 21, 2016 extract

Select Region _MA Regions
Select DOS Period YTD 2016-04

Average $$ per HCC	Average HCC per Member	PMPM Rate for Risk Score of 1.0	Continuous KP MA Members	Total Risk Score	Number of HCC's per Point
2,721	1.19	630.32	1,261,910	0.8902	35,083

		Impact on Revenues			Impact on Score			
Condition Category	Description	Annual $ Weights	Number of Unique Cases	Estimated Revenue Contribution	HCC Coefficient	Risk Score Contribution	Number of Cases per 10K Members	New HCC for PY2014?
HCC195	Disabled, Cystic Fibrosis	18,267	24	438	2.415	0.000	0.2	-
HCC196	Disabled, Complications of Specified Implanted De	3,805	326	1,240	0.503	0.000	2.6	-
HCC197	Cancer*Immune Disorders	7,163	2,356	16,876	0.947	0.002	18.7	-
HCC198	Congestive Heart Failure*Chronic Obstructive Puln	1,959	16,356	32,042	0.259	0.003	129.6	-
HCC199	Congestive Heart Failure*Renal Disease	2,398	9,249	22,177	0.317	0.002	73.3	-
HCC200	Chronic Obstructive Pulmonary Disease*Cardiores	3,449	12,845	44,304	0.456	0.005	101.8	-
HCC201	Diabetes*Congestive Heart Failure	1,377	29,454	40,547	0.182	0.004	233.4	-
HCC202	Sepsis*Cardiorespiratory Failure	1,619	3,900	6,313	0.214	0.001	30.9	-
HCC203	MALE, AGE 0-34	915	2,379	2,177	0.121	0.000	18.9	-
HCC204	MALE, AGE 35-44	938	3,650	3,423	0.124	0.000	28.9	-
HCC205	MALE, AGE 45-54	1,369	7,695	10,535	0.181	0.001	61.0	-
HCC206	MALE, AGE 55-59	2,035	7,988	16,253	0.269	0.002	63.3	-
HCC207	MALE, AGE 60-64	2,352	12,669	29,802	0.311	0.003	100.4	-
HCC208	MALE, AGE 65-69	2,178	139,532	303,956	0.288	0.032	1105.7	-
HCC209	MALE, AGE 70-74	2,693	148,672	400,336	0.356	0.042	1178.2	-
HCC210	MALE, AGE 75-79	3,343	101,553	339,516	0.442	0.036	804.8	-
HCC211	MALE, AGE 80-84	4,107	69,296	284,612	0.543	0.030	549.1	-
HCC212	MALE, AGE 85-89	5,166	39,355	203,313	0.683	0.021	311.9	-
HCC213	MALE, AGE 90-94	6,414	15,474	99,253	0.848	0.010	122.6	-
HCC214	MALE, AGE 95+	7,776	4,004	31,134	1.028	0.003	31.7	-
HCC215	FEMALE, AGE 0-34	1,490	2,013	3,000	0.197	0.000	16.0	-
HCC216	FEMALE, AGE 35-44	1,551	4,062	6,299	0.205	0.001	32.2	-
HCC217	FEMALE, AGE 45-54	1,989	8,877	17,659	0.263	0.002	70.3	-
HCC218	FEMALE, AGE 55-59	2,466	9,681	23,872	0.326	0.003	76.7	-
HCC219	FEMALE, AGE 60-64	2,965	14,942	44,304	0.392	0.005	118.4	-
HCC220	FEMALE, AGE 65-69	2,178	179,082	390,112	0.288	0.041	1419.1	-
HCC221	FEMALE, AGE 70-74	2,632	182,151	479,464	0.348	0.050	1443.5	-
HCC222	FEMALE, AGE 75-79	3,305	124,097	410,192	0.437	0.043	983.4	-
HCC223	FEMALE, AGE 80-84	4,077	88,683	361,555	0.539	0.038	702.8	-
HCC224	FEMALE, AGE 85-89	5,121	56,493	289,287	0.677	0.030	447.7	-
HCC225	FEMALE, AGE 90-94	6,165	29,164	179,783	0.815	0.019	231.1	-
HCC226	FEMALE, AGE 95+	6,354	10,398	66,065	0.840	0.007	82.4	-
HCC227	MEDICAID FEMALE, DISABLED	643	18,275	11,750	0.085	0.001	144.8	-
HCC228	MEDICAID FEMALE, AGED	1,142	59,580	68,049	0.151	0.007	472.1	-
HCC229	MEDICAID MALE, DISABLED	650	14,587	9,489	0.086	0.001	115.6	-
HCC230	MEDICAID MALE, AGED	1,339	30,780	41,209	0.177	0.004	243.9	-
HCC231	ORIGINALLY-DISABLED FEMALE	1,808	45,228	81,762	0.239	0.009	358.4	-
HCC232	ORIGINALLY-DISABLED MALE	1,233	40,941	50,477	0.163	0.005	324.4	-

ER-729

EXHIBIT 19

Central Office on
ICD-9-CM

American Hospital Association
155 N. Wacker Drive, Suite 400
Chicago, IL 60606-1725
312-422-3366
312-278-0838

February 7, 2014

Gloryanne Bryant
Regional Director
HIM
Kaiser Permanente
1800 Harrison St., #24
Oakland, CA 94612

Dear Ms. Bryant,

This letter is in response to your request for clarification regarding status code assignment for a newborn on a ventilator.

Code V46.11, Dependence on respirator status, implies long-term use of a ventilator and should only be applied when the patient requires continued ventilator support. While there is no time frame set on what constitutes ventilator dependency, this code should be reported when the patient requires continued ventilator support for an unexpected extended period of time and not for the short-term acute phase of a condition. Therefore, it is not used for newborns who are placed on a vent for a short period.

Unfortunately due to a code set freeze in preparation for ICD-10-CM/PCS implementation, there will be no changes to the official coding guidelines, as well as revisions to the ICD-9-CM diagnosis codes or changes to the Index to Diseases.

I trust this information will be of assistance to you.

Sincerely,

Diane Komar

Diane Komar, RHIT
Coding Consultant

Ref. #50003482.1213

AHA CENTRAL OFFICE
An American Hospital Association Service

American Hospital Association

This coding information is being provided specifically to you based on the facts and details you provided. The American Hospital Association has used its best efforts to provide accurate coding advice, but this advice should not be construed as providing clinical advice, dictating reimbursement policy, or a substitution for the judgment of a practitioner. This information is provided for individual reference only. Any reprint or distribution of all or part of this correspondence, without the express written consent of the American Hospital Association's Central Office on ICD-9-CM, is strictly prohibited.

No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
VOLUME 5 of 9

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Attorneys for Plaintiffs and Appellants,
Marcia Stein and Rodolfo Bone

TAB 17

EXHIBIT 20

1) Lindy Petersen sent an email on 10/24 to review some cases on a TPMG HCC audit in preparation for Covered California.

From: Lindy A Petersen/CA/KAIPERM
To: Victoria M Hernandez/CA/KAIPERM@KAIPERM
Cc: Marcus Lee/CA/KAIPERM, Hans Eric Tan/CA/KAIPERM
Date: 10/24/2013 04:24 PM
Subject: Interesting Findings for V46.11 & V46.13

Hi Victoria,

I wanted to give you a heads up on a project my team has been working on. In preparation for Covered California, my team audited infant stays longer than 6 days in 2012. We had some interesting findings in regards to HSS-HCC 125 - Respirator Dependence/ Tracheostomy Status (V46.11 & V46.13). While reviewing the charts, the auditors noticed documentation of the infant being on a ventilator for several days. In these cases the V-codes were not captured by the physician or HIM coder. I am providing you with a list of MRNs for your review. I am curious to know if these are missed opportunities, or if there is a specific reason for not capturing the codes.

Marcus Lee will be meeting with Rod Madamba on Monday, 11/4/13 to discuss our findings. I would greatly appreciate your expert opinion on these encounters.

[attachment "V4611_V4613 Findings.xlsx" deleted by Lindy A Petersen/CA/KAIPERM]

Thank you and have a wonderful day.

Lindy Petersen, CPC, CCS
AHIMA Approved ICD-10-CM/PCS Trainer
Manager, Auditing and Coding Services
The Permanente Medical Group, Inc.
Encounter Information Operations
1950 Franklin St., 7th Floor
(510) 987-4963 / 8-427-4963
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Lindy.A.Petersen@KP.org

"Every life is a story, make yours a best seller."

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2) On 11/4 @ 3 pm, Rod Madamba asked me and Dawna Toews to join the meeting with TPMG (primary discussion was regarding V46.11, Mechanical Ventilation Dependence Status and V46.13, Encounter for weaning from ventilator on newborn cases). Attendees were Rod

Madamba, Dawna Toews, Marcus Lee, Hans Eric Tan and Victoria Hernandez. I gave feedback that V46.13 would not be apppropriate for initial newborn hospital visits because this code is for principal diagnosis assignment for the specific purpose of weaning the patient from the ventilator (as reason for admission). Code V46.11 is questionable for initial visits versus follow up visits with newborns on continuous vent. It was discussed that HIM would perform additional research on this code as it pertains to newborns.

Fw: Interesting Findings for V46.11 & V46.13
Lindy A Petersen to: Victoria M Hernandez
Cc: Marcus Lee, Hans Eric Tan, Roderick C Madamba
11/04/2013 05:28 PM
Hide Details

From: Lindy A Petersen/CA/KAIPERM
To: Victoria M Hernandez/CA/KAIPERM@KAIPERM
Cc: Marcus Lee/CA/KAIPERM, Hans Eric Tan/CA/KAIPERM, Roderick C Madamba/CA/KAIPERM@KAIPERM
History: This message has been replied to.

Hi Victoria,

I filtered the file to the Explicit V46.11 & V46.13. When you want to look at the entire file, just select "Select all" for column "O".

Infant ACA for RevCycle.xlsx

Please let me know if you have any questions.

Thank you,

Lindy Petersen, CPC, CCS
AHIMA Approved ICD-10-CM/PCS Trainer
Manager, Auditing and Coding Services
The Permanente Medical Group, Inc.
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3) Dawna Toews and I reviewed Faye Brown and Coding Guidelines which only mentioned general guidelines and definition on V46.11 but not specific to newborns. We agreed that V46.11 is in reference to patients "dependent" to mechanical vent which is more long term.

CODING CLINIC REFERENCES

Mechanical ventilation using patient's equipment

Coding Clinic, **Second Quarter 2013** Page:25 Effective with discharges: July 8, 2013

Question:

We have a patient with progressive muscular dystrophy dependent on mechanical ventilation at night and as needed during the day, who was admitted to the hospital in acute on chronic respiratory failure with acute tracheobronchitis. While in the hospital, the patient was able to connect to his own ventilator via his tracheostomy tube. The respiratory therapist did follow the patient during his stay. Since the patient is using his own ventilator, should we report the ventilator procedure code?

Answer:

It would be appropriate to assign a code from subcategory 96.7, Other continuous mechanical ventilation, for patients admitted on a home ventilator, since the patient is still receiving mechanical ventilation and is utilizing significant hospital resources. Begin counting the duration from the time of the admission. The count ends at the time of discharge. Ownership of equipment has no bearing on code assignment. Code V46.11, Other dependence on machines, Respirator, should be assigned as an additional code to indicate the dependence on mechanical ventilation.

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Respirator dependence

Coding Clinic, **Fourth Quarter 2004** Page: 100 to 101 Effective with discharges: October 1, 2004

Related Information

Respirator Dependence

Effective October 1, 2004, code V46.1, Other dependence on machines, respirator, has been expanded to distinguish between respirator dependence status **(V46.11)** and encounters for respirator dependence during power failure **(V46.12).** Code V46.11 is used only if there are no complications or malfunctions of the respirator equipment, and is always a secondary code. By contrast, code V46.12 is only acceptable as a principal or first-listed code.

```
V46 Other dependence on machines

    V46.1 Respirator

New Code  V46.11 Dependence on respirator,
                 status

New Code  V46.12 Encounter for respirator
                 dependence during power
                 failure
```

OFFICIAL ICD-9-CM GUIDELINES FOR CODING AND REPORTING

3) Status

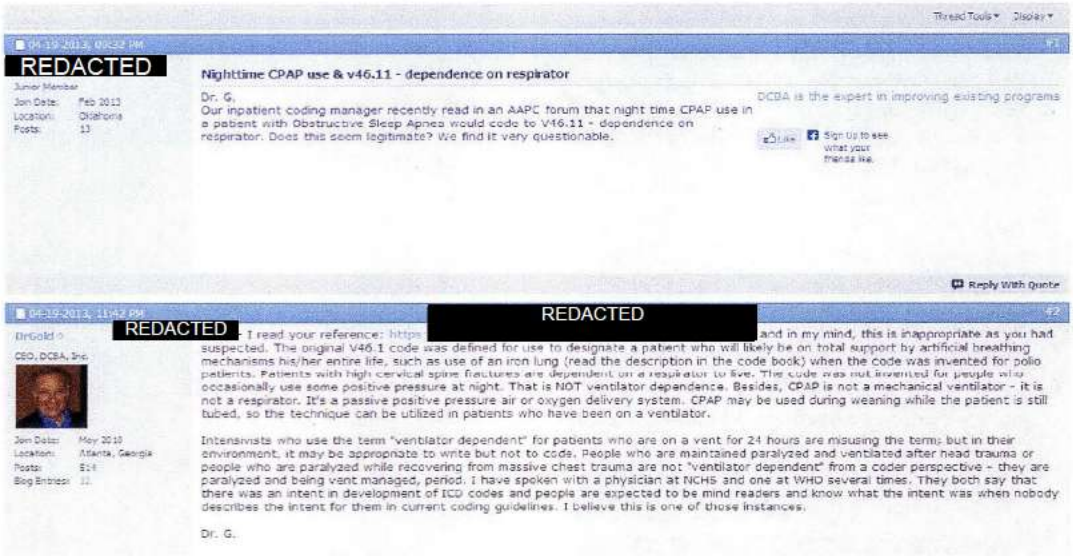
Status codes indicate that a patient is a carrier of a disease, has the sequelae or residual of a past disease or condition, or has another factor influencing a person's health status. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code V42.1, Heart transplant status, should not be used with code 996.83, Complications of transplanted heart. The status code does not provide additional information. The

FROM DR. ROBERT GOLD, ASSOCIATION OF CLINICAL DOCUMENTATION IMPROVEMENT SPECIALISTS (ACDIS) ADVISORY BOARD and CEO FOR DCBA CLINICAL DOCUMENTATION IMPROVEMENT

http://www.cditalk.com/threads/496-Nighttime-CPAP-use-amp-v46-11-dependence-on-respirator

Thread: Nighttime CPAP use & v46.11 - dependence on respirator



REDACTED

Nighttime CPAP use & v46.11 - dependence on respirator

Dr. G.
Our inpatient coding manager recently read in an AAPC forum that night time CPAP use in a patient with Obstructive Sleep Apnea would code to V46.11 - dependence on respirator. Does this seem legitimate? We find it very questionable.

DCDA is the expert in improving existing programs

Reply With Quote

REDACTED REDACTED

I read your reference: https and in my mind, this is inappropriate as you had suspected. The original V46.1 code was defined for use to designate a patient who will likely be on total support by artificial breathing mechanisms his/her entire life, such as use of an iron lung (read the description in the code book) when the code was invented for polio patients. Patients with high cervical spine fractures are dependent on a respirator to live. The code was not invented for people who occasionally use some positive pressure at night. That is NOT ventilator dependence. Besides, CPAP is not a mechanical ventilator - it is not a respirator. It's a passive positive pressure air or oxygen delivery system. CPAP may be used during weaning while the patient is still tubed, so the technique can be utilized in patients who have been on a ventilator.

Intensivists who use the term "ventilator dependent" for patients who are on a vent for 24 hours are misusing the terms but in their environment, it may be appropriate to write but not to code. People who are maintained paralyzed and ventilated after head trauma or people who are paralyzed while recovering from massive chest trauma are not "ventilator dependent" from a coder perspective - they are paralyzed and being vent managed, period. I have spoken with a physician at NCHS and one at WHO several times. They both say that there was an intent in development of ICD codes and people are expected to be mind readers and know what the intent was when nobody describes the intent for them in current coding guidelines. I believe this is one of those instances.

Dr. G.

PEDIATRICS OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3103275/

WHAT'S KNOWN ON THIS SUBJECT:

Children dependent on long-term mechanical ventilation are a diverse group who experience respiratory failure due to a variety of chronic conditions. Previous state-based analyses estimated a prevalence of 6 to 14 per 100 000 children but did not focus on age differences.

WHAT THIS STUDY ADDS:

The rate of hospital discharges for children dependent on long-term mechanical ventilation has grown to 173.6 per 100 000 nonnewborn pediatric discharges in 2006. Young children and infants consume the highest proportion of health care resources and should be an area of additional study.

4) **Code V46.11 was discussed with Gloryanne Bryant who also agreed with me and Dawna on not capturing this code for newborn initial visits where the newborn was weaned and discharged home. Since there were no specific Coding Clinic references specific to newborns, Gloryanne was to submit a question to Coding Clinic, which she has always done so in the past as point person for NCAL Regional HIM (i.e. Coding Roundtable, common trends, etc.).**

5) Email sent to Sue Bowman, AHIMA Senior Director of Coding and Compliance

From: Sue Bowman [Sue.Bowman@ahima.org]
Sent: 11/22/2013 01:25 PM GMT
To: Gloryanne Bryant; "nleon@aha.org" <nleon@aha.org>
Subject: RE: Question: V46.11 Dependence on respiratory, status (ventilator) on newborns.

Gloryanne,

V46.11 is intended for "dependence" on a ventilator – meaning long-term dependence (such as patients with spinal cord injuries or progressive neuromuscular diseases such as multiple sclerosis) – not for short-term use of a ventilator during an acute illness, following surgery, etc. So it seems unlikely that a newborn would be declared ventilator-dependent?

Sue Bowman, MJ, RHIA, CCS, FAHIMA
Senior Director, Coding Policy and Compliance

AHIMA | American Health Information Management Association
Phone: 312.233.1115 | Fax: 847.251.4742
sue.bowman@ahima.org

From: Gloryanne.H.Bryant@kp.org [mailto:Gloryanne.H.Bryant@kp.org]
Sent: Thursday, November 21, 2013 2:56 PM
To: Sue Bowman; nleon@aha.org
Subject: Question: V46.11 Dependence on respiratory, status (ventilator) on newborns.

Hi there, KP Question came up and I can not locate any guidance .....(I think the question is financially driven HCC - through the HIX methodology)

When a newborn is put on a vent, do we also add the V46.11 Dependence on respiratory, status (ventilator) on newborns??
Our practice has been not to add this to the initial newborn record.

thoughts?

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS
AHIMA Approved ICD-10-CM/PCS Trainer
National Director Coding Quality, Education, Systems and Support
Regional HIM
NCAL Revenue Cycle
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1800 Harrison St. 24th Floor, Oakland, CA 94612
510 625-3980 (tel)
510 625-5701 (fax)
email: Gloryanne.h.bryant@kp.org
Please visit the NCAL HIM resources, tools and information online at our wiki:
http://wiki.kp.org/wiki/x/fYDGBQ

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6) On 11/25/13, we had an onsite staff meeting for our Regional Coding Review Managers and the topic on V46.11 coding was discussed and we all agreed that V46.11 would not be appropriate for newborn initial visits or follow up visits and if the newborn was weaned and discharged home.

7) A follow up phone conference meeting was held on 12/3 @ 4pm (invitation sent by Sharonda Morris and Marcus Lee was chair). Attendees were Erica Eastham, Hans Eric Tan, Lindy Petersen, Marcus Lee, Rod Madamba and Victoria Hernandez. HIM provided our feedback and references on V46.11 and it was revealed that TPMG has moved forward with the policy of capturing ventilator dependence (V46.11) if a newborn was placed on mechanical vent for at least 12 continuous hours. This policy was to carry over with CDI (on HIM inpatient coding). HIM mentioned that based on the references and code definition of code V46.11, this scenario would not meet this code. I shared that a letter was sent to Coding Clinic posing this question specific to newborns. I mentioned that TPMG and HIM had a call pre-scheduled on 12/16 (routine phone conference).

8) Rod gave me a contact person for Lucile Packard to inquire on their coding practice with newborn coding and V46.11. I sent an email to Andrea Houghton, Lucile Packard Coding Manager

RE. Contact info...
Houghton, Andrea to: Victoria M Hernandez 12/04/2013 04:48 PM
Hide Details

From: "Houghton, Andrea" <AHoughton@LPCH.ORG>
To: Victoria M Hernandez/CA/KAIPERM@KAIPERM
History: This message has been replied to and forwarded.
1 attachment

Coding Roundtable 20130 3_for Kaiser.doc

Hi, I'm attaching the conversation that the Children's Hospital Association (CHA) group had re: V46.11 (see yellow highlighted section). It is somewhat of a different conversation than the one you are having but with similar outcome. The CHA decided that it would not capture V46.11 in these cases. I agree with you-V46.11 is really for use in patients who are on vent chronically in Long Term Care or a SNF. It really would not be appropriate to capture in a patient who is on a ventilator for an acute respiratory condition, even if it progressed to a chronic state. Since you are capturing the respiratory condition that causes the patient to be on the ventilator and you have also captured the procedure code for ventilator assistance, V46.11 is not needed (and is a bit redundant).

Hope this helps...

From: Houghton, Andrea
Sent: Wednesday, December 04, 2013 3:48 PM
To: 'victoria.m.hernandez@kp.org'
Subject: Contact info...

Hi Victoria, I just saw your email...I don't check my personal email much while I am at work so this is the best email to reach me at. Feel free to call or email me any time re: coding issues.

Andrea Houghton, MPH, RHIA, CCS, CCS-P, CDIP
AHIMA-Approved ICD-10-CM/PCS Trainer
Coding Manager
Health Information Management Services
Lucile Packard Children's Hospital
4700 Bohannon Road Suite #274, M/C 5900
Menlo Park, CA 94025
Tel: 650.723.0751 Cell: 619.518.4752 Fax: 650.325.1788

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9) On the same morning of 12/4, I read an email sent by Dr. Cachola (CDI) to review a power point presentation on criteria for coding the diagnoses for pediatric HHS HCCs by the medical group. The topic on V46.11 and 12 hours continuous ventilation was also in the power point. I called Dr. Cachola and explained the same discussion we had with TPMG. She asked me to join a phone call with CDI and Dr. Bliss at 1pm and I agreed.

10) Still on 12/4 morning, I got a call from Anne Cadwell and Dr. Bliss who had Marcus Lee, Erica Eastham and other TPMG staff in their room asking me to provide a copy of the letter sent to Coding Clinic and that all letters/questions must first be preapproved by the Coding Governance Committee. I said I don't have a copy of the letter and that they may contact Gloryanne Bryant, who is out of state. They asked for her cell # which I provided but also told them that it's best to get a hold of Gloryanne via email.

11) Dawna Toews and I joined the CDI call with Dr. Bliss. We mentioned that the first time we heard about the 12-hour continuous ventilation rule = V46.11 was after 4pm the day before (when Rod and I were on the TPMG call). We were only asked to provide feedback, research, references/resources on V46.11, which we did but did not know that new policies were already taking place nor were included in the conversation. The Managing Director of HIM has been the point person to submitting questions to Coding Clinic as a result of Coding Roundtable, new topics, gray areas in coding, etc. Coders would not code V46.11 in this scenario and to change this practice, we would need additional guidance, update or change to support capturing this code in these scenarios straight from Coding Guidelines or Coding Clinic. We shared feedback from Dr. Gold (CDI expert), AHIMA and Lucile Packard. We were asked not to inquire outside KP anymore.

12) On 12/8, Dr. Cachola gave me an update (see email below)

From: Shirley Cachola/CA/KAIPERM
To: Victoria M Hernandez/CA/KAIPERM@KAIPERM, Julie A Hager/CA/KAIPERM@KAIPERM
Cc: Diane Ott/P0/KAIPERM@Kaiperm, Roderick C Madamba/CA/KAIPERM@KAIPERM
Date: 12/06/2013 09:30 PM
Subject: Re: Fw: HHS Codes

Thanks, Victoria - what we've agreed to with the med. group is to use "respirator dependence" for patients with tracheal intubation until the specifics are clarified by the coding clinic and to use "acute respiratory failure" for non-trached patients. Not sure this meets compliance since it is not defined but this is how med. group wishes to proceed for now.

Julie - can you add the information below to the "asthma" portion of the powerpoint as a slide? Thanks!

Shirley Cachola, MD
Director, Clinical Documentation Integrity
1800 Harrison, 10th flr., RM 104R05
NCAL Kaiser Permanente
Oakland, CA 94612-3430

phone: outside line: (510) 625-5652
Blackberry: (510) 882-0184
tieline: 8-428-5652

13) AHA email response regarding V46.11 on newborns

From: Gloryanne H Bryant/CA/KAIPERM
To: Victoria M Hernandez/CA/KAIPERM@KAIPERM
Cc: Dawna M Toews/CA/KAIPERM@KAIPERM
Date: 12/06/2013 08:22 AM
Subject: Fw: Question: V46.11 Dependence on respiratory, status (ventilator) on newborns.

Here's the AHA email response.....but I did submit the fax.

Gloryanne

----- Forwarded by Gloryanne H Bryant/CA/KAIPERM on 12/06/2013 08:21 AM -----

From: "Rapier, Anita" <arapier@aha.org>
To: Gloryanne H Bryant/CA/KAIPERM@KAIPERM
Cc: "Ayala, Karen" <kayala@aha.org>, "Leon-Chisen, Nelly" <nleon@aha.org>, "sue.bowman@ahima.org" <sue.bowman@ahima.org>
Date: 12/06/2013 08:17 AM
Subject: RE: Question: V46.11 Dependence on respiratory, status (ventilator) on newborns.

Yes, that is my interpretation.

From: Gloryanne.H.Bryant@kp.org [mailto:Gloryanne.H.Bryant@kp.org]
Sent: Friday, December 06, 2013 10:13 AM
To: Rapier, Anita
Cc: Ayala, Karen; Leon-Chisen, Nelly; sue.bowman@ahima.org
Subject: Re: Question: V46.11 Dependence on respiratory, status (ventilator) on newborns.

thanks
Thus if a newborn was placed on a vent for 12 or even 20 hours and then at discharge is NO longer on the vent, we would not assign the V 46.11 status code to that discharge/stay.

Gloryanne Bryant, RHIA, CDIP, CCS, CCDS
AHIMA Approved ICD-10-CM/PCS Trainer
National Director Coding Quality, Education, Systems and Support
Regional HIM

National Revenue Cycle
Kaiser Foundation Health Plan Inc & Hospitals
1 Kaiser Plaza- 15th floor, Office #1543, Oakland, CA 94612
510 625-3980 (tel)
510 625-5701 (fax)
email: Gloryanne.h.bryant@kp.org
Please visit the NCAL HIM resources, tools and information online at our wiki:
http://wiki.kp.org/wiki/x/fYDGBQ
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From: "Rapier, Anita" <arapier@aha.org>
To: Gloryanne H Bryant/CA/KAIPERM@KAIPERM
Cc: "Leon-Chisen, Nelly" <nleon@aha.org>, "sue.bowman@ahima.org" <sue.bowman@ahima.org>, "Ayala, Karen" <kayala@aha.org>
Date: 12/06/2013 08:11 AM
Subject: Question: V46.11 Dependence on respiratory, status (ventilator) on newborns.

Hi Gloryanne,

Karen forwarded your question, since Nelly is out of the office on vacation. Traditionally, code V46.11 (respirator dependence status) is used to describe patients who have been dependent on mechanical ventilation over a period of time. It is not used for newborns who are placed on a vent for a short period. This is something that the Co-ops might agree to add to the ICD-10-CM Coding Guidelines since the ICD-9-CM Coding Guidelines are no longer being updated.

Anita

Anita Rapier, RHIT, CCS
Senior Coding Consultant
AHIMA Approved ICD-10-CM/PCS Trainer
American Hospital Association
155 N. Wacker Drive, Suite 400
Chicago, IL 60606-1725
Ph: 312-422-3386
Fax: 312-268-0838
arapier@aha.org

EXHIBIT 21

----- Forwarded by Victoria M Hernandez/CA/KAIPERM on 12/05/2013 03:22 PM -----

From: Shirley Cachola/CA/KAIPERM
To: Victoria M Hernandez/CA/KAIPERM@KAIPERM
Cc: Julie A Hager/CA/KAIPERM@KAIPERM
Date: 12/05/2013 03:19 PM
Subject: call with Dr. Bliss

Victoria - so sorry you got in the line of fire with some of Dr. Bliss's irritation with the letter of clarification that was sent to coding clinic without notifying the med. group around this respirator dependence issue--we both got the information late (I got it from med. group on 12/3 and sent it to you). Apparently, they had consulted compliance but went forward without clarification (we've been trying to develop these criteria with them for training since Sept.) Dr. Bliss wasn't upset with you but with the compliance folks. Thanks for taking the call and explaining. Our current plan is not to use respirator dependence but use acute respiratory failure instead, unless you see a problem with it. Let us know about the feedback from coding clinic if that will come to you or Gloryanne.

Julie - please substitute acute respiratory failure in place of respirator dependence per discussion with Dr. Bliss. Thanks!

Shirley Cachola, MD
Director, Clinical Documentation Integrity
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NCAL Kaiser Permanente
Oakland, CA 94612-3430

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tieline: 8-428-5652

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EXHIBIT 22

Gloryanne Bryant <gloryanneb@sbcglobal.net>
To
victoriamhernandez@yahoo.com
Today at 5:29 PM
pls print out

gloryanneb@sbcglobal.net

--- On Mon, 12/9/13, <Gloryanne.H.Bryant@kp.org> wrote:

> From: <Gloryanne.H.Bryant@kp.org>
> Subject: Fw: Fw: HHS Codes
> To: gloryanneb@sbcglobal.net
> Date: Monday, December 9, 2013, 10:30 AM
>
>
> Dawna M Toews
>
> -----
> Original Message -----
>
> From: > Dawna M Toews
>
> Sent: 12/09/2013 08:01 AM PST
>
> To: Gloryanne Bryant
>
> Cc: Victoria Hernandez
>
> Subject: Re: Fw: HHS Codes
>
> How do you proceed when it is clearly out of compliance. Is Sue Muscarella
> aware.? I am not inclined to continue working for a company
> that blatantly ignores guidelines I have promised to follow,
> and that put me in jeopardy of losing my professional
> licensing.
>
>
> Nor will I put the license of my coders on the line without clear guidance from our
> cooperating parties. We cannot move forward with this
> type of guidance without an answer from Coding Clinic.
>
> Dawna M. Toews, MBA, RHIT,
> CCS, CRCR
> AHIMA Approved ICD 10 CM/PCS
> Trainer
>

> Regional Director Coding
> Operations
> NCAL Revenue Cycle
> Kaiser Foundations Health
> Plan Inc& Hospitals
> 1800 Harrison St., 24th
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> 510--625-5650 (tel)
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> Thank you.
>
>
>
>
> Gloryanne H
> Bryant---12/08/2013 10:31:38 PM---Not good. Gloryanne
> Bryant, RHIA, CDIP, CCS, CCDS AHIMA Approved ICD-10-CM/PCS
> Trainer
>
>
>
> From: Gloryanne H Bryant/CA/KAIPERM
>
> To: Victoria M Hernandez/CA/KAIPERM@KAIPERM
>
> Cc: Dawna M Toews/CA/KAIPERM@KAIPERM
>
> Date: 12/08/2013 10:31 PM
>
> Subject: Re: Fw: HHS Codes
>
> Not good.
>
> Gloryanne Bryant, RHIA,CDIP, CCS, CCDS
> AHIMA Approved ICD-10-CM/PCS Trainer
> National Director Coding Quality, Education, Systems and
> Support
> Regional HIM
> National Revenue Cycle
> Kaiser Foundation Health Plan Inc & Hospitals
> 1 Kaiser Plaza- 15th floor, Office #1543, Oakland, CA 94612

> 510 625-3980 (tel)
> 510 625-5701 (fax)
> email: Gloryanne.h.bryant@kp.org
>
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> online at our wiki: http://wiki.kp.org/wiki/x/fYDGBQ
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>
> Victoria M
> Hernandez---12/08/2013 10:26:28 PM---FYI
>
>
>
> From: Victoria M Hernandez/CA/KAIPERM
>
> To: Gloryanne H Bryant/CA/KAIPERM@KAIPERM,
> Dawna M Toews/CA/KAIPERM@KAIPERM
>
> Date: 12/08/2013 10:26 PM
>
> Subject: Fw: HHS Codes
>
> FYI
>
>
>

> VICTORIA M. HERNANDEZ, RHIA, CCS, CDIP, CRCR, AHIMA-Approved
> ICD-10-CM/PCS Trainer
> Regional Associate Director of Hospital Coding, Northern
> California
> NCAL Revenue Cycle HIM
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> Tie-line:8-428-5674
> iPhone: (510) 495-5638
> Facsimile: (510) 625-5701
> Email:Victoria.M.Hernandez@kp.org
>
> Please visit the NCAL HIM resources, tools and information online
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> Coders' Corner: https://wiki.kp.org/wiki/x/g4DGBQ
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> Forwarded by Victoria M Hernandez/CA/KAIPERM on 12/08/2013
> 10:26 PM -----
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>
> From: Shirley Cachola/CA/KAIPERM
>
> To: Victoria M Hernandez/CA/KAIPERM@KAIPERM,
> Julie A Hager/CA/KAIPERM@KAIPERM
>
> Cc: Diane Ott/PO/KAIPERM@Kaiperm, Roderick C
> Madamba/CA/KAIPERM@KAIPERM

>
> Date: 12/08/2013 09:30 PM
>
> Subject: Re: Fw: HHS Codes
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>
> Thanks, Victoria - what
> we've agreed to with the med. group is to use
> "respirator dependence" for patients with tracheal
> intubation until the specifics are clarified by the coding
> clinic and to use "acute respiratory failure" for
> non-trached patients. Not sure this meets compliance
> since it is not defined but this is how med. group wishes to
> proceed for now.
>
>
>
> Julie - can you add the
> information below to the "asthma" portion of the
> powerpoint as a slide? Thanks!
>
>
>
> Shirley Cachola, MD
>
> Director, Clinical Documentation Integrity
>
> 1800 Harrison, 10th flr., RM 104R05
>
> NCAL Kaiser Permanente
>
> Oakland, CA 94612-3430
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> Thank you.
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> Victoria M
> Hernandez---12/08/2013 07:31:12 PM---Hi Dr. Cachola, Besides
> the revision/discussion on mechanical ventilation, we would
> just add the fol
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>
>
> From: Victoria M Hernandez/CA/KAIPERM
>
> To: Shirley Cachola/CA/KAIPERM@KAIPERM
>
> Cc: Diane Ott/PO/KAIPERM@KAIPERM, Julie A
> Hager/CA/KAIPERM@KAIPERM, Roderick C
> Madamba/CA/KAIPERM@KAIPERM
>
> Date: 12/08/2013 07:31 PM
>
> Subject: Re: Fw: HHS Codes
>
> Hi Dr. Cachola,

> Besides the revision/discussion on mechanical ventilation, we would just
> add the following comments on the asthma slide (or something
> similar). Thank you.
>
>
> VICTORIA M. HERNANDEZ, RHIA, CCS, CDIP, CRCR, AHIMA-Approved
> ICD-10-CM/PCS Trainer
>
> Regional Associate Director of Hospital Coding, Northern

> California
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> NCAL Revenue Cycle HIM
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> Facsimile:
> (510) 625-5701
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> Email:
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>
> Shirley
> Cachola---12/03/2013 02:39:56 PM---Victoria - the attachment
> below is the med. group presentation of criteria for coding
> the diagnoses
>
>
>
> From: Shirley Cachola/CA/KAIPERM
>
> To: Victoria M
> Hernandez/CA/KAIPERM@KAIPERM
>
> Cc: Roderick C Madamba/CA/KAIPERM@KAIPERM,
> Julie A Hager/CA/KAIPERM@KAIPERM, Diane
> Ott/PO/KAIPERM@Kaiperm
>
> Date: 12/03/2013 02:39 PM
>
> Subject: Fw: HHS Codes
>
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>
> Victoria - the attachment
> below is the med. group presentation of criteria for coding
> the diagnoses for pedi. HHS HCC's to use for querying in
> 2014. Julie has the associated codes for the
> HCC's. We are missing anorexia/bulemia, which will
> be provided by med. group later. Please discuss with
> Rod and review for approval/corrections prior to us
> presenting the information to the CDI SC's on 12/10
> (Tues).
>
>
>
> Shirley Cachola, MD
>
> Director, Clinical Documentation Integrity
>
> 1800 Harrison, 10th flr., RM 104R05
>
> NCAL Kaiser Permanente
>
> Oakland, CA 94612-3430
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> -----
> Forwarded by Shirley Cachola/CA/KAIPERM on 12/03/2013 02:34
> PM -----
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>
> From: Erica E Eastham/CA/KAIPERM
>
> To: Donna K McIvor/CA/KAIPERM@KAIPERM
>
> Cc: David Bliss/CA/KAIPERM@KAIPERM, Julie A
> Hager/CA/KAIPERM@KAIPERM, Shirley
> Cachola/CA/KAIPERM@KAIPERM, Susan D
> Ingebretsen/CA/KAIPERM@KAIPERM
>
> Date: 12/03/2013 08:50 AM
>
> Subject: Re: HHS Codes
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>
> [attachment
> "Presentation to PICU PEDIHBS and NICU CDI Nurses_
> 20131202 v6.pptx" deleted by Victoria M
> Hernandez/CA/KAIPERM]
>
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>
> Thanks,
>
> Erica
>
>
>
> Erica E. Eastham, CCS-P
>
> AHIMA Approved ICD-10-CM/PCS Trainer
>
> Director, Documentation Quality and Training
>
> The Permanente Medical Group, Inc. - Encounter
> Information Operations
>
> 1950 Franklin St. Oakland, CA. 94612
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> Cell (510) 414-4774
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> Assistant: Denise M Smith (510) 987-4793, tie 8-427
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> Thank you.
>
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>
> Donna K
> McIvor---12/03/2013 08:22:04 AM---Hi Dr Bliss and Erica, Dr.
> Cachola asked about the criteria for the NICU, PICU and
> adult HHS codes?
>
>
>
> From: Donna K McIvor/CA/KAIPERM
>
> To: David Bliss/CA/KAIPERM, Erica E
> Eastham/CA/KAIPERM@KAIPERM
>
> Cc: Shirley Cachola/CA/KAIPERM@KAIPERM, Susan
> D Ingebretsen/CA/KAIPERM@KAIPERM, Julie A
> Hager/CA/KAIPERM@KAIPERM
>
> Date: 12/03/2013 08:22 AM
>
> Subject: HHS Codes
>

> Hi Dr Bliss and Erica,
>
> Dr. Cachola asked about the
> criteria for the NICU, PICU and adult HHS codes? I guess that these
> were supposed to be provided by Thanksgiving for CDI
> and HIM to review prior to our CDI 12/10 mtg.?
>
>
>
> So that is why I am sending this email out to you - for your feedback on these HHS
> codes.

> Donna K. McIvor, RN,MSN, CRCR
> Regional Manager, Clinical
> Documentation Integrity (CDI)
>

> NCAL Revenue Cycle Integrity
> Kaiser Foundation Health Plan
> Inc & Hospitals
> 1800 Harrison St. 10th Floor,
> Oakland, CA 94612
> Office:(510) 625-6434
> Blackberry:(510)
> 606-0191
>
> FAX: (510) 625-3340
>
> Email: Donna.K.McIvor@kp.org
>
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Asmtha – cont'd

- Extrinsic Asthma NOS
- Extrinsic Asthma with status asthmaticus
- Extrinsic Asthma with acute exacerbation
- Intrinsic Asthma NOS
- Intrinsic Asthma with status asthmaticus
- Intrinsic Asthma with acute exacerbation
- Chronic Obstructive Asthma NOS
- Chronic Obstructive Asthma with status asthmaticus
- Chronic Obstructive Asthma with acute exacerbation
- Exercise Induced Bronchospasm
- Cough variant Asthma
- Asthma NOS
- Asthma with status asthmaticus
- Asthma NOS with acute exacerbation

- Simple Asthma NOS **does** increase the risk score.
- "possible", "probable", "suspected" will count for coding **if** documented at the time of discharge..
  - Example: Probable Asthma is acceptable.

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EXHIBIT 23

Kaiser Permanente

Neonatal Intensive Care Unit Diagnostic Guidelines

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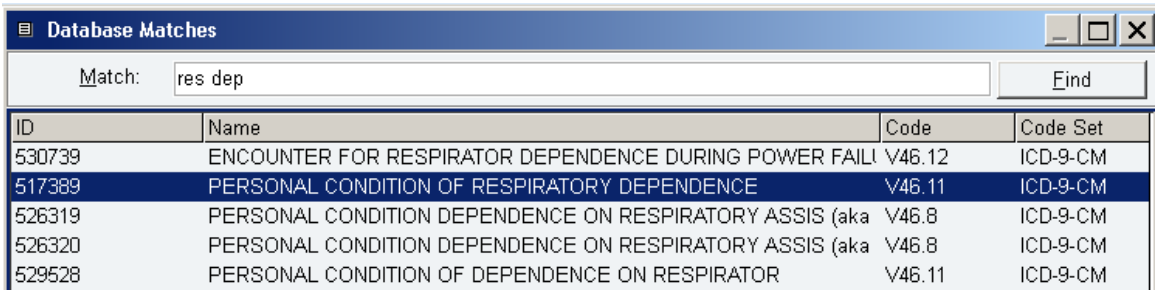
Acute Respiratory Failure	Page 2
Congestive Heart Failure	Page 3
Shock	Page 13
SIRS / Sepsis	Page 15

Respirator / Ventilator Dependence

There are no clear-cut coding references that define the description "Dependence on respirator, status" for code V46.11. Coders are instructed by all coding references to assign codes based on physician documentation. Due to the lack of coding guidelines and encoder edits, it is best to depend on the guidance of the physician's documentation for code assignment.

TPMG NICU Leadership in collaboration with NCAL HIMS has agreed to following criteria for assignment of 'Dependence on respirator, status' [V46.11]

- Patient has an endotracheal tube or tracheostomy tube in place and is receiving respiratory support from a conventional (volume or pressure limited modes) or high frequency ventilator for > 30 days, or
- Patient was discharged home on a respirator.



Acute Respiratory Failure

One of the most common and concerning complications seen in low-birth-weight infants is chronic lung disease.

Noninvasive ventilation (NIV), a term applied to a variety of devices capable of supporting neonatal ventilation without the use of an endotracheal tube, is receiving increasing attention as means to reduce damage often incurred with mechanical ventilation.

This guideline will provide an overview of some of the types of NIV being used in neonates and when those mechanisms of delivery would qualify a patient as having Acute Respiratory Failure.

TYPES OF NONINVASIVE VENTILATION

CPAP

CPAP, the application of continuous pressure throughout the respiratory cycle, can be provided by a variety of devices ranging from simple bubble CPAP to sophisticated dedicated mechanical ventilators. CPAP pressure is generated by 1 of 2 mechanisms: varying the flow rate (variable flow devices) or providing a constant flow of gases and varying the pressure by another mechanism (continuous flow devices).
Continuous flow devices include the following: neonatal ventilators that provide a continuous flow of fresh gas and vary the level of positive pressure by controlling gas outflow; and bubble CPAP that generates pressure by submerging the expiratory tubing in a water chamber with the level of water determining the level of CPAP. Bubble CPAP creates chest wall vibration similar to that of high-frequency ventilation that may increase gas exchange although this is disputed.

High-flow nasal cannula

Positive pressure is also generated with the use of nasal cannula. The level of pressure generated by nasal prongs varies according to the flow rate, the type of cannula used, and infant size.

Phasic positive pressure devices

Phasic NIV consists of positive pressure applied across the respiratory cycle combined with periods of increased airway pressure. Intermittent increases in airway pressure (breaths) may be delivered at regular intervals (nonsynchronized) or synchronized with infant inspiratory efforts. The majority of systems currently in use in North America feature some type of synchronization; synchronized NIPPV has also received the most attention in clinical trials.

KP NCAL defines Acute Respiratory Failure as follows:

When any of the following treatments are used individually or collectively for more than 12 continuous hours

- The patient has nasal prongs in place and is having her respiration supported with any device providing nasal continuous positive airway pressure (NCPAP), BIPAP (bi-level positive airway pressure), or NIPPV (non-invasive positive pressure ventilation). The later 2 modalities are enhanced versions of NCPAP with interspersed positive pressure breaths.
- HFNC (high flow nasal cannula) of 2L or more (which is the equivalent of NCPAP).

Congestive Heart Failure

Congestive Heart Failure relative to the Infant Model (birth to 1year), Affordable Care Act
Some supporting literature in regards to diagnosis and guidance in documentation

Reminder: Prior to Infant Model initiation, HYDROPS is fetal congestive heart failure so feasible to make diagnosis at time of birth

Additional References:
A Neonatology Review, 2nd edition, 2010, Dara Brodsky, MD
B NEOREVIEWS Vol. 7 No. 2 February 1, 2006 pp. e88 -e94 (doi: 10.1542/neo.7-2-e88)
C NEOREVIEWS September 1, 2010 vol. 11 no. 9 e495-e502 doi:10.1542/neo.11-9-e495
D NEOREVIEWS Vol. 1 No. 8 August 1, 2000 pp. e139 -e145 (doi: 10.1542/neo.1-8-e139)
E Specialty Review in Neonatology, Feb 19-24, 2013; presentation by Laurie Armsby, MD, Division of Pediatric Cardiology, Oregon Health Sciences University

Congestive Heart Failure in Newborn period outline:
PDA (patent ductus arteriosus)
Congenital Heart Disease (structural)
Inadequate myocardial function (myopathies, metabolic, vascular, infectious, etc)

Reference A.
Clinical Diagnosis

C. CONGESTIVE HEART FAILURE (CHF)

Signs and symptoms resulting from inability of heart to meet demands of body

Hydrops if severe fetal CHF; otherwise, symptoms can include tachypnea, tachycardia, hepatosplenomegaly, weak peripheral pulses, +/- gallop

CXR with increased heart size, increased PVM; Kerley B lines — short horizontal linear densities in lung extending to pleura due to interstitial edema; often difficult to detect in neonates

Medical management with diuretics, inotropic agents

Reference B.
Pulmonary edema can be caused postnatally by many disorders; those that occur frequently during the neonatal period are patent ductus arteriosus or structural congenital heart disease with marked left-to-right shunting.

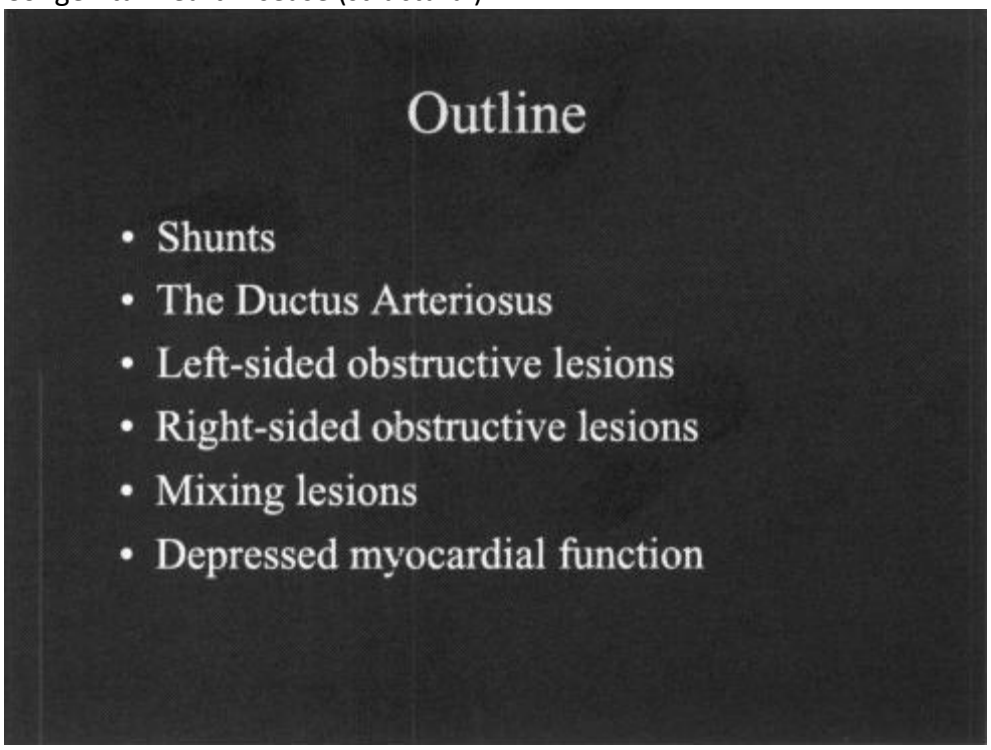
The most common mechanism causing increased fluid movement out of the microvasculature is an increase in the transvascular pressure gradients, as clinically occurs in congestive heart failure (CHF).

Reference C.
Patent Ductus Arteriosus: in Preterm Infants

Table.
Hemodynamically Significant Patent Ductus Arteriosus (HSDA)

Echocardiographic Criteria
Transductal diameter (TDD) >1.5 mm Unrestrictive pulsatile transductal flow Left heart volume loading (eg, left atrium-to-aortic root ratio of 1.5 to 2:1)
Systemic Hypoperfusion (Decreased Qs)
Systemic hypotension Evidence of end-organ hypoperfusion, renal insufficiency, NEC, IVH Acidosis (lactic, metabolic)
Pulmonary Overcirculation (Increased Qp)
Oxygenation failure Increased ventilation requirements Radiologic evidence of cardiomegaly or pulmonary edema

Reference D.
Congenital Heart Disease (structural)



Pathophysiology of PDA in the Preterm Infant

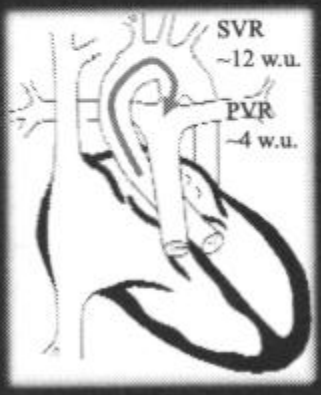
Principles:

- Pulmonary overcirculation
- Diastolic run-off (wide PP)
- Increased cardiac work

Pathophysiology of PDA in the Preterm Infant

Pulmonary overcirculation

- Excessive volume in pulmonary circulation
- Enlarged MPA, LA/LV
- Stretched PFO with L→R shunt
- Poor oxygen/$C0_2$ exchange
- Tachypnea, increased work of breathing
- Incrd pulm vascularity on CXR
- Steal from systemic circulation
- Poor feeding/weight gain



Recognizing the Pre-term Neonate with a PDA

Sx:
Fatigued, sweaty

Sn:
Tachypneic, mildly hypoxic, rales, tachycardic, poor wt gain, bounding pulses, continuous murmur

CXR:
Incr'd vascular markings & MPA, ± cardiomegaly

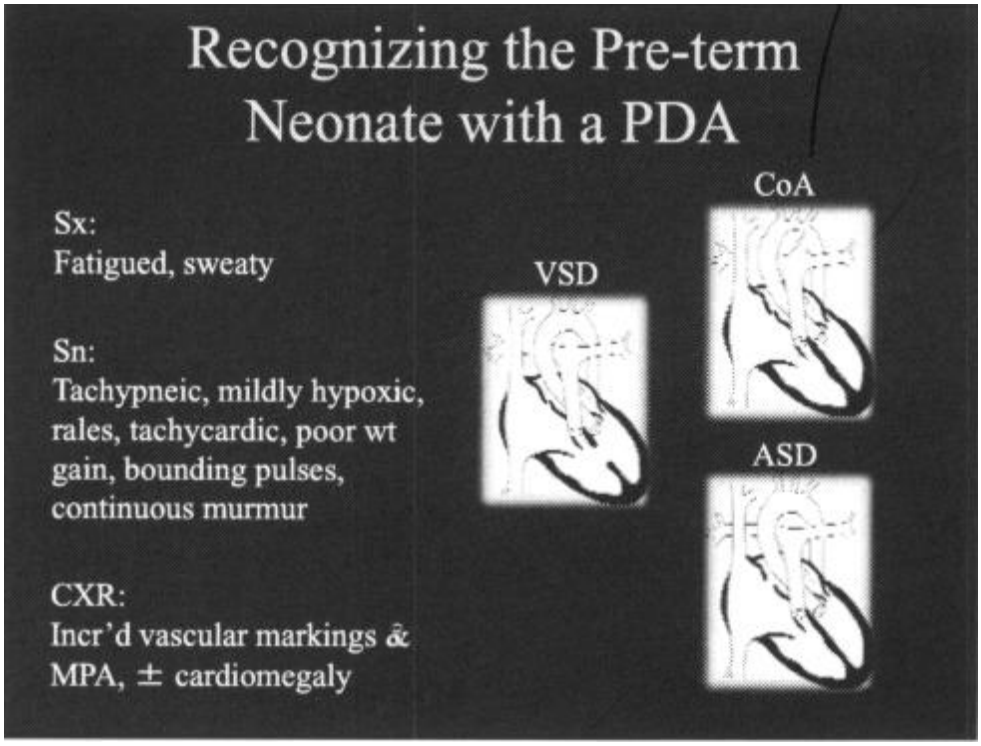
Recognizing the Pre-term Neonate with a PDA

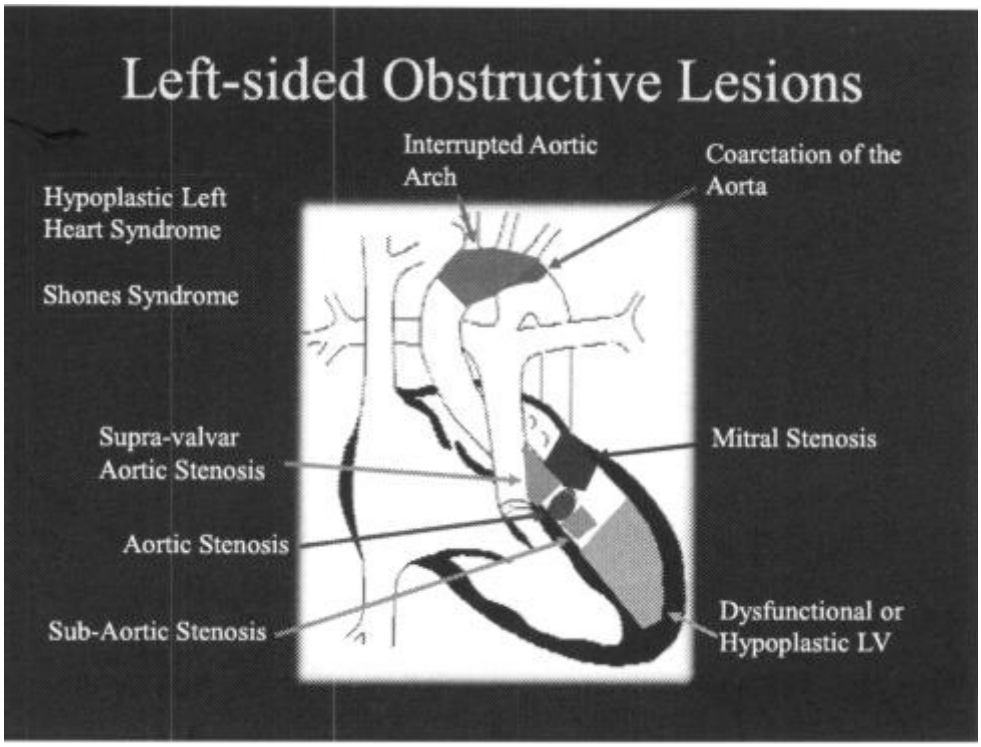
Sx:
Fatigued, sweaty

Sn:
Tachypneic, mildly hypoxic, rales, tachycardic, poor wt gain, bounding pulses, continuous murmur

CXR:
Incr'd vascular markings & MPA, ± cardiomegaly

Question #3: What other cardiac lesions present like this?


Recognizing the Pre-term Neonate with a PDA
Sx:
Fatigued, sweaty
Sn:
Tachypneic, mildly hypoxic, rales, tachycardic, poor wt gain, bounding pulses, continuous murmur
CXR:
Incr'd vascular markings & MPA, ± cardiomegaly
VSD
CoA
ASD


Left-sided Obstructive Lesions
Hypoplastic Left Heart Syndrome
Shones Syndrome
Interrupted Aortic Arch
Coarctation of the Aorta
Supra-valvar Aortic Stenosis
Aortic Stenosis
Sub-Aortic Stenosis
Mitral Stenosis
Dysfunctional or Hypoplastic LV

Recognizing the Infant with a Left-sided obstructive lesion

Before ductus closes:
Systolic murmur, differential 0_2 sats

As/after ductus closes:
Gallop, ± murmur, weak pulses, cool extremities, poor perfusion, tachypnea, cardiogenic shock, acidosis

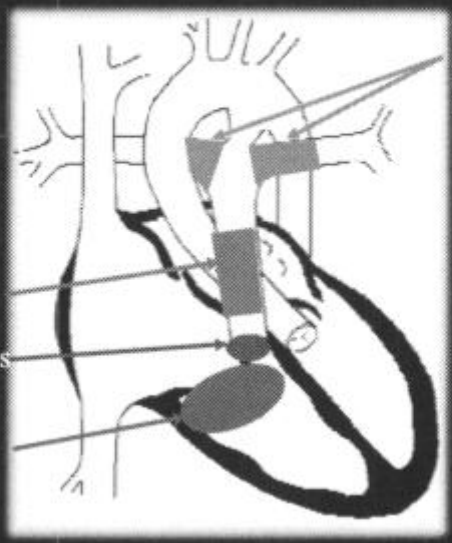
Dominant early feature: cardiogenic shock (resembling sepsis)

CXR:
Incr'd vascular markings, ± cardiomegaly

Right-sided Obstructive Lesions

Tetralogy of Fallot

Pulm Atresia/VSD



branch pulmonary stenosis

supravalvar pulmonary stenosis

pulmonary stenosis or atresia

tricuspid stenosis or atresia
neonatal Ebsteins

Recognizing the Infant with a Right-sided obstructive lesion

Before ductus closes:
± Systolic murmur, hypoxemia, bounding pulses

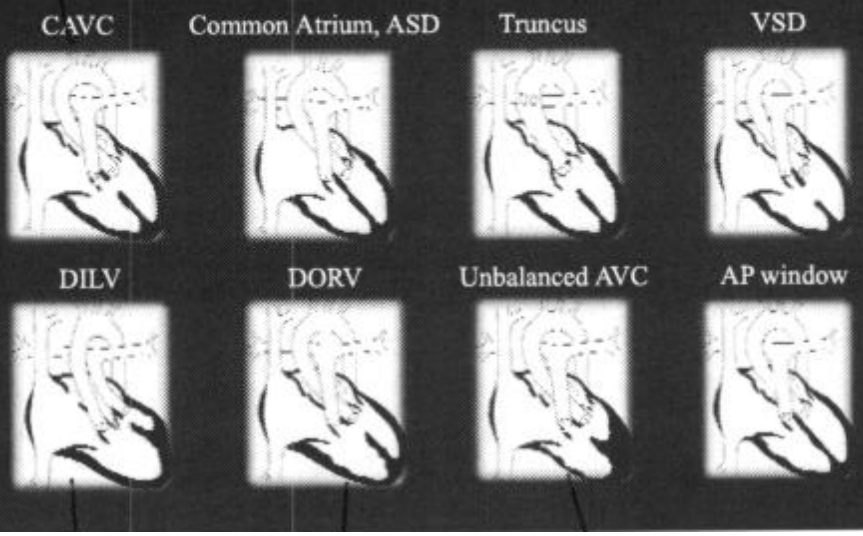
As/after ductus closes:
± murmur, tachypnea, severe hypoxemia; followed by cardiogenic shock, acidosis

Dominant early feature: cyanosis

CXR:
Decr'd vascular markings

Mixing Lesions

Question #12: Name 8 mixing lesions



Recognizing the Infant with a mixing lesion

Before ductus closes:
± systolic murmur, hypoxemia

As/after ductus closes:
no difference

In the older infant:
tachypnea, murmur, hypoxemia, poor wt gain, poor feeding, diaphoresis

Dominant early feature: murmur

CXR:
Increased vascular markings, ± cardiomegaly

Recognizing the Infant with a cardiomyopathy

Hypotension, tachycardia, poor perfusion, cool extremities, diaphoresis

Dominant early feature: poor perfusion, tachycardia

CXR:
Cardiomegaly

E.
DILATED CARDIOMYOPATHY
PHYSICAL EXAMINATION
The signs of congestive heart failure include tachypnea, tachycardia, narrow pulse pressure with decreased peripheral pulses, hepatomegaly, and pallor. In severe cases, there may be cardiovascular collapse. Cyanosis is rare, but wheezing is common. Rales are seldom present in infants, but may be noted in older children.
Results of the cardiac examination may be subtle. Muffling of heart sounds occasionally is noted, although a gallop is a much more common finding. In some cases, the murmur of mitral insufficiency may be appreciated at the apex.

HYPERTROPHIC CARDIOMYOPATHY
Infants who have hypertrophic cardiomyopathy most typically present with congestive symptoms, including tachypnea, poor feeding, and growth failure. In some cases, the diagnosis is made because of a prior diagnosis in another family member; occasionally, a near-miss sudden death episode from arrhythmia is the sentinel event. Congestive symptoms are due to diastolic dysfunction of the left ventricle that causes elevated pulmonary venous pressure. This does not correlate well with the degree of left ventricular obstruction.
PHYSICAL EXAMINATION
The physical examination findings generally are related to the presence of left ventricular outflow obstruction. The degree of outflow obstruction is highly variable, and it may be absent. In patients who do not have outflow obstruction, findings on physical examination may be entirely normal, suggesting the need for routine echocardiography in patients whose history strongly suggests the possibility of hypertrophic cardiomyopathy. Patients who have outflow obstruction will have evidence of a systolic ejection murmur in the aortic region. Infants may have a subpulmonary obstruction as well, giving rise to a somewhat louder systolic murmur in the pulmonic valve area. In infants, hepatomegaly also may be observed.

CDI Criteria:

Documentation of PDA
Existing dxs that would include CHF
Review of chest xray that shows evidence of pulm edema, cardiomegaly
Echo with existing Problem List dx of heart dz
Lasix (daily)
Restriction of fluids prior to diruetics

SHOCK

Shock is a complex syndrome of circulatory dysfunction associated with reduced oxygen and nutrient delivery to peripheral and ultimately to central organs. The etiology is multifactorial. The major secondary complication of severe shock is a syndrome characterized as Systemic Inflammatory Response Syndrome (SIRS).

Likely clinical contexts for development of shock:

- Feto-maternal hemorrhage
- Vasa previa
- Cord accidents/acute bleeding
- Perinatal asphyxia
- ELBW infant
- Chorioamnionitis
- Severe sepsis
- Unreplaced fluid losses

Clinical features of shock

- Hypotension
- Peripheral vasoconstriction
- Poor capillary refill (>3 seconds)
- Tachycardia
- Bradycardia in ELBW
- Tachypnea
- Hypoxia
- Metabolic/lactic acidosis
- CNS disturbances (lethargy, irritability)
- Oliguria (<0.5 ml/kg/hours)
- Coagulopathy

Treatment may include:

- Respiratory support
- Volume expansion
- Alkali therapy
- Vasopressor agents
- Antibiotics
- Blood products

Considerations for coding: There is no single diagnostic test or clinical parameter that defines shock in the neonatal population. **If two or more of the following 6 conditions are present the patient warrants are diagnosis of shock.**

Blood pressure: Shock usually includes a component of hypotension, however blood pressure may be normal in the early phase of shock (compensated). The presenting signs may be tachycardia (>180 bpm) or a change in heart rate over the baby's previous baseline rate. In conjunction with other evidence of poor tissue perfusion or organ dysfunction in at least one other system (see below) the coding for shock may be appropriate.

A single volume bolus , possibly repeated again is used often for blood pressure readings falling below a target range , or for metabolic acidosis, without evidence of other organ dysfunction. Those situations would not qualify for a shock coding.

However, hypotension (need for > 2 boluses) without improvement, or need for an inotrope would support a shock coding.

Evidence of cardiac dysfunction: an echocardiogram indicating poor myocardial function, decreased cardiac output , or an obstructive cardiac lesion in conjunction with hypotension, or persistent acidosis or other evidence of organ dysfunction would warrant a shock coding.

Capillary Refill Time (CRT) and Central-peripheral Temperature difference (CPTd) : delayed capillary refill (>3 sec) or CPTd (>2 ° C) may help support a shock diagnosis, but should not be the sole criteria for a shock coding.

Acidosis : a persistent lactic acidosis (>2.5 mmol/liter) would be supportive of a shock coding if other causes (inborn error of metabolism) have been ruled out.

Urine output: decreased urine output may be physiologic in the first 24 hours, and there are some technical difficulties in obtaining accurate measurements. Oliguria (<.5ml/kg/hour) would be supportive of a shock coding if other factors (volume status, intrinsic renal disease) have been ruled out.

Coagulopathy: active bleeding or abnormal coagulation studies would be an ominous late sign of shock. If other etiologies are ruled out, coagulopathy would be supportive of a shock coding.

SIRS / SEPSIS

The clinical syndrome defined by the presence of ***both*** infection and a systemic inflammatory response (SIRS).

Infection

Documented or suspected
Positive blood or CSF culture for a pathogenic organism
Negative blood culture but treatment with antibiotics by the medical team for 7 days; no apparent infection at another site

SIRS (Need at least 3 of the following):

General parameters

Fever (temperature >38.5°C)
Hypothermia (core temperature <36°C)
Heart rate >180 bpm
Tachypnea: >60 breaths/minute
Lethargic
Significant edema or positive fluid balance (>20 ml/kg over 24 h)
Hyperglycemia (plasma glucose >180 mg/dL)
Apnea > ususal baseline

Inflammatory parameters

Leukocytosis (white blood cell count >20,000/µl)
Leukopenia (white blood cell count <5,000/µl)
Normal white blood cell count with >15% immature forms
Plasma C reactive protein >3

Hemodynamic parameters

Arterial hypotension (systolic blood pressure <or mean arterial pressure <2 SD below normal for age)
Shock

Organ dysfunction parameters

Arterial hypoxemia (PaO_2/FiO_2 <300)
Acute oliguria (urine output <0.5 ml kg/hour)
Creatinine >1.5 mg/dL
Coagulation abnormalities (international normalized ratio >1.7 or activated partial thromboplastin time >60 s)
Ileus
Thrombocytopenia (platelet count <100,000/µl)

Tissue perfusion parameters

Hyperlactatemia (>2 mmol/l)
Decreased capillary refill or mottling (capillary refill time >3seconds)

EXHIBIT 24

SDAL

HEALTH CARE REFORM

Health Insurance Exchange (HIX)
Neonatology
Documentation and Coding 2014

CLINICAL DOCUMENTATION & Audit Operations

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Today's Discussion

- SCAL Neonatology Training Plan
- Healthcare Reform and the Risk Adjustment Payment Model
- The Infant Model
- Documentation and Coding Guidelines
- SCAL Neonatology High Acuity HIX Diagnoses
- Appendix

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Commonly Used Acronyms

- HIX: Health Insurance Exchange
- HHS: Department of Health and Human Services
- HCC: Hierarchical Conditions Categories
- CMS: Centers for Medicare and Medicaid Services

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SCAL Neonatology Training Team

- SCAL Neonatology Training Team
  - David Braun, MD, Regional Physician Coordinator, Perinatal Services
  - Mandhir Gupta, MD, Physician Coordinator, Downey Medical Center
  - Terri Ma, Practice Specialist, Clinical Documentation and Audit Operations
- Worked in collaboration with NCAL Neonatology
- Data Analysis included:
  - CPQCC California Perinatal Quality Care Collaborative
  - Pulled ICD 9 Codes reportd for all patients in CPQCC
  - Reviewing Utilization reports for Neonatology to identify areas of missed opportunities

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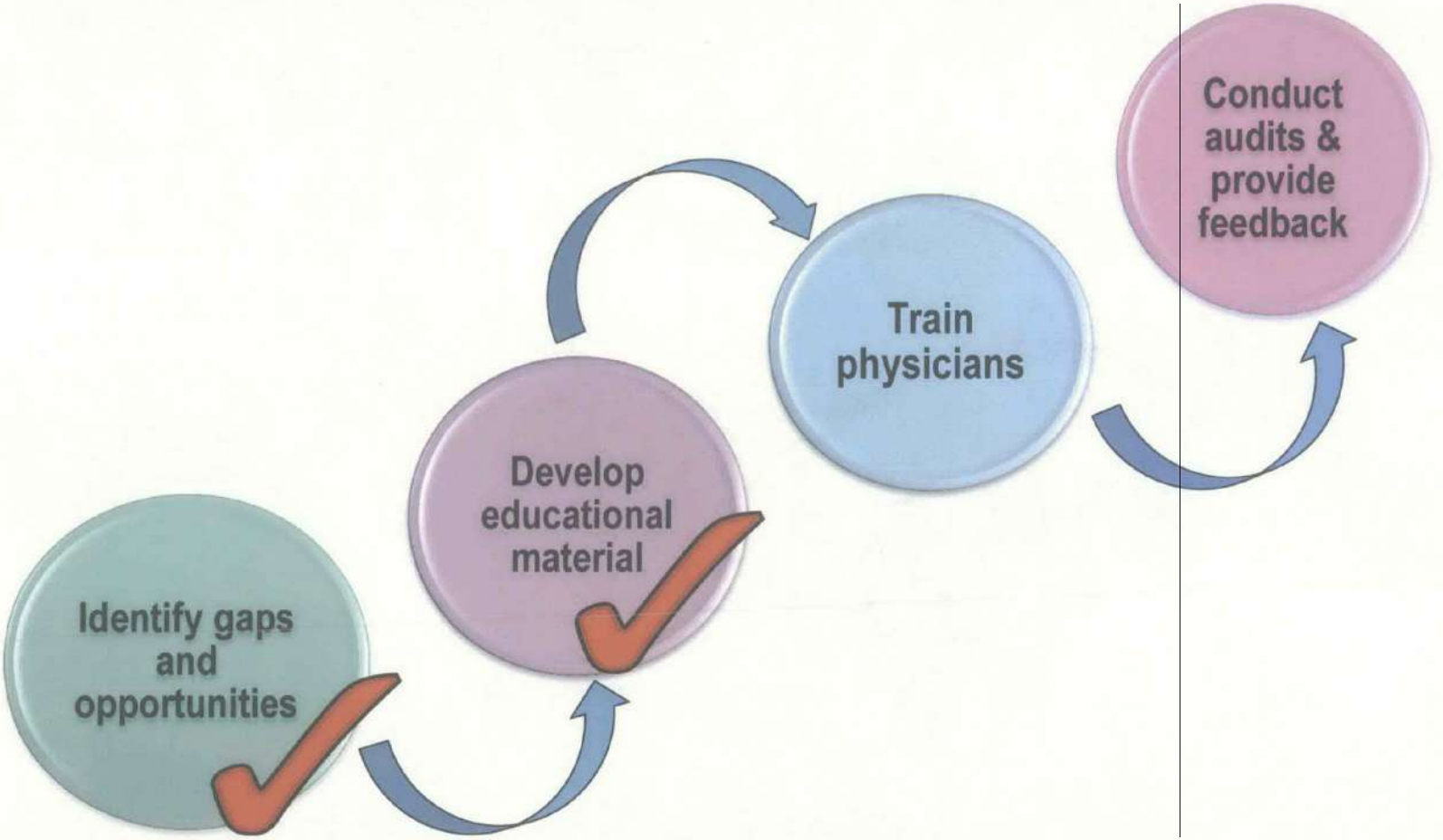
Steps of Implementation



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Risk Adjustment Payment Model

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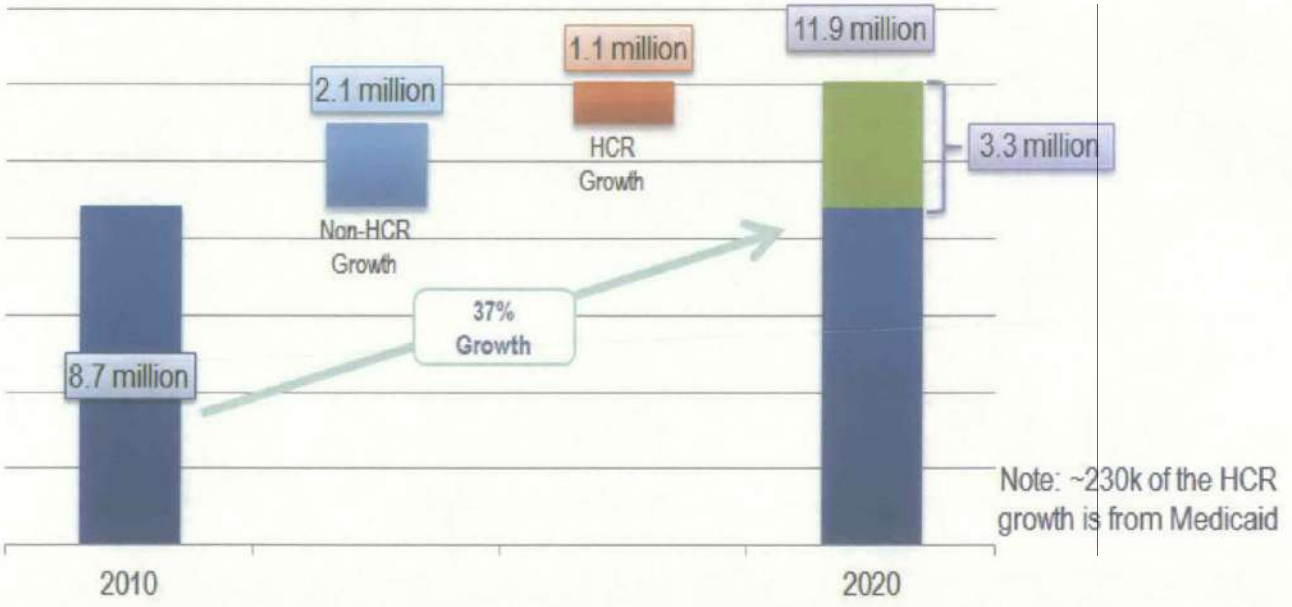
Why is Risk Adjustment Important?

- Health Insurance Exchanges takes effect on- **1/1/2014**
- Health Insurance Exchanges (HIX) will drive about 1/3 of KP's membership growth over the next 10 years

Projected KP Membership Growth



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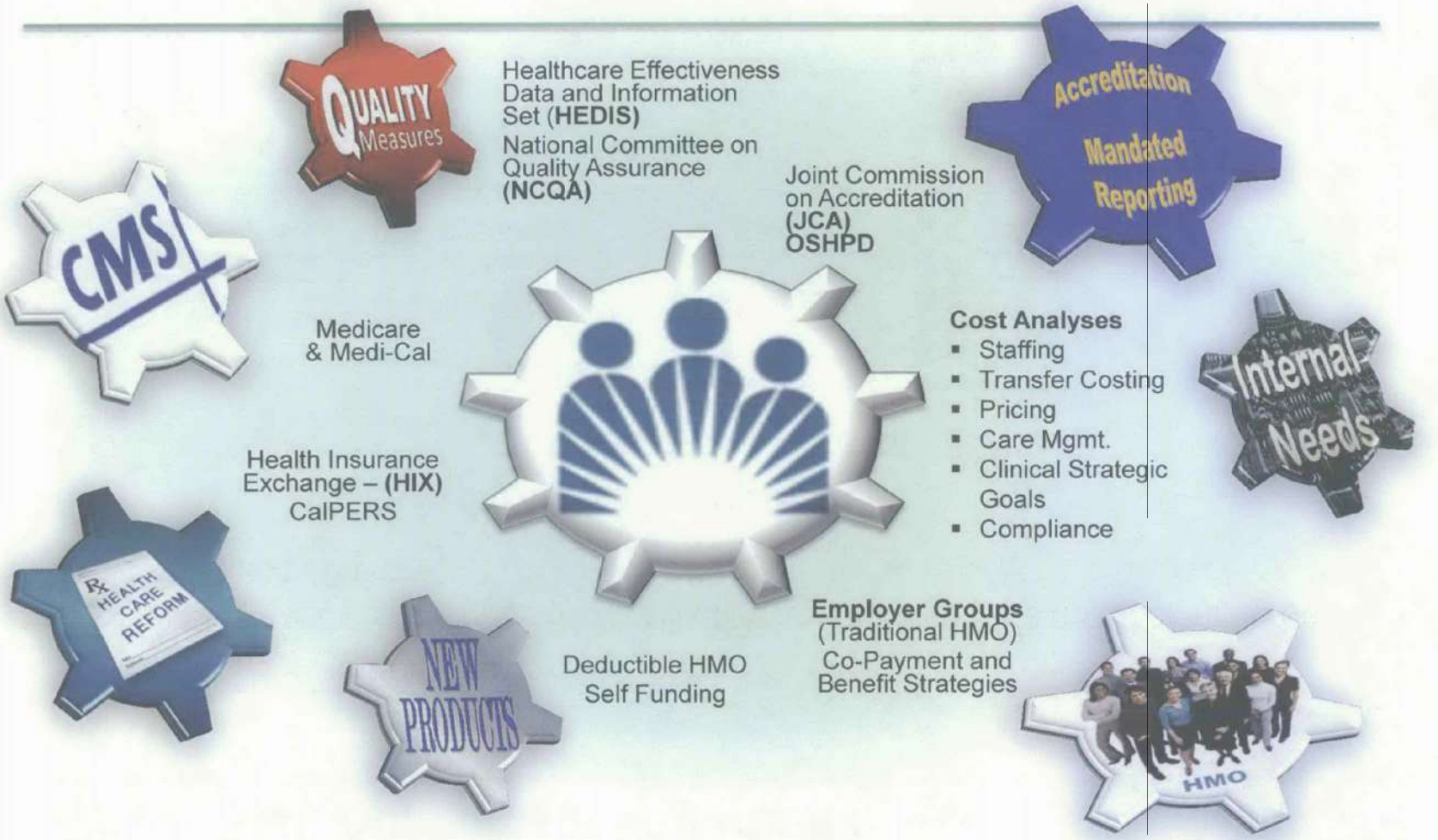
Medical Coding Impacts Every Aspect of Our Organization



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Risk Adjustment Payment Model Comparison

Medicare Advantage

- Since 2003
- Member age: 65+
- 79 HCCs
- 3,033 Diagnoses
- Prospective Payment Model: data captured for current year will impact payment for the following year

Health Insurance Exchanges

- New for 2014
- Member age: 0 – 64
- 127 HCCs
- 3,473 Diagnoses
- Concurrent Payment Model: 2014 data capture impacts 2014 payment

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Health Insurance Exchange (HIX) HCC Model

- Model is concurrent: 2014 data capture impacts 2014 payments
- Diagnoses must be reported at a **minimum** once each calendar year
  - by SCPMG physicians and/or physician extenders
  - at any setting including in-patient, out-patient and ED
- Diagnoses must be reported from a face-to-face encounter

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Neonatal Patients Are Important in HIX:

- Percentages of members with HIX-HCCs (based on FFS Data)
  - *Adult 19%*
  - *Child 9%*
  - **Infant 45%**

45% of infant members will have an HHS-HCC diagnosis

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The Infant Model

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The Infant Model

- Ages **0 – 24** months

- Infant risk score is determined by **Maturity** and **Severity** of diagnosis
- A **Severity Level** is assigned to each diagnosis in the Infant Model
  - Includes virtually all of the adult and child HCCs (and more)
  - Severity Levels: 1 through 5
- Many of the more severe conditions will be hospital diagnoses

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HIX Newborn Maturity Categories

Maturity Category	Birth Weight (grams)
Extremely Immature	< 500
	500 – 749
	750 – 999
Immature	1000 – 1499
	1500 – 1999
Premature	2000 – 2499
Malnourished & Multiples	No requirement
Term	Normal or High

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Examples of Severity Categories

Severity Category	Examples of HHS-HCCs included
Severity Level 5	Respirator Dependence/Tracheostomy Status
Severity Level 5	Hypoplastic Left Heart Syndrome and Other Severe Congenital Heart Disorders, Congestive Heart Failure
Severity Level 4	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock
Severity Level 4	Aspiration and Specified Bacterial Pneumonias and Other Severe Lung Infections
Severity Level 3	HIV/AIDS
Severity Level 3	Acute Liver Failure/Disease, Including Neonatal Hepatitis
Severity Level 2	Drug Dependence
Severity Level 2	Protein-Calorie Malnutrition
Severity Level 1	Acute Pancreatitis/Other Pancreatic Disorders and Intestinal Malabsorption
Severity Level 1	Chronic Kidney Disease, Severe (Stage 4)

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This is How Newborn Maturity & Severity Comes Together

	Severity Category Scores				
Newborn Maturity Level	**Severity 1**	**Severity 2**	**Severity 3**	**Severity 4**	**Severity 5**
Extremely Immature < 999 grams	59	59	59	222	391
Immature 1000 - 2499 grams	31	31	44	87	205
Premature/Multiples	6	8	17	32	171
Term	1.00	3	6	19	131
Age 1	0.33	2	3	10	61

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Newborn HHS HCC Case Examples

Case Example	Maturity	Condition	Severity	Risk Score
Premature infant weights 745 g with **"Respiratory Distress Syndrome"**	Extremely Immature	Respiratory Distress Syndrome	4	222
Premature infant weights 1010 g with **"Respiratory Distress Syndrome"**	Immature	Respiratory Distress Syndrome	4	87
Premature infant weights 1010 g with **"Newborn Respiratory Disease"**	Immature	Newborn Respiratory Disease	Not an HIX HCC Diagnosis	Base Payment for Premature Infant

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Documentation and Coding Guidelines

REL0001036

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Documentation and Coding Guidelines

- Indicate the Primary / Principle Diagnosis (chiefly responsible for services provided)
- Document and report :
  - all coexisting conditions that require/affect patient treatment and/or management.
  - personal/family history if it impacts treatment
  - evaluation and/or treatment of all diagnoses
  - all diagnoses to the highest degree of specificity & certainty
  - cause-and-effect relationship of an underlying disease and its manifestation(s).

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SCAL Neonatology High Acuity HIX Conditions

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Neonatology High Acuity HIX Diagnoses

- **Selection criteria was based on:**
  - low reporting rate in 2012
  - high HIX severity level
  - the need for standard clinical or coding definition

- **Five conditions were selected for training:**

Respirator Dependence	Severity 5
CHF	Severity 5
SIRS, Sepsis/Severe Sepsis, Septic Shock	Severity 4
Necrotizing Enterocolitis Stage 1	Severity 5
Protein-Calorie Malnutrition	Severity 2

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ER-800

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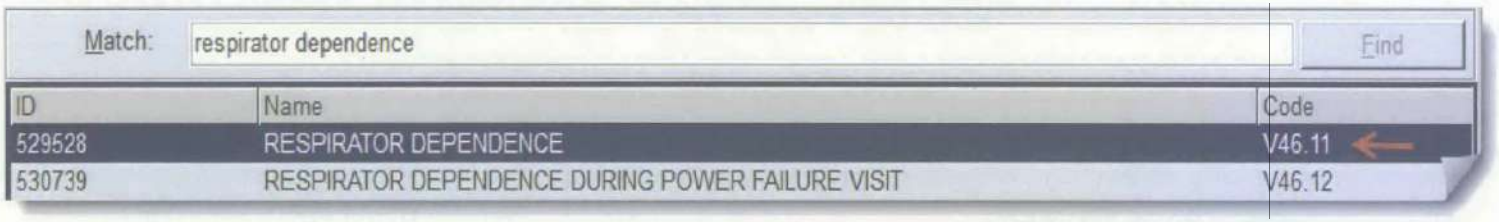
Respirator Dependence

- **Challenge:**
  - There are no clear-cut time frame set on what constitutes ventilator dependence.
  - Coding Clinic stated: "this code should be reported when the patient requires continued ventilator support for an unexpected extended period of time and not for short –term acute phase of a condition. "
  - High HIX severity level with a low reporting rate in 2012



- **Our recommendation: define respiratory dependence as:**
  - Duration of care > 21 days
  - Type of care: any combination of
    - HFNC >= 2 LPM, NCPAP, BIPAP, and/or NIPPV
    - Endotracheal CPAP, conventional ventilator care, or HFOV

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ER-801

Congestive Heart Failure

- **Challenge:**
  - High HIX severity level with a low reporting rate in 2012
  - Need for a standard clinical or reporting definition
- **Our Recommendations: code CHF if:**
  - **Patient has a reason for failure**

    Examples:
    - PDA (patent ductus arteriosus)
    - Congenital Heart Disease (structural)
    - Inadequate myocardial function (myopathies, metabolic, vascular, infectious, etc)

Match: congestive heart failure Find

Name	Code
HYPERTENSIVE HEART DISEASE, W CHF (CONGESTIVE HEART FAILURE)	402.91,428.0
CHF (CONGESTIVE HEART FAILURE)	428.0

  - **Objective Evidence of CHF or its treatment:**

    Examples:
    - Symptomatic PDA
    - Moderate or large PDA on echo
    - Chest x-ray with haziness and/or cardiomegaly
    - Elevated BNP
    - Restriction of fluids, dopamine, Lasix, indomethacin, PDA ligation

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ER-802

SIRS

Challenge:

- High HIX severity level with a low reporting rate in 2012
- Need for a standard clinical or reporting definition

Our recommendation: at least 3 of the following):

- Fever (temperature >38.5°C)
- Hypothermia (core temperature <36°C)
- Heart rate >180 bpm
- Tachypnea: >60 breaths/minute
- Lethargy
- Significant edema or positive fluid balance (>20 ml/kg over 24 h)
- Hyperglycemia (plasma glucose >180 mg/dL)
- Apnea > usual baseline

Match: sirs Find

ID	Name	Code	
507238	SIRS DUE TO INFECTION W ACUTE ORGAN DYSFUNCTION	038.9, 995.92	← Severe sepsis w/acute organ dysfunction
507239	SIRS DUE TO INFECTION WO ORGAN DYSFUNCTION	038.9, 995.91	← Sepsis
537279	SIRS DUE TO NONINFECTIOUS PROCESS W ACUTE ORGAN FAILURE	995.94	← SIRS noninfectious w/acute organ failure
537259	SIRS DUE TO NONINFECTIOUS PROCESS WO ACUTE ORGAN FAILURE	995.93	← SIRS noninfectious w/o acute organ failure
523875	SIRS WO ORGAN DYSFUNCTION	995.90	← SIRS

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ER-803

Sepsis

Challenge:

- Might be incorrectly reported as SIRS or bacteremia
- Need for a standard clinical or reporting definition
- High HIX severity level with a low reporting rate in 2012

Our recommendation: meets criteria if:

- The clinical syndrome defined by the presence of ***both*** infection and a systemic inflammatory response (SIRS).
- **Documentation needed:**
  - Documentation of SIRS
  - Documentation of Infection
- **Diagnostic Criteria - Infection:**
  - Confirmed or suspected:
  - Positive blood or CSF culture for a pathogenic organism
  - Negative blood culture but treatment with antibiotics for ≥7 days; no apparent infection at another site

Match: sepsis Find

ID	Name	Code
533687	NEONATAL EARLY ONSET SEPSIS, ON OR BEFORE DAY 3	771.81
533689	NEONATAL LATE ONSET SEPSIS, AFTER DAY 3	771.81

Note: Use additional codes to identify severe sepsis (995.92) and any associated acute organ dysfunction, if applicable

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Severe Sepsis

Challenge:

- Not frequently coded distinctly from "generic" sepsis
- Need for a standard clinical or reporting definition
- High HIX severity level with a low reporting rate in 2012

Our recommendation: remember to distinguish

Definition:

- Severe sepsis with acute organ dysfunction. 995.92

Match: severe sepsis — Find

ID	Name	Code
535369	SEVERE SEPSIS W ACUTE ORGAN DYSFUNCTION	038.9, 995.92
502822	SEVERE SEPSIS W ACUTE ORGAN DYSFUNCTION, W ANAEROBIC SEPTICEMIA	038.3, 995.92
507967	SEVERE SEPSIS W ACUTE ORGAN DYSFUNCTION, W COAGULASE NEGATIVE STAPH SEPTI	038.19, 995.92
502823	SEVERE SEPSIS W ACUTE ORGAN DYSFUNCTION, W E COLI SEPTICEMIA	038.42, 995.92
502830	SEVERE SEPSIS W ACUTE ORGAN DYSFUNCTION, W PSEUDOMONAS SEPTICEMIA	038.43, 995.92
502833	SEVERE SEPSIS W ACUTE ORGAN DYSFUNCTION, W SERRATIA SEPTICEMIA	038.44, 995.92
502834	SEVERE SEPSIS W ACUTE ORGAN DYSFUNCTION, W STAPH SEPTICEMIA, FINAL ID PENDIN	038.10, 995.92

Note: Use additional codes specify acute organ dysfunction, such as septic shock 785.52

Documentation needed:

- Documentation of SIRS with infection (confirmed or suspected)
- Documentation of acute organ dysfunction

Diagnostic Criteria - Organ Dysfunction:

- Arterial hypoxemia (PaO_2/FiO_2 <300)
- Acute oliguria (urine output <0.5 ml kg/hour)
- Creatinine >1.5 mg/dL
- Coagulation abnormalities (INR >1.7 or activated partial thromboplastin time >60 s)
- Ileus
- Thrombocytopenia (platelet count <100,000/µl)

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ER-805

Shock (Septic, Cardiogenic, Hypovolemic)

Challenge:

- Not frequently coded distinctly from "generic" sepsis
- Need for a standard clinical or reporting definition
- High HIX severity level with a low reporting rate in 2012

Our recommendation: remember to distinguish

Definition:

- Shock is a complex syndrome of circulatory dysfunction associated with reduced oxygen and nutrient delivery to peripheral and ultimately to central organs. The etiology is multifactorial. Major classes of shock include cardiogenic, hypovolemic, and septic shock.

Diagnostic Criteria:

- Hypotension
- Peripheral vasoconstriction

Examples of Common Clinical Context:

- Feto-maternal hemorrhage (772.0-772.9)*
- Vasa previa (663.50-663.53)*
- Cord accidents/acute bleeding (663.00-663.93)*
- Perinatal asphyxia (768.3-768.6, 768.9)*
- ELBW infant (765.00-765.09)*
- Chorioamnionitis (762.7)
- Severe sepsis (995.92)*
- Unreplaced fluid losses

Match: shock

ID	Name	Code
516050	SHOCK	785.50
514444	CARDIOGENIC SHOCK	785.51
513215	HYPOVOLEMIC SHOCK	785.59
513213	SEPTIC SHOCK	785.52
502809	SEPTIC SHOCK W ACUTE ORGAN DYSFUNCTION, W ANAEROBIC S	038.3, 995.92, 785.52
507968	SEPTIC SHOCK W ACUTE ORGAN DYSFUNCTION, W COAGULASE I	038.19, 995.92, 785.52
502810	SEPTIC SHOCK W ACUTE ORGAN DYSFUNCTION, W E COLI SEPTI	038.42, 995.92, 785.52
507976	SEPTIC SHOCK W ACUTE ORGAN DYSFUNCTION, W ENTEROCOCC	038.8, 995.92, 785.52
508008	SEPTIC SHOCK W ACUTE ORGAN DYSFUNCTION, W GONOCOCCAI	098.89, 995.92, 785.52
502813	SEPTIC SHOCK W ACUTE ORGAN DYSFUNCTION, W MENINGOCOC	036.2, 995.92, 785.52
502853	SEPTIC SHOCK W ACUTE ORGAN DYSFUNCTION, W OTHER SEPTI	038.8, 995.92, 785.52

*Code range contains multiple HIX HCC codes

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Stage 1 Necrotizing Enterocolitis in Newborn

Challenge:

- Neonatologists are reluctant to report Stage 1 NEC
- HIX HCC reimbursement for NEC Stage 1 same as Stage 2 and 3.
- High HIX severity level with a low reporting rate in 2012

Our recommendation: remember to diagnose

- **Stage 1 Suspected: 777.51**
  - Nonspecific systemic signs including lethargy, abdominal distention, and blood in stool. Radiology studies may be normal or positive for bowel dilation. Without pneumatosis, without perforation.
  - And treated with NPO and antibiotics for at least 5 days

Match: neonatal necrotizing enterocolitis Find

ID	Name	Code
535608	NEONATAL NECROTIZING ENTEROCOLITIS	777.50
535730	NEONATAL NECROTIZING ENTEROCOLITIS, STAGE 1 ←	777.51
535729	NEONATAL NECROTIZING ENTEROCOLITIS, STAGE 2	777.52
535728	NEONATAL NECROTIZING ENTEROCOLITIS, STAGE 3	777.53

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Malnutrition

Challenge:

- High HIX severity level with a low reporting rate in 2012
- Need for a standard clinical and/or reporting definition

Definition:

a. AAP:

- Weight (or weight for height) is less than 2 SD below mean for sex and age **(<3%ile).**
- Weight curve has crossed more than 2 percentile lines ON NCHS growth charts after having achieved a previously stable pattern.

b. Z score to be -2

- Z score can be calculated from available excel sheets by CDC, link enclosed.

http://www.cdc.gov/growthcharts/zscore.htm

c. Other References : *See Appendix for additional references and guidelines…*

Our Recommendation:

c. Go with 3% as it closely matches Z score of -2.

Reference: Pediatric Nutrition handbook By AAP, 5th edition , page 443-445

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Summary

- Physicians are the best person to represent the disease burden of the patient.
- **Complete** & **Accurate** documentation is the key to **Quality** patient care and **Appropriate** reimbursement.

Document everything that the patient has and report what you document

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Frequently Asked Questions (FAQ)

1. **What happens if I over code?**

   You should always document what you do and report what you document.

2. **Will I received feedback on how well I am coding?**

   SCPMG Clinical Documentation and Audit Operations department will conduct on going audits for all physicians. Audit feedback reports will be provided to physicians on a monthly bases. 5-10 patients will be audited for each physician per month.

3. **How much is each risk score?**

   We do not have the actual amount for the HIX risk score. However, the higher the risk score usually means the higher the reimbursement.

4. **What's new and what are the changes to the current process?**

   There are no major changes to the current process. Just remember to document and report all diagnoses.

5. **Who do I call if I have any questions?**

   See Contact List.

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Contact

- SCAL Neonatology Training Team:
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    Regional Physician Coordinator, Perinatal Services

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  - **Mandhir Gupta, MD**

    Physician Coordinator, Downey Medical Center

    (562) 461-6230
  - **Terri Ma, RHIA**

    Practice Specialist, Clinical Documentation and Audit Operations

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Appendix

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Malnutrition

Helpful Hints:

1. Before any intervention make sure that the child is actually has failure to thrive, not "just small" Remember that 3-5 % of the healthy population, by definition, will be below the -2SD of the norm. (Your clues will be parental heights, proportionality, birth weight, gestational age, birth length and most importantly past trajectory.)

2. IUGR kids: if their birth length was normal expect "excellent" catch-up growth. They are actually at risk for future obesity. If birth length is also below the 5th percentile, they are likely to remain small.

3. One data point raises red flags. Diagnosis of FTT requires follow up (prospective or retrospective) over time.

4. A good start as a f/u interval is Qweek or Q2w weight-checks. You can gradually increase it as the child starts to catch up.

5. The requirements should be individualized as soon as possible. The guidelines are for populations. Remember the bell curve. There is a huge distance between two tails of it and what is appropriate for one half of the population is too much or too llittle for the other half.

SIS

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Malnutrition

Helpful Hints:

6. Your job in the clinic is not to teach "nutrition 101". The caregiver is not interested in learning what works for the average x-year-old. They are there, mostly because what works for the average child has not worked for this little one.

7. Remember: siblings are NOT controls. Do not rule out abuse or neglect just because other sibs are fine. It is typical for only one of the children to have FTT due to neglect.

8. Use the appropriate charts. Especially for special medical conditions and 1st generation immigrants. But, it is always better to use them together w/ the CDC charts.

9. As you all know, HISTORY is the most important part of the evaluation.

10. Was the pregnancy planned? It may be useful in uncovering attachment problems, but difficult to ask directly. I find it easier to ask "How long into the pregnancy did you find out that you were pregnant?" Mothers usually volunteer information if they did not want the child.

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Malnutrition

Helpful Hints:

11. Genetics referrals can be helpful, to adjust expectations and setting realistic goals, if nothing else.

12. There is no "FTT Battery" of labs. Send your CBC and CMP, but everything else should depend on indications.

13. Observe at least one feeding. There is a validated scale (NCAST) to score feeding interaction.

14. Collaborate w/ speech closely. Most of "preferences" or "dislikes" are based on oromotor problems (or sometimes intolerances)

15. The absolute threshold for referral is developmental delay. (By the way, developmental delay is a very unfortunate euphorism. The correct term should be "developmental loss")

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Malnutrition

Helpful Hints:

16. The minimal catch up growth is around 10 gms/day. 15 gm/day is a realistic expectation. Be happy w/ 20 gm/day. Celebrate at 30 gm/day.

17. the nutrition support sequence is : 3 meals+2 snacks → supplements → tube feeding → TPN Tube feeding is either NG, NJ or G-tube. There is no reason under the sun to feed a child with a NG tube for more than 4-6 weeks.

18. FTT etiologies can be divided into three groups: Organic, inorganic and mixed. "Mixed" constitutes 99.9% of the total, making the grouping absolutely meaningless.

19. "psychosocial etiology" and "environmental reasons" do NOT imply neglect – no matter how much DCFS workers wish that they do.

20. Make sure that the family has the resources and the skills to follow recommendations and confirm who the caregiver is before going ahead with interventions.

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Malnutrition

Helpful Hints:

21. Make sure all eligible patients sign up w/ WIC, Food Stamps.

22. Think twice before giving waiver letters to mothers for FTT. Rare, but very unfortunately, there are some cases where these letters cause a conflict of interest.

23. If in doubt and wish to discuss FTT cases, call me anytime.

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Malnutrition

CLASSIFICATION OF MALNUTRITION IN CHILDREN :

	Mild Malnutrition	Moderate Malnutrition	Severe Malnutrition
Percent Ideal Body Weight	80-90%	70-79%	< 70%
Percent of Usual Body Weight	90-95%	80-89%	< 80%
Albumin (g/dL)	2.8-3.4	2.1-2.7	< 2.1
Transferrin (mg/dL)	150 - 200	100 - 149	< 100
Total Lymphocyte Count (per µL)	1200 - 2000	800 - 1199	< 800

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Malnutrition

CLASSIFICATION OF MALNUTRITION IN CHILDREN :

Gomez Classification: The child's weight is compared to that of a normal child (50th percentile) of the same age. It is useful for population screening and public health evaluations.

percent of reference weight for age = ((patient weight) / (weight of normal child of same age)) * 100

percent of reference weight for age	Interpretation
90 - 110%	normal
75 - 89%	Grade I: mild malnutrition
60 - 74%	Grade II: moderate malnutrition
< 60%	Grade III: severe malnutrition

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Malnutrition

CLASSIFICATION OF MALNUTRITION IN CHILDREN :

Wellcome Classification: evaluates the child for edema and with the Gomez classification system.

Weight for Age (Gomez)	With Edema	Without Edema
60-80%	kwashiorkor	undernutrition
< 60%	marasmic-kwashiorkor	marasmus

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Malnutrition

CLASSIFICATION OF MALNUTRITION IN CHILDREN :

Waterlow Classification: Chronic malnutrition results in stunting. Malnutrition also affects the child's body proportions eventually resulting in body wastage.

percent weight for height = ((weight of patient) / (weight of a normal child of the same height)) * 100percent height for age = ((height of patient) / (height of a normal child of the same age)) * 100

	Weight for Height (wasting)	Height for Age (stunting)
Normal	> 90	> 95
Mild	80 - 90	90 - 95
Moderate	70 - 80	85 - 90
Severe	< 70	< 85

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Malnutrition

CLASSIFICATION OF MALNUTRITION IN CHILDREN :

Serum Albumin: considered to be the single best nutritional test to predict patient outcome. breakpoint for clinically relevant malnutrition: ranges from 3.0 to 3.5 g/dL

Level of Malnutrition	Albumin g/dL
normal	3.5 - 4.8
mild	2.8 - 3.4
moderate	2.1 - 2.7
severe	< 2.1

Instant Nutritional Assessment: uses measurements of serum albumin and total lymphocyte counts at admission to evaluate the patient's nutritional status.

Serum Albumin	Total Lymphocyte Count	Complications	Death
>= 3.5 g/dL	>= 1500 per µL	3.0%	0.9%
>= 3.5 g/dL	< 1500 per µL	7.5%	2.2%
< 3.5 g/dL	>= 1500 per µL	23.8%	0%
< 3.5 g/dL	< 1500 per µL	11.8%	17.6%

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Malnutrition

CLASSIFICATION OF MALNUTRITION IN CHILDREN :

Nutritional Needs: A simple rules of thumb: typical formula and breast milk are 20 kcal/oz

Group	Particulars	Body WtKg	Net energy kcal/d	Protein g/d	Fat g/d	Calcium mg/d	Iron mg/d	Vit.A. µpg/d retinol	Vit.A. pg/d ß-carotene
Infants	0-6 months	5.4	108/kg	2.05/kg		500			
	6-12 months	8.6	98/kg	1.65/kg				350	1200
Children	1-3 years	12.2	1240	22	25	400	12	400	1600
	4-6years	19.0	1690	30	25	400	18	400	
	7-9 years	26.9	1950	41	25	400	26	600	2400
Boys	10-12 years	35.4	2190	54	22	600	34	600	2400
Girls	10-12 years	31.5	1970	57			19		

Up to 5 years of age begin with a base of 1,000 calories and add 100 calories for each year. (e.g. a **1 year-old** would need approximately **1000 + 100 calories= 1100 calories/day, a 2 year-old** would need **1000 + 200 calories= 1200 calories/day**.)

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EXHIBIT 25

Northern California HCC Risk Scores Trends by HCC (Part C - 2014 Model)

As of May 21, 2016 extract

Select Region: Northern California

82 - Respirator Dependence/Tracheostomy Statu

Coefficient: 1.520

Measurement	CY 2014	CY 2015	YTD 2015-04	YTD 2016-04	YOY YTD Increase	% of YOY YTD Increase
Continous KP MA Member	442,242	467,350	490,046	513,401	23,355	4.8%
HCC Annual Revenue Weight	12,204	12,073	12,073	12,073	0	0.0%
Count	1,276	1,380	1,147	1,189	42	3.7%
Rates per 10K	28.9	29.5	23.4	23.2	0	-1.1%
Risk Score Contribution	0.004	0.004	0.004	0.004	0.000	-1.1%
Estimate Revenue Contribution (in 000's)	15,573	16,661	13,848	14,355	507	3.7%

NCAL Freq/count of HCC 82 = 1380, with $12,073 estimated $ value for yr; 1380 X12,073 annual value =$16,661,000.

HCC 82 includes Vent Dependence Status ICD-10-CM code

Notes | Rates and Weight | Data_Period | By HCC | Across_Region

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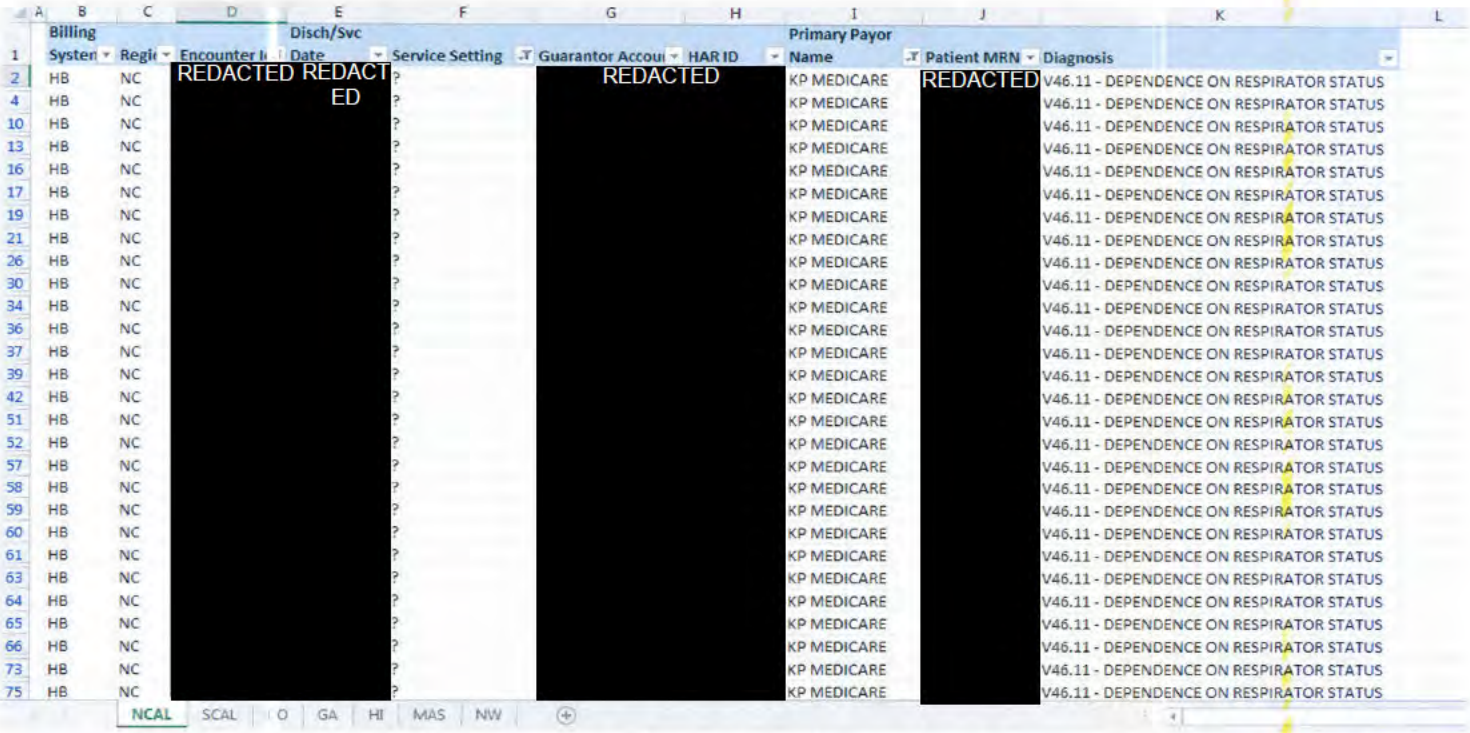

	Billing Syster	Regi	Encounter I	Disch/Svc Date	Service Setting	Guarantor Accou	HAR ID	Primary Payor Name	Patient MRN	Diagnosis
2	HB	NC	[redacted]			[redacted]		KP MEDICARE	[redacted]	V46.11 - DEPENDENCE ON RESPIRATOR STATUS
4	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
10	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
13	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
16	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
17	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
19	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
21	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
26	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
30	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
34	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
36	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
37	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
39	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
42	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
51	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
52	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
57	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
58	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
59	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
60	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
61	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
63	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
64	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
65	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
66	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
73	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS
75	HB	NC						KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS

NCAL | SCAL | O | GA | HI | MAS | NW

Data report on the Frequency of Vent Status Codes in all setting and in all regions (see tabs). Sorted by Payer: only KP Medicare (MA) or Sr Adv.; Billing System identifies Hosp based encounter (HB) or ProFee/Physician based encounter (PB). Encounter ID is the account # and Guarantor Acct is __ and HAR ID _____and Pat MRN is the Med Record #.

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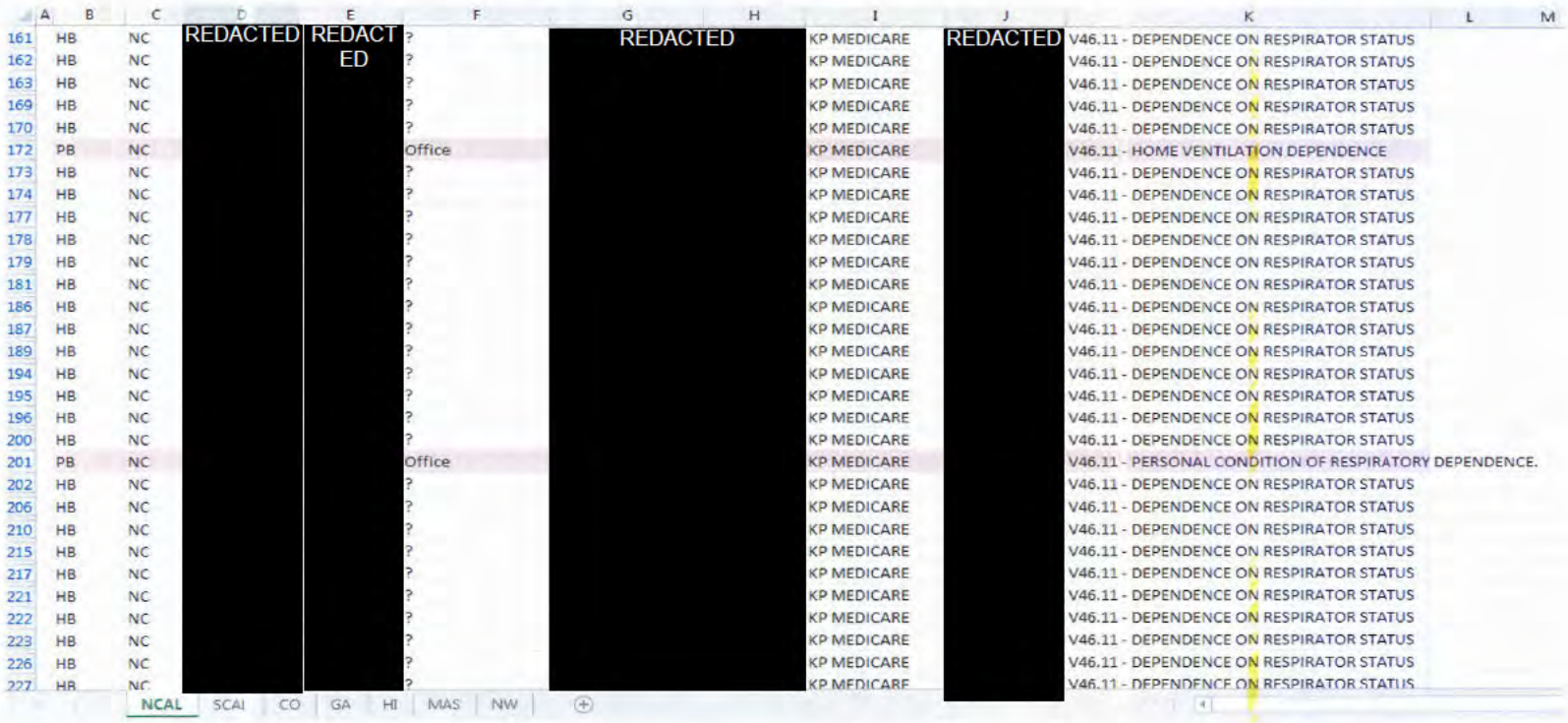

	A	B	C	D	E	F	G	H	I	J	K	L	M
161		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	REDACTED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
162		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
163		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
169		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
170		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
172		PB	NC			Office			KP MEDICARE		V46.11 - HOME VENTILATION DEPENDENCE		
173		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
174		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
177		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
178		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
179		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
181		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
186		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
187		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
189		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
194		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
195		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
196		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
200		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
201		PB	NC			Office			KP MEDICARE		V46.11 - PERSONAL CONDITION OF RESPIRATORY DEPENDENCE.		
202		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
206		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
210		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
215		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
217		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
221		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
222		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
223		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
226		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
227		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		

NCAL | SCAL | CO | GA | HI | MAS | NW

Identified PB and hi-lighted in light purple color. For NCAL only four PB encounters coding of Vent in year 2010 and only nine in 2011… but…

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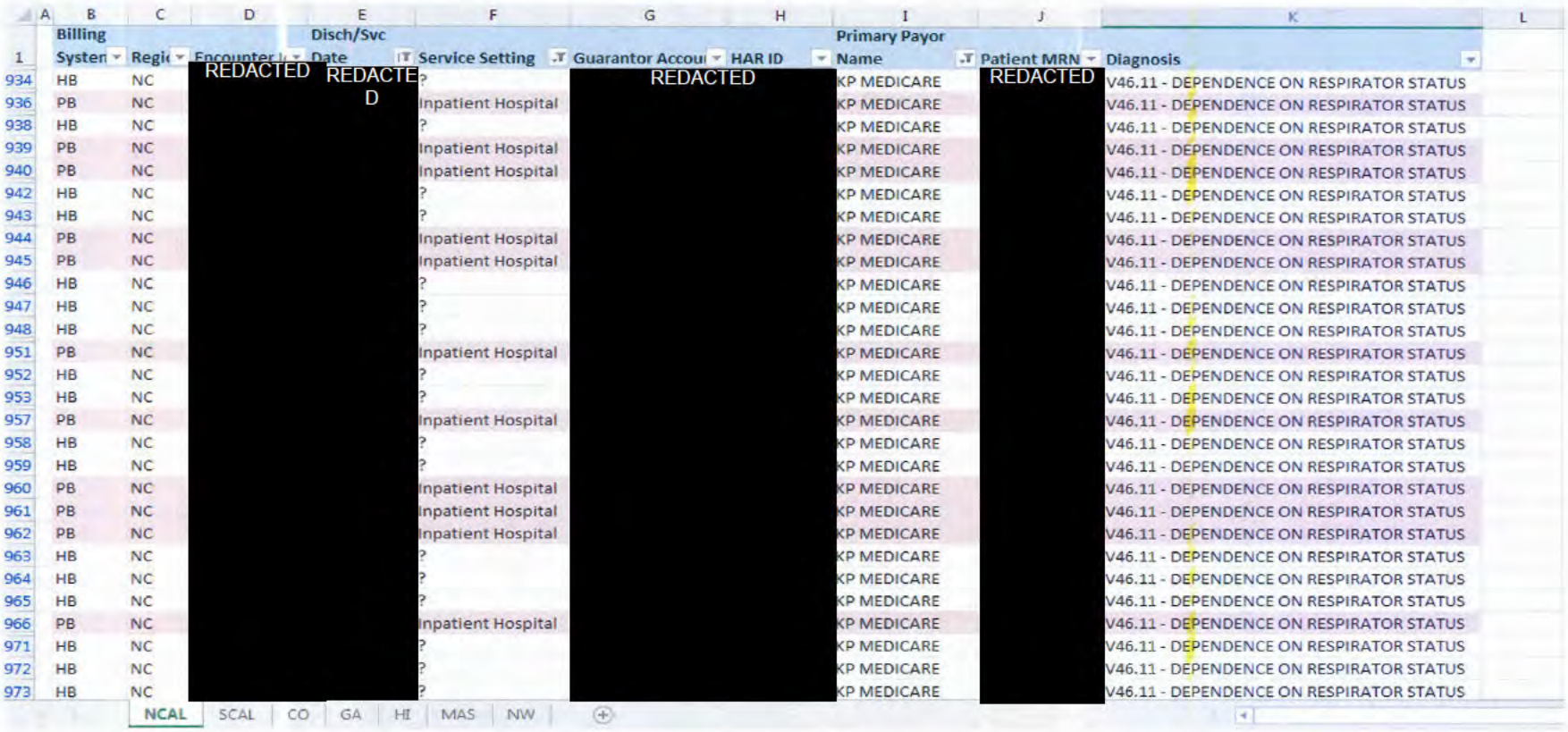

	A	B	C	D	E	F	G	H	I	J	K	L
1		Billing Systen	Regi	Encounter	Disch/Svc Date	Service Setting	Guarantor Accou	HAR ID	Primary Payor Name	Patient MRN	Diagnosis	
934		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	REDACTED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
936		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
938		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
939		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
940		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
942		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
943		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
944		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
945		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
946		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
947		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
948		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
951		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
952		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
953		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
957		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
958		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
959		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
960		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
961		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
962		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
963		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
964		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
965		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
966		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
971		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
972		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
973		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	

NCAL | SCAL | CO | GA | HI | MAS | NW

In 2012 the PB setting began to assign (pick the Dx) of vent dependence status more frequently. Some of the Dx were selected for a physician inpatient visit (bedside). The HB Dx is at the time of discharge.

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	A	B	C	D	E	F	G	H	I	J	K	L
1155		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	REDACTED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1156		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1158		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1159		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1160		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1161		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1162		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1163		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1166		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1167		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1168		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1169		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1172		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1173		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1176		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1177		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1179		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1185		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1186		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1188		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1189		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1191		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1192		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1197		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1198		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1199		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1202		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1203		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1206		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
1207		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	

NCAL | SCAL | CO | GA | HI | MAS | NW

Here you see the inpatient hospital encounter with PB coding of vent dependence status. But….

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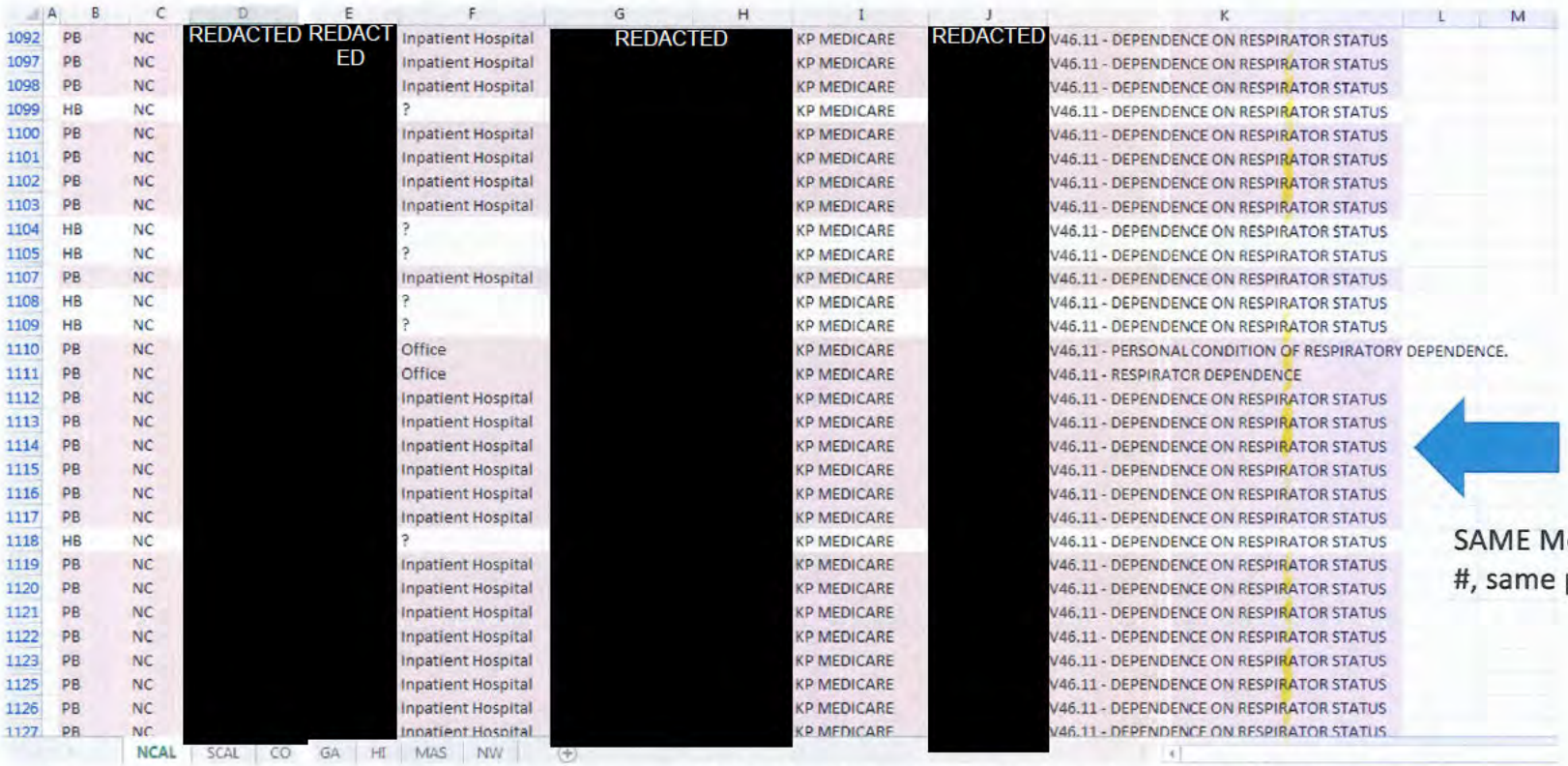

	A	B	C	D	E	F	G	H	I	J	K	L	M
1092		PB	NC	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	REDACTED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1097		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1098		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1099		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1100		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1101		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1102		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1103		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1104		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1105		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1107		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1108		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1109		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1110		PB	NC			Office			KP MEDICARE		V46.11 - PERSONAL CONDITION OF RESPIRATORY DEPENDENCE.		
1111		PB	NC			Office			KP MEDICARE		V46.11 - RESPIRATOR DEPENDENCE		
1112		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1113		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1114		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1115		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1116		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1117		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1118		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1119		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1120		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1121		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1122		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1123		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1125		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1126		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		
1127		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS		

NCAL | SCAL | CO | GA | HI | MAS | NW

SAME Med Rec #, same patient

Here you see in yellow the PB hospital encounters all with the Vent Dependence status code assigned BUT the HB has not assigned that code. 2012 Regions were discussing the capture of vent status code, esp NCAL and SCAL. HIM Coding provided guidance and directions but Med Groups and Regions continued to pressure and push to capture this code.

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	A	B	C	D	E	F	G	H	I	J	K	L
1		Billing Systen	Regi	Encounter I	Disch/Svc Date	Service Setting	Guarantor Accou	HAR ID	Primary Payor Name	Patient MRN	Diagnosis	
2100		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	REDACTED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2102		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2104		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2105		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2108		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2110		PB	NC			Office			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2111		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2113		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2115		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2118		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2119		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2120		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2122		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2125		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2128		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2131		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2132		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2138		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2139		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2140		PB	NC			Office			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2141		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2143		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2144		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2145		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2148		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2149		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2150		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2153		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	

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Here you see the Hospital assigning the Vent status code and also assigned by the PB side on the same day.

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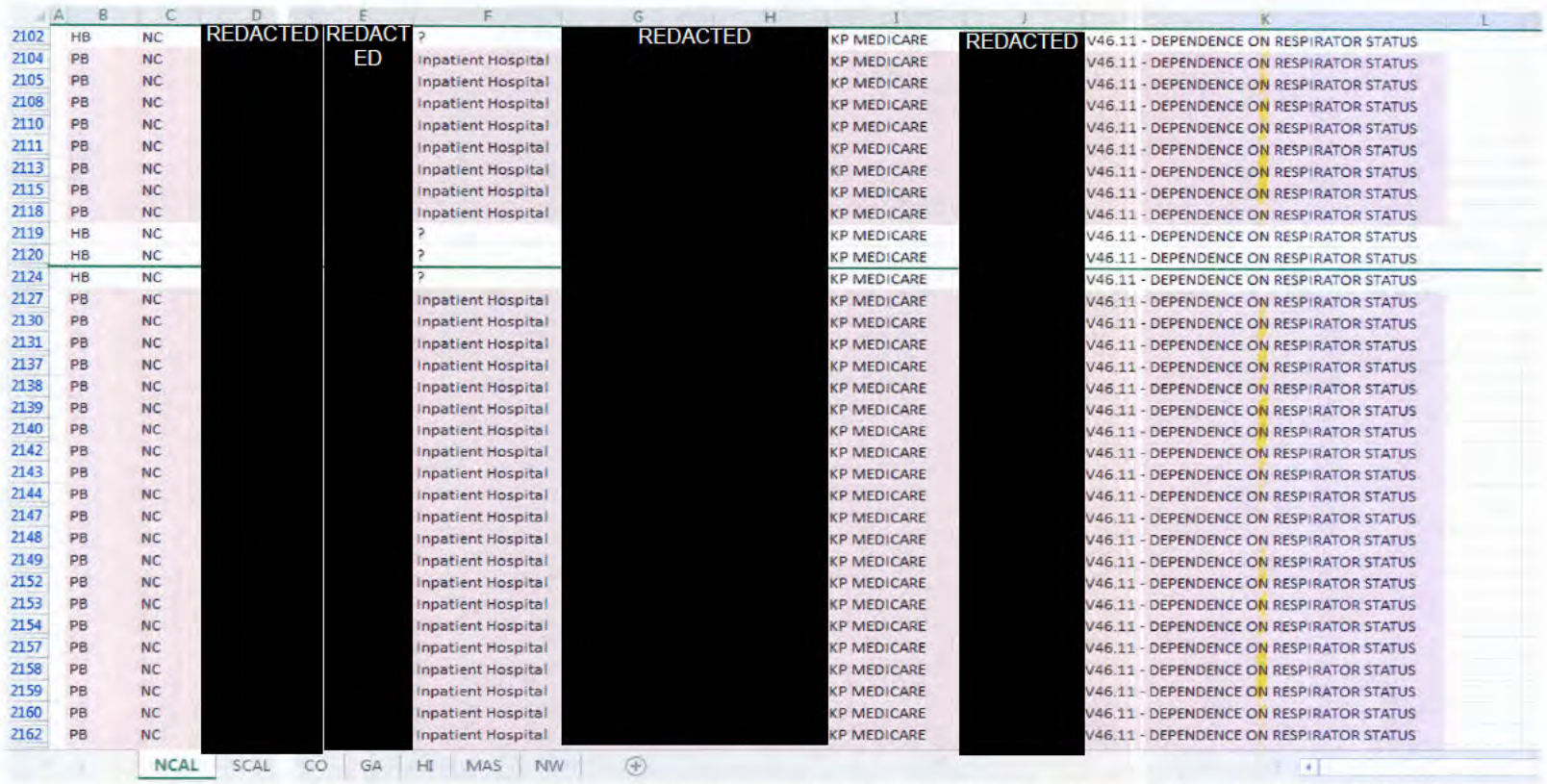

	A	B	C	D	E	F	G	H	I	J	K	L
2102		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	REDACTED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2104		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2105		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2108		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2110		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2111		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2113		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2115		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2118		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2119		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2120		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2124		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2127		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2130		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2131		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2137		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2138		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2139		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2140		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2142		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2143		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2144		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2147		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2148		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2149		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2152		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2153		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2154		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2157		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2158		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2159		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2160		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2162		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	

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Notice the PB encounters in a series for the same patient, same hospitalization, several days in a row. What is notworthy is there isn't a HB code assignment for the patient (MRN) – which leads you to believe that the patient did NOT leave the hospital on a vent. Which would result in the Vent dependence status code being assigned.

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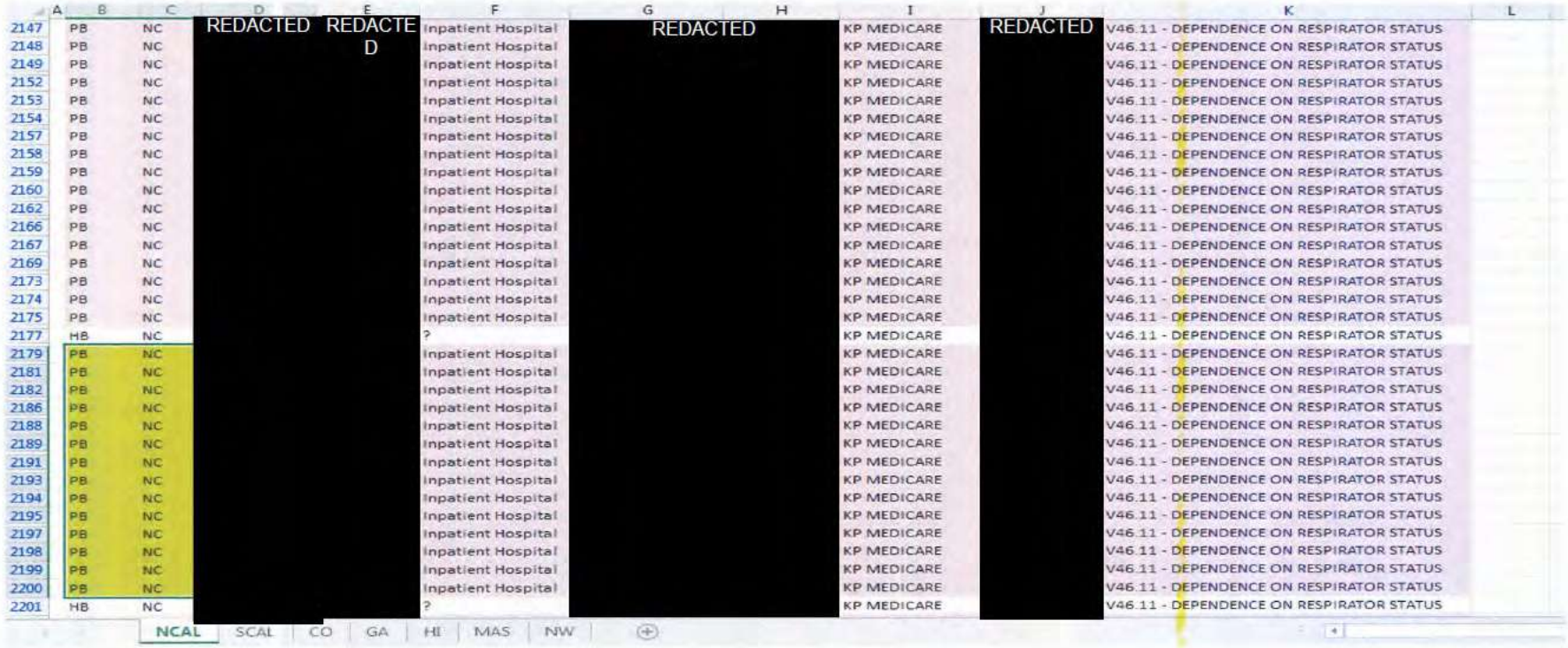

	A	B	C	D	E	F	G	H	I	J	K	L
2147		PB	NC	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	REDACTED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2148		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2149		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2152		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2153		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2154		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2157		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2158		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2159		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2160		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2162		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2166		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2167		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2169		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2173		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2174		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2175		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2177		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2179		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2181		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2182		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2186		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2188		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2189		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2191		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2193		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2194		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2195		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2197		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2198		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2199		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2200		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2201		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	

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Two patients in the hospital and there is NO HB coding of Vent Dependance status, only PB.

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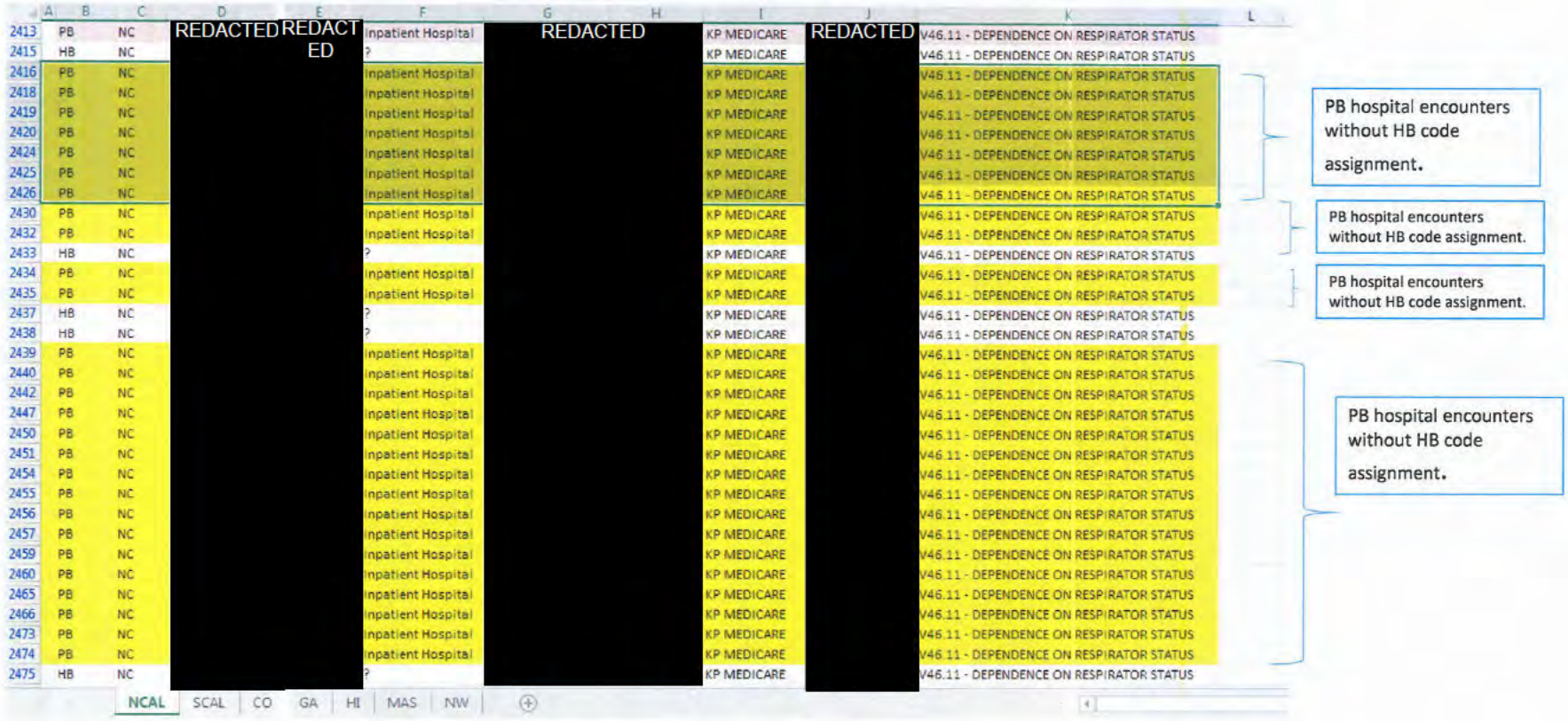

	A	B	C	D	E	F	G	H	I	J	K	L
2413		PB	NC	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	REDACTED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2415		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2416		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2418		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2419		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2420		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2424		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2425		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2426		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2430		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2432		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2433		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2434		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2435		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2437		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2438		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2439		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2440		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2442		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2447		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2450		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2451		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2454		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2455		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2456		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2457		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2459		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2460		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2465		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2466		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2473		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2474		PB	NC			Inpatient Hospital			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	
2475		HB	NC			?			KP MEDICARE		V46.11 - DEPENDENCE ON RESPIRATOR STATUS	

NCAL | SCAL | CO | GA | HI | MAS | NW

PB hospital encounters without HB code assignment.

PB hospital encounters without HB code assignment.

PB hospital encounters without HB code assignment.

PB hospital encounters without HB code assignment.

These appear to be Physician assigned codes (Epic Dx Pick List), no HB code assignment from coding staff. Most likely Dx code selection and HCC errors.

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	Billing Systen	Regi	Encounter I	Disch/Svc Da	Service Setti	Guarantor Account	HAR ID	Primary Payor Nan	Diagnosis	Disch_ Disp	Disch_Disp_Name	Length_ of_Sta
2	HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	5
3	HB	NC			?			KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	24
4	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
5	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	3
6	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6
7	HB	NC			?			MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
8	HB	NC			?			KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	10
9	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
10	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organize	28
11	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facili	52
12	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organize	15
13	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) wi	50
14	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4
15	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organize	66
16	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) wi	26
17	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) wi	26
18	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
19	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) wi	109
20	HB	NC			Skilled Nursing			MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	591
21	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under	67
22	HB	NC			?			MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6
23	HB	NC			?			MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital fo	83
24	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) wi	35
25	HB	NC			?			KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	708
26	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6
27	HB	NC			?			MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	62
28	HB	NC			?			LIBERTY MUTUAL INSU	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) wi	10
29	HB	NC			?			LIBERTY MUTUAL INSU	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) wi	10

NCAL SCAL HI NW

This NCAL Hospital encounters (4 Hospital Regions) ONLY report sort shows the Length of Stay (LOS) and Discharge Disposition (where the patient was sent after discharge from the acute care hospital). Those going to Home after discharge are suspect. Those with LOS below 6 days are also suspect. Per MD Pulm expert(Dr Wm Haik), even going to Home Health with vent would be unusual. Continued to next slide…

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	A	B	C	D	E	F	G	H	I	J	K	L	M
1		Billing Systen	Regi	Encounter I	Disch/Svc Da	Service Setti	Guarantor Account	HAR ID	Primary Payor Nan	Diagnosis	Disch_ Disp	Disch_Disp_Name	Length_ of_Sta
2		HB	NC	REDACTED	REDAC TED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
4		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
10		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facili	1
13		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
16		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
17		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital fo	1
19		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
21		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
26		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
30		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
34		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
36		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
37		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
39		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	1
42		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
51		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
52		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
57		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
58		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
59		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
60		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
61		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
63		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
64		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
65		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
66		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
69		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
73		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1

NCAL SCAL HI N...

NCAL sorted payer of KP Medicare or Medicare Adv; Sorted by MRN is smallest to largest number; sorted by LOS (days with smallest days to largest /longest).

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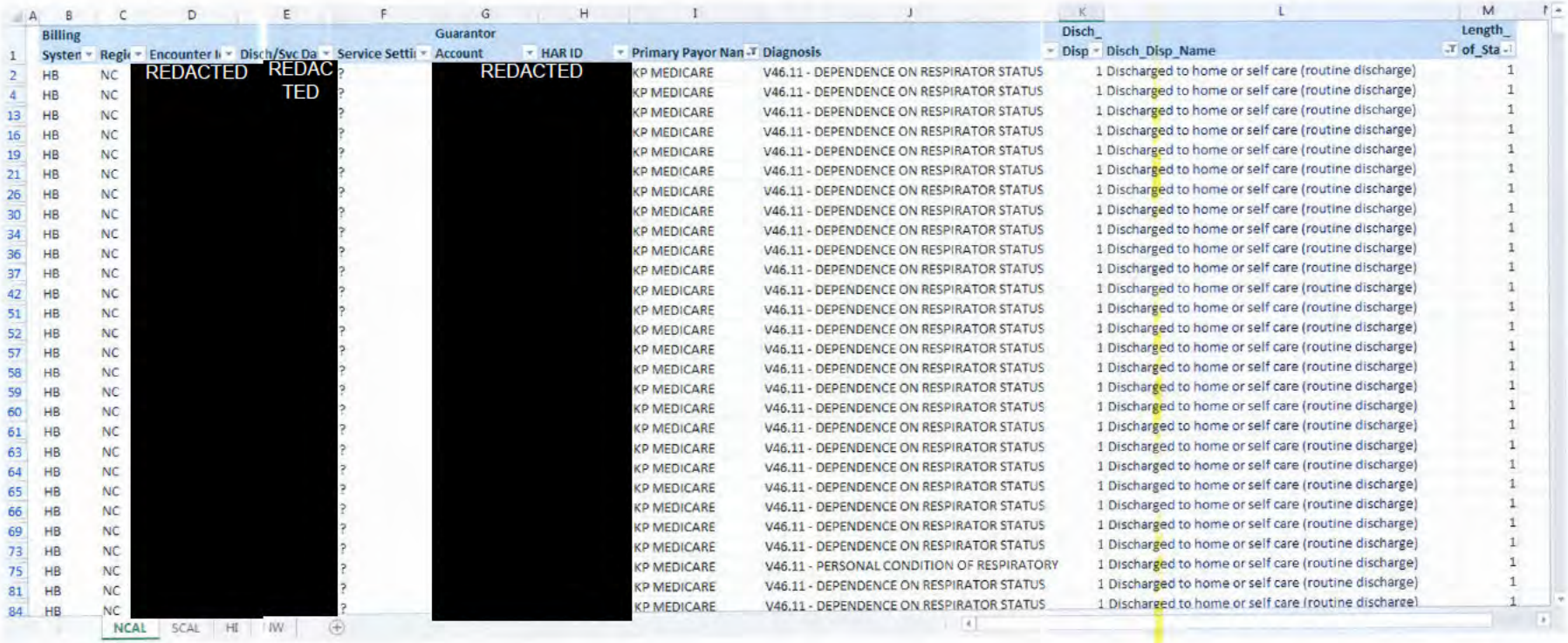

	Billing Systen	Regi	Encounter I	Disch/Svc Da	Service Setti	Guarantor Account	HAR ID	Primary Payor Nan	Diagnosis	Disch_ Disp	Disch_Disp_Name	Length_ of_Sta
2	HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
4	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
13	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
16	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
19	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
21	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
26	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
30	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
34	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
36	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
37	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
42	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
51	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
52	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
57	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
58	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
59	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
60	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
61	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
63	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
64	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
65	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
66	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
69	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
73	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
75	HB	NC			?			KP MEDICARE	V46.11 - PERSONAL CONDITION OF RESPIRATORY	1	Discharged to home or self care (routine discharge)	1
81	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
84	HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1

NCAL SCAL HI IW

Additional "Sort" on Disch Disposition to Home (1) and to Home Health (6) and "Sort" of the Disch/Date, starting with 2010 going down to 2016..

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	A	B	C	D	E	F	G	H	I	J	K	L	M
1		Billing Systen	Regi	Encounter I	Disch/Svc Da	Service Setti	Guarantor Account	HAR ID	Primary Payor Nan	Diagnosis	Disch_ Disp	Disch_Disp_Name	Length_ of_Sta
2		HB	NC	REDACTED	REDAC TED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
4		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
13		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
16		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
20		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
25		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
29		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
33		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
35		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
36		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
41		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
50		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
51		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
56		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
57		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
58		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
59		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
61		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
62		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
63		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
64		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
67		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
72		HB	NC			?			KP MEDICARE	V46.11 - PERSONAL CONDITION OF RESPIRATORY	1	Discharged to home or self care (routine discharge)	1
78		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
81		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
82		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
85		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1

NCAL SCAL HI NW

2010 NCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 7

2011 NCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 12

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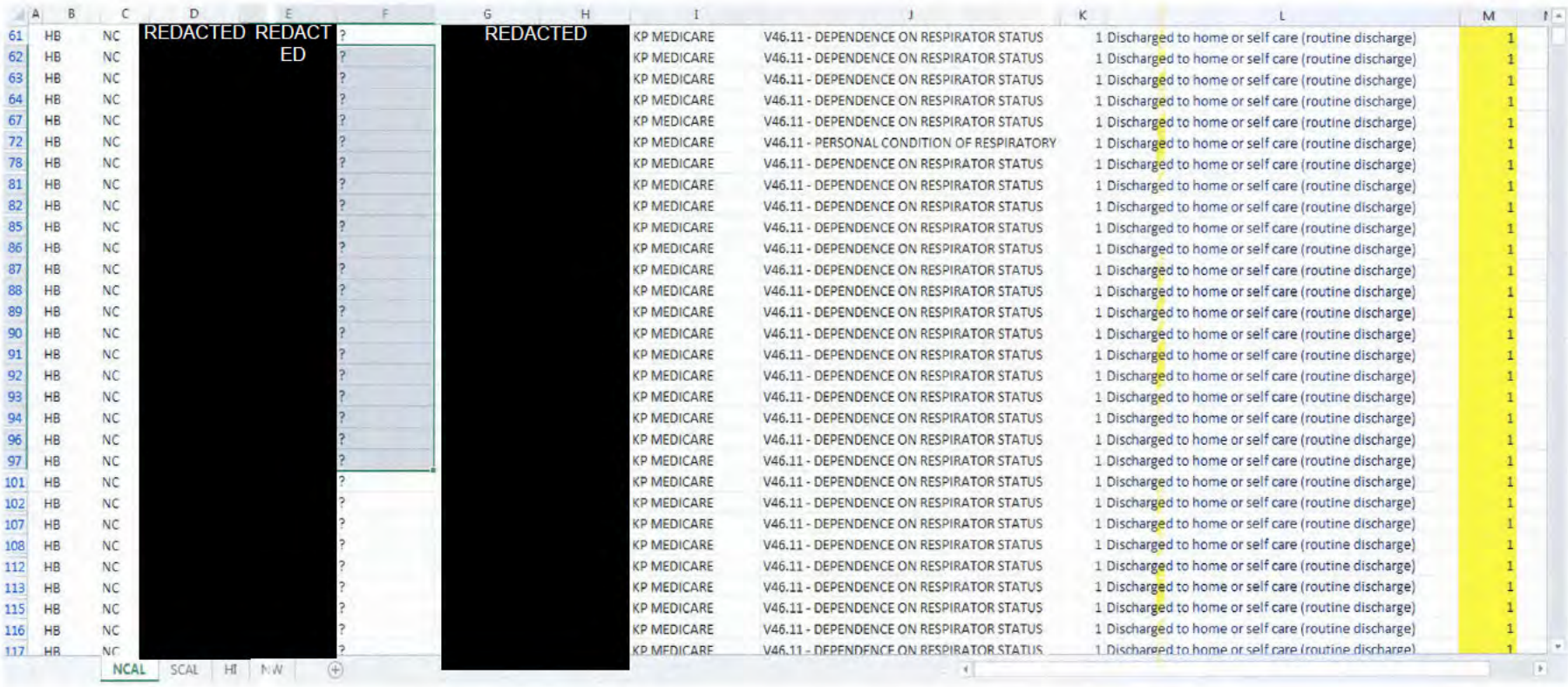

	A	B	C	D	E	F	G	H	I	J	K	L	M
61		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
62		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
63		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
64		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
67		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
72		HB	NC			?			KP MEDICARE	V46.11 - PERSONAL CONDITION OF RESPIRATORY		1 Discharged to home or self care (routine discharge)	1
78		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
81		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
82		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
85		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
86		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
87		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
88		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
89		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
90		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
91		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
92		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
93		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
94		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
96		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
97		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
101		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
102		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
107		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
108		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
112		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
113		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
115		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
116		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
117		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1

NCAL SCAL HI NW

2012 NCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 20

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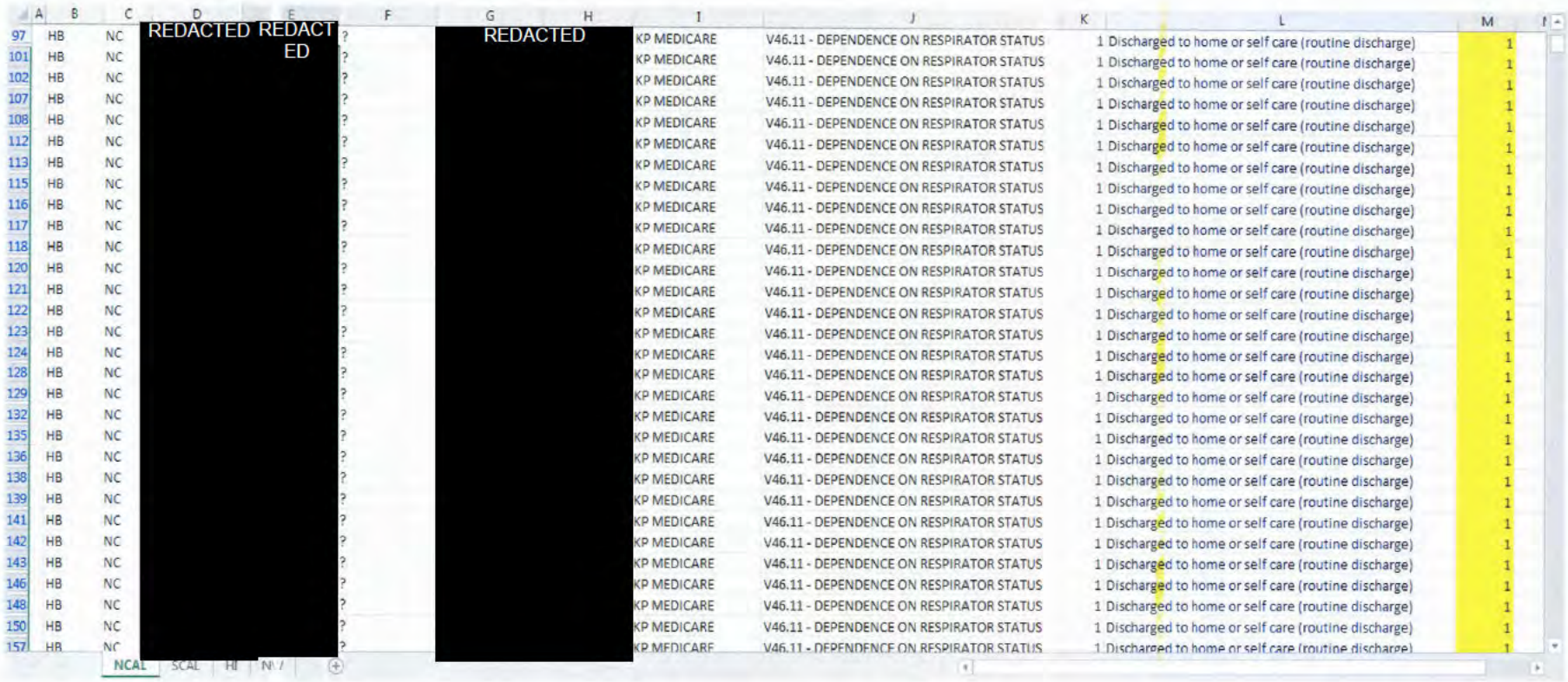

	A	B	C	D	E	F	G	H	I	J	K	L	M
97		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
101		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
102		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
107		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
108		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
112		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
113		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
115		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
116		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
117		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
118		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
120		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
121		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
122		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
123		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
124		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
128		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
129		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
132		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
135		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
136		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
138		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
139		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
141		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
142		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
143		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
146		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
148		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
150		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
157		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1

NCAL SCAL HI NV

2013 NCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 38

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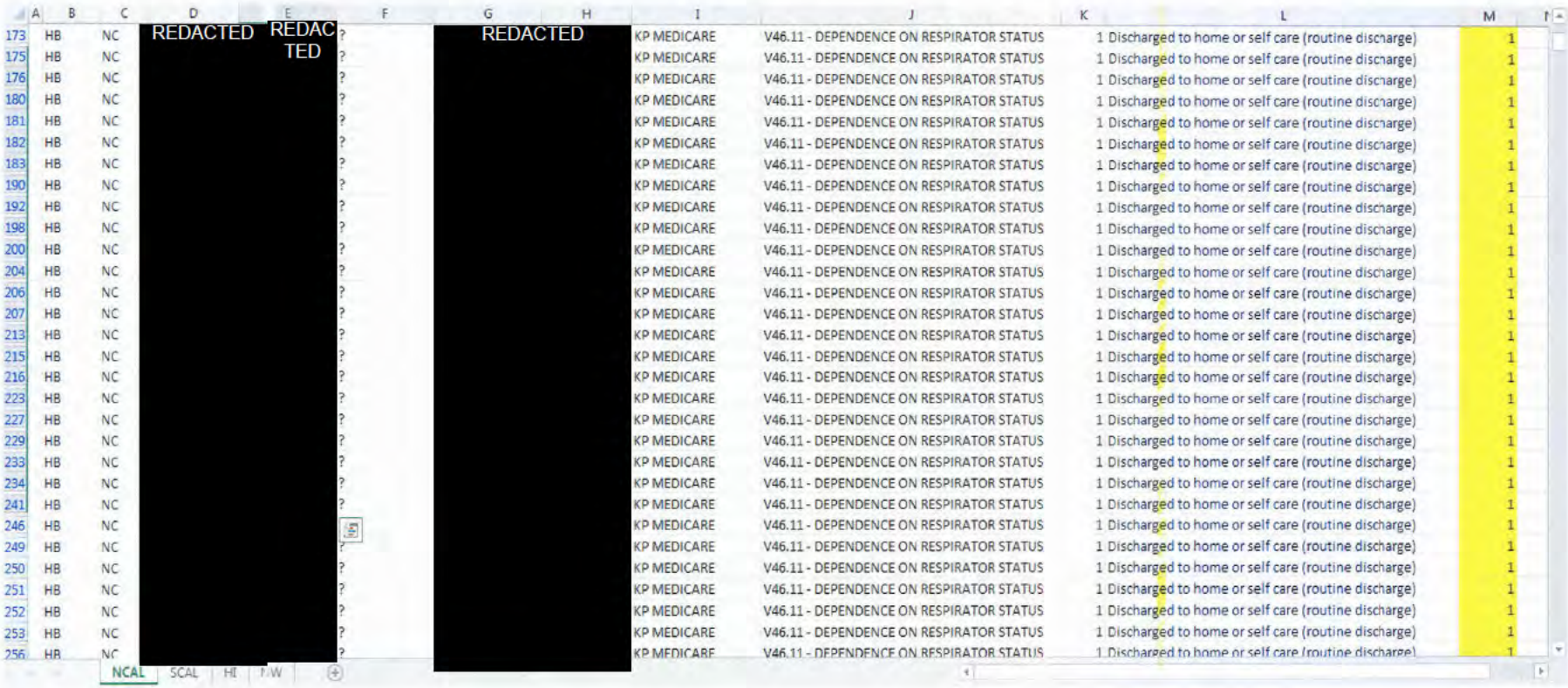

	A	B	C	D	E	F	G	H	I	J	K	L	M
173		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
175		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
176		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
180		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
181		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
182		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
183		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
190		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
192		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
198		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
200		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
204		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
206		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
207		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
213		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
215		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
216		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
223		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
227		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
229		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
233		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
234		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
241		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
246		HB	NC						KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
249		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
250		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
251		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
252		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
253		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
256		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1

NCAL | SCAL | HI | P.W

2014 NCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 22

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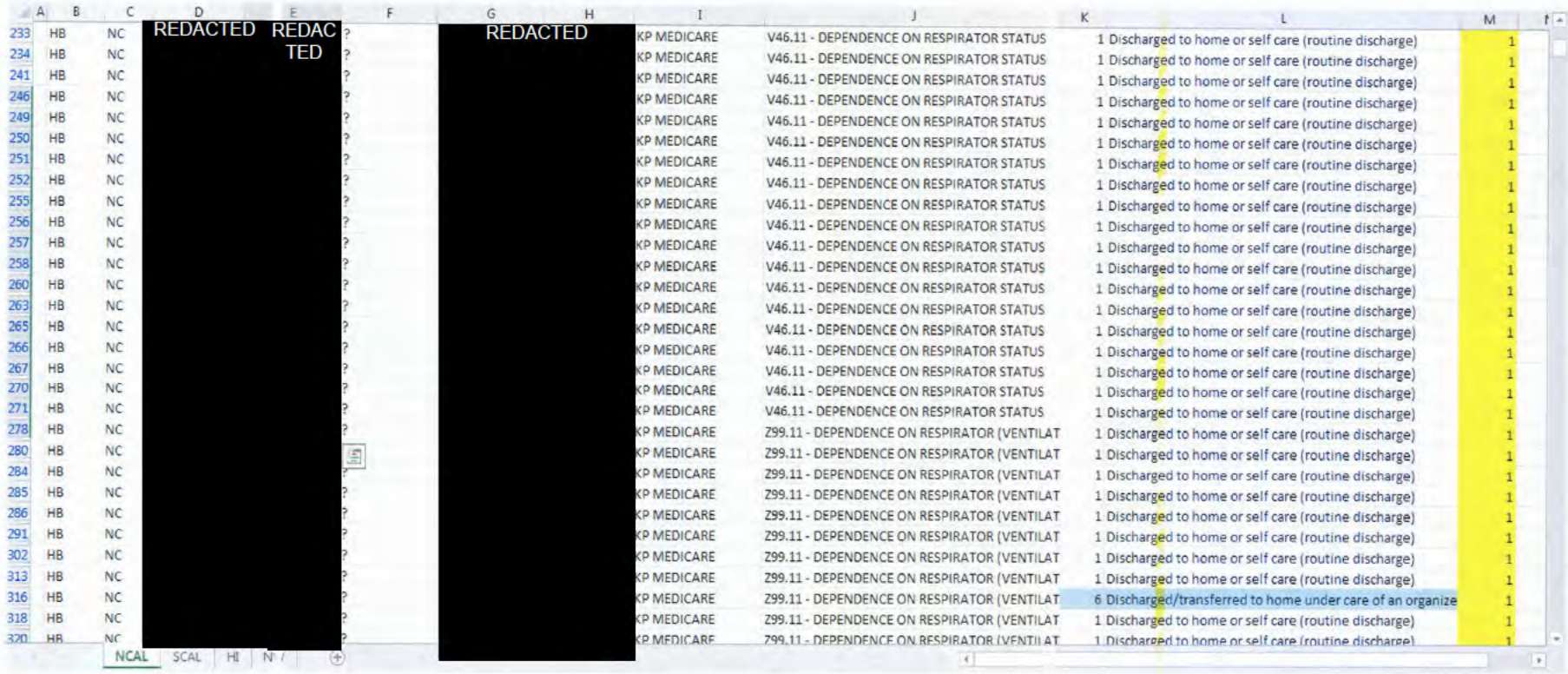

	A	B	C	D	E	F	G	H	I	J	K	L	M
233		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
234		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
241		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
246		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
249		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
250		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
251		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
252		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
255		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
256		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
257		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
258		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
260		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
263		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
265		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
266		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
267		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
270		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
271		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
278		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
280		HB	NC						KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
284		HB	NC						KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
285		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
286		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
291		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
302		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
313		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
316		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	6	Discharged/transferred to home under care of an organize	1
318		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1
320		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT	1	Discharged to home or self care (routine discharge)	1

NCAL SCAL HI

2015 NCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 17

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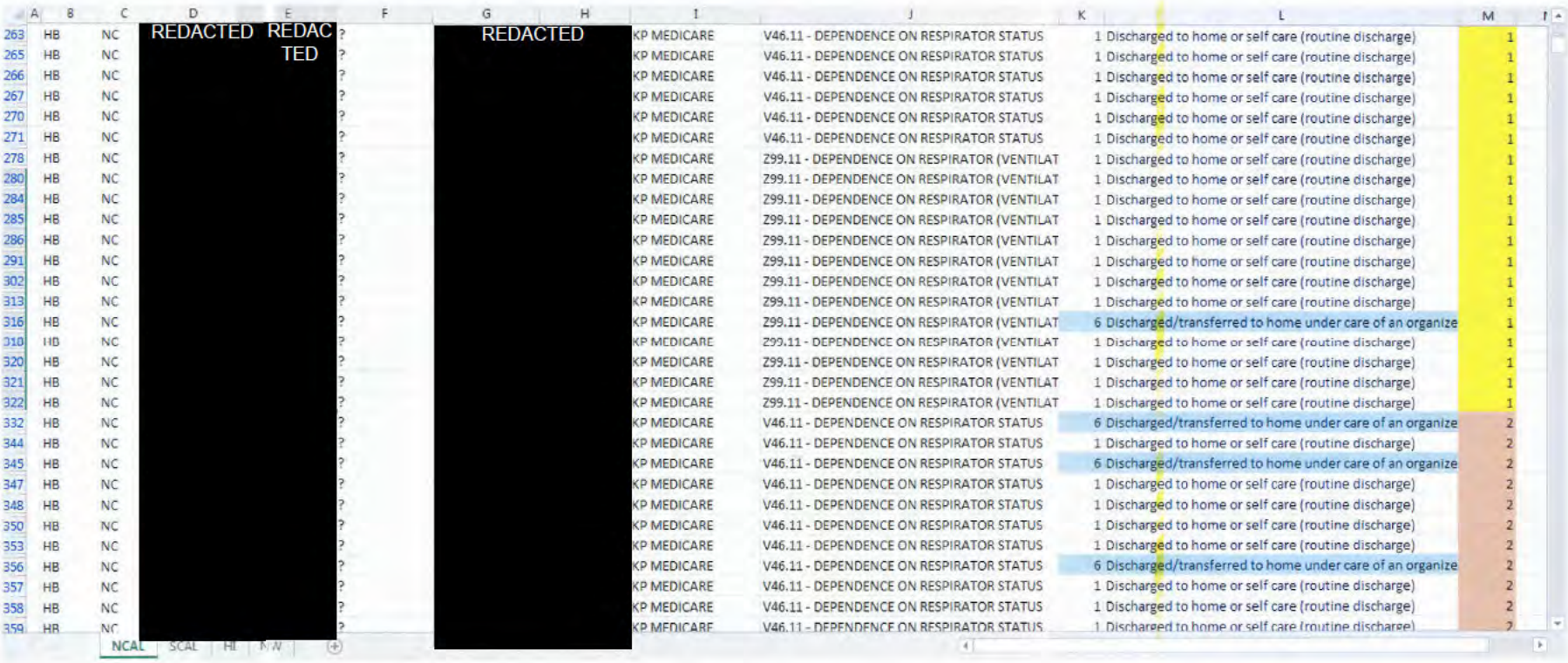

	A	B	C	D	E	F	G	H	I	J	K	L	M
263		HB	NC	REDACTED	REDACTED	?	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
265		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
266		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
267		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
270		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
271		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1
278		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
280		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
284		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
285		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
286		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
291		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
302		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
313		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
316		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		6 Discharged/transferred to home under care of an organize	1
318		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
320		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
321		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
322		HB	NC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1
332		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		6 Discharged/transferred to home under care of an organize	2
344		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	2
345		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		6 Discharged/transferred to home under care of an organize	2
347		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	2
348		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	2
350		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	2
353		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	2
356		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		6 Discharged/transferred to home under care of an organize	2
357		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	2
358		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	2
359		HB	NC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	2

NCAL SCAL HI NW

2016 NCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 12

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Southern California HCC Risk Scores Trends by HCC (Part C - 2014 Model)

As of May 21, 2016 extract

Select Region: Southern California

82 - Respirator Dependence/Tracheostomy Statu

Coefficient: 1.520

Measurement	CY 2014	CY 2015	YTD 2015-04	YTD 2016-04	YOY YTD Increase	% of YOY YTD Increase
Continous KP MA Member	436,576	468,084	488,246	514,104	25,858	5.3%
HCC Annual Revenue Weight	10.847	11.244	11.244	11.244	0	0.0%
Count	1,062	1,171	1,031	1,133	102	9.9%
Rates per 10K	24.3	25.0	21.1	22.0	1	4.4%
Risk Score Contribution	0.004	0.004	0.003	0.003	0.000	4.4%
Estimate Revenue Contribution (in 000's)	11,519	13,167	11,593	12,740	1,147	9.9%

Notes | Rates and Weight | Data Period | By HCC | Across Region

NCAL Freq/count of HCC 82 = 1171, with $11244 estimated $ value for yr; 1171 X 11,244 annual value =$13,167,000.

HCC 82 includes Vent Dependence Status ICD-10-CM code

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1		Billing System	Region	Encounter I	Disch/Svc Date	Service Setting	Guarantor Account	HAR ID	Primary Payor Name	Diagnosis	Disch_ Disp	Disch_Disp_Name	Length_ of_Sta	
2		HB	SC	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
5		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
6		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
7		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
10		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
11		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
13		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
14		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
16		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
19		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
21		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
22		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
23		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
24		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
25		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
26		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
27		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
28		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
29		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
31		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
32		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
38		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
42		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
43		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
44		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
48		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
50		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
51		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	

NCAL SCAL HI TW

2010 SCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 5

2011 SCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 8

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N
1		Billing System	Regio n	Encounter I	Disch/Svc Date	Service Setting	Guarantor Account	HAR ID	Primary Payor Name	Diagnosis	Disch_ Disp	Disch_Disp_Name	Length_ of_Sta	
2		HB	SC	REDACTED	REDAC TED	Inpatient Hospital	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
5		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
6		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
9		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
10		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
12		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
14		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
17		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
19		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
20		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
21		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
22		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
23		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
24		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
25		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
27		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
33		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
37		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
38		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
42		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
44		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
45		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
46		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
47		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
48		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
49		HB	SC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
50		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
51		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	

NCAL SCAL HI NV

2012 SCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 7

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N
25		HB	SC	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
27		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
33		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
37		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
38		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
42		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
44		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
45		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
46		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
47		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
48		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
49		HB	SC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
50		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
51		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
52		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
53		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
54		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
59		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
60		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
61		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
62		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
67		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
69		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
70		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
73		HB	SC			Office			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
75		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
76		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
77		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
79		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
80		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	

NCAL | SCAL | HI | NW

2013 SCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 7

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N
45		HB	SC	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
46		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
47		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
48		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
49		HB	SC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
50		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
51		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
52		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
53		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
54		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
59		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
60		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
61		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
67		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
68		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
71		HB	SC			Office			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
73		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
74		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
75		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
77		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
82		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an org	1	
88		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
89		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
90		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an org	1	
91		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
93		HB	SC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
94		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
97		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
100		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	
101		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1	

NCAL SCAL HI NV

2014 SCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 16

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N
90		HB	SC	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		6 Discharged/transferred to home under care of an org	1	
91		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
93		HB	SC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
94		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
97		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
100		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
103		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
105		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
106		HB	SC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
107		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
108		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
109		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
110		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
113		HB	SC			Office			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
114		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
119		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
121		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
122		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
123		HB	SC			Office			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
125		HB	SC			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
126		HB	SC			?			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS		1 Discharged to home or self care (routine discharge)	1	
127		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
129		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
130		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
134		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
135		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
137		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
138		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
141		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
142		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	

NCAL SCAL HI NW

2015 SCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 29

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	A	B	C	D	E	F	G	H	I	J	K	L	M	N
142		HB	SC	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
143		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
144		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
147		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
151		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
153		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
154		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
155		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
161		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
164		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
170		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
172		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
173		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
176		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
177		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
178		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
179		HB	SC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
181		HB	SC			Office			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
182		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
185		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
186		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
187		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
188		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
189		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
192		HB	SC			?			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
193		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
194		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
197		HB	SC			Office			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
198		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	
202		HB	SC			Inpatient Hospital			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILAT		1 Discharged to home or self care (routine discharge)	1	

NCAL SCAL N 7

2016 SCAL Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 45

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	Billing System	Regi	Encounter	Disch/Svc Da	Service Setting	Guarantor Account	HAR ID	Primary Payor Name	Diagnosis	Disch_ Disp	Disch_Disp_Name	Length_of _Stay
14	HB	HI	REDACTED	REDACTED	Inpatient Hospital	REDACTED		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	63
19	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
38	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi:	31
41	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	7
45	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	15
49	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi:	17
61	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi:	15
71	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	83
72	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
91	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi:	78
99	HB	HI			Inpatient Hospital			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4

NCAL SCAL HI NW

2010-2016 HI Region Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 1

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	Billing System	Regi	Encounter I	Disch/Svc Da	Service Setting	Guarantor Accou	HAR ID	Primary Payor Name	Diagnosis	Disch _Dis	Disch_Disp_Name	Length_of _Stay
5	HB	NW	REDACTED	REDAC TED	Inpatient Hospital	REDACTED		SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
6	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
7	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
8	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
9	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
11	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
12	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	1	Discharged to home or self care (routine discharge)	1
13	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	1	Discharged to home or self care (routine discharge)	1
16	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
22	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
25	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
26	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
27	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
28	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
29	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	1	Discharged to home or self care (routine discharge)	2
30	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	1	Discharged to home or self care (routine discharge)	2
31	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	3
32	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	1	Discharged to home or self care (routine discharge)	3
34	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	1	Discharged to home or self care (routine discharge)	3
35	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi	4
39	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi	4
45	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi	4
46	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi	4
51	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organi	4
52	HB	NW			Inpatient Hospital			SR ADVNTG	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4
63	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	6	Discharged/transferred to home under care of an organi	4
64	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	1	Discharged to home or self care (routine discharge)	4
69	HB	NW			Inpatient Hospital			SR ADVNTG	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILA	1	Discharged to home or self care (routine discharge)	4

NCAL SCAL HI NW

2010-2016 HI Region Vent LOS = 1 day and Disch Disp = Home or HH; Total encounters/cases = 8

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EXHIBIT 26

Billing System	Region	Encounter Id	Disch/Svc Date	Service Setting	Guarantor Account	HAR ID	Primary Payor Name	Diagnosis	Disch_ Disp	Disch_Disp_Name	Length_of_ Stay
HB	NC	REDACTED	REDACTED	?	REDACTED		?	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC			?			?	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC			?			AETNA-COMMERCIAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	3
HB	NC			?			ATHENS ADMINISTRATORS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
HB	NC			?			BLUE CROSS MEDI-CAL	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	4
HB	NC			?			BLUE CROSS MEDI-CAL	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	4
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	5
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	5
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	5
HB	NC			?			BLUE CROSS MEDI-CAL	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	8
HB	NC			?			BLUE CROSS MEDI-CAL	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	8
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	19
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	32
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	33
HB	NC			?			BLUE CROSS MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	39
HB	NC			?			BLUE CROSS OF CA	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?			BLUE CROSS OF CA	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?			BLUE CROSS OF CA	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	11
HB	NC			?			BLUE CROSS OF CA	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	11
HB	NC			?			BLUE CROSS OF CA	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	13
HB	NC			?			BLUE CROSS OF CA	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	33
HB	NC			?			BLUE CROSS SENIOR	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	21
HB	NC			?			BLUE CROSS SENIOR	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	21
HB	NC			?			BLUE SHIELD OF CA	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	11
HB	NC			?			CALVIVA - MEDICAID	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	33
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC			?			CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	2
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC			?			CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	2
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	3
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	3
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	3
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	3
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	3
HB	NC			?			CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	3
HB	NC			?			CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	3
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4
HB	NC			?			CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4

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HB	NC	REDACTED	REDACTED	REDACTED	CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	4
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	6
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	6
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	7
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	7
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	7
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	8
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home he	8
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	8
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	8
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	9
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	11
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	13
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	19
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	19
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	19
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	19
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	20
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	20
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	32
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	37
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	37
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	40
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	40
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	70 Discharge/transfer to another type of health care institution not def	40
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	70 Discharge/transfer to another type of health care institution not def	40
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	45
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	50
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	60
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	60
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	65
HB	NC				CCS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	70
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	92
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	119
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	130
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	132
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	143
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	5 Discharged/Transferred to a Designated Cancer Center or Children~s	144
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	5 Discharged/Transferred to a Designated Cancer Center or Children~s	144
HB	NC				CCS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	213
HB	NC				CENTRAL CA ALLIANCE FOR	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	16
HB	NC				CITY & CNTY OF S.F.W/C	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	544
HB	NC				COMMERCIAL-GENERIC	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	9
HB	NC				COMMERCIAL-GENERIC	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home he	28
HB	NC				COMMERCIAL-GENERIC	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home he	28
HB	NC				COMMERCIAL-GENERIC	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	38
HB	NC				CONTRA COSTA HLTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				CONTRA COSTA HLTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8

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HB	NC	[redacted]	[redacted]	?	[redacted]	CONTRA COSTA HLTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		CONTRA COSTA HLTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	12
HB	NC			?		CONTRA COSTA HLTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	12
HB	NC			?		CONTRA COSTA HLTH PLAN	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	22
HB	NC			?		CONTRA COSTA HLTH PLAN	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	22
HB	NC			?		CONTRA COSTA HLTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified LongTerm Care Hosp	25
HB	NC			?		CONTRA COSTA HLTH PLAN	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	69
HB	NC			?		CONTRA COSTA HLTH PLAN	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	69
HB	NC			?		DEPT OF VETERANS AFFAIRS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	58
HB	NC			?		FARMERS INSURANCE GROU	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	29
HB	NC			?		FARMERS INSURANCE GROU	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	29
HB	NC			?		HEALTH NET COMMERCIAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	3
HB	NC			?		HEALTH NET COMMERCIAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	25
HB	NC			?		HEALTH NET MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?		HEALTH NET MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	49
HB	NC			?		HEALTH NET MEDI-CAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	54
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	35
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	35
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	46
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	13
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	29
HB	NC			?		HEALTH PLAN OF SAN MATE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	29
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1

HB	NC	REDACTED	?	REDACTED	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		Office		KFHP 1000	V46.11 - HOME VENTILATION DEPENDENCE	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1

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HB	NC	REDACTED	REDACTED	?	REDACTED	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1

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HB	NC	REDACTED	REDACTED	?	REDACTED	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?

HB	NC	[redacted]	[redacted]	?	[redacted]	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)
HB	NC			?

HB	NC	REDACTED	REDACTED	?	REDACTED	KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp 1
HB	NC			?		KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi 2
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient 2

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HB	NC	REDACTED	REDACTED	REDACTED	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home he	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	65 Discharged/transferred to a psychiatric hospital or psychiatric distinc	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	3
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home he	3
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3

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HB	NC	REDACTED	REDACTED	REDACTED	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	4
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	4
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	66 Discharged/transferred to a Critical Access Hospital (CAH)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	66 Discharged/transferred to a Critical Access Hospital (CAH)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	5
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	5
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	6
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	6

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HB	NC	[redacted]	[redacted]	?	[redacted]	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under Medicaid	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	6
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	7
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	7
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	7
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	7
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under Medicaid	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	8
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	8
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	50	Hospice - home	8
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	50	Hospice - home	8
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9

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HB	NC	REDACTED	REDACTED	?	REDACTED	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4	Discharged/transferred to a Facility that Provides Custodial or Suppc	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	10
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	10
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	10
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	11
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	12
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	12
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	12
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12

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HB	NC	REDACTED	REDACTED	?	REDACTED	KHHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	12
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	12
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	12
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	13
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	13
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	13
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	50	Hospice - home	14
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	50	Hospice - home	14
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	14
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	15
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	15
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50	Hospice - home	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not defi	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	16
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	17
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	17
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50	Hospice - home	17
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	17
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	17
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	17
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	18

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HB	NC	[redacted]	[redacted]	?	[redacted]	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	18
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	18
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	18
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	19
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	19
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51	Hospice - medical facility (Certified) Providing Hospice Level of Care	19
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	20
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not def	20
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	20
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	20
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50	Hospice - home	20
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	20
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	21
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	21
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	21
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4	Discharged/transferred to a Facility that Provides Custodial or Suppo	21
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	22
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	22
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	22
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	22
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	23
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	23
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not def	24
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not def	24
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	25
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	25
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	25
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	25

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HB	NC	[redacted]	[redacted]	[redacted]	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	26
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	7	Left against medical advice or discontinued care	26
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	26
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	28
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	28
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	29
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	29
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	29
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home he	29
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	30
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home he	30
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	30
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	30
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	31
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	31
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4	Discharged/transferred to a Facility that Provides Custodial or Suppo	31
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	31
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	32
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	32
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	32
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	33
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	33
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	34
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	34
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	34
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	34
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4	Discharged/transferred to a Facility that Provides Custodial or Suppo	34
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	35
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	35
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	35
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	35
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	36
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	36
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	36
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	37
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	37
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	37
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	37
HB	NC				KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	37
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	38
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	38
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	38
HB	NC				KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	38
HB	NC		Skilled Nursing Fa		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	39

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HB	NC	[redacted]	?	[redacted]	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	39
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	39
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	39
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	39
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	39
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	40
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	40
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	41
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	41
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	41
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	41
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	42
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	43
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	43
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	44
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	44
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	44
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	45
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	46
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	47
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	49
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	49
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	49
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4	Discharged/transferred to a Facility that Provides Custodial or Suppo	49
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	50
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	50
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	50
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	51
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	52
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	52
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	52
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	52
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	52
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4	Discharged/transferred to a Facility that Provides Custodial or Suppo	53
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	53
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	54
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	54
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	55
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	57
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	57
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	58
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	58
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	58
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	59
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	60
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	60
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	60
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	60
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	60
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under Medicaid	61
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	61
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	62
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	62
HB	NC		Skilled Nursing Fa		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	63

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HB	NC	[redacted]	REDACTED	Skilled Nursing Fa	[redacted]	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	64
HB	NC			Skilled Nursing Fa		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	64
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	64
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	64
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	64
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	65
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	65
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	65
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	66
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	66
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	66
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	66
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	66
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	67
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	67
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	68
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	70
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	71
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	73
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	73
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	73
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	74
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	75
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	75
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	75
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	76
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	76
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	78
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	79
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	81
HB	NC			?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	82
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	83
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	83
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	86
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	86
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	88
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	91
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	93
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	93
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	96
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	96
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	96
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	99
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	99
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	102
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	103
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	103
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	105
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	106
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	106
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	106
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	106
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	108
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	117
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	117
HB	NC			?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	128

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HB	NC	[redacted]	?	[redacted]	KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	134
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	136
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	137
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	140
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	147
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	152
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	152
HB	NC		Skilled Nursing F		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	153
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	157
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	182
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	182
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	182
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	182
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	188
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	190
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	195
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	233
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	243
HB	NC		?		KFHP 1000	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	318
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	358
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	364
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	364
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	522
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	589
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	645
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	708
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	788
HB	NC		?		KFHP 1000	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	1457
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	5 Discharged/transferred to a Designated Cancer Center or Children's	2
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	3
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	3
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	3
HB	NC		?		KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	3
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC		?		KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	4
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	6
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	6
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	65 Discharged/transferred to a psychiatric hospital or psychiatric distinc	7
HB	NC		?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4 Discharged/transferred to a Facility that Provides Custodial or Suppo	8

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HB	NC	REDACTED	REDACTED	?	REDACTED	KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4 Discharged/transferred to a Facility that Provides Custodial or Suppc	8
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	8
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	8
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	8
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	12
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	12
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	12
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	12
HB	NC			?		KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	12
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	13
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	14
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	14
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	14
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	14
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	15
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	15
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	17
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			?		KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	19
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	20
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	21
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	21
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	24
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	24
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	26
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	26
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	26
HB	NC			?		KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	27
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	28
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	28
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	29
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	29
HB	NC			?		KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	70 Discharge/transfer to another type of health care institution not defi	29
HB	NC			?		KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	29
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	30
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	34
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	38
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	39
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	39
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	41
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	41
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	43
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	48
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	48
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	52
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	54
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	55
HB	NC			?		KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	55

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HB	NC	[redacted]	[redacted]	[redacted]	KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	62
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	63
HB	NC				KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	67
HB	NC				KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	67
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	73
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	73
HB	NC				KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	75
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	98
HB	NC				KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	107
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	127
HB	NC				KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	132
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	158
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	202
HB	NC				KFHP 1001	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	237
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	257
HB	NC				KFHP 1001	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	257
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	7 Left against medical advice or discontinued care	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	7 Left against medical advice or discontinued care	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2

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HB	NC	REDACTED	REDACTED	?	REDACTED	XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	9 Admitted as an inpatient to this hospital	2
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	4
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	4
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	4
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	4
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	5
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	5
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	5
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	6
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	6
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	6
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	6
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	6
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	6
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	8
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	8
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	8
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	8
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	8
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	8
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	9
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	9
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	9
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	9
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	10
HB	NC			?		XFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	10
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		XFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11

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HB	NC	REDACTED	REDACTED	?	REDACTED	KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	11
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	11
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	12
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	12
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	12
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	16
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	16
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	20
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	20
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	24
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	28
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	29
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	31
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	39
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	40
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	42
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	48
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	51
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	53
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	59
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	71
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	83
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	95
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	107
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	107
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	113
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	113
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	114
HB	NC			?		KFHP 1003	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	118
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	131
HB	NC			?		KFHP 1003	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	156
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP HEALTH CARE REFORM	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	65 Discharged/transferred to a psychiatric hospital or psychiatric distinc	2
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC			?		KP HEALTH CARE REFORM	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	6
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	6
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	8
HB	NC			?		KP HEALTH CARE REFORM	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			?		KP HEALTH CARE REFORM	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	26
HB	NC			?		KP HEALTH CARE REFORM	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	26
HB	NC			?		KP HEALTH CARE REFORM	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	30
HB	NC			?		KP HEALTH CARE REFORM	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	30
HB	NC			?		KP HEALTH CARE REFORM	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	38

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HB	NC	[redacted]	?	[redacted]	KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	38
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not defi	43
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	55
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	168
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	168
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	1
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64	Discharged/transferred to a nursing facility certified under Medicaid	2
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	5
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	5
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	50	Hospice - home	21
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	28
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	29
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	29
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	35
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	35
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	58
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under Medicaid	71
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	88
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	88
HB	NC		?		KP HEALTH CARE REFORM -	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	117
HB	NC		?		KP HEALTH CARE REFORM -	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	141
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under Medicaid	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not defi	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	1

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HB	NC	REDACTED	REDACTED	?	REDACTED	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP MEDICARE	V46.11 - PERSONAL CONDITION OF RESPIRATORY DEPENI	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS

HB	NC	REDACTED	REDACTED	?	REDACTED	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient 1
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge) 1

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HB	NC	[redacted]	?	[redacted]	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home he	1
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	4 Discharged/transferred to a Facility that Provides Custodial or Suppo	1
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51 Hospice - medical facility (Certified) Providing Hospice Level of Care	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2

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HB	NC	REDACTED	REDACTED	?	REDACTED	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	2
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	2
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	2
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3

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HB	NC	REDACTED	REDACTED	REDACTED	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	4 Discharged/transferred to a Facility that Provides Custodial or Suppc	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	3
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4

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HB	NC	[redacted]	?	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64 Discharged/transferred to a nursing facility certified under Medicaid	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64 Discharged/transferred to a nursing facility certified under Medicaid	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	4
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	4
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	5
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5

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HB	NC	REDACTED	REDACTED	REDACTED	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	6

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HB	NC	REDACTED	REDACTED	?	REDACTED	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6	
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	6	
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	6	
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50	Hospice - home	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6	

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HB	NC	[redacted]		[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	6
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	6
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	66 Discharged/transferred to a Critical Access Hospital (CAH)	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	7
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	7

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HB	NC	[redacted]	?	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	7
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home he	7
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	7
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home he	7
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	7
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	7
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	8
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	8
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	8
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	8
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under Medicaid	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under Medicaid	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8

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HB	NC	[redacted]	?	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home he	8
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64	Discharged/transferred to a nursing facility certified under Medicaid	8
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC	?	?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC	?	?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC	?	?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	9
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9

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HB	NC	[redacted]	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	9
HB	NC	?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC	?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatien	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	9
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not def	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10

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HB	NC	REDACTED	REDACTED	?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4 Discharged/transferred to a Facility that Provides Custodial or Suppc	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51 Hospice - medical facility (Certified) Providing Hospice Level of Care	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	10
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	10
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	11
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	12

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HB	NC	[redacted]	?	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	12
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	12
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	12
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	12
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	13
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	13
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	13
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	13
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	13
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	13
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	13

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HB	NC	[redacted]		[redacted]	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	13
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	13
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	13
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	7	Left against medical advice or discontinued care	14
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	7	Left against medical advice or discontinued care	14
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	14
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	14
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64	Discharged/transferred to a nursing facility certified under Medicaid	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15

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HB	NC	[redacted]	[redacted]	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	15
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	16
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	16
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4 Discharged/transferred to a Facility that Provides Custocial or Suppo	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4 Discharged/transferred to a Facility that Provides Custocial or Suppo	17
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	17

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HB	NC	[redacted]	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51	Hospice - medical facility (Certified) Providing Hospice Level of Care	17
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51	Hospice - medical facility (Certified) Providing Hospice Level of Care	17
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	17
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	17
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	17
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not def	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	16
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	18
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	18
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home he	18
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19

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HB	NC	[redacted]	?	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	19
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	19
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	19
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	19
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	19
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	19
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64	Discharged/transferred to a nursing facility certified under Medicaid	19
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64	Discharged/transferred to a nursing facility certified under Medicaid	19
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	19
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	19
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home he	19
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not defi	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	20
HB	NC	?	?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home he	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	20
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	20
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	20
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	20
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	21
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50	Hospice - home	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50	Hospice - home	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	21

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HB	NC	REDACTED	REDACTED	REDACTED	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	21
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64 Discharged/transferred to a nursing facility certified under Medicaid	21
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64 Discharged/transferred to a nursing facility certified under Medicaid	21
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	22
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	23
HB	NC				KP MEDICARE	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	23
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	23
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	24
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	24
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	24
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	24
HB	NC				KP MEDICARE	V45.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	24
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	24
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	24
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	25

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HB	NC	[redacted]	?	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	25
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	25
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	25
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	26
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	26
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	27
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	27
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	28
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	28

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HB	NC	[redacted]	[redacted]	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51 Hospice - medical facility (Certified) Providing Hospice Level of Care	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	28
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	28
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	28
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	29
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	29
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	29
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	29
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	29
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	29
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	29
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	29
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	29
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	30
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	30
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	30
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	30
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	30
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	30
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	30
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4 Discharged/transferred to a Facility that Provides Custodial or Suppo	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	31
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	31
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	32
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	32
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	32
HB	NC				KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	32
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	33
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	33
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	33
HB	NC				KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	33

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HB	NC	[redacted]	?	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		33
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		33
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		33
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		34
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		34
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		34
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient		34
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		34
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		34
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h		34
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired		34
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired		34
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		34
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		34
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		35
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		35
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h		35
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		35
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		35
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		35
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital		36
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		36
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) in		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) in		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		37
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		37
HB	NC		?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp		37
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h		38
HB	NC		?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired		38

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HB	NC	[redacted]	[redacted]	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	38
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	38
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	39
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	39
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	39
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	39
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	39
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	39
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	40
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	40
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	40
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	40
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	40
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	40
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	40
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	41
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	41
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	41
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	41
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	41
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	41
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	41
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	41
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50	Hospice - home	42
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	42
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	42
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	42
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	42
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	42
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	42
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	42
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	42
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	43
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	43
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	43
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	44
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	44
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	44
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51	Hospice - medical facility (Certified) Providing Hospice Level of Care	44
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51	Hospice - medical facility (Certified) Providing Hospice Level of Care	44
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	44
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	44
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	44
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	45
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	45
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	45
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	45
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	45
HB	NC			KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	45
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	46
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	46
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	46
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	46
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	47
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	47
HB	NC			KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	47

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HB	NC	[redacted]	[redacted]	?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	47
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	47
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	47
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	47
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	47
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	48
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	48
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	48
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	48
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	48
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	48
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	49
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	49
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	49
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	49
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	49
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	50
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	50
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	50
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	50
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	50
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	50
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	51
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	51
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	51
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4 Discharged/transferred to a Facility that Provides Custodial or Suppc	52
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	52
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	53
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	53
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	53
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	53
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	54
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	54
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	54
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	55
HB	NC		Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	55
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	55
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	56
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	56
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	56
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	56
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	57
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	57
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	57
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	57
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	57
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	57
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	58
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	58
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	58
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	58

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HB	NC	REDACTED	REDACTED	?	REDACTED	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	58
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	58
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	58
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	59
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	59
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	59
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	59
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	59
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	60
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	60
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	60
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	60
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	60
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	61
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	61
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	61
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	61
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	61
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	61
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	61
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	61
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	62
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	63
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	63
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	63
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	63
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	63
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	64
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	65
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	65
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	66 Discharged/transferred to a Critical Access Hospital (CAH)	66
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	66
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	66
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	66
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	67
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	67
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	68
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	68
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	68
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	68
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	68
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	69
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	69
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	69
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	70
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	70
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	70
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	70
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	70
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	71
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	71
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	71
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	71
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	71
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	72
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	74

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HB	NC	REDACTED	REDACTED	?	REDACTED	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	75
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	76
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	76
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	77
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2 Discharged/transferred to a short-term general hospital for inpatient	78
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	79
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	79
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	79
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	80
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	80
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	80
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	81
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	81
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	81
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	82
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	83
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	83
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	83
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	83
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	84
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	84
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	84
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	84
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	84
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	85
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	86
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	86
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	86
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	89
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	89
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	89
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	90
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	92
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	92
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	93
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	93
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	94
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	94
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	95
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	97
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	98
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	99
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	100
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	102
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	103
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	106
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not def	107
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	108
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	109
HB	NC			?		KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	109
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	110
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	110
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	111
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	112
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	112
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	117

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HB	NC	[redacted]	[redacted]	?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4 Discharged/transferred to a Facility that Provides Custodial or Suppo	119
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	122
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	122
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	126
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	126
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	126
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	126
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	127
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	132
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	132
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	134
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	136
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home he	136
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	138
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	138
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	139
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	64 Discharged/transferred to a nursing facility certified under Medicaid	139
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	148
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	152
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	152
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	154
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	154
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	155
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	155
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	51 Hospice - medical facility (Certified) Providing Hospice Level of Care	155
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	156
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	158
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	158
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	158
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	158
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	161
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	168
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	178
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	179
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	183
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	186
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	194
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	195
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	211
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	214
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	215
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	225
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	228
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	232
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	233
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	244
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	245
HB	NC			Skilled Nursing F	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	251
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	279
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	279
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	281
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	282
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	285
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	285
HB	NC			?	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	70 Discharge/transfer to another type of health care institution not defi	290
HB	NC			?	KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	308

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HB	NC	REDACTED	REDACTED	?	REDACTED	KP MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	313
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	331
HB	NC			Skilled Nursing Fa		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	333
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	342
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	346
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	399
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	406
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	406
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	435
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	443
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	445
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	457
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	492
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	507
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	638
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	736
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	801
HB	NC			?		KP MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	984
HB	NC			?		KPIC/HARRINGTON	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC			?		KPIC/HARRINGTON	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	8
HB	NC			?		KPIC/HARRINGTON	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		LIBERTY MUTUAL INSURANC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not defi	1
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	2
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	2
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home he	3
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	4
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	4
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	66 Discharged/transferred to a Critical Access Hospital (CAH)	5
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	6
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	7
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	8
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	8
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	8

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HB	NC	REDACTED	REDACTED	?	REDACTED	MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	11
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	12
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	12
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	13
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	13
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	14
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	18
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	21
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	21
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	22
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	24
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	27
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	28
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	33
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	33
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	33
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	35
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	35
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	36
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	37
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	38
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	9	Admitted as an inpatient to this hospital	42
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	44
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	45
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	49
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6	Discharged/transferred to home under care of an organized home h	55
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	58
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	58
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	58
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	58
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	60
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	62
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	64
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30	Still patient	67
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	68
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	69
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not def	79
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not def	79
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	83
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	105
HB	NC			?		MEDI-CAL EDS	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	105
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9	Admitted as an inpatient to this hospital	116
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30	Still patient	125
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30	Still patient	125
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	151
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	201
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30	Still patient	203

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HB	NC	[redacted]	[redacted]	Skilled Nursing Fa	[redacted]	MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	212
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	225
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	288
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	359
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	385
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	385
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	591
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	592
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	940
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	961
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	1088
HB	NC			?		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1175
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	1699
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	1699
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	1908
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	1930
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	2046
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	2249
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	2319
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	3150
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not def	3302
HB	NC			Skilled Nursing Fa		MEDI-CAL EDS	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	3956
HB	NC			?		MEDICAL FINANCIAL ASSIST.	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		MEDICAL FINANCIAL ASSIST.	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	28
HB	NC			?		MEDICAL FINANCIAL ASSIST.	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	28
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	1
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	1
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	1
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	4 Discharged/transferred to a Facility that Provides Custodial or Suppo	1
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	2
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	2
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	2
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	50 Hospice - home	2
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	2
HB	NC			Skilled Nursing Fa		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	3
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	3
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	3
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	3
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	4
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4

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HB	NC	REDACTED	REDACTED	?	REDACTED	MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	4
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1	Discharged to home or self care (routine discharge)	5
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	5
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not def	6
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	6
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	6
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	7
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	7
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	7
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	51	Hospice - medical facility (Certified) Providing Hospice Level of Care	7
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	51	Hospice - medical facility (Certified) Providing Hospice Level of Care	7
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	8
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9

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HB	NC	[redacted]	[redacted]	?	[redacted]	MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	9
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	9
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	65	Discharged/transferred to a psychiatric hospital or psychiatric distinc	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	10
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	10
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	11
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	12
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	12
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	12
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	13
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	13
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	14
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	14
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70	Discharge/transfer to another type of health care institution not defi	15
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	15
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	15
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50	Hospice - home	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	16
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17

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HB	NC	REDACTED	REDACTED	?	REDACTED	MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	17
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	18
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	18
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	18
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63	Discharged/transferred to a Medicare Certified Long Term Care Hosp	18
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	19
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	19
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	20
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	2	Discharged/transferred to a short-term general hospital for inpatient	20
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	4	Discharged/transferred to a Facility that Provides Custodial or Suppo	21
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	21
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	21
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	21
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	21
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	21
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	22
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	22
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	22
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	22
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	22
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	22
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	23
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	23
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	24
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	24
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	25
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	25
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	25
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	25
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20	Expired	25
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	26
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	26
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	26
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	26
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	27
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	28
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	28
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	29
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1	Discharged to home or self care (routine discharge)	29
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	29
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	31
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	31
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	32
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	33
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	33
HB	NC			?		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	33
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	34
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	34
HB	NC			?		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	34

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HB	NC	[redacted]	[redacted]	[redacted]	MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	36
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	36
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	37
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	38
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	38
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	42
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	43
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	43
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	43
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	46
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	46
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	6 Discharged/transferred to home under care of an organized home h	46
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	47
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	47
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	49
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	49
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	1 Discharged to home or self care (routine discharge)	49
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	50
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	51
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	55
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	63
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	70
HB	NC		Skilled Nursing Fa		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	75
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	76
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	79
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	82
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	82
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	85
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	111
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	137
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	137
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	161
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	169
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	194
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	217
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	240
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	266
HB	NC		Skilled Nursing Fa		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	277
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	297
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	297
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	301
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	316
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	318
HB	NC		Skilled Nursing Fa		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	9 Admitted as an inpatient to this hospital	412
HB	NC				MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	469
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	517
HB	NC		Skilled Nursing Fa		MEDICARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	30 Still patient	602
HB	NC		Skilled Nursing Fa		MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	70 Discharge/transfer to another type of health care institution not def	919
HB	NC				MEDICARE	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	1655
HB	NC				MEDICARE HMO OTHER	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	6
HB	NC				MEDICARE HMO OTHER	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC				MEDICARE HMO OTHER	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC				MOLINA HEALTHCARE (MED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	4
HB	NC				MOLINA HEALTHCARE (MED	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC				PARTNERSHIP HEALTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				PARTNERSHIP HEALTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7

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HB	NC	[redacted]	[redacted]	[redacted]	ARTNERSHIP HEALTH PLAN	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	7
HB	NC				ARTNERSHIP HEALTH PLAN	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	7
HB	NC				ARTNERSHIP HEALTH PLAN	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not def	615
HB	NC				RESUMPTIVE MEDI-CAL EL	Z99.11 - DEPENDENCE ON RESPIRATOR (VENTILATOR) STA	20 Expired	10
HB	NC				ANTA CLARA FAMILY HEAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	8
HB	NC				ANTA CLARA FAMILY HEAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	8
HB	NC				ANTA CLARA FMLY MED HI	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	64 Discharged/transferred to a nursing facility certified under Medicaid	1
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	1
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	2
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	2
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not def	6
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	70 Discharge/transfer to another type of health care institution not def	6
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	10
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	10
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	16
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	20
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	20
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	22
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	35
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	42
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	42
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	47
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	47
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	68
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6 Discharged/transferred to home under care of an organized home h	68
HB	NC				ELF-FUNDED/KPIC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	50 Hospice - home	100
HB	NC				UTTER HEALTH INSURANCE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20 Expired	8
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	7
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	8
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	15
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	63 Discharged/transferred to a Medicare Certified Long Term Care Hosp	15
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	17
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	18
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	18
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	18
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	19
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2 Discharged/transferred to a short-term general hospital for inpatient	22
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	24
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62 Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	30
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	32
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	42
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	109
HB	NC				TROVER SOLUTIONS INC	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3 Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	109
HB	NC				UNITED HEALTHCARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	1 Discharged to home or self care (routine discharge)	13

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HB	NC	REDACTED	REDACTED	?	REDACTED	UNITED HEALTHCARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC			?		UNITED HEALTHCARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	6	Discharged/transferred to home under care of an organized home h	13
HB	NC			?		UNITED HEALTHCARE	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	17
HB	NC			?		UNITED HEALTHCARE	Z99.11 - DEPENDENCE ON RESPIRATOR [VENTILATOR] ST/	20	Expired	24
HB	NC			?		UNITED HEALTHCARE	Z99.11 - DEPENDENCE ON RESPIRATOR [VENTILATOR] ST/	20	Expired	24
HB	NC			?		UNITED HEALTHCARE-MEDI	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	5
HB	NC			?		UNITED HEALTHCARE-MEDI	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	5
HB	NC			?		UNITED HEALTHCARE-MEDI	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC			?		UNITED HEALTHCARE-MEDI	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	27
HB	NC			Skilled Nursing F		VA BENEFITS PALO ALTO	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	157
HB	NC			?		VST MBR KP NCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	13
HB	NC			?		VST MBR KP NCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	62	Discharged/transferred to an inpatient rehabilitation facility (IRF) inc	32
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	6
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	6
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	20	Expired	8
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	16
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	16
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	16
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	63
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	3	Discharged/transferred to Skilled Nursing Facility (SNF) with Medicar	63
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	480
HB	NC			?		VST MBR KP SCAL	V46.11 - DEPENDENCE ON RESPIRATOR STATUS	2	Discharged/transferred to a short-term general hospital for inpatient	480

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EXHIBIT 27

On Thursday, December 26, 2013 3:57 PM, "Gloryanne.H.Bryant@kp.org" <Gloryanne.H.Bryant@kp.org> wrote:

Victoria M Hernandez

----- Original Message -----
From: Victoria M Hernandez
Sent: 12/26/2013 03:27 PM PST
To: Gloryanne Bryant
Subject: Fw: TPMG Vent Audit Results

FYI

VICTORIA M. HERNANDEZ, RHIA, CCS, CDIP, CRCR, AHIMA-Approved ICD-10-CM/PCS Trainer
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Please visit the NCAL HIM resources, tools and information online at our wiki:
HIM page: https://w ki.kp.org/wiki/x/fYDGBQ
Coders' Corner: https://wiki.kp.org/w ki/x/g4DGBQ
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----- Forwarded by Victoria M Hernandez/CA/KAIPERM on 12/26/2013 03:27 PM -----

From: Victoria M Hernandez/CA/KAIPERM
To: Roderick C Madamba/CA/KAIPERM@KAIPERM
Date: 12/26/2013 03:26 PM
Subject: TPMG Vent Audit Results

Hi Rod,

I had Loren and Ronda validate the coding from the TPMG vent audit cases and they disagreed with 100% of their recommendation. I'll keep this on file until we officially hear back from Coding Clinic. Thanks.

(See attached file: V4611 Vent Dependence Jan 1 to Aug 31 2013.xls)

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HIM page: https://w ki.kp.org/wiki/x/fYDGBQ
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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
3	[redacted]	REDACTED	[redacted]			
4						
5				V46.11	DEPENDENCE ON RESPIRATOR STATUS	266,537.60
6						
7				V46.11	DEPENDENCE ON RESPIRATOR STATUS	19,435.95
8						
9				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,121.00
10						
11				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,662.45
12						
13				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,410.45
14						
15				V46.11	DEPENDENCE ON RESPIRATOR STATUS	36,637.85
16						
17				V46.11	DEPENDENCE ON RESPIRATOR STATUS	5,591.75
18						
19				V46.11	DEPENDENCE ON RESPIRATOR STATUS	24,209.05
20						
21				V46.11	DEPENDENCE ON RESPIRATOR STATUS	68,857.05
22						
23				V46.11	DEPENDENCE ON RESPIRATOR STATUS	92,591.00
24						
25				V46.11	DEPENDENCE ON RESPIRATOR STATUS	708,741.72
26						
27				V46.11	DEPENDENCE ON RESPIRATOR STATUS	191,813.35
28						
29				V46.11	DEPENDENCE ON RESPIRATOR STATUS	209,149.80
30						
31				V46.11	DEPENDENCE ON RESPIRATOR STATUS	470,652.25
32						

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
3			REDACTED					REDACTED
4								
5	13	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
6								
7	8	Inpatient			Medicare Unassigned	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
8								
9	2	Emergency			Medicare Advantage	UNK	Unknown DRG	
10								
11	6	Emergency			KP Medicaid	UNK	Unknown DRG	
12								
13	7	Emergency			KP Traditional	UNK	Unknown DRG	
14								
15	3	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
16								
17	6	Emergency			Medicare Advantage	UNK	Unknown DRG	
18								
19	5	Observation			KP Traditional	UNK	Unknown DRG	
20								
21	4	Inpatient			Medicare Advantage	689	KIDNEY & URINARY TRACT INFECTIONS W MCC	
22								
23	3	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
24								
25	18	Inpatient			Medicare Advantage	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
26								
27	5	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
28								
29	12	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
30								
31	16	Inpatient			Medicare Advantage	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
32								

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
3	REDACTED	
4		
5		Transfer from a Hospital (Different Facility)
6		
7		Transfer from a Hospital (Different Facility)
8		
9		Non-Health Care Facility Point of Origin
10		
11		Non-Health Care Facility Point of Origin
12		
13		Non-Health Care Facility Point of Origin
14		
15		Non-Health Care Facility Point of Origin
16		
17		Non-Health Care Facility Point of Origin
18		
19		Non-Health Care Facility Point of Origin
20		
21		Non-Health Care Facility Point of Origin
22		
23		Non-Health Care Facility Point of Origin
24		
25		Non-Health Care Facility Point of Origin
26		
27		Non-Health Care Facility Point of Origin
28		
29		Non-Health Care Facility Point of Origin
30		
31		Non-Health Care Facility Point of Origin
32		

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
3		
4		
5	SN/IC - D/T to SNF with Medicare Certification	E
6		
7	DIED - Expired	E
8		
9	HOME - Discharge to Home or Self Care (Routine Discharge)	
10		
11	HOME - Discharge to Home or Self Care (Routine Discharge)	
12		
13	HOME - Discharge to Home or Self Care (Routine Discharge)	
14		
15	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
16		
17	HOME - Discharge to Home or Self Care (Routine Discharge)	
18		
19	HOME - Discharge to Home or Self Care (Routine Discharge)	
20		
21	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
22		
23	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
24		
25	DIED - Expired	E
26		
27	SN/IC - D/T to SNF with Medicare Certification	E
28		
29	DIED - Expired	E
30		
31	DIED - Expired	E
32		

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
33	[redacted]	REDACTED	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	137,885.40
34						
35				V46.11	DEPENDENCE ON RESPIRATOR STATUS	61,258.80
36						
37				V46.11	DEPENDENCE ON RESPIRATOR STATUS	123,361.05
38						
39				V46.11	DEPENDENCE ON RESPIRATOR STATUS	30,561.85
40						
41				V46.11	DEPENDENCE ON RESPIRATOR STATUS	36,985.10
42						
43				V46.11	DEPENDENCE ON RESPIRATOR STATUS	53,522.25
44						
45				V46.11	DEPENDENCE ON RESPIRATOR STATUS	359.00
46						
47				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,843.00
48						
49				V46.11	DEPENDENCE ON RESPIRATOR STATUS	296,653.30
50						
51				V46.11	DEPENDENCE ON RESPIRATOR STATUS	88,149.50
52						
53						
54				V46.11	DEPENDENCE ON RESPIRATOR STATUS	34,239.51
55						
56						
57				V46.11	DEPENDENCE ON RESPIRATOR STATUS	747,858.95
58						
59				V46.11	DEPENDENCE ON RESPIRATOR STATUS	232,740.40
60						
61				V46.11	DEPENDENCE ON RESPIRATOR STATUS	272,467.75

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
33	4	Inpatient	REDACTED		Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	REDACTED
34								
35	5	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
36								
37	8	Inpatient			KP Traditional	064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	
38								
39	8	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
40								
41	3	Inpatient			Commercial	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
42								
43	7	Inpatient			Commercial	061	ACUTE ISCHEMIC STROKE W USE OF THROMBOLYTIC AGENT W MCC	
44								
45	25	Emergency			Medicare Advantage	UNK	Unknown DRG	
46								
47	18	Emergency			Medicare Advantage	UNK	Unknown DRG	
48								
49	16	Inpatient			HDHP	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	
50								
51	7	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
52								
53								
54	8	Hospital Ambulatory Surgery			KP Traditional	UNK	Unknown DRG	
55								
56								
57	20	Inpatient			Medicare Advantage	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
58								
59	4	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
60								
61	3	Inpatient			TPL Non-Lien	064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
33	REDACTED	Non-Health Care Facility Point of Origin
34		
35		Non-Health Care Facility Point of Origin
36		
37		Transfer from a Hospital (Different Facility)
38		
39		Clinic or Physician's Office
40		
41		Non-Health Care Facility Point of Origin
42		
43		Non-Health Care Facility Point of Origin
44		
45		Non-Health Care Facility Point of Origin
46		
47		Non-Health Care Facility Point of Origin
48		
49		Non-Health Care Facility Point of Origin
50		
51		Non-Health Care Facility Point of Origin
52		
53		
54		Non-Health Care Facility Point of Origin
55		
56		
57		Clinic or Physician's Office
58		
59		Non-Health Care Facility Point of Origin
60		
61		Transfer from a Hospital (Different Facility)

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
33	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
34		
35	HOME HEALTH SERVICES - Discharge to Home Hospice	E
36		
37	SN/IC - D/T to SNF with Medicare Certification	E
38		
39	DIED - Expired	N
40		
41	OTHER CARE TO ANOTHER HOSP - D/T to Another Type	E
42		
43	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
44		
45	HOME - Discharge to Home or Self Care (Routine Discharge)	
46		
47	HOME - Discharge to Home or Self Care (Routine Discharge)	
48		
49	DIED - Expired	E
50		
51	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
52		
53		
54	HOME - Discharge to Home or Self Care (Routine Discharge)	
55		
56		
57	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
58		
59	DIED - Expired	E
60		
61	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
62	[redacted]	REDACTED	[redacted]			
63	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	285,637.40
64	[redacted]	[redacted]	[redacted]			
65	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	57,156.10
66	[redacted]	[redacted]	[redacted]			
67	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,190,451.25
68	[redacted]	[redacted]	[redacted]			
69	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	829,444.50
70	[redacted]	[redacted]	[redacted]			
71	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	6,304.40
72	[redacted]	[redacted]	[redacted]			
73	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	19,500.64
74	[redacted]	[redacted]	[redacted]			
75	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	234,884.90
76	[redacted]	[redacted]	[redacted]			
77	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,804.65
78	[redacted]	[redacted]	[redacted]			
79	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	27,961.65
80	[redacted]	[redacted]	[redacted]			
81	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	99,073.75
82	[redacted]	[redacted]	[redacted]			
83	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	25,861.25
84	[redacted]	[redacted]	[redacted]			
85	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	703,615.65
86	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	
87	[redacted]	[redacted]	[redacted]			
88	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	67,459.55
89	[redacted]	[redacted]	[redacted]			
90	[redacted]	[redacted]	[redacted]			
91	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	147,517.95

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	G	H	I	J	K	L	M	N
1								
2	DX_POS	ACCT_CLASS	ADM_DATE	DISCH_DATE	LOB_NAME	DRG_NUMBER	DRG_DESCRIPTION	ATTENDING_PROV_ID
62			REDACTED					REDACTED
63	22	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
64								
65	2	Inpatient			KP Traditional	378	G.I. HEMORRHAGE W CC	
66								
67	16	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
68								
69	11	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
70								
71	10	Outpatient			KP Traditional	UNK	Unknown DRG	
72								
73	7	Hospital Ambulatory Surgery			Medicare Advantage	UNK	Unknown DRG	
74								
75	4	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
76								
77	5	Observation			KP Traditional	UNK	Unknown DRG	
78								
79	2	Inpatient			KP Traditional	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
80								
81	6	Inpatient			KP Traditional	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
82								
83	3	Inpatient			KP Traditional	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
84								
85	21	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
86	21							
87								
88	8	Inpatient			KP Traditional	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
89								
90								
91	2	Inpatient			KP Traditional	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
62	REDACTED	
63		Transfer from a Hospital (Different Facility)
64		
65		Non-Health Care Facility Point of Origin
66		
67		Transfer from a Hospital (Different Facility)
68		
69		Transfer from a Hospital (Different Facility)
70		
71		Non-Health Care Facility Point of Origin
72		
73		Non-Health Care Facility Point of Origin
74		
75		Non-Health Care Facility Point of Origin
76		
77		Non-Health Care Facility Point of Origin
78		
79		Non-Health Care Facility Point of Origin
80		
81		Non-Health Care Facility Point of Origin
82		
83		Transfer from a Hospital (Different Facility)
84		
85		Transfer from a Hospital (Different Facility)
86		
87		
88		Non-Health Care Facility Point of Origin
89		
90		
91		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
62		
63	DIED - Expired	E
64		
65	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
66		
67	SN/IC - D/T to SNF with Medicare Certification	E
68		
69	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
70		
71	HOME - Discharge to Home or Self Care (Routine Discharge)	
72		
73	HOME - Discharge to Home or Self Care (Routine Discharge)	
74		
75	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
76		
77	HOME - Discharge to Home or Self Care (Routine Discharge)	
78		
79	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
80		
81	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
82		
83	SN/IC - D/T to SNF with Medicare Certification	E
84		
85	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
86	HOME - Discharge to Home or Self Care (Routine Discharge)	E
87		
88	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
89		
90		
91	HOME - Discharge to Home or Self Care (Routine Discharge)	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
92	[redacted]	REDACTED	[redacted]			
93				V46.11	DEPENDENCE ON RESPIRATOR STATUS	368,778.60
94						
95				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,932.00
96						
97				V46.11	DEPENDENCE ON RESPIRATOR STATUS	690,475.08
98						
99				V46.11	DEPENDENCE ON RESPIRATOR STATUS	60,620.35
100						
101				V46.11	DEPENDENCE ON RESPIRATOR STATUS	368,207.05
102						
103				V46.11	DEPENDENCE ON RESPIRATOR STATUS	467,973.91
104						
105				V46.11	DEPENDENCE ON RESPIRATOR STATUS	82,005.20
106						
107				V46.11	DEPENDENCE ON RESPIRATOR STATUS	8,339.35
108						
109				V46.11	DEPENDENCE ON RESPIRATOR STATUS	52,093.75
110						
111				V46.11	DEPENDENCE ON RESPIRATOR STATUS	34,119.10
112				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
113						
114				V46.11	DEPENDENCE ON RESPIRATOR STATUS	107,331.15
115						
116				V46.11	DEPENDENCE ON RESPIRATOR STATUS	256,217.85
117						
118						
119				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,005,002.00
120				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
121						
122				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,404,480.00

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
92			REDACTED					REDACTED
93	13	Inpatient			Medicare Advantage	377	G.I. HEMORRHAGE W MCC	
94								
95	11	Emergency			Medicare Advantage	UNK	Unknown DRG	
96								
97	34	Inpatient			KP Traditional	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	
98								
99	4	Inpatient			KP Medicaid	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	
100								
101	7	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
102								
103	15	Inpatient			KP Traditional	856	POSTOPERATIVE OR POST-TRAUMATIC INFECTIONS W O.R. PROC W MCC	
104								
105	5	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
106								
107	10	Outpatient			KP Traditional	UNK	Unknown DRG	
108								
109	3	Inpatient			Medicare Advantage	378	G.I. HEMORRHAGE W CC	
110								
111	7	Inpatient			Medicare Advantage	378	G.I. HEMORRHAGE W CC	
112	7							
113								
114	4	Inpatient			KP Traditional	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
115								
116	12	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
117								
118								
119	3	Inpatient			Medicaid	988	NON-EXTENSIVE O.R. PROC UNRELATED TO PRINCIPAL DIAGNOSIS W CC	
120	3							
121								
122	3	Inpatient			Medicaid	092	OTHER DISORDERS OF NERVOUS SYSTEM W CC	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
92	REDACTED	
93		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
94		
95		Transfer from Another Health Care Facility
96		
97		Clinic or Physician's Office
98		
99		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
100		
101		Transfer from a Hospital (Different Facility)
102		
103		Clinic or Physician's Office
104		
105		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
106		
107		Non-Health Care Facility Point of Origin
108		
109		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
110		
111		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
112		
113		
114		Non-Health Care Facility Point of Origin
115		
116		Transfer from a Hospital (Different Facility)
117		
118		
119		Transfer from Another Health Care Facility
120		
121		
122		Transfer from a Hospital (Different Facility)

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
92		
93	SN/IC - D/T to SNF with Medicare Certification	E
94		
95	HOME - Discharge to Home or Self Care (Routine Discharge)	
96		
97	DIED - Expired	E
98		
99	SN/IC - D/T to SNF with Medicare Certification	E
100		
101	DIED - Expired	E
102		
103	DIED - Expired	E
104		
105	SN/IC - D/T to SNF with Medicare Certification	E
106		
107	HOME - Discharge to Home or Self Care (Routine Discharge)	
108		
109	SN/IC - D/T to SNF with Medicare Certification	E
110		
111	HOME - Discharge to Home or Self Care (Routine Discharge)	E
112	SN/IC - D/T to SNF with Medicare Certification	E
113		
114	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
115		
116	DIED - Expired	E
117		
118		
119	HOME - Discharge to Home or Self Care (Routine Discharge)	E
120	ACUTE CARE TO ANOTHER HOSP-D/T to a Medicare Certified Long Term Care Hosp (LTCH)	E
121		
122	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
123	[redacted]	REDACTED	[redacted]			
124				V46.11	DEPENDENCE ON RESPIRATOR STATUS	292,600.00
125				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
126						
127				V46.11	DEPENDENCE ON RESPIRATOR STATUS	219,450.00
128				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
129						
130				V46.11	DEPENDENCE ON RESPIRATOR STATUS	295,526.00
131				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
132						
133				V46.11	DEPENDENCE ON RESPIRATOR STATUS	228,228.00
134				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
135						
136				V46.11	DEPENDENCE ON RESPIRATOR STATUS	308,693.00
137						
138				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,463.00
139						
140						
141				V46.11	DEPENDENCE ON RESPIRATOR STATUS	95,958.00
142						
143				V46.11	DEPENDENCE ON RESPIRATOR STATUS	38,103.00
144						
145				V46.11	DEPENDENCE ON RESPIRATOR STATUS	295,200.20
146						
147				V46.11	DEPENDENCE ON RESPIRATOR STATUS	214,051.20
148						
149				V46.11	DEPENDENCE ON RESPIRATOR STATUS	339,817.75
150						

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
123			REDACTED					REDACTED
124	7	Inpatient			Medicaid	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
125	7							
126								
127	9	Inpatient			Medicaid	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
128	9							
129								
130	6	Inpatient			Medicaid	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
131	6							
132								
133	5	Inpatient			Commercial	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
134	5							
135								
136	2	Inpatient			Medicaid	092	OTHER DISORDERS OF NERVOUS SYSTEM W CC	
137								
138	10	Inpatient			Medicaid	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
139								
140								
141	10	Inpatient			Medicare	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
142								
143	2	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
144								
145	9	Inpatient			KP Traditional	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
146								
147	10	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
148								
149	9	Inpatient			KP DHMO	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
150								

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
123	REDACTED	
124		Transfer from a Hospital (Different Facility)
125		
126		
127		Transfer from a Hospital (Different Facility)
128		
129		
130		Transfer from a Hospital (Different Facility)
131		
132		
133		Transfer from a Hospital (Different Facility)
134		
135		
136		Transfer from a Hospital (Different Facility)
137		
138		Transfer from a Hospital (Different Facility)
139		
140		
141		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
142		
143		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
144		
145		Transfer from a Hospital (Different Facility)
146		
147		Clinic or Physician's Office
148		
149		Clinic or Physician's Office
150		

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
123		
124	HOME - Discharge to Home or Self Care (Routine Discharge)	E
125	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
126		
127	DIED - Expired	E
128	HOME - Discharge to Home or Self Care (Routine Discharge)	E
129		
130	DIED - Expired	E
131	HOME - Discharge to Home or Self Care (Routine Discharge)	E
132		
133	DIED - Expired	E
134	HOME - Discharge to Home or Self Care (Routine Discharge)	E
135		
136	OTHER CARE W/I THIS HOSP - Admitted as an Inpt to this Hosp	E
137		
138	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
139		
140		
141	DIED - Expired	E
142		
143	SN/IC - D/T to SNF with Medicare Certification	E
144		
145	SN/IC - D/T to SNF with Medicare Certification	E
146		
147	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
148		
149	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
150		

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
151	[redacted]	REDACTED	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	246,072.65
152						
153				V46.11	DEPENDENCE ON RESPIRATOR STATUS	27,683.15
154						
155						
156				V46.11	DEPENDENCE ON RESPIRATOR STATUS	403,778.25
157						
158				V46.11	DEPENDENCE ON RESPIRATOR STATUS	81,263.85
159						
160				V46.11	DEPENDENCE ON RESPIRATOR STATUS	78,298.63
161						
162				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,720.95
163						
164				V46.11	DEPENDENCE ON RESPIRATOR STATUS	35,142.25
165						
166				V46.11	DEPENDENCE ON RESPIRATOR STATUS	7,058.35
167						
168				V46.11	DEPENDENCE ON RESPIRATOR STATUS	54,174.15
169						
170				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,492,663.80
171						
172				V46.11	DEPENDENCE ON RESPIRATOR STATUS	33,352.80
173						
174				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,287,868.85
175						
176				V46.11	DEPENDENCE ON RESPIRATOR STATUS	204,422.75
177						
178				V46.11	DEPENDENCE ON RESPIRATOR STATUS	72,477.30
179						
180				V46.11	DEPENDENCE ON RESPIRATOR STATUS	59,893.85

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
151	16	Inpatient	REDACTED		Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	REDACTED
152								
153	3	Inpatient			Medicare Advantage	069	TRANSIENT ISCHEMIA	
154								
155								
156	9	Inpatient			KP Traditional	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
157								
158	11	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
159								
160	3	Inpatient			KP Traditional	137	MOUTH PROCEDURES W CC/MCC	
161								
162	11	Emergency			Medicare Advantage	UNK	Unknown DRG	
163								
164	3	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
165								
166	5	Emergency			KP Traditional	UNK	Unknown DRG	
167								
168	2	Inpatient			Medicare Advantage	189	PULMONARY EDEMA & RESPIRATORY FAILURE	
169								
170	13	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
171								
172	2	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
173								
174	14	Inpatient			KP Medicaid	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
175								
176	4	Inpatient			KP Traditional	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
177								
178	5	Inpatient			Medicaid	193	SIMPLE PNEUMONIA & PLEURISY W MCC	
179								
180	3	Inpatient			KP Traditional	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
151	REDACTED	Transfer from a Hospital (Different Facility)
152		
153		Transfer from One Distinct Unit to another Distinct Unit in Same Hospital
154		
155		
156		Non-Health Care Facility Point of Origin
157		
158		Transfer from Another Health Care Facility
159		
160		Non-Health Care Facility Point of Origin
161		
162		Non-Health Care Facility Point of Origin
163		
164		Non-Health Care Facility Point of Origin
165		
166		Non-Health Care Facility Point of Origin
167		
168		Non-Health Care Facility Point of Origin
169		
170		Non-Health Care Facility Point of Origin
171		
172		Non-Health Care Facility Point of Origin
173		
174		Non-Health Care Facility Point of Origin
175		
176		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
177		
178		Transfer from a Hospital (Different Facility)
179		
180		Information Not Available

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
151	SN/IC - D/T to SNF with Medicare Certification	E
152		
153	SN/IC - D/T to SNF with Medicare Certification	E
154		
155		
156	HOME - Discharge to Home or Self Care (Routine Discharge)	E
157		
158	SN/IC - D/T to an Intermediate Care Facility (ICF)	E
159		
160	HOME - Discharge to Home or Self Care (Routine Discharge)	E
161		
162	HOME - Discharge to Home or Self Care (Routine Discharge)	
163		
164	HOME - Discharge to Home or Self Care (Routine Discharge)	E
165		
166	OTHER CARE TO ANOTHER HOSP - D/T to Another Type	
167		
168	SN/IC - D/T to SNF with Medicare Certification	E
169		
170	DIED - Expired	E
171		
172	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
173		
174	SN/IC - D/T to a Nursing Facility Certified under Medicaid but not Certified under Me	E
175		
176	SN/IC - D/T to an Intermediate Care Facility (ICF)	E
177		
178	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
179		
180	SN/IC - D/T to a Nursing Facility Certified under Medicaid but not Certified under Me	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
181	[redacted]	REDACTED	[redacted]			
182				V46.11	DEPENDENCE ON RESPIRATOR STATUS	156,065.15
183						
184				V46.11	DEPENDENCE ON RESPIRATOR STATUS	143,635.40
185						
186				V46.11	DEPENDENCE ON RESPIRATOR STATUS	21,643.30
187						
188				V46.11	DEPENDENCE ON RESPIRATOR STATUS	26,372.80
189						
190				V46.11	DEPENDENCE ON RESPIRATOR STATUS	573,692.05
191						
192				V46.11	DEPENDENCE ON RESPIRATOR STATUS	8,451.00
193						
194				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,625,777.75
195						
196				V46.11	DEPENDENCE ON RESPIRATOR STATUS	349,414.50
197						
198				V46.11	DEPENDENCE ON RESPIRATOR STATUS	69,619.75
199						
200				V46.11	DEPENDENCE ON RESPIRATOR STATUS	61,787.05
201						
202				V46.11	DEPENDENCE ON RESPIRATOR STATUS	251,188.55
203						
204				V46.11	DEPENDENCE ON RESPIRATOR STATUS	82,514.90
205						
206				V46.11	DEPENDENCE ON RESPIRATOR STATUS	75,996.25
207						
208						
209				V46.11	DEPENDENCE ON RESPIRATOR STATUS	652,678.70

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
181			REDACTED					REDACTED
182	5	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
183								
184	4	Inpatient			KP Traditional	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	
185								
186	3	Inpatient			Medicaid	100	SEIZURES W MCC	
187								
188	3	Inpatient			Medicaid	100	SEIZURES W MCC	
189								
190	14	Inpatient			KP Traditional	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
191								
192	2	Inpatient			Medicaid	206	OTHER RESPIRATORY SYSTEM DIAGNOSES W/O MCC	
193								
194	10	Inpatient			KP Traditional	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
195								
196	5	Inpatient			TPL Non-Lien	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	
197								
198	9	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
199								
200	7	Inpatient			KP Traditional	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
201								
202	5	Inpatient			KP DHMO	864	FEVER	
203								
204	5	Inpatient			KP DHMO	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
205								
206	8	Inpatient			Medicare Advantage	091	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	
207								
208								
209	13	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
181	REDACTED	
182		Transfer from a Hospital (Different Facility)
183		
184		Non-Health Care Facility Point of Origin
185		
186		Transfer from a Hospital (Different Facility)
187		
188		Transfer from a Hospital (Different Facility)
189		
190		Transfer from a Hospital (Different Facility)
191		
192		Non-Health Care Facility Point of Origin
193		
194		Transfer from a Hospital (Different Facility)
195		
196		Transfer from a Hospital (Different Facility)
197		
198		Transfer from a Hospital (Different Facility)
199		
200		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
201		
202		Transfer from a Hospital (Different Facility)
203		
204		Transfer from a Hospital (Different Facility)
205		
206		Transfer from a Hospital (Different Facility)
207		
208		
209		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
181		
182	SN/IC - D/T to SNF with Medicare Certification	E
183		
184	SN/IC - D/T to SNF with Medicare Certification	E
185		
186	HOME - Discharge to Home or Self Care (Routine Discharge)	E
187		
188	HOME - Discharge to Home or Self Care (Routine Discharge)	E
189		
190	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
191		
192	HOME - Discharge to Home or Self Care (Routine Discharge)	E
193		
194	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
195		
196	SN/IC - D/T to SNF with Medicare Certification	E
197		
198	DIED - Expired	E
199		
200	SN/IC - D/T to SNF with Medicare Certification	E
201		
202	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
203		
204	DIED - Expired	E
205		
206	DIED - Expired	E
207		
208		
209	SN/IC - D/T to SNF with Medicare Certification	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
210	[redacted]	REDACTED	[redacted]			
211				V46.11	DEPENDENCE ON RESPIRATOR STATUS	68,296.70
212						
213				V46.11	DEPENDENCE ON RESPIRATOR STATUS	11,014.60
214						
215				V46.11	DEPENDENCE ON RESPIRATOR STATUS	895,714.85
216						
217				V46.11	DEPENDENCE ON RESPIRATOR STATUS	67,381.45
218						
219				V46.11	DEPENDENCE ON RESPIRATOR STATUS	106,774.55
220						
221						
222				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,995.80
223						
224				V46.11	DEPENDENCE ON RESPIRATOR STATUS	527,608.95
225						
226				V46.11	DEPENDENCE ON RESPIRATOR STATUS	44,691.25
227						
228				V46.11	DEPENDENCE ON RESPIRATOR STATUS	63,863.40
229						
230				V46.11	DEPENDENCE ON RESPIRATOR STATUS	237,802.15
231						
232						
233				V46.11	DEPENDENCE ON RESPIRATOR STATUS	384,431.17
234						
235				V46.11	DEPENDENCE ON RESPIRATOR STATUS	137,666.25
236						
237				V46.11	DEPENDENCE ON RESPIRATOR STATUS	28,050.15

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	G	H	I	J	K	L	M	N
1								
2	DX_POS	ACCT_CLASS	ADM_DATE	DISCH_DATE	LOB_NAME	DRG_NUMBER	DRG_DESCRIPTION	ATTENDING_PROV_ID
210			REDACTED					REDACTED
211	5	Inpatient			Medicare Advantage	070	NONSPECIFIC CEREBROVASCULAR DISORDERS W MCC	
212								
213	2	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
214								
215	16	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
216								
217	4	Inpatient			Medicaid	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
218								
219	3	Inpatient			KP Traditional	091	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	
220								
221								
222	21	Emergency			Medicare Advantage	UNK	Unknown DRG	
223								
224	7	Inpatient			Medicare Advantage	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
225								
226	4	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
227								
228	4	Inpatient			Medicare Unassigned	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
229								
230	16	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
231								
232								
233	9	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
234								
235	4	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
236								
237	3	Inpatient			KP DHMO	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
210	REDACTED	
211		Non-Health Care Facility Point of Origin
212		
213		Transfer from a Hospital (Different Facility)
214		
215		Non-Health Care Facility Point of Origin
216		
217		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
218		
219		Transfer from a Hospital (Different Facility)
220		
221		
222		Non-Health Care Facility Point of Origin
223		
224		Transfer from a Hospital (Different Facility)
225		
226		Transfer from a Hospital (Different Facility)
227		
228		Transfer from a Hospital (Different Facility)
229		
230		Transfer from a Hospital (Different Facility)
231		
232		
233		Non-Health Care Facility Point of Origin
234		
235		Non-Health Care Facility Point of Origin
236		
237		Transfer from a Hospital (Different Facility)

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
210		
211	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
212		
213	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
214		
215	SN/IC - D/T to SNF with Medicare Certification	E
216		
217	DIED - Expired	E
218		
219	SN/IC - D/T to SNF with Medicare Certification	E
220		
221		
222	HOME - Discharge to Home or Self Care (Routine Discharge)	
223		
224	HOME HEALTH SERVICES - Discharge to Home Hospice	E
225		
226	HOME - Discharge to Home or Self Care (Routine Discharge)	E
227		
228	SN/IC - D/T to SNF with Medicare Certification	E
229		
230	DIED - Expired	E
231		
232		
233	DIED - Expired	E
234		
235	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
236		
237	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
238	[redacted]	REDACTED	[redacted]			
239				V46.11	DEPENDENCE ON RESPIRATOR STATUS	122,383.23
240						
241				V46.11	DEPENDENCE ON RESPIRATOR STATUS	78,590.05
242						
243				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,086,866.40
244						
245				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,266,839.70
246						
247				V46.11	DEPENDENCE ON RESPIRATOR STATUS	114,533.05
248						
249				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,451,308.70
250						
251				V46.11	DEPENDENCE ON RESPIRATOR STATUS	164,542.15
252						
253				V46.11	DEPENDENCE ON RESPIRATOR STATUS	172,039.93
254						
255				V46.11	DEPENDENCE ON RESPIRATOR STATUS	141,822.10
256						
257				V46.11	DEPENDENCE ON RESPIRATOR STATUS	190,605.45
258						
259				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,298.85
260						
261				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,323.60
262						
263				V46.11	DEPENDENCE ON RESPIRATOR STATUS	452,948.50
264						
265				V46.11	DEPENDENCE ON RESPIRATOR STATUS	89,233.55
266						

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
238			REDACTED					REDACTED
239	3	Inpatient			Medicare Advantage	668	TRANSURETHRAL PROCEDURES W MCC	
240								
241	2	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
242								
243	13	Newborn			Medicaid	789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	
244								
245	5	Inpatient			Medicaid	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
246								
247	3	Inpatient			Medicare Unassigned	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
248								
249	18	Newborn			KP Traditional	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
250								
251	10	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
252								
253	3	Inpatient			Medicare Advantage	163	MAJOR CHEST PROCEDURES W MCC	
254								
255	9	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
256								
257	10	Inpatient			Medicare Advantage	064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	
258								
259	16	Emergency			Medicare Advantage	UNK	Unknown DRG	
260								
261	14	Emergency			Medicare Advantage	UNK	Unknown DRG	
262								
263	5	Inpatient			KP Traditional	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
264								
265	13	Inpatient			Medicaid	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
266								

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
238	REDACTED	
239		Non-Health Care Facility Point of Origin
240		
241		Non-Health Care Facility Point of Origin
242		
243		Born Inside this Hospital
244		
245		Transfer from a Hospital (Different Facility)
246		
247		Non-Health Care Facility Point of Origin
248		
249		Born Inside this Hospital
250		
251		Non-Health Care Facility Point of Origin
252		
253		Non-Health Care Facility Point of Origin
254		
255		Transfer from a Hospital (Different Facility)
256		
257		Non-Health Care Facility Point of Origin
258		
259		Clinic or Physician's Office
260		
261		Non-Health Care Facility Point of Origin
262		
263		Non-Health Care Facility Point of Origin
264		
265		Non-Health Care Facility Point of Origin
266		

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
238		
239	HOME - Discharge to Home or Self Care (Routine Discharge)	E
240		
241	HOME - Discharge to Home or Self Care (Routine Discharge)	E
242		
243	DIED - Expired	E
244		
245	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
246		
247	SN/IC - D/T to SNF with Medicare Certification	E
248		
249	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
250		
251	DIED - Expired	E
252		
253	HOME - Discharge to Home or Self Care (Routine Discharge)	E
254		
255	DIED - Expired	E
256		
257	DIED - Expired	Y
258		
259	HOME - Discharge to Home or Self Care (Routine Discharge)	
260		
261	HOME - Discharge to Home or Self Care (Routine Discharge)	
262		
263	HOME - Discharge to Home or Self Care (Routine Discharge)	E
264		
265	Acute Care to Another Hosp-D/T to Critical Access Hosp (Rural Hosp)	E
266		

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
267	[redacted]	REDACTED	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	45,918.10
268						
269				V46.11	DEPENDENCE ON RESPIRATOR STATUS	18,007.80
270						
271				V46.11	DEPENDENCE ON RESPIRATOR STATUS	59,117.35
272						
273				V46.11	DEPENDENCE ON RESPIRATOR STATUS	14,202.10
274						
275				V46.11	DEPENDENCE ON RESPIRATOR STATUS	99,083.35
276						
277				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,308.90
278						
279				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,391.70
280						
281				V46.11	DEPENDENCE ON RESPIRATOR STATUS	8,410.00
282						
283				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,921.00
284						
285						
286				V46.11	DEPENDENCE ON RESPIRATOR STATUS	183,786.72
287						
288				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,891,992.77
289						
290				V46.11	DEPENDENCE ON RESPIRATOR STATUS	505,810.11
291						
292				V46.11	DEPENDENCE ON RESPIRATOR STATUS	269,760.10
293						
294				V46.11	DEPENDENCE ON RESPIRATOR STATUS	155,435.20
295						

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
267	4	Inpatient	REDACTED		KP DHMO	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	REDACTED
268								
269	2	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
270								
271	12	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
272								
273	5	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
274								
275	6	Inpatient			KP Traditional	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
276								
277	2	Outpatient			Medicaid	UNK	Unknown DRG	
278								
279	11	Emergency			Medicaid	UNK	Unknown DRG	
280								
281	13	Emergency			KP Traditional	UNK	Unknown DRG	
282								
283	15	Emergency			Medicare Advantage	UNK	Unknown DRG	
284								
285								
286	10	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
287								
288	3	Inpatient			Medicare Advantage	673	OTHER KIDNEY & URINARY TRACT PROCEDURES W MCC	
289								
290	11	Inpatient			KP Traditional	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
291								
292	13	Inpatient			KP Medicaid	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
293								
294	5	Inpatient			Medicare Advantage	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	
295								

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
267	REDACTED	Non-Health Care Facility Point of Origin
268		
269		Clinic or Physician's Office
270		
271		Transfer from a Hospital (Different Facility)
272		
273		Transfer from a Hospital (Different Facility)
274		
275		Transfer from a Hospital (Different Facility)
276		
277		Non-Health Care Facility Point of Origin
278		
279		Non-Health Care Facility Point of Origin
280		
281		Non-Health Care Facility Point of Origin
282		
283		Non-Health Care Facility Point of Origin
284		
285		
286		Transfer from a Hospital (Different Facility)
287		
288		Non-Health Care Facility Point of Origin
289		
290		Clinic or Physician's Office
291		
292		Non-Health Care Facility Point of Origin
293		
294		Transfer from Another Health Care Facility
295		

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
267	DIED - Expired	E
268		
269	HOME - Discharge to Home or Self Care (Routine Discharge)	E
270		
271	SN/IC - D/T to SNF with Medicare Certification	E
272		
273	DIED - Expired	E
274		
275	DIED - Expired	E
276		
277	HOME - Discharge to Home or Self Care (Routine Discharge)	
278		
279	HOME - Discharge to Home or Self Care (Routine Discharge)	
280		
281	OTHER CARE AT ANOTHER HOSP - D/T to a psych hosp or psych distinct part unit of a hos	
282		
283	HOME - Discharge to Home or Self Care (Routine Discharge)	
284		
285		
286	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
287		
288	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
289		
290	SN/IC - D/T to SNF with Medicare Certification	E
291		
292	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
293		
294	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
295		

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
296	[redacted]	REDACTED	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	405,763.06
297						
298				V46.11	DEPENDENCE ON RESPIRATOR STATUS	128,442.15
299						
300				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,416.00
301						
302				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,784.00
303						
304				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,165.25
305						
306				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,600.45
307						
308				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,445.50
309						
310				V46.11	DEPENDENCE ON RESPIRATOR STATUS	16,246.90
311						
312				V46.11	DEPENDENCE ON RESPIRATOR STATUS	204,147.36
313						
314				V46.11	DEPENDENCE ON RESPIRATOR STATUS	593,714.60
315						
316				V46.11	DEPENDENCE ON RESPIRATOR STATUS	109,515.65
317						
318				V46.11	DEPENDENCE ON RESPIRATOR STATUS	760,488.05
319						
320						
321				V46.11	DEPENDENCE ON RESPIRATOR STATUS	17,989.45
322						
323						
324				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,287,286.66
325				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
326						
327				V46.11	DEPENDENCE ON RESPIRATOR STATUS	277,920.15
328						

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
296	10	Inpatient	REDACTED		Medicaid	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	REDACTED
297								
298	4	Inpatient			Medicare Advantage	052	SPINAL DISORDERS & INJURIES W CC/MCC	
299								
300	22	Emergency			Medicare Advantage	UNK	Unknown DRG	
301								
302	7	Emergency			KP DHMO	UNK	Unknown DRG	
303								
304	6	Emergency			Medicare Advantage	UNK	Unknown DRG	
305								
306	7	Emergency			Medicare Advantage	UNK	Unknown DRG	
307								
308	21	Emergency			Medicare Advantage	UNK	Unknown DRG	
309								
310	16	Hospital Ambulatory Surgery			KP Traditional	UNK	Unknown DRG	
311								
312	9	Inpatient			KP DHMO	459	SPINAL FUSION EXCEPT CERVICAL W MCC	
313								
314	11	Inpatient			KP Traditional	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	
315								
316	16	Inpatient			Medicare Advantage	974	HIV W MAJOR RELATED CONDITION W MCC	
317								
318	25	Inpatient			Medicaid	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
319								
320								
321	5	Inpatient			KP Medicaid	166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	
322								
323								
324	23	Inpatient			Medicare Cost	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
325	23							
326								
327	5	Inpatient			Self Funding	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	
328								

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
296	REDACTED	Transfer from a Hospital (Different Facility)
297		
298		Transfer from a Hospital (Different Facility)
299		
300		Transfer from Another Health Care Facility
301		
302		Non-Health Care Facility Point of Origin
303		
304		Non-Health Care Facility Point of Origin
305		
306		Non-Health Care Facility Point of Origin
307		
308		Non-Health Care Facility Point of Origin
309		
310		Non-Health Care Facility Point of Origin
311		
312		Transfer from Another Health Care Facility
313		
314		Transfer from a Hospital (Different Facility)
315		
316		Non-Health Care Facility Point of Origin
317		
318		Non-Health Care Facility Point of Origin
319		
320		
321		Transfer from Another Health Care Facility
322		
323		
324		Non-Health Care Facility Point of Origin
325		
326		
327		Transfer from a Hospital (Different Facility)
328		

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
296	SN/IC - D/T to SNF with Medicare Certification	E
297		
298	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
299		
300	HOME - Discharge to Home or Self Care (Routine Discharge)	
301		
302	HOME - Discharge to Home or Self Care (Routine Discharge)	
303		
304	HOME - Discharge to Home or Self Care (Routine Discharge)	
305		
306	HOME - Discharge to Home or Self Care (Routine Discharge)	
307		
308	HOME - Discharge to Home or Self Care (Routine Discharge)	
309		
310	HOME - Discharge to Home or Self Care (Routine Discharge)	
311		
312	OTHER CARE TO ANOTHER HOSP - D/T to Another Type	E
313		
314	SN/IC - D/T to SNF with Medicare Certification	E
315		
316	DIED - Expired	E
317		
318	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
319		
320		
321	HOME - Discharge to Home or Self Care (Routine Discharge)	E
322		
323		
324	ACUTE CARE W/I THIS HOSP - Admitted as an Inpt to this Hosp	E
325	DIED - Expired	E
326		
327	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
328		

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
329	[redacted]	REDACTED	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	226,483.36
330						
331				V46.11	DEPENDENCE ON RESPIRATOR STATUS	27,107.26
332						
333				V46.11	DEPENDENCE ON RESPIRATOR STATUS	144,522.05
334						
335				V46.11	DEPENDENCE ON RESPIRATOR STATUS	243,325.51
336						
337				V46.11	DEPENDENCE ON RESPIRATOR STATUS	128,814.00
338				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
339						
340				V46.11	DEPENDENCE ON RESPIRATOR STATUS	208,120.02
341						
342				V46.11	DEPENDENCE ON RESPIRATOR STATUS	363,724.31
343						
344				V46.11	DEPENDENCE ON RESPIRATOR STATUS	64,833.73
345						
346						
347				V46.11	DEPENDENCE ON RESPIRATOR STATUS	386,907.65
348						
349				V46.11	DEPENDENCE ON RESPIRATOR STATUS	213,608.95
350						
351				V46.11	DEPENDENCE ON RESPIRATOR STATUS	70,397.10
352						
353				V46.11	DEPENDENCE ON RESPIRATOR STATUS	11,274.90
354						
355				V46.11	DEPENDENCE ON RESPIRATOR STATUS	87,260.30

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
329	7	Inpatient	REDACTED		Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	REDACTED
330								
331	3	Inpatient			KP Traditional	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
332								
333	12	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
334								
335	11	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
336								
337	5	Inpatient			Medicare Advantage	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	
338	5							
339								
340	8	Inpatient			Medicare	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
341								
342	18	Inpatient			KP Traditional	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
343								
344	6	Inpatient			Medicare Advantage	064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	
345								
346								
347	9	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
348								
349	5	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
350								
351	7	Inpatient			Medicare Advantage	417	LAPAROSCOPIC CHOLECYSTECTOMY W/O C.D.E. W MCC	
352								
353	4	Inpatient			KP Medicaid	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
354								
355	6	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
329	REDACTED	Transfer from a Hospital (Different Facility)
330		
331		Non-Health Care Facility Point of Origin
332		
333		Transfer from a Hospital (Different Facility)
334		
335		Non-Health Care Facility Point of Origin
336		
337		Transfer from a Hospital (Different Facility)
338		
339		
340		Non-Health Care Facility Point of Origin
341		
342		Non-Health Care Facility Point of Origin
343		
344		Non-Health Care Facility Point of Origin
345		
346		
347		Non-Health Care Facility Point of Origin
348		
349		Transfer from a Hospital (Different Facility)
350		
351		Non-Health Care Facility Point of Origin
352		
353		Non-Health Care Facility Point of Origin
354		
355		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
329	SN/IC - D/T to SNF with Medicare Certification	E
330		
331	RESIDENTIAL CARE - Discharge to Home or Self Care (Routine Discharge)	E
332		
333	HOME - Discharge to Home or Self Care (Routine Discharge)	E
334		
335	SN/IC - D/T to SNF with Medicare Certification	E
336		
337	SN/IC - D/T to SNF with Medicare Certification	E
338	HOME - Discharge to Home or Self Care (Routine Discharge)	E
339		
340	DIED - Expired	E
341		
342	DIED - Expired	E
343		
344	DIED - Expired	E
345		
346		
347	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
348		
349	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
350		
351	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
352		
353	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
354		
355	DIED - Expired	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
356	[redacted]	REDACTED	[redacted]			
357				V46.11	DEPENDENCE ON RESPIRATOR STATUS	75,942.95
358						
359				V46.11	DEPENDENCE ON RESPIRATOR STATUS	51,009.15
360						
361						
362				V46.11	DEPENDENCE ON RESPIRATOR STATUS	663.20
363						
364				V46.11	DEPENDENCE ON RESPIRATOR STATUS	675.15
365						
366				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,506.60
367						
368				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,296.00
369						
370				V46.11	DEPENDENCE ON RESPIRATOR STATUS	600.45
371						
372				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,161.55
373						
374				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,855.40
375						
376				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,394.45
377						
378				V46.11	DEPENDENCE ON RESPIRATOR STATUS	667.00
379						
380				V46.11	DEPENDENCE ON RESPIRATOR STATUS	667.70
381						
382				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,245.85
383						
384				V46.11	DEPENDENCE ON RESPIRATOR STATUS	605.50
385						
386				V46.11	DEPENDENCE ON RESPIRATOR STATUS	600.45
387						
388				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,933.45
389						
390				V46.11	DEPENDENCE ON RESPIRATOR STATUS	600.45
391						
392				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,196.00
393						

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
356			REDACTED					REDACTED
357	7	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
358								
359	9	Inpatient			KP Medicaid	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
360								
361								
362	6	Outpatient			KP Traditional	UNK	Unknown DRG	
363								
364	7	Outpatient			KP Traditional	UNK	Unknown DRG	
365								
366	7	Outpatient			KP Traditional	UNK	Unknown DRG	
367								
368	7	Outpatient			KP Traditional	UNK	Unknown DRG	
369								
370	8	Outpatient			KP Traditional	UNK	Unknown DRG	
371								
372	9	Outpatient			KP Traditional	UNK	Unknown DRG	
373								
374	14	Outpatient			KP Traditional	UNK	Unknown DRG	
375								
376	5	Outpatient			KP Traditional	UNK	Unknown DRG	
377								
378	11	Outpatient			KP Traditional	UNK	Unknown DRG	
379								
380	3	Outpatient			KP Traditional	UNK	Unknown DRG	
381								
382	11	Outpatient			KP Traditional	UNK	Unknown DRG	
383								
384	12	Outpatient			KP Traditional	UNK	Unknown DRG	
385								
386	3	Outpatient			KP Traditional	UNK	Unknown DRG	
387								
388	13	Outpatient			KP Traditional	UNK	Unknown DRG	
389								
390	8	Outpatient			KP Traditional	UNK	Unknown DRG	
391								
392	14	Outpatient			KP Traditional	UNK	Unknown DRG	
393								

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
356	REDACTED	
357		Non-Health Care Facility Point of Origin
358		
359		Non-Health Care Facility Point of Origin
360		
361		
362		Non-Health Care Facility Point of Origin
363		
364		Non-Health Care Facility Point of Origin
365		
366		Non-Health Care Facility Point of Origin
367		
368		Non-Health Care Facility Point of Origin
369		
370		Non-Health Care Facility Point of Origin
371		
372		Non-Health Care Facility Point of Origin
373		
374		Non-Health Care Facility Point of Origin
375		
376		Non-Health Care Facility Point of Origin
377		
378		Non-Health Care Facility Point of Origin
379		
380		Non-Health Care Facility Point of Origin
381		
382		Non-Health Care Facility Point of Origin
383		
384		Non-Health Care Facility Point of Origin
385		
386		Non-Health Care Facility Point of Origin
387		
388		Non-Health Care Facility Point of Origin
389		
390		Non-Health Care Facility Point of Origin
391		
392		Non-Health Care Facility Point of Origin
393		

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
356		
357	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
358		
359	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
360		
361		
362	HOME - Discharge to Home or Self Care (Routine Discharge)	
363		
364	HOME - Discharge to Home or Self Care (Routine Discharge)	
365		
366	HOME - Discharge to Home or Self Care (Routine Discharge)	
367		
368	HOME - Discharge to Home or Self Care (Routine Discharge)	
369		
370	HOME - Discharge to Home or Self Care (Routine Discharge)	
371		
372	HOME - Discharge to Home or Self Care (Routine Discharge)	
373		
374	HOME - Discharge to Home or Self Care (Routine Discharge)	
375		
376	HOME - Discharge to Home or Self Care (Routine Discharge)	
377		
378	HOME - Discharge to Home or Self Care (Routine Discharge)	
379		
380	HOME - Discharge to Home or Self Care (Routine Discharge)	
381		
382	HOME - Discharge to Home or Self Care (Routine Discharge)	
383		
384	HOME - Discharge to Home or Self Care (Routine Discharge)	
385		
386	HOME - Discharge to Home or Self Care (Routine Discharge)	
387		
388	HOME - Discharge to Home or Self Care (Routine Discharge)	
389		
390	HOME - Discharge to Home or Self Care (Routine Discharge)	
391		
392	HOME - Discharge to Home or Self Care (Routine Discharge)	
393		

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
394	[redacted]	REDACTED	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,308.45
395						
396				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,166.45
397						
398				V46.11	DEPENDENCE ON RESPIRATOR STATUS	958.45
399						
400				V46.11	DEPENDENCE ON RESPIRATOR STATUS	5,422.05
401						
402				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,060,434.29
403						
404				V46.11	DEPENDENCE ON RESPIRATOR STATUS	586,482.00
405						
406				V46.11	DEPENDENCE ON RESPIRATOR STATUS	529,168.65
407						
408				V46.11	DEPENDENCE ON RESPIRATOR STATUS	418,771.83
409						
410				V46.11	DEPENDENCE ON RESPIRATOR STATUS	18,361.55
411						
412				V46.11	DEPENDENCE ON RESPIRATOR STATUS	25,440.50
413						
414				V46.11	DEPENDENCE ON RESPIRATOR STATUS	48,928.95
415						
416				V46.11	DEPENDENCE ON RESPIRATOR STATUS	36,248.95
417						
418				V46.11	DEPENDENCE ON RESPIRATOR STATUS	34,290.85
419						
420				V46.11	DEPENDENCE ON RESPIRATOR STATUS	68,836.65
421						
422				V46.11	DEPENDENCE ON RESPIRATOR STATUS	86,578.50
423						

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
394	17	Outpatient	REDACTED		KP Traditional	UNK	Unknown DRG	REDACTED
395								
396	8	Outpatient			KP Traditional	UNK	Unknown DRG	
397								
398	5	Outpatient			KP Traditional	UNK	Unknown DRG	
399								
400	12	Emergency			Self Funding	UNK	Unknown DRG	
401								
402	16	Inpatient			KP Traditional	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
403								
404	13	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
405								
406	13	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
407								
408	10	Inpatient			Medicare	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
409								
410	7	Inpatient			KP Traditional	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
411								
412	5	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
413								
414	7	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
415								
416	3	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
417								
418	5	Inpatient			Medicare Advantage	394	OTHER DIGESTIVE SYSTEM DIAGNOSES W CC	
419								
420	15	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
421								
422	9	Inpatient			Medicare Advantage	389	G.I. OBSTRUCTION W CC	
423								

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
394	REDACTED	Non-Health Care Facility Point of Origin
395		
396		Non-Health Care Facility Point of Origin
397		
398		Non-Health Care Facility Point of Origin
399		
400		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
401		
402		Non-Health Care Facility Point of Origin
403		
404		Non-Health Care Facility Point of Origin
405		
406		Non-Health Care Facility Point of Origin
407		
408		Transfer from a Hospital (Different Facility)
409		
410		Non-Health Care Facility Point of Origin
411		
412		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
413		
414		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
415		
416		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
417		
418		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
419		
420		Non-Health Care Facility Point of Origin
421		
422		Non-Health Care Facility Point of Origin
423		

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
394	HOME - Discharge to Home or Self Care (Routine Discharge)	
395		
396	HOME - Discharge to Home or Self Care (Routine Discharge)	
397		
398	HOME - Discharge to Home or Self Care (Routine Discharge)	
399		
400	SN/IC - D/T to a Nursing Facility Certified under Medicaid but not Certified under Me	
401		
402	SN/IC - D/T to SNF with Medicare Certification	E
403		
404	DIED - Expired	E
405		
406	DIED - Expired	E
407		
408	SN/IC - D/T to SNF with Medicare Certification	E
409		
410	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
411		
412	SN/IC - D/T to SNF with Medicare Certification	E
413		
414	SN/IC - D/T to SNF with Medicare Certification	E
415		
416	SN/IC - D/T to SNF with Medicare Certification	E
417		
418	SN/IC - D/T to SNF with Medicare Certification	E
419		
420	SN/IC - D/T to SNF with Medicare Certification	E
421		
422	SN/IC - D/T to SNF with Medicare Certification	E
423		

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
424	[redacted]	REDACTED	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	9,684.45
425						
426				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,984,766.29
427						
428				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,268,755.15
429						
430				V46.11	DEPENDENCE ON RESPIRATOR STATUS	50,287.30
431						
432				V46.11	DEPENDENCE ON RESPIRATOR STATUS	52,549.20
433						
434				V46.11	DEPENDENCE ON RESPIRATOR STATUS	50,465.30
435						
436				V46.11	DEPENDENCE ON RESPIRATOR STATUS	47,042.45
437						
438				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,190,442.90
439						
440				V46.11	DEPENDENCE ON RESPIRATOR STATUS	146,234.85
441						
442				V46.11	DEPENDENCE ON RESPIRATOR STATUS	424,158.25
443						
444				V46.11	DEPENDENCE ON RESPIRATOR STATUS	107,565.75
445						
446				V46.11	DEPENDENCE ON RESPIRATOR STATUS	242,638.60
447						
448				V46.11	DEPENDENCE ON RESPIRATOR STATUS	181,449.20
449						
450				V46.11	DEPENDENCE ON RESPIRATOR STATUS	81,935.50
451						
452				V46.11	DEPENDENCE ON RESPIRATOR STATUS	6,367.20

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	G	H	I	J	K	L	M	N
1								
2	DX_POS	ACCT_CLASS	ADM_DATE	DISCH_DATE	LOB_NAME	DRG_NUMBER	DRG_DESCRIPTION	ATTENDING_PROV_ID
424	3	Inpatient	REDACTED		KP Traditional	642	INBORN AND OTHER DISORDERS OF METABOLISM	REDACTED
425								
426	31	Inpatient			KP Traditional	326	STOMACH, ESOPHAGEAL & DUODENAL PROC W MCC	
427								
428	21	Inpatient			Medicare Advantage	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
429								
430	3	Inpatient			Medicare Advantage	388	G.I. OBSTRUCTION W MCC	
431								
432	4	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
433								
434	2	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
435								
436	8	Inpatient			Medicare Advantage	698	OTHER KIDNEY & URINARY TRACT DIAGNOSES W MCC	
437								
438	17	Inpatient			Medicare Advantage	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	
439								
440	4	Inpatient			Medicare Advantage	291	HEART FAILURE & SHOCK W MCC	
441								
442	13	Inpatient			Medicare Advantage	231	CORONARY BYPASS W PTCA W MCC	
443								
444	3	Inpatient			Commercial	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
445								
446	4	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
447								
448	6	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
449								
450	4	Inpatient			KP Traditional	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
451								
452	3	Observation			KP Traditional	UNK	Unknown DRG	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
424	REDACTED	Non-Health Care Facility Point of Origin
425		
426		Non-Health Care Facility Point of Origin
427		
428		Non-Health Care Facility Point of Origin
429		
430		Non-Health Care Facility Point of Origin
431		
432		Non-Health Care Facility Point of Origin
433		
434		Non-Health Care Facility Point of Origin
435		
436		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
437		
438		Transfer from a Hospital (Different Facility)
439		
440		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
441		
442		Transfer from a Hospital (Different Facility)
443		
444		Non-Health Care Facility Point of Origin
445		
446		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
447		
448		Non-Health Care Facility Point of Origin
449		
450		Non-Health Care Facility Point of Origin
451		
452		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
424	HOME - Discharge to Home or Self Care (Routine Discharge)	E
425		
426	DIED - Expired	N
427		
428	SN/IC - D/T to SNF with Medicare Certification	E
429		
430	DIED - Expired	E
431		
432	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
433		
434	SN/IC - D/T to SNF with Medicare Certification	E
435		
436	SN/IC - D/T to SNF with Medicare Certification	E
437		
438	SN/IC - D/T to SNF with Medicare Certification	E
439		
440	SN/IC - D/T to SNF with Medicare Certification	E
441		
442	SN/IC - D/T to SNF with Medicare Certification	E
443		
444	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
445		
446	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
447		
448	SN/IC - D/T to SNF with Medicare Certification	E
449		
450	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
451		
452	HOME - Discharge to Home or Self Care (Routine Discharge)	

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
453	[redacted]	REDACTED	[redacted]			
454				V46.11	DEPENDENCE ON RESPIRATOR STATUS	12,812.25
455						
456				V46.11	DEPENDENCE ON RESPIRATOR STATUS	663,047.00
457						
458				V46.11	DEPENDENCE ON RESPIRATOR STATUS	603.80
459						
460				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,474.80
461						
462				V46.11	DEPENDENCE ON RESPIRATOR STATUS	663.65
463						
464				V46.11	DEPENDENCE ON RESPIRATOR STATUS	600.45
465						
466				V46.11	DEPENDENCE ON RESPIRATOR STATUS	99,232.80
467						
468				V46.11	DEPENDENCE ON RESPIRATOR STATUS	6,770.45
469						
470				V46.11	DEPENDENCE ON RESPIRATOR STATUS	9,164.45
471						
472				V46.11	DEPENDENCE ON RESPIRATOR STATUS	7,290.45
473						
474				V46.11	DEPENDENCE ON RESPIRATOR STATUS	7,229.85
475						
476				V46.11	DEPENDENCE ON RESPIRATOR STATUS	7,290.45
477						
478				V46.11	DEPENDENCE ON RESPIRATOR STATUS	61,057.35
479						
480				V46.11	DEPENDENCE ON RESPIRATOR STATUS	515,021.70
481						
482				V46.11	DEPENDENCE ON RESPIRATOR STATUS	11,047.25

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	G	H	I	J	K	L	M	N
1								
2	DX_POS	ACCT_CLASS	ADM_DATE	DISCH_DATE	LOB_NAME	DRG_NUMBER	DRG_DESCRIPTION	ATTENDING_PROV_ID
453			REDACTED					REDACTED
454	2	Inpatient			KP Traditional	642	INBORN AND OTHER DISORDERS OF METABOLISM	
455								
456	6	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
457								
458	13	Outpatient			KP Traditional	UNK	Unknown DRG	
459								
460	16	Outpatient			KP Traditional	UNK	Unknown DRG	
461								
462	16	Outpatient			KP Traditional	UNK	Unknown DRG	
463								
464	3	Outpatient			KP Traditional	UNK	Unknown DRG	
465								
466	6	Inpatient			Medicaid	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
467								
468	2	Inpatient			KP Traditional	642	INBORN AND OTHER DISORDERS OF METABOLISM	
469								
470	2	Inpatient			KP Traditional	642	INBORN AND OTHER DISORDERS OF METABOLISM	
471								
472	2	Inpatient			KP Traditional	642	INBORN AND OTHER DISORDERS OF METABOLISM	
473								
474	16	Observation			Medicare Advantage	UNK	Unknown DRG	
475								
476	2	Inpatient			KP Traditional	642	INBORN AND OTHER DISORDERS OF METABOLISM	
477								
478	11	Inpatient			KP Traditional	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
479								
480	6	Inpatient			Medicare Advantage	056	DEGENERATIVE NERVOUS SYSTEM DISORDERS W MCC	
481								
482	2	Inpatient			KP Traditional	092	OTHER DISORDERS OF NERVOUS SYSTEM W CC	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
453	REDACTED	
454		Non-Health Care Facility Point of Origin
455		
456		Transfer from a Hospital (Different Facility)
457		
458		Non-Health Care Facility Point of Origin
459		
460		Non-Health Care Facility Point of Origin
461		
462		Non-Health Care Facility Point of Origin
463		
464		Non-Health Care Facility Point of Origin
465		
466		Non-Health Care Facility Point of Origin
467		
468		Non-Health Care Facility Point of Origin
469		
470		Non-Health Care Facility Point of Origin
471		
472		Non-Health Care Facility Point of Origin
473		
474		Non-Health Care Facility Point of Origin
475		
476		Non-Health Care Facility Point of Origin
477		
478		Non-Health Care Facility Point of Origin
479		
480		Transfer from a Hospital (Different Facility)
481		
482		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
453		
454	HOME - Discharge to Home or Self Care (Routine Discharge)	E
455		
456	SN/IC - D/T to SNF with Medicare Certification	E
457		
458	HOME - Discharge to Home or Self Care (Routine Discharge)	
459		
460	HOME - Discharge to Home or Self Care (Routine Discharge)	
461		
462	HOME - Discharge to Home or Self Care (Routine Discharge)	
463		
464	HOME - Discharge to Home or Self Care (Routine Discharge)	
465		
466	ACUTE CARE TO ANOTHER HOSP-D/T to a Medicare Certified Long Term Care Hosp (LTCH)	E
467		
468	HOME - Discharge to Home or Self Care (Routine Discharge)	E
469		
470	HOME - Discharge to Home or Self Care (Routine Discharge)	E
471		
472	HOME - Discharge to Home or Self Care (Routine Discharge)	E
473		
474	HOME - Discharge to Home or Self Care (Routine Discharge)	
475		
476	HOME - Discharge to Home or Self Care (Routine Discharge)	E
477		
478	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
479		
480	SN/IC - D/T to SNF with Medicare Certification	E
481		
482	HOME - Discharge to Home or Self Care (Routine Discharge)	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
483	[redacted]	REDACTED	[redacted]			
484	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	75,800.95
485	[redacted]	[redacted]	[redacted]			
486	[redacted]	[redacted]	[redacted]			
487	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	79,580.45
488	[redacted]	[redacted]	[redacted]			
489	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	21,438.60
490	[redacted]	[redacted]	[redacted]			
491	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,307.00
492	[redacted]	[redacted]	[redacted]			
493	[redacted]	[redacted]	[redacted]			
494	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	574,501.05
495	[redacted]	[redacted]	[redacted]			
496	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	48,073.50
497	[redacted]	[redacted]	[redacted]			
498	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	54,961.95
499	[redacted]	[redacted]	[redacted]			
500	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	190,824.00
501	[redacted]	[redacted]	[redacted]			
502	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	548,269.25
503	[redacted]	[redacted]	[redacted]			
504	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,337.10
505	[redacted]	[redacted]	[redacted]			
506	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,062.50
507	[redacted]	[redacted]	[redacted]			
508	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	5,635.95
509	[redacted]	[redacted]	[redacted]			
510	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,748.90
511	[redacted]	[redacted]	[redacted]			
512	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,015.35
513	[redacted]	[redacted]	[redacted]			
514	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,496.40
515	[redacted]	[redacted]	[redacted]			
516	[redacted]	[redacted]	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,528.75

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	G	H	I	J	K	L	M	N
1								
2	DX_POS	ACCT_CLASS	ADM_DATE	DISCH_DATE	LOB_NAME	DRG_NUMBER	DRG_DESCRIPTION	ATTENDING_PROV_ID
483			REDACTED					REDACTED
484	4	Inpatient			KP Traditional	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
485								
486								
487	4	Inpatient			Medicare Advantage	064	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W MCC	
488								
489	2	Inpatient			KP Medicaid	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
490								
491	12	Emergency			Medicare Advantage	UNK	Unknown DRG	
492								
493								
494	12	Inpatient			Medicare Advantage	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
495								
496	3	Inpatient			Medicare Advantage	389	G.I. OBSTRUCTION W CC	
497								
498	3	Inpatient			Medicare Unassigned	915	ALLERGIC REACTIONS W MCC	
499								
500	17	Inpatient			Medicare Advantage	907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	
501								
502	11	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
503								
504	16	Emergency			Medicare Advantage	UNK	Unknown DRG	
505								
506	14	Emergency			Medicare Advantage	UNK	Unknown DRG	
507								
508	19	Emergency			Medicare Advantage	UNK	Unknown DRG	
509								
510	23	Emergency			Medicare Advantage	UNK	Unknown DRG	
511								
512	29	Emergency			Medicare Advantage	UNK	Unknown DRG	
513								
514	35	Emergency			Medicare Advantage	UNK	Unknown DRG	
515								
516	17	Emergency			Medicare Advantage	UNK	Unknown DRG	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
483	REDACTED	
484		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
485		
486		
487		Transfer from a Hospital (Different Facility)
488		
489		Transfer from a Hospital (Different Facility)
490		
491		Non-Health Care Facility Point of Origin
492		
493		
494		Non-Health Care Facility Point of Origin
495		
496		Non-Health Care Facility Point of Origin
497		
498		Non-Health Care Facility Point of Origin
499		
500		Non-Health Care Facility Point of Origin
501		
502		Non-Health Care Facility Point of Origin
503		
504		Non-Health Care Facility Point of Origin
505		
506		Non-Health Care Facility Point of Origin
507		
508		Non-Health Care Facility Point of Origin
509		
510		Non-Health Care Facility Point of Origin
511		
512		Non-Health Care Facility Point of Origin
513		
514		Non-Health Care Facility Point of Origin
515		
516		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
483		
484	SN/IC - D/T to SNF with Medicare Certification	E
485		
486		
487	DIED - Expired	E
488		
489	HOME - Discharge to Home or Self Care (Routine Discharge)	E
490		
491	HOME - Discharge to Home or Self Care (Routine Discharge)	
492		
493		
494	SN/IC - D/T to SNF with Medicare Certification	E
495		
496	HOME - Discharge to Home or Self Care (Routine Discharge)	E
497		
498	HOME - Discharge to Home or Self Care (Routine Discharge)	E
499		
500	SN/IC - D/T to SNF with Medicare Certification	E
501		
502	HOME HEALTH SERVICES - Discharge to Home Hospice	E
503		
504	HOME - Discharge to Home or Self Care (Routine Discharge)	
505		
506	HOME - Discharge to Home or Self Care (Routine Discharge)	
507		
508	HOME - Discharge to Home or Self Care (Routine Discharge)	
509		
510	HOME - Discharge to Home or Self Care (Routine Discharge)	
511		
512	HOME - Discharge to Home or Self Care (Routine Discharge)	
513		
514	HOME - Discharge to Home or Self Care (Routine Discharge)	
515		
516	HOME - Discharge to Home or Self Care (Routine Discharge)	

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
517	[redacted]	REDACTED	[redacted]			
518				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,581.30
519						
520				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,038.20
521						
522				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,952.70
523						
524				V46.11	DEPENDENCE ON RESPIRATOR STATUS	427,934.65
525						
526				V46.11	DEPENDENCE ON RESPIRATOR STATUS	91,780.95
527						
528				V46.11	DEPENDENCE ON RESPIRATOR STATUS	88,730.35
529						
530				V46.11	DEPENDENCE ON RESPIRATOR STATUS	24,776.50
531						
532				V46.11	DEPENDENCE ON RESPIRATOR STATUS	304,594.65
533						
534				V46.11	DEPENDENCE ON RESPIRATOR STATUS	40,858.05
535						
536						
537				V46.11	DEPENDENCE ON RESPIRATOR STATUS	786,623.42
538						
539				V46.11	DEPENDENCE ON RESPIRATOR STATUS	26,469.30
540						
541				V46.11	DEPENDENCE ON RESPIRATOR STATUS	222,682.05
542						
543				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,936.00
544						
545				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,345.00
546						
547				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,696.00

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
517			REDACTED					REDACTED
518	25	Emergency			Medicare Advantage	UNK	Unknown DRG	
519								
520	14	Emergency			Self Funding	UNK	Unknown DRG	
521								
522	10	Emergency			KP Traditional	UNK	Unknown DRG	
523								
524	12	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
525								
526	8	Inpatient			Medicare Advantage	280	ACUTE MYOCARDIAL INFARCTION, DISCHARGED ALIVE W MCC	
527								
528	5	Inpatient			Medicare Advantage	329	MAJOR SMALL & LARGE BOWEL PROCEDURES W MCC	
529								
530	10	Inpatient			Medicaid	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
531								
532	7	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
533								
534	3	Inpatient			Medicare Advantage	189	PULMONARY EDEMA & RESPIRATORY FAILURE	
535								
536								
537	13	Inpatient			Commercial	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
538								
539	3	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
540								
541	11	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
542								
543	11	Emergency			KP Traditional	UNK	Unknown DRG	
544								
545	9	Emergency			KP Traditional	UNK	Unknown DRG	
546								
547	3	Emergency			KP Traditional	UNK	Unknown DRG	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
517	REDACTED	
518		Non-Health Care Facility Point of Origin
519		
520		Non-Health Care Facility Point of Origin
521		
522		Non-Health Care Facility Point of Origin
523		
524		Non-Health Care Facility Point of Origin
525		
526		Non-Health Care Facility Point of Origin
527		
528		Non-Health Care Facility Point of Origin
529		
530		Non-Health Care Facility Point of Origin
531		
532		Transfer from a Hospital (Different Facility)
533		
534		Transfer from a Hospital (Different Facility)
535		
536		
537		Non-Health Care Facility Point of Origin
538		
539		Transfer from a Hospital (Different Facility)
540		
541		Non-Health Care Facility Point of Origin
542		
543		Non-Health Care Facility Point of Origin
544		
545		Non-Health Care Facility Point of Origin
546		
547		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
517		
518	HOME - Discharge to Home or Self Care (Routine Discharge)	
519		
520	HOME - Discharge to Home or Self Care (Routine Discharge)	
521		
522	HOME - Discharge to Home or Self Care (Routine Discharge)	
523		
524	HOME - Discharge to Home or Self Care (Routine Discharge)	E
525		
526	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
527		
528	HOME - Discharge to Home or Self Care (Routine Discharge)	E
529		
530	HOME - Discharge to Home or Self Care (Routine Discharge)	E
531		
532	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
533		
534	HOME HEALTH SERVICES - Discharge to Home Hospice	E
535		
536		
537	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
538		
539	DIED - Expired	E
540		
541	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
542		
543	HOME - Discharge to Home or Self Care (Routine Discharge)	
544		
545	HOME - Discharge to Home or Self Care (Routine Discharge)	
546		
547	HOME - Discharge to Home or Self Care (Routine Discharge)	

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
548	[redacted]	REDACTED	[redacted]			
549				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,334.00
550						
551				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,571.70
552						
553				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,784.25
554						
555				V46.11	DEPENDENCE ON RESPIRATOR STATUS	844,318.35
556						
557				V46.11	DEPENDENCE ON RESPIRATOR STATUS	652,692.10
558				V46.11	DEPENDENCE ON RESPIRATOR STATUS	
559						
560				V46.11	DEPENDENCE ON RESPIRATOR STATUS	77,105.70
561						
562				V46.11	DEPENDENCE ON RESPIRATOR STATUS	310,168.65
563						
564				V46.11	DEPENDENCE ON RESPIRATOR STATUS	15,309.05
565						
566				V46.11	DEPENDENCE ON RESPIRATOR STATUS	271,139.25
567						
568				V46.11	DEPENDENCE ON RESPIRATOR STATUS	140,712.35
569						
570				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,413.00
571						
572				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,739.00
573						
574				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,125.55
575						
576				V46.11	DEPENDENCE ON RESPIRATOR STATUS	333,708.20
577						

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
548			REDACTED					REDACTED
549	14	Emergency			KP Traditional	UNK	Unknown DRG	
550								
551	16	Emergency			KP Traditional	UNK	Unknown DRG	
552								
553	11	Emergency			KP Traditional	UNK	Unknown DRG	
554								
555	13	Inpatient			Medicare Advantage	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
556								
557	11	Inpatient			Medicare Advantage	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
558	11							
559								
560	5	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
561								
562	6	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
563								
564	3	Inpatient			Medicare Advantage	640	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	
565								
566	5	Inpatient			Self-Pay	963	OTHER MULTIPLE SIGNIFICANT TRAUMA W MCC	
567								
568	7	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
569								
570	7	Emergency			Medicare Advantage	UNK	Unknown DRG	
571								
572	7	Emergency			KP Traditional	UNK	Unknown DRG	
573								
574	10	Emergency			KP Traditional	UNK	Unknown DRG	
575								
576	9	Inpatient			Medicaid	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
577								

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
548	REDACTED	
549		Non-Health Care Facility Point of Origin
550		
551		Non-Health Care Facility Point of Origin
552		
553		Non-Health Care Facility Point of Origin
554		
555		Transfer from a Hospital (Different Facility)
556		
557		Non-Health Care Facility Point of Origin
558		
559		
560		Non-Health Care Facility Point of Origin
561		
562		Transfer from a Hospital (Different Facility)
563		
564		Transfer from a Hospital (Different Facility)
565		
566		Non-Health Care Facility Point of Origin
567		
568		Non-Health Care Facility Point of Origin
569		
570		Non-Health Care Facility Point of Origin
571		
572		Non-Health Care Facility Point of Origin
573		
574		Non-Health Care Facility Point of Origin
575		
576		Non-Health Care Facility Point of Origin
577		

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
548		
549	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	
550		
551	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	
552		
553	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	
554		
555	SN/IC - D/T to SNF with Medicare Certification	E
556		
557	SN/IC - D/T to SNF with Medicare Certification	E
558	HOME - Discharge to Home or Self Care (Routine Discharge)	E
559		
560	DIED - Expired	E
561		
562	SN/IC - D/T to SNF with Medicare Certification	E
563		
564	SN/IC - D/T to SNF with Medicare Certification	E
565		
566	HOME - Discharge to Home or Self Care (Routine Discharge)	E
567		
568	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
569		
570	HOME - Discharge to Home or Self Care (Routine Discharge)	
571		
572	HOME - Discharge to Home or Self Care (Routine Discharge)	
573		
574	HOME - Discharge to Home or Self Care (Routine Discharge)	
575		
576	SN/IC - D/T to SNF with Medicare Certification	E
577		

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
578	[redacted]	REDACTED	[redacted]	V46.11	DEPENDENCE ON RESPIRATOR STATUS	678,582.75
579						
580				V46.11	DEPENDENCE ON RESPIRATOR STATUS	0.00
581						
582				V46.11	DEPENDENCE ON RESPIRATOR STATUS	340,795.71
583						
584						
585				V46.11	DEPENDENCE ON RESPIRATOR STATUS	187,644.35
586						
587				V46.11	DEPENDENCE ON RESPIRATOR STATUS	359.00
588						
589				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,450.90
590						
591				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,392.00
592						
593				V46.11	DEPENDENCE ON RESPIRATOR STATUS	11,748.52
594						
595				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,009.65
596						
597				V46.11	DEPENDENCE ON RESPIRATOR STATUS	2,170.00
598						
599						
600				V46.11	DEPENDENCE ON RESPIRATOR STATUS	52,910.30
601						
602				V46.11	DEPENDENCE ON RESPIRATOR STATUS	20,121.20
603						
604				V46.11	DEPENDENCE ON RESPIRATOR STATUS	19,309.40
605						
606				V46.11	DEPENDENCE ON RESPIRATOR STATUS	15.00
607						
608				V46.11	DEPENDENCE ON RESPIRATOR STATUS	171,295.90
609						
610				V46.11	DEPENDENCE ON RESPIRATOR STATUS	95,459.70
611						
612				V46.11	DEPENDENCE ON RESPIRATOR STATUS	7,638.40

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	G	H	I	J	K	L	M	N
1								
2	DX_POS	ACCT_CLASS	ADM_DATE	DISCH_DATE	LOB_NAME	DRG_NUMBER	DRG_DESCRIPTION	ATTENDING_PROV_ID
578	7	Inpatient	REDACTED		Medicaid	166	OTHER RESP SYSTEM O.R. PROCEDURES W MCC	REDACTED
579								
580	3	Inpatient			Medicare Advantage	189	PULMONARY EDEMA & RESPIRATORY FAILURE	
581								
582	10	Inpatient			Medicare	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
583								
584								
585	8	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
586								
587	7	Emergency			Medicare Advantage	UNK	Unknown DRG	
588								
589	5	Emergency			KP Traditional	UNK	Unknown DRG	
590								
591	10	Emergency			KP Traditional	UNK	Unknown DRG	
592								
593	16	Hospital Ambulatory Surgery			Medicare Advantage	UNK	Unknown DRG	
594								
595	7	Outpatient			KP Traditional	UNK	Unknown DRG	
596								
597	5	Emergency			Medicare Advantage	UNK	Unknown DRG	
598								
599								
600	4	Inpatient			Medicare Advantage	920	COMPLICATIONS OF TREATMENT W CC	
601								
602	9	Hospital Ambulatory Surgery			KP Traditional	UNK	Unknown DRG	
603								
604	9	Hospital Ambulatory Surgery			Medicare Advantage	UNK	Unknown DRG	
605								
606	12	Hospital Ambulatory Surgery			KP Traditional	UNK	Unknown DRG	
607								
608	4	Inpatient			KP Traditional	052	SPINAL DISORDERS & INJURIES W CC/MCC	
609								
610	6	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
611								
612	19	Hospital Ambulatory Surgery			Medicare Advantage	UNK	Unknown DRG	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
578	REDACTED	Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
579		
580		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
581		
582		Non-Health Care Facility Point of Origin
583		
584		
585		Non-Health Care Facility Point of Origin
586		
587		Non-Health Care Facility Point of Origin
588		
589		Non-Health Care Facility Point of Origin
590		
591		Non-Health Care Facility Point of Origin
592		
593		Non-Health Care Facility Point of Origin
594		
595		Non-Health Care Facility Point of Origin
596		
597		Non-Health Care Facility Point of Origin
598		
599		
600		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
601		
602		Non-Health Care Facility Point of Origin
603		
604		Non-Health Care Facility Point of Origin
605		
606		Non-Health Care Facility Point of Origin
607		
608		Transfer from a Hospital (Different Facility)
609		
610		Non-Health Care Facility Point of Origin
611		
612		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
578	SN/IC - D/T to SNF with Medicare Certification	E
579		
580		E
581		
582	OTHER CARE TO ANOTHER HOSP - D/T to an Inpt Rehab Facility (IRF) including Rehab Dist	E
583		
584		
585	SN/IC - D/T to SNF with Medicare Certification	E
586		
587	HOME - Discharge to Home or Self Care (Routine Discharge)	
588		
589	HOME - Discharge to Home or Self Care (Routine Discharge)	
590		
591	HOME - Discharge to Home or Self Care (Routine Discharge)	
592		
593	HOME - Discharge to Home or Self Care (Routine Discharge)	
594		
595	HOME - Discharge to Home or Self Care (Routine Discharge)	
596		
597	HOME - Discharge to Home or Self Care (Routine Discharge)	
598		
599		
600	SN/IC - D/T to SNF with Medicare Certification	E
601		
602	HOME - Discharge to Home or Self Care (Routine Discharge)	
603		
604	HOME - Discharge to Home or Self Care (Routine Discharge)	
605		
606	HOME - Discharge to Home or Self Care (Routine Discharge)	
607		
608	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
609		
610	DIED - Expired	E
611		
612	HOME - Discharge to Home or Self Care (Routine Discharge)	

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
613	[redacted]	REDACTED	[redacted]			
614				V46.11	DEPENDENCE ON RESPIRATOR STATUS	329,497.95
615						
616				V46.11	DEPENDENCE ON RESPIRATOR STATUS	77,613.00
617						
618				V46.11	DEPENDENCE ON RESPIRATOR STATUS	92,647.95
619						
620				V46.11	DEPENDENCE ON RESPIRATOR STATUS	142,253.35
621						
622				V46.11	DEPENDENCE ON RESPIRATOR STATUS	19,215.85
623						
624				V46.11	DEPENDENCE ON RESPIRATOR STATUS	55,758.15
625						
626				V46.11	DEPENDENCE ON RESPIRATOR STATUS	55,711.40
627						
628				V46.11	DEPENDENCE ON RESPIRATOR STATUS	88,230.20
629						
630				V46.11	DEPENDENCE ON RESPIRATOR STATUS	100,358.45
631						
632						
633				V46.11	DEPENDENCE ON RESPIRATOR STATUS	18,494.50
634						
635				V46.11	DEPENDENCE ON RESPIRATOR STATUS	210,507.75
636						
637				V46.11	DEPENDENCE ON RESPIRATOR STATUS	459,510.00
638						
639				V46.11	DEPENDENCE ON RESPIRATOR STATUS	196,835.10

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	G	H	I	J	K	L	M	N
1								
2	DX_POS	ACCT_CLASS	ADM_DATE	DISCH_DATE	LOB_NAME	DRG_NUMBER	DRG_DESCRIPTION	ATTENDING_PROV_ID
613			REDACTED					REDACTED
614	6	Inpatient			Medicare	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
615								
616	3	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
617								
618	2	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
619								
620	4	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
621								
622	3	Inpatient			Medicare Advantage	640	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W MCC	
623								
624	4	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
625								
626	3	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
627								
628	4	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
629								
630	6	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
631								
632								
633	2	Inpatient			Medicare Advantage	872	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W/O MCC	
634								
635	7	Inpatient			HDHP	075	VIRAL MENINGITIS W CC/MCC	
636								
637	17	Inpatient			Medicare Advantage	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	
638								
639	7	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
613	REDACTED	
614		Non-Health Care Facility Point of Origin
615		
616		Non-Health Care Facility Point of Origin
617		
618		Non-Health Care Facility Point of Origin
619		
620		Non-Health Care Facility Point of Origin
621		
622		Non-Health Care Facility Point of Origin
623		
624		Non-Health Care Facility Point of Origin
625		
626		Non-Health Care Facility Point of Origin
627		
628		Non-Health Care Facility Point of Origin
629		
630		Non-Health Care Facility Point of Origin
631		
632		
633		Non-Health Care Facility Point of Origin
634		
635		Non-Health Care Facility Point of Origin
636		
637		Non-Health Care Facility Point of Origin
638		
639		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
613		
614	SN/IC - D/T to SNF with Medicare Certification	E
615		
616	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
617		
618	HOME - Discharge to Home or Self Care (Routine Discharge)	E
619		
620	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
621		
622	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
623		
624	HOME - Discharge to Home or Self Care (Routine Discharge)	E
625		
626	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
627		
628	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
629		
630	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
631		
632		
633	SN/IC - D/T to SNF with Medicare Certification	E
634		
635	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	E
636		
637	SN/IC - D/T to SNF with Medicare Certification	E
638		
639	DIED - Expired	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
640	[redacted]	REDACTED	[redacted]			
641				V46.11	DEPENDENCE ON RESPIRATOR STATUS	115,043.90
642						
643				V46.11	DEPENDENCE ON RESPIRATOR STATUS	116,022.55
644						
645				V46.11	DEPENDENCE ON RESPIRATOR STATUS	80,806.73
646						
647				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,292,424.10
648						
649				V46.11	DEPENDENCE ON RESPIRATOR STATUS	278,857.75
650						
651				V46.11	DEPENDENCE ON RESPIRATOR STATUS	64,999.00
652						
653				V46.11	DEPENDENCE ON RESPIRATOR STATUS	258,240.25
654						
655				V46.11	DEPENDENCE ON RESPIRATOR STATUS	79,404.20
656						
657				V46.11	DEPENDENCE ON RESPIRATOR STATUS	50,790.35
658						
659				V46.11	DEPENDENCE ON RESPIRATOR STATUS	410,490.80
660						
661				V46.11	DEPENDENCE ON RESPIRATOR STATUS	123,822.05
662						
663				V46.11	DEPENDENCE ON RESPIRATOR STATUS	174,700.30
664						
665				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,823.20
666						
667				V46.11	DEPENDENCE ON RESPIRATOR STATUS	222,562.73

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	G	H	I	J	K	L	M	N
1								
2	**DX_POS**	**ACCT_CLASS**	**ADM_DATE**	**DISCH_DATE**	**LOB_NAME**	**DRG_NUMBER**	**DRG_DESCRIPTION**	**ATTENDING_PROV_ID**
640			REDACTED					REDACTED
641	9	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
642								
643	10	Inpatient			Medicare	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
644								
645	3	Inpatient			KP Traditional	163	MAJOR CHEST PROCEDURES W MCC	
646								
647	12	Inpatient			Medicare Advantage	091	OTHER DISORDERS OF NERVOUS SYSTEM W MCC	
648								
649	13	Inpatient			Self Funding	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
650								
651	7	Inpatient			Medicaid	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
652								
653	23	Inpatient			Medicare Advantage	371	MAJOR GASTROINTESTINAL DISORDERS & PERITONEAL INFECTIONS W MCC	
654								
655	2	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
656								
657	4	Inpatient			Medicare Advantage	208	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT <96 HOURS	
658								
659	11	Inpatient			KP Traditional	004	TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W/O MAJ O.R.	
660								
661	15	Inpatient			KP Traditional	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
662								
663	6	Inpatient			Medicare Advantage	207	RESPIRATORY SYSTEM DIAGNOSIS W VENTILATOR SUPPORT 96+ HOURS	
664								
665	2	Emergency			Medicare Advantage	UNK	Unknown DRG	
666								
667	5	Inpatient			Medicare Advantage	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
640	REDACTED	
641		Non-Health Care Facility Point of Origin
642		
643		Information Not Available
644		
645		Non-Health Care Facility Point of Origin
646		
647		Transfer from a Hospital (Different Facility)
648		
649		Non-Health Care Facility Point of Origin
650		
651		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
652		
653		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
654		
655		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
656		
657		Transfer from Skilled Nursing (SNF), Intermediate Care (ICF) or Assisted Living (ALF)
658		
659		Non-Health Care Facility Point of Origin
660		
661		Clinic or Physician's Office
662		
663		Non-Health Care Facility Point of Origin
664		
665		Non-Health Care Facility Point of Origin
666		
667		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
640		
641	SN/IC - D/T to SNF with Medicare Certification	E
642		
643	DIED - Expired	E
644		
645	HOME - Discharge to Home or Self Care (Routine Discharge)	E
646		
647	DIED - Expired	E
648		
649	DIED - Expired	E
650		
651	SN/IC - D/T to SNF with Medicare Certification	E
652		
653	DIED - Expired	E
654		
655	DIED - Expired	E
656		
657	SN/IC - D/T to SNF with Medicare Certification	E
658		
659	SN/IC - D/T to SNF with Medicare Certification	E
660		
661	DIED - Expired	E
662		
663	SN/IC - D/T to SNF with Medicare Certification	E
664		
665	HOME - Discharge to Home or Self Care (Routine Discharge)	
666		
667	DIED - Expired	E

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	A	B	C	D	E	F
1	NCHIM0009 DX IN ANY POSITION DETAIL	Medical Center Area: ALL	DX Codes: V46.11	Discharge From dates :	REDACTED	
2	**HAR_ACCOUNT_ID**	**PATIENT_MRN**	**PAT_NAME**	**ICD CODE**	**DX_NAME**	**TOT_CHGS**
668	[redacted]	REDACTED	[redacted]			
669				V46.11	DEPENDENCE ON RESPIRATOR STATUS	161,733.20
670						
671				V46.11	DEPENDENCE ON RESPIRATOR STATUS	167,606.90
672						
673				V46.11	DEPENDENCE ON RESPIRATOR STATUS	5,496.35
674						
675				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,232.30
676						
677				V46.11	DEPENDENCE ON RESPIRATOR STATUS	12,117.55
678						
679				V46.11	DEPENDENCE ON RESPIRATOR STATUS	5,915.30
680						
681				V46.11	DEPENDENCE ON RESPIRATOR STATUS	4,336.90
682						
683				V46.11	DEPENDENCE ON RESPIRATOR STATUS	3,188.10
684						
685				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,025.00
686						
687				V46.11	DEPENDENCE ON RESPIRATOR STATUS	1,947.00
688						
689				V46.11	DEPENDENCE ON RESPIRATOR STATUS	5,396.80
690						
691				V46.11	DEPENDENCE ON RESPIRATOR STATUS	5,850.00
692						
693				V46.11	DEPENDENCE ON RESPIRATOR STATUS	977.00
694						
695				V46.11	DEPENDENCE ON RESPIRATOR STATUS	23,890.15
696						
697				V46.11	DEPENDENCE ON RESPIRATOR STATUS	51,665.20
698						
699				V46.11	DEPENDENCE ON RESPIRATOR STATUS	291,485.22

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	G	H	I	J	K	L	M	N
1								
2	DX_POS	ACCT_CLASS	ADM_DATE	DISCH_DATE	LOB_NAME	DRG_NUMBER	DRG_DESCRIPTION	ATTENDING_PROV_ID
668			REDACTED					REDACTED
669	13	Inpatient			Medicare Advantage	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
670								
671	4	Inpatient			KP DHMO	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
672								
673	26	Emergency			Medicare Advantage	UNK	Unknown DRG	
674								
675	15	Emergency			KP Traditional	UNK	Unknown DRG	
676								
677	9	Emergency			Medicare Advantage	UNK	Unknown DRG	
678								
679	25	Emergency			Medicare Advantage	UNK	Unknown DRG	
680								
681	19	Emergency			Medicare Advantage	UNK	Unknown DRG	
682								
683	10	Emergency			KP Traditional	UNK	Unknown DRG	
684								
685	18	Emergency			Medicare Advantage	UNK	Unknown DRG	
686								
687	31	Emergency			Medicare Advantage	UNK	Unknown DRG	
688								
689	10	Emergency			Medicare Advantage	UNK	Unknown DRG	
690								
691	11	Emergency			KP Traditional	UNK	Unknown DRG	
692								
693	6	Emergency			Medicare Advantage	UNK	Unknown DRG	
694								
695	4	Inpatient			KP DHMO	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV 96+ HOURS W MCC	
696								
697	3	Inpatient			Medicare Advantage	870	SEPTICEMIA OR SEVERE SEPSIS W MV 96+ HOURS	
698								
699	12	Inpatient			Medicare Cost	003	ECMO OR TRACH W MV 96+ HRS OR PDX EXC FACE, MOUTH & NECK W MAJ O.R.	

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	O	P
1		
2	**PROV_NAME**	**ADMIT_SRC**
668	REDACTED	
669		Non-Health Care Facility Point of Origin
670		
671		Non-Health Care Facility Point of Origin
672		
673		Non-Health Care Facility Point of Origin
674		
675		Non-Health Care Facility Point of Origin
676		
677		Non-Health Care Facility Point of Origin
678		
679		Non-Health Care Facility Point of Origin
680		
681		Non-Health Care Facility Point of Origin
682		
683		Non-Health Care Facility Point of Origin
684		
685		Non-Health Care Facility Point of Origin
686		
687		Non-Health Care Facility Point of Origin
688		
689		Non-Health Care Facility Point of Origin
690		
691		Non-Health Care Facility Point of Origin
692		
693		Clinic or Physician's Office
694		
695		Non-Health Care Facility Point of Origin
696		
697		Non-Health Care Facility Point of Origin
698		
699		Non-Health Care Facility Point of Origin

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	Q	R
1		
2	**DISCH_DISPOSITION**	**POA**
668		
669	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E
670		
671	SN/IC - D/T to SNF with Medicare Certification	E
672		
673	HOME - Discharge to Home or Self Care (Routine Discharge)	
674		
675	HOME - Discharge to Home or Self Care (Routine Discharge)	
676		
677	HOME - Discharge to Home or Self Care (Routine Discharge)	
678		
679	OTHER CARE W/I THIS HOSP - Admitted as an Inpt to this Hosp	
680		
681	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	
682		
683	HOME - Discharge to Home or Self Care (Routine Discharge)	
684		
685	HOME - Discharge to Home or Self Care (Routine Discharge)	
686		
687	HOME - Discharge to Home or Self Care (Routine Discharge)	
688		
689	ACUTE CARE TO ANOTHER HOSP - D/T to Another Short Term	
690		
691	HOME - Discharge to Home or Self Care (Routine Discharge)	
692		
693	HOME - Discharge to Home or Self Care (Routine Discharge)	
694		
695	SN/IC - D/T to SNF with Medicare Certification	E
696		
697	SN/IC - D/T to SNF with Medicare Certification	E
698		
699	HOME HEALTH SERVICE - D/T to Home Under Care of Organized Home Health Service Organiz	E

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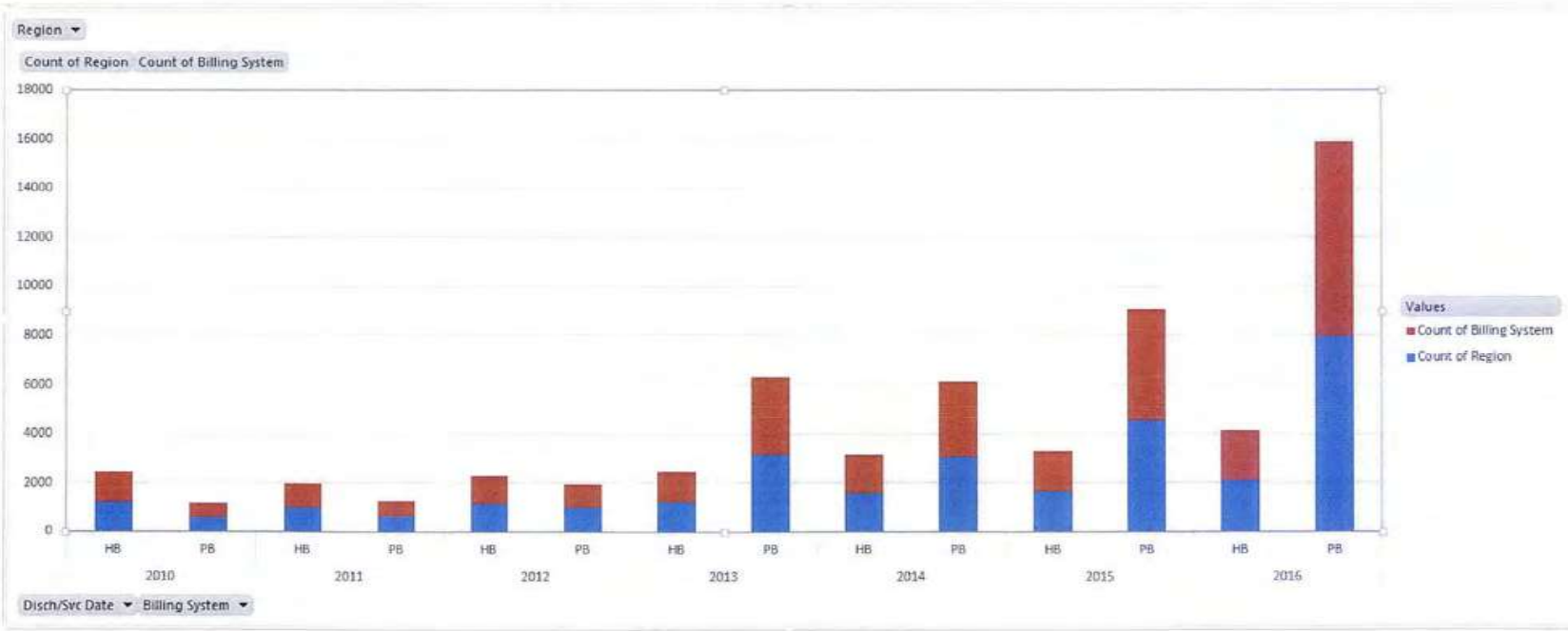
EXHIBIT 28

ALL REGIONS: 2010-2016 Volumes – Vent Dependence Code



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ALL REGIONS: 2010-2016

Region	(All)	
Row Labels	Count of Region	Count of Billing System
2010	1811	1811
HB	1224	1224
PB	587	587
2011	1633	1633
HB	1001	1001
PB	632	632
2012	2101	2101
HB	1130	1130
PB	971	971
2013	4393	4393
HB	1238	1238
PB	3155	3155
2014	4625	4625
HB	1563	1563
PB	3062	3062
2015	6176	6176
HB	1652	1652
PB	4524	4524
2016	10015	10015
HB	2072	2072
PB	7943	7943
Grand Total	30754	30754

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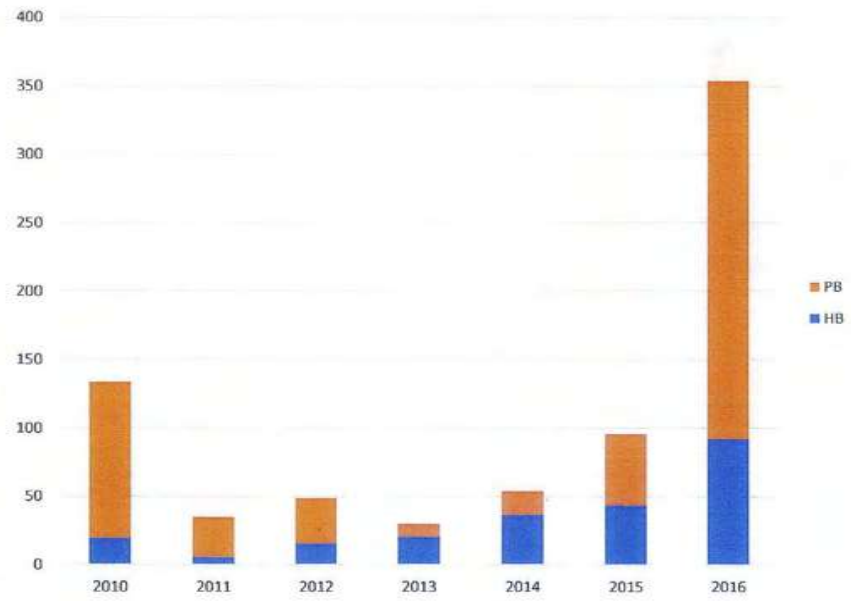
NW REGION

NW Vent Dependence Code			
Count of Diagnosis	Column Labels		
Row Labels	HB	PB	Grand Total
2010	20	114	134
2011	6	29	35
2012	16	33	49
2013	21	9	30
2014	37	17	54
2015	44	52	96
2016	92	262	354
Grand Total	236	516	752



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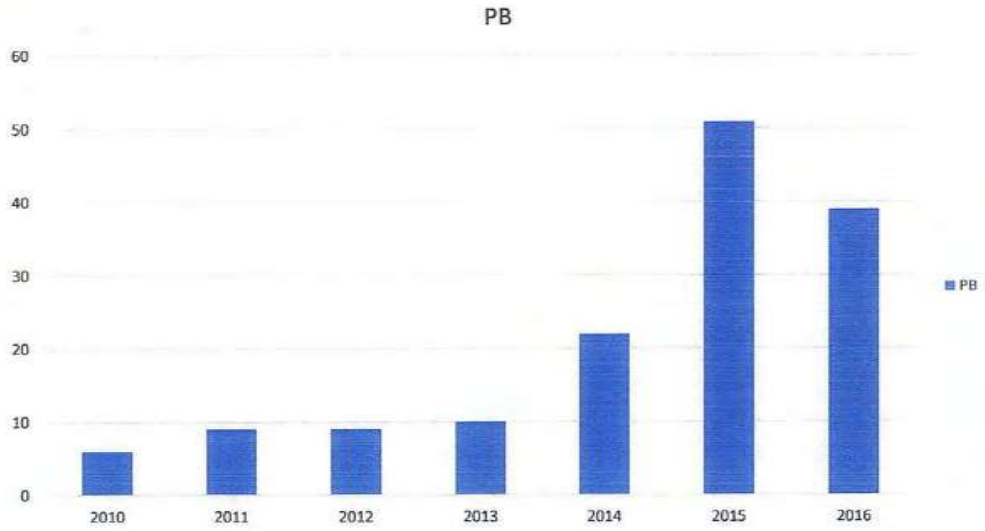
MAS REGION

MAS Vent Dependence Code		
Count of Diagnosis	Column Labels	
Row Labels	PB	Grand Total
2010	6	6
2011	9	9
2012	9	9
2013	10	10
2014	22	22
2015	51	51
2016	39	39
Grand Total	146	146



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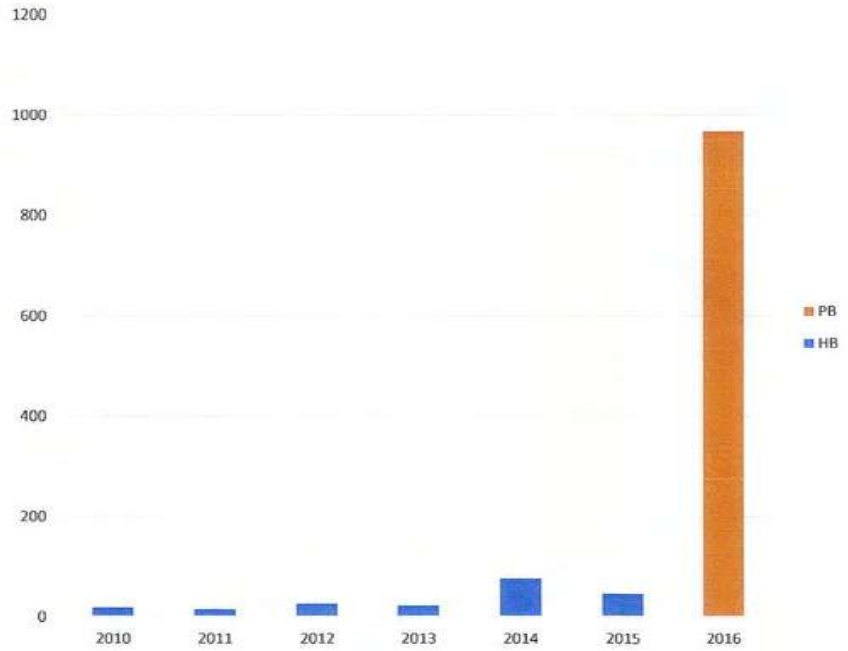
HI REGION

HI Vent Dependence Code			
Count of Diagnosis	Column Labels		
Row Labels	HB	PB	Grand Total
2010		18	18
2011		15	15
2012		26	26
2013		22	22
2014		76	76
2015		46	46
2016		968	968
Grand Total	203	968	1171



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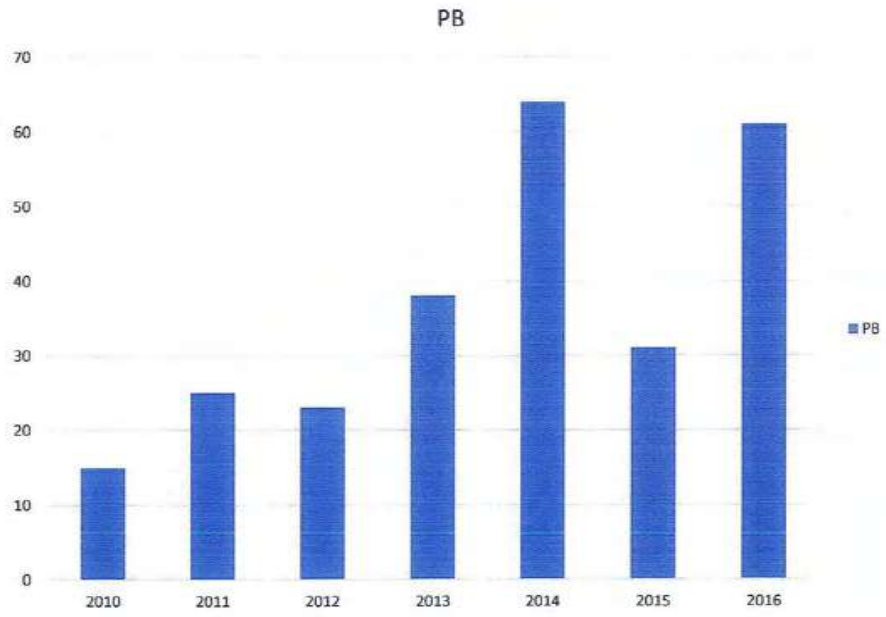
GA Region

GA Vent Dependence Code		
Count of Diagnosis	Column Labels	
Row Labels	PB	Grand Total
2010	15	15
2011	25	25
2012	23	23
2013	38	38
2014	64	64
2015	31	31
2016	61	61
Grand Total	257	257



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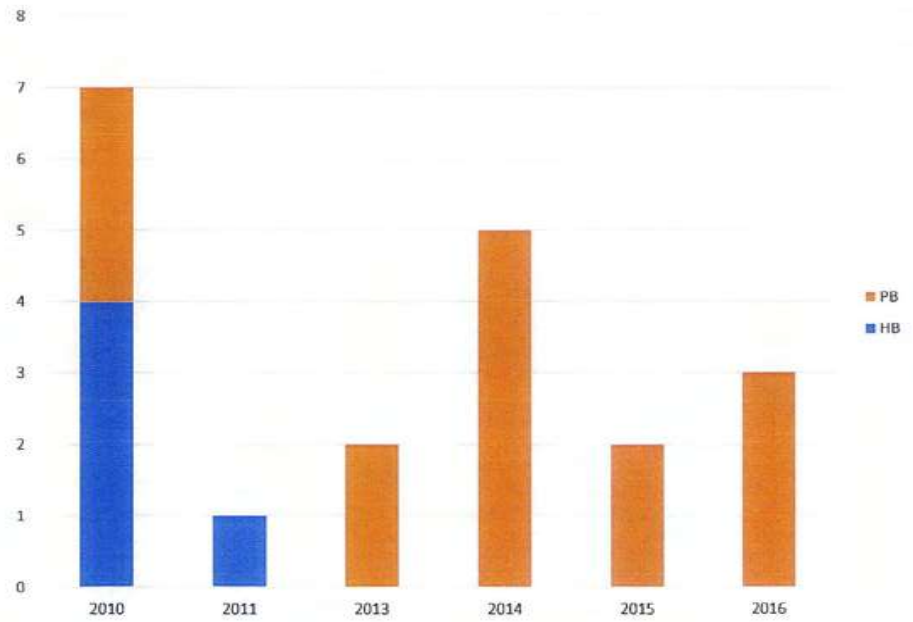
CO Region

CO	Vent Dependence Code		
Count of Diagnosis	Column Labels		
Row Labels	HB	PB	Grand Total
2010	4	3	7
2011	1		1
2013		2	2
2014		5	5
2015		2	2
2016		3	3
Grand Total	5	15	20



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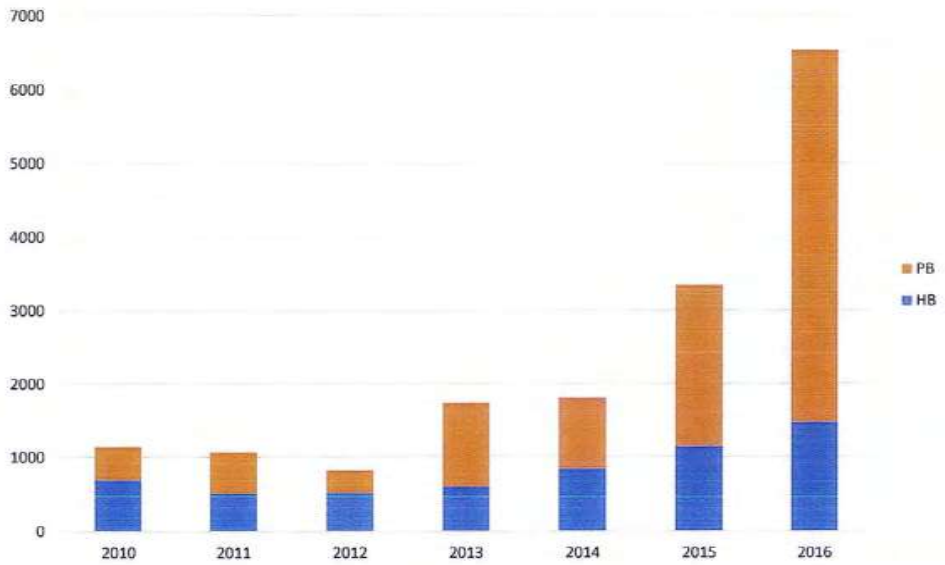
SCAL REGION

SCAL			
Vent Dependence Code			
Count of Diagnosis	Column Labels		
Row Labels	HB	PB	Grand Total
2010	706	441	1147
2011	516	552	1068
2012	527	295	822
2013	606	1137	1743
2014	854	951	1805
2015	1155	2188	3343
2016	1483	5048	6531
Grand Total	5847	10612	16459



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NCAL REGION

Vent Dependence Code		NCAL	
Count of Diagnosis	Column Labels		
Row Labels	HB	PB	Grand Total
2010	476	6	482
2011	463	17	480
2012	561	607	1168
2013	589	1946	2535
2014	637	1943	2580
2015	412	1799	2211
2016	451	2042	2493
Grand Total	3589	8360	11949

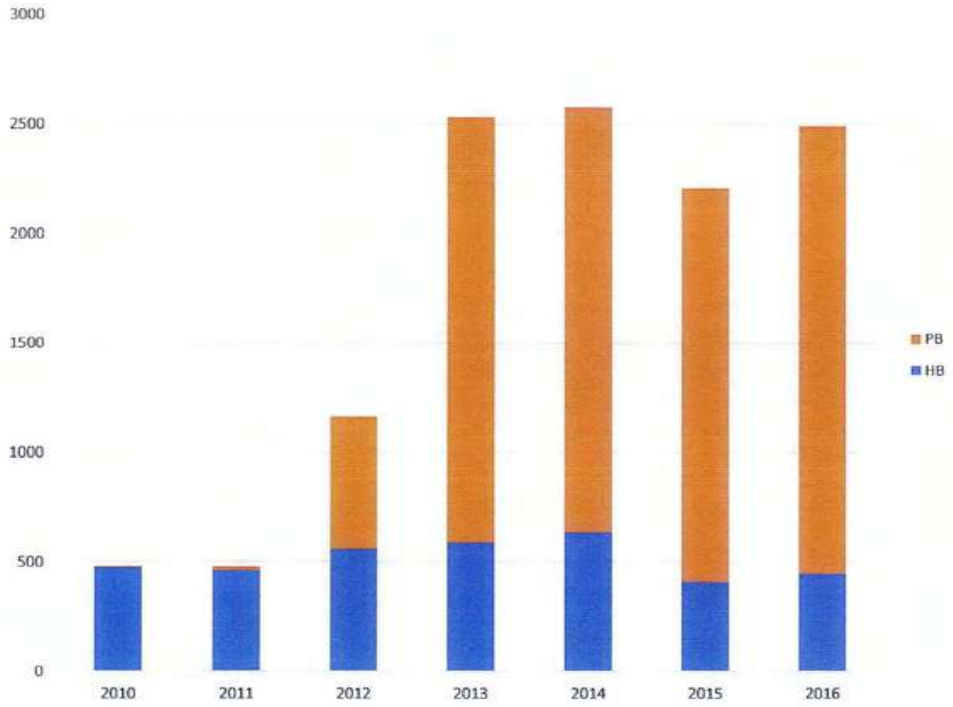

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EXHIBIT 29

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American Health Information Management Association Standards of Ethical Coding

Introduction

Coding is recognized as one of the core health information management (HIM) functions within healthcare. Due to the complex regulatory requirements affecting the health information coding process, coding professionals are frequently faced with ethical coding and coding-related challenges. The Standards of Ethical Coding are **important** established guidelines for any coding professional and are based on the American Health Information Management Association's (AHIMA's) Code of Ethics. Both reflect expectations of professional conduct for coding professionals involved in diagnostic and/or procedural coding, data abstraction and related coding and/or data activities.

A Code of Ethics sets forth professional values and ethical principles. In addition, a code of ethics offers ethical guidelines to which professionals aspire and by which their actions can be expected and be judged. HIM and coding professionals are expected to demonstrate professional values by their actions to patients, employers, members of the healthcare team, the public, and the many stakeholders they serve. A Code of Ethics is important in helping guide the decision-making process and can be referenced by individuals, agencies, organizations, and bodies (such as licensing and regulatory boards, insurance providers, courts of law, government agencies, and other professional groups). The Code of Ethics[1] is relevant to all AHIMA members, students, and CCHIIM credentialed HIM and coding professionals, regardless of their professional functions, the settings in which they work, or the populations they serve. All core health information coding activities are performed in compliance with state and federal regulations, and employer policies and procedures.[2]

The AHIMA Standards of Ethical Coding are intended to assist and guide coding professionals whether credentialed or not; including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students. The standards outline expectations for making ethical decisions in the workplace and demonstrate coding professionals' commitment to integrity during the coding process, regardless of the purpose for which the codes are being reported. They are relevant to all coding professionals, regardless of the healthcare setting (e.g., inpatient, outpatient, post-acute care, alternative care, etc.) in which they work or function.

These Standards of Ethical Coding have been revised in order to reflect the current healthcare environment and modern coding practices. This document is in two parts; part one includes the standards and part two contains the standards, guidelines, and examples. Additionally, definitions have been added for some key words and terms used throughout the document. The following definitions relate to and are used within the context of these Standards for consistency and continuity.

DEFINITIONS

The purpose of this definition section is to achieve clarity without needless repetition. These definitions are intended to reflect everyday meaning. It is not within the scope of this document to establish new definitions for the words.

Coding Professional: Individuals whether credentialed or not; including but not limited to coding staff, coding auditors, coding educators, clinical documentation improvement (CDI) professionals, and managers responsible for decision-making processes and operations as well as HIM/coding students.

Coding-related activities: The activities includes selection, research, and completion of code assignment, querying, other health record data abstraction, data analytics and reporting with codes, coding audits, remote coding, and coding educational activities and functions.

Data: All healthcare data elements including clinical, demographic, and financial.

Documentation: Clinical documentation found in the health record (medical record) in any format.

Encounter: The term *encounter* is used for all settings, including hospital admissions. All healthcare settings include the following: hospitals (inpatient and outpatient), physician offices, post-acute care (e.g., long- and short-term care), and other non-acute care (e.g., home health, hospice).

Established practices: Refers to processes and methods that are recognized and generally accepted such as AHIMA practice briefs and accrediting body standards.

Healthcare professionals: Those who are educated and skilled in any aspect of healthcare including direct and indirect patient care.

Provider: The term provider is used throughout the guidelines to mean physician or any qualified healthcare practitioner who is legally accountable for establishing the patient's diagnosis.

Query: A clarification or question to the provider through written, verbal, or electronic means regarding or related to clinical documentation in the health record.

Requirements: ICD coding conventions, official coding and reporting guidelines approved by the Cooperating Parties, the CPT rules established by the American Medical Association, applicable state and federal regulations, and any other official coding rules and guidelines (e.g., AHA Coding Clinic ICD-10-CM/PCS; AHA Coding Clinic for HCPCS; AMA CPT Assistant; AMA CPT Code book) established for use with mandated standard code sets.

Standards of Ethical Coding

1. Apply accurate, complete, and consistent coding practices that yield quality data.
2. Gather and report all data required for internal and external reporting, in accordance with applicable requirements and data set definitions.
3. Assign and report, in any format, only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, and requirements.
4. Query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices.
5. Refuse to participate in, support, or change reported data and/or narrative titles, billing data, clinical documentation practices, or any coding related activities intended to skew or misrepresent data and their meaning that do not comply with requirements.
6. Facilitate, advocate, and collaborate with healthcare professionals in the pursuit of accurate, complete and reliable coded data and in situations that support ethical coding practices.
7. Advance coding knowledge and practice through continuing education, including but not limited to meeting continuing education requirements.
8. Maintain the confidentiality of protected health information in accordance with the Code of Ethics.[3]
9. Refuse to participate in the development of coding and coding related technology that is not designed in accordance with requirements.
10. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.
11. Refuse to participate in and/or conceal unethical coding, data abstraction, query practices, or any inappropriate activities related to coding and address any perceived unethical coding related practices.

The Standards for Ethical Coding and How to Interpret the Standards of Ethical Coding

Standards and Guidelines

The following ethical standards are based on the core values of the American Health Information Management Association in the AHIMA Code of Ethics and apply to all coding professionals. Guidelines for each ethical standard are a non-inclusive list of behaviors and situations that can help to clarify the standard. They are not meant to be a comprehensive list of all situations that can occur.

1. Apply accurate, complete, and consistent coding practices that yield quality data.

Coding professionals shall:

1.1. Support selection of appropriate diagnostic, procedure, and other types of health service related codes (e.g., present on admission indicator, discharge status).

1.2. Develop and comply with comprehensive internal coding policies and procedures that are consistent with requirements.

Example: Develop internal policies and procedures for the coding function such as Facility Coding Guidelines that do not conflict with the Requirements and use as a framework for the work process, and education and training is provided on their use.

1.3. Foster an environment that supports honest and ethical coding practices resulting in accurate and reliable data.

Example: Regularly discussing the standards of ethical coding at staff meetings.

Coding professionals **shall not**:

1.4. Distort or participate in improper preparation, alteration, or suppression of coded information.

Example: Assigning diagnosis and/or procedure codes based on clinical documentation not recognized in requirements *(*as defined above in the definitions*).*

1.5. Misrepresent the patient's medical conditions and/or treatment provided, are not supported by the health record documentation.

Example: Permitting coding practices that misrepresent the provider documentation for a given date of service or encounter such as using codes from a previous encounter on the current encounter (except with bundled payment models or other methodologies).

2. Gather and report all data required for internal and external reporting, in accordance with applicable requirements and data set definitions.

Coding professionals **shall**:

2.1. Adhere to the ICD coding conventions, official coding and reporting guidelines approved by the Cooperating Parties, the CPT rules established by the American Medical Association, and any other official coding rules and guidelines established for use with mandated standard code sets.

Example: Using current and/or appropriate resource tools that assist with proper sequencing and reporting to stay in compliance with existing reporting requirements.

2.2. Select and sequence diagnosis and procedure codes, present on admission, discharge status in accordance with the definitions of required data sets in all healthcare settings.

3. Assign and report, in any format, only the codes and data that are clearly and consistently supported by health record documentation in accordance with applicable code set and abstraction conventions, and requirements.

Coding professionals **shall**:

3.1. Apply skills, knowledge of currently mandated coding and classification systems, and official resources to select the appropriate diagnostic and procedural codes (including applicable modifiers), and other codes representing healthcare services (including substances, equipment, supplies, or other items used in the provision of healthcare services).

Example: Researching and/or confirming the appropriate code for a clinical condition when not indexed in the classification.

4. Query and/or consult as needed with the provider for clarification and additional documentation prior to final code assignment in accordance with acceptable healthcare industry practices.

Coding professionals **shall**:

4.1. Participate in the development of query policies that support documentation improvement and meet regulatory, legal, and ethical standards for coding and reporting.

Example: Guidelines for Achieving a Compliant Query Practice (2016 Update) [3]

4.2. Use queries as a communication tool to improve the accuracy of code assignment and the quality of health record documentation.

Example: Designing and adhering to policies regarding the circumstances when providers should be queried to promote complete and accurate coding and complete documentation, regardless of whether reimbursement will be affected.

Example: In some situations a query to the provider will be initiated after the initial completion of the coding due to late documentation, etc., this should be conducted in a timely manner.

4.3 Query with established practice brief guidance when there is conflicting, incomplete, illegible, imprecise, or ambiguous information, (e.g., concurrent, pre-bill, and retrospective).

Coding professionals **shall not**:

4.4. Query the provider when there is no clinical information in the health record that necessitates a query.

Example: Querying the provider regarding the presence of gram-negative pneumonia on every pneumonia case/encounter.

4.5. Utilize health record documentation from or in other encounters to generate a provider query.

5. Refuse to participate in, support or change reported data and/or narrative titles, billing data, clinical documentation practices, or any coding related activities intended to skew or misrepresent data and their meaning that do not comply with requirements.

Coding professionals **shall**:

5.1. Select and sequence the codes such that the organization receives the optimal reimbursement to which the facility is legally entitled, remembering that it is unethical and illegal to increase reimbursement by means that contradict requirements.

5.2. Bring to the attention of the organization management any identified inappropriate coding practices that do not comply with requirements.

Example: Communicating with management and/or utilize organization’s compliance hot line to report inappropriate coding practices.

Example: Bringing coding errors to the attention of the administration and/or coding leadership as soon as possible.

Coding professionals **shall not**:

5.3. Misrepresent the patient's clinical picture through intentional incorrect coding or omission of diagnosis or procedure codes, or the addition of diagnosis or procedure codes unsupported by health record documentation, to inappropriately increase reimbursement, justify medical necessity, improve publicly reported data, or qualify for insurance policy coverage benefits.

Example: Changing a code at the patient's and/or business office’s request so that the service will be covered by the patient's insurance when not supported by the clinical documentation and /or requirements.

5.4. Exclude diagnosis or procedure codes inappropriately in order to misrepresent the quality of care provided.

Example: Omitting and/or altering a code to misrepresent the quality outcomes or metrics that is not supported by clinical documentation and requirements.

Example: Reporting codes for quality outcomes that inaccurately improve a healthcare organization's quality profile or pay-for-performance results (e.g. POA, risk adjustment methodologies).

6. Facilitate, advocate, and collaborate with healthcare professionals in the pursuit of accurate, complete and reliable coded data and in situations that support ethical coding practices.

Coding professionals **shall**:

6.1. Assist with and educate providers, clinicians, and others by advocating proper documentation practices and further specificity for both diagnoses and procedures when needed to more precisely reflect the acuity, severity, and the occurrence of events.

Example: Providing regular education sessions on new requirements or requirement changes.

Example: Reviewing and sharing requirements and Standards for Ethical Coding with providers, clinicians, and others.

7. Advance coding knowledge and practice through continuing education, including but not limited to meeting continuing education requirements.

Coding professionals **shall**:

7.1. Maintain and continually enhance coding competencies in order to stay abreast of changes in codes, documentation, and coding requirements.

Example: Participating in educational programs, reading required publications, and maintaining professional certifications.

8. Maintain the confidentiality of protected health information in accordance with the Code of Ethics.[4]

Coding professionals **shall**:

8.1. Protect all confidential information obtained in the course of professional service, including personal, health, financial, genetic, and outcome information.

8.2. Access only that information necessary to perform their duties.

8.3. Maintain a remote coding work area that protects confidential health information.

Example: Health information should be protected from public and/or family viewing.

9. Refuse to participate in the development of coding and coding related technology that is not designed in accordance with requirements.

Coding professionals **shall**:

9.1. Utilize all tools, both electronic and hard copy that are available to ensure accurate code assignment.

9.2. Recognize that computer assisted coding (CAC) and/or electronic encoders are only tools and are not a substitute for the coding professional's judgment.

9.3. Utilize electronic code and code title selection technology in a manner that is compliant with coding requirements.

10. Demonstrate behavior that reflects integrity, shows a commitment to ethical and legal coding practices, and fosters trust in professional activities.

Coding professionals **shall**:

10.1. Act in an honest manner and bring honor to self, peers, and the profession.

10.2. Represent truthfully and accurately their credentials, professional education, and experience.

10.3. Demonstrate ethical principles and professional values in their actions to patients, employers, other members of the healthcare team, consumers, and other stakeholders served by the healthcare data they collect and report.

11. Refuse to participate in and/or conceal unethical coding, data abstraction, query practices, or any inappropriate activities related to coding and address any perceived unethical coding related practices.

Coding professionals **shall**:

11.1. Act in a professional and ethical manner at all times.

11.2. Take adequate measures to discourage, prevent, expose, and correct the unethical conduct of colleagues.

11.3. Be knowledgeable about established policies and procedures for handling concerns about colleagues' unethical behavior. These include policies and procedures created by AHIMA, licensing and regulatory bodies, employers, supervisors, agencies, and other professional organizations.

11.4. Seek resolution if there is a belief that a colleague(s) has acted unethically or if there is a belief of incompetence or impairment by discussing concerns with the colleague(s) when feasible and when such discussion is likely to be productive.

Example: Taking action through appropriate formal channels (i.e., internal escalation process or compliance hot line, and/or contact an accreditation or regulatory body, and/or the AHIMA Professional Ethics Committee).

11.5. Consult with a colleague(s) when feasible and assist the colleague(s) in taking remedial action when there is direct knowledge of a health information management colleague's incompetence or impairment.

Coding professionals **shall not**:

11.6. Participate in, condone, or be associated with dishonesty, fraud and abuse, or deception. A non-exhaustive list of examples includes:

- Participating in or allowing inappropriate patterns of retrospective documentation to avoid suspension and/or increase reimbursement
- Coding an inappropriate level of service
- Miscoding to avoid conflict with others
- Adding, deleting, and altering health record documentation
- Coding from documentation that is Copied and pasted from another clinician's documentation without identification of the original author and date
- Engaging in and supporting negligent coding practices
- Participating in or allowing inappropriate retrospective provider querying.
- Reporting a code for the sake of convenience or to affect reporting for a desired effect on the results

Revised and approved by the House of Delegates December 12, 2016.

Footnotes

1. Code of Ethics, October 2, 2011
2. Ibid.
3. Guidelines for Achieving a Compliant Query Practice (2016 Update)
4. Code of Ethics. Principle III.

Resources

Code of Ethics

Ethical Standards for Clinical Documentation Improvement (CDI) Professionals

ICD-10-CM Official Guidelines for Coding and Reporting

ICD-10-PCS Official Guidelines for Coding and Reporting

No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
VOLUME 6 of 9

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Attorneys for Plaintiffs and Appellants,
Marcia Stein and Rodolfo Bone

TAB 18

EXHIBIT 30

From: Nancy J Andersen/CA/KAIPERM
To: Teresa S Welsh/CO/KAIPERM@KAIPERM
Cc: James M Taylor/CO/KAIPERM@KAIPERM
Date: 10/15/2013 12:50 PM
Subject: CO Region Physician Query for Severe Obesity

Hi Dr. Welsh,

I just left you a voice message a few minutes ago regarding my interest in talking with you about the CO region's approach to the physician query process.

I attended the recent RRG meeting and was very interested in your presentation on CO region's approach to capturing the diagnosis of severe (morbid) obesity through the use of the Medicare Query function in HealthConnect. As a long time health information management professional, I am very familiar with the physician query process and applaud CO region's efforts to effectively document clinically appropriate diagnoses.

I do have a couple of concerns regarding the query language used and how it may be viewed by CMS and the OIG.

The issue of "leading" physician queries is not a new topic of discussion within the healthcare community and in fact there have been many articles published about the appropriate query language to use as well as a Practice Brief from the American Health Information Management Association (AHIMA) which I've attached for your reference.

Industry standards regarding the use of physician queries generally follow the AHIMA Practice Brief, which in part states the following:

"It is recommended that queries be written with precise language, identifying clinical indications from the health record and asking the provider to make a clinical interpretation of these facts based on his or her professional judgment of the case. Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption."

The language of concern on the slide below - "this patient has a suspected diagnosis" introduces a diagnosis or suspected diagnosis not previously mentioned by the provider and from a compliance perspective may be interpreted as "leading". Additionally, the provider must also be given the option in their response to a query to state the clinical indicator, in this case a BMI value, is not significant or the significance is not known. The query below appears to be directive in nature, indicating what the provider should document, rather than querying the provider for his or her professional determination of the clinical facts.

Regulation of Queries: The coding and reporting guidelines adopted by HHS by regulation those guidelines have the force of law once adopted by HHS. While the *Official ICD-9-CM Guidelines for Coding and Reporting* had previously been approved by the ICD-9-CM Cooperating Parties: CMS, the American Hospital Association (AHA), American Health Information Management Association (AHIMA), and the National Center for Health Statistics (NCHS), those guidelines have the force of law once adopted by HHS.

The Official Coding Guidelines do allow queries to be written when a diagnosis is not clearly documented and clarification is required. A query may be initiated when there is conflicting, incomplete, or ambiguous documentation in the health record. In an October 11, 2001 memorandum, CMS clarified its position. As described by the Texas Medical Foundation (TMF) Quality Institute, the quality integrity organization (QIO) for Texas, CMS said:*"Use of the physician query form is permissible to the extent it provides clarification and is consistent with other medical record documentation."*

CMS's position is that a query form should not

- be leading
- introduce new information not otherwise contained in the medical record

Dear Dr. ***,

This patient has Suspected Diagnosis: Severe Obesity

Supporting Data: BMI >=40.

- If you agree that this data indicates a diagnosis that should be documented, please:
- Double click above to open the chart as an addendum.
- Add the diagnosis to the diagnosis entry field.
- Slide all chronic diagnoses over to the problem list.
- Add supporting data or other documentation into the progress note, if indicated.
- FYI: Please use your clinical judgment in addition to the data provided to determine the correct diagnosis. If the suspected diagnosis was not evaluated, managed, or considered during this particular encounter, please update the problem list and make a plan to address it at the next visit with this patient. If the diagnosis suspected is not correct, please delete this query. This query was sent to you as a part of routine Panel Support to improve clinical documentation. If you have any questions about the Medicare Query process or the Panel Support Reviews, please reply, or forward questions to Teresa Welsh MD.

- Thank you,

- Medicare Risk Auditor

Attached are two slides with examples of compliant language which I hope you will find helpful. The revised language will not be considered "leading" while I believe still retaining the original intent of your query forms.

Please let me know a convenient time for a discussion regarding how best to ensure the capture of all appropriate diagnoses while maintaining a compliant physician query process for your region.

Warm Regards,

Nancy J Andersen MS RHIA CCS CRCR AHIMA-Approved ICD-10-CM/PCS Trainer
Senior Compliance Manager Care Delivery and Health Information Management
National Compliance Ethics and Integrity Office
Kaiser Foundation Health Plan Inc

Blackberry: 510-418-2455
nancy j andersen@kp org

Embed a culture of compliance across the care delivery enterprise that inspires the highest level of ethics and integrity

NOTICE TO RECIPIENT: If you are not the intended recipient of this e-mail, you are prohibited from sharing, copying, or otherwise using or disclosing its contents. If you have received this e-mail in error, please notify the sender immediately by reply e-mail and permanently delete this e-mail and any attachments without reading, forwarding or saving them. Thank you.

EXHIBIT 31

1. NW-CDI _Angina
2. NW-CDI_ Art Open
3. NW-CDI_ CHF
4. NW-CDI_CVA
5. NW-CDI_Deliruim
6. NW-CDI_DM
7. NW-CDI_DM Comp
8. NW-CDI DM Dyslipidemia
9. NW-CDI_MI
10. NW-CDI_PCM
11. NW-CDI_PNA
12. NW-CDI_RENAL
13. NW-CDI_RESP
14. NW-CDI_SEPSIS
15. NW-CDI_SIRS
16. NW-CDI_SKIN
17. NW-CDI_Urosepsis
18. NW-CDI_AA
19. NW-CDI_BMI
20. NW-CDI_NICU-NEC
21. NW-CDI_NICU-FGR
22. NW-CDI_NICU-DIC
23. NW-CDI_NICU-Aspiration
24. NW-CDI_NICU-RDS
25. NW-CDI_NICU-PNA
26. NW-CDI_NICU-CRD
27. NW-CDI_NICU-ARF
28. NW-CDI_NICU-SIRS
29. NW-CDI_NICU-SEPSIS
30. NW-CDI_General
31. NW-CDI_PVD
32. NW-CDI_C Edema
33. NW-CDI_DI Neutropenia
34. NW-CDI_Pancytopenia
35. NW-CDI_Aneurysm
36. NW_CDI_NICU Blood Group

MOST OF THESE QUERIES DO NOT PROVIDE ADDITIONAL OPTIONS FOR THE PROVIDER AS DIRECTED BY THE AHIMA PRACTICE BRIEF ON ACHIEVING A COMPLIANT QUERY PROCESS (i.e. "clinically undetermined", "unknown", etc.

NW-CDI_ ANGINA

Dear Dr._____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

Angina Pectoris
(New onset, Stable, typical, atypical)

Prinzmetal angina
Angina Decubitus (nocturnal angina)

Other (please specify)

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

By directing the physician to "update the Problem List", this diagnosis will carry over in KPHC (EHR) and always appear in future visits, even if not related. Many records display "old" conditions with missing "treatment date".

NW-CDI_ Art Open

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

To more accurately assign the correct diagnosis code; please respond to the following by documenting:

Location (colostomy, tracheostomy, etc)

Size or Type, if applicable

Specify if complication (infection, mechanical)

Status (stable, functional)

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_ CHF

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient. The presence of any Variant of Heart Failure (CHF) was documented in the _____ dated _____.

Based on your independent professional judgment, please update documentation if the above indicators are clinically significant and can be further specified as:

Acute, Chronic or Acute on Chronic	Unspecified (Please Specify)
Systolic, Diastolic or Combined	Other cardiomyopathy (please specify)

Is the condition secondary to another disease process (please specify: hypertension, valvular disease, rheumatic heart disease, endocarditis, pericarditis, myocarditis, cardiac or other surgery, other.)

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_ CVA

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please update documentation if all acute deficits are clinically significant and can be further specified as:

Hemiplegia	Monoplegia
Other sequelae (aphasia, apraxia, ataxia, dysphagia, vertigo, etc)	Undetermined

If applicable, please document if the condition is **due to hemorrhage** (please specify: subarachnoid, intracerebral, intracranial, subdural, laterality) or **due to causes other than hemorrhage** (please specify: thrombosis, embolism, unspecified occlusion or stenosis).

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_ Deliruim

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

If applicable, please clarify any known or suspected underlying cause of Altered Mental Status. Based on your clinical judgment, please document if the clinical interpretation indicates a more clinically significant diagnosis, which may include one of the following:

Deliruim (please specify if alcohol withdrawal, intoxication, drug induced, drug withdrawal, or other cause)

Encephalopathy (please specify: toxic, metabolic, septic, uremic, hepatic, anoxic, or other)

Other (please specify) Not Applicable

Please document the appropriate diagnosis, include treatment plan and update the Problem List. Thank you,

---

This "DM" CDI query is leading since it's introducing the single DM diagnosis which has "not yet dx". The query label already lists the diagnosis of "DM" and no options are available for other conditions or options for "unknown", "unspecified" , "clinically undetermined" or "other". This is not providing a reasonable option which as mentioned in the AHIMA Practice Brief.

NW-CDI_ DM

Dear Dr. _____

A review of the patient record fo
necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
DM (not yet dx)

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

DM (please specify: type 1, type 2, drug/chemical induced, with or without coma)

If applicable, please document if the condition is linked to another disease process (please specify: hyperosmolarity, hypoglycemia, ketoacidosis, renal, neurological, ophthalmic, oral, skin, circulatory, arthropathy)

Please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_ DM Comp

Dear Dr._____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

If applicable, please document if the condition is linked to another disease process. Please specify:

Neuropathy, Chronic Kidney Disease, Nephropathy, Retinopathy, Cataract, Dyslipidemia, Peripheral Vascular Disease, Diabetic Ulcer, Skin, Oral, Other, or No Chronic Complications.)

Please document the appropriate diagnosis, include treatment plan and update the Problem List. Thank you,

---

NW-CDI_DM Dyslipidemia

Dear Dr._____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

Clinical Indicators: (Triglycerides > 150 and/or HDL < 35 and dx Diabetes)

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

Diabetic Dyslipidemia Other (please specify)

No clinical significance

A **"cause and effect"** relationship between diagnoses may not be assumed and coded unless documented by the physician. Please document (underlying condition/manifestation) if any relationship exists between these conditions and the patient's diabetes.

Please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_MI

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

STEMI (please specify: **anterior wall-** left main coronary artery, left anterior descending artery, other coronary artery of anterior wall, **inferior wall-** right coronary artery, other coronary artery of inferior wall, **other-** left circumflex coronary artery, other specified.)

Non-ST elevation MI (NSTEMI)

If applicable, please document any recent acute MIs within 28 days of admission and whether or not the current MI has occurred within 28 days of a previous MI. Additionally, please document if the patient has a history of an MI (older than 28 days), and any associated diagnoses/conditions.

Please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_PCM

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

Malnutrition Mild

Malnutrition Moderate

There are no additional options listed for this malnutrition query such as "clinically undetermined" or "unknown" (SAME AS OTHER QUERIES IN THIS DOCUMENT) .

Malnutrition Severe Other (please specify)

In addition, please document any associated diagnoses such as, due to acute disease, if applicable.

Please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_PNA

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Include Type: aspiration, community-acquired, health care associated, ventilator associated, or other

If applicable, please clarify any **known or suspected** underlying causative organism

Other Pneumonia (please specify) **Unknown / Not Applicable**

Please document if the condition is linked to another disease process (please specify: respiratory failure, sepsis, underlying lung disease, other.)

Please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_RENAL

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

Acute Renal Failure (ARF) (if applicable, please specify: due to acute tubular necrosis (ATN), acute cortical necrosis, or other as specified)

Acute on Chronic Renal Failure **Chronic Renal Failure with Stage**

Other (please specify)

In addition, please document any associated diagnoses/conditions if applicable.

Please provide the appropriate diagnosis, include treatment plan and update the Problem List.
Thank You,

NW-CDI_RESP

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

Acute Respiratory Failure

Chronic Respiratory failure

Acute on chronic respiratory failure

If respiratory failure, Please specify hypoxic, hypercapnic, or mixed

Other (please specify)

Not Clinically Relevant

In addition, please document any associated diagnoses/conditions if applicable.

Please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_SEPSIS

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

Sepsis without organ dysfunction

Severe Sepsis with organ dysfunction
(please specify: organ dysfunction- respiratory failure, encephalopathy, acute kidney failure, other)

Septic Shock

Other (please specify)

If applicable, please document if sepsis is due to: device, implant, graft, infusion, abortion.

Please provide the appropriate diagnosis, include treatment plan and update the Problem List.
Thank You,

NW-CDI_SIRS

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

SIRS without organ dysfunction (noninfectious cause)

SIRS with Organ dysfunction (noninfectious cause)

Other (please specify)

Not Clinically Relevant

SIRS meets 2 of the following criteria:

T>38 (100.4) or <36 (96.8
HR > 90
RR > 20 or PaCO2 < 32
WBC >12,000 or < 4,000 --OR-- >10% bandemia (1 point even if both)

If applicable, please document cause(trauma, burn, etc)

Please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW-CDI_SKIN

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

"Wound" Or "Pressure Ulcer" was documented by the RN or Wound Ostomy Nurse dated: __(date)____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

Pressure Ulcer

Vascular Ulcers

(please specify: site, stage, with gangrene
if applicable and document if ulcer is present on admit)

Postoperative Complication

Chronic Ulcer
(except pressure ulcer) with site documented

Other / Unable to Determine

If applicable, please document the type, such as: arteriosclerotic, decubitus, diabetic, gangrenous.

Please provide the appropriate diagnosis, include treatment plan and update the Problem List.
Thank You,

NW-CDI_Urosepsis

Dear Dr._____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

Urosepsis is a nonspecific entity for coding purposes. Please specify any suspected or known associated illness and/or etiology of the Urosepsis.

Sepsis due to Urinary Tract Infection

Severe Sepsis due to Urinary Tract Infection

Urinary tract infection

Other condition (please specify)

In addition, please document if the condition is present of admission or clinically undetermined.

A **"cause and effect"** relationship between diagnoses may not be assumed and coded unless documented by the physician. If applicable, please document (underlying condition/manifestation) if any relationship exists between these conditions, such as: sepsis and UTI.

Please provide the appropriate diagnosis, include treatment plan and update the Problem List.
Thank You,

NW-CDI_AA

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please update documentation if the above indicators are clinically significant and can be further specified as:

Aortic Atherosclerosis

Atherosclerosis of Valve (please specify valve)

Other Atherosclerosis

Insignificant / Undetermined

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank You,

---

NW-CDI_BMI

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

- Severe Obesity, defined as BMI equal to or greater than 40 with or without co-morbidities
- Severe Obesity, defined as BMI 35-39.9 with 1 or more co-morbidity
- Obesity, BMI 30-35
- Comorbidity is at least in-part "due to" severe obesity

Please document any applicable comorbidities which may include: coronary artery disease, diabetes, degenerative joint disease, hypertension, hyperlipidemia, obstructive sleep apnea

If applicable, please document the appropriate diagnosis, include treatment plan, and update the Problem List. Thank you

---

NW-CDI_NICU-FGR

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Gestational Age: As specified by attending provider for newborn.
Birthweight: Below the 10th percentile for babies of the same gestational age.
Length & head circumference may be variable.
Calculators: Web based size for gestational age calculator: http://peditools.org/fenton2013

Based on your independent clinical judgment, please update documentation if the above indicators are clinically significant and can be further specified as:

- Fetal Growth Retardation
- Light for Dates without mention of
- Light for Dates with signs of Fetal Malnutrition
- Fetal Malnutrition without mention of

Fetal Malnutrition
- Other

Light for Dates
- Not able to be determined

Please specify weight with diagnosis. If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank You,

---

NW-CDI_NICU-Blood Group

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please update documentation if the above indicators are clinically significant and can be further specified as:

Hemolytic disease due to Rh isoimmunization

Hemolytic disease due to ABO isoimmunization

Hemolytic disease due to other and unspecified isoimmunization

Other (Please Specify)

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank you,

---

NW-CDI_NICU-DIC

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please update documentation if the above indicators are clinically significant and can be further specified as:

Neonatal Coagulopathy

Disseminated Intravascular Coagulation

Neonatal Thrombocytopenia

Other (please specify) / Unknown

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List.

Thank you,

NW-CDI_NICU-Aspiration

Dear Doctor,

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Applicable definitions:

a) **Meconium:** Meconium stained amniotic fluid and respiratory distress (tachypnea, grunting, nasal flaring, or retraction) within 1h of birth and abnormal CXR (coarse, irregular air space densities, areas of diminished aeration and consolidation alternating with areas of hyperinflation) and absence of culture proven sepsis/pneumonia or RDS.
b) **Amniotic fluid, blood, or stomach contents:** O2 requirement within 1h of birth and pulmonary infiltrates on CXR and no meconium in the amniotic fluid and no RDS, culture proven sepsis/pneumonia, or cardiac disease

Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified:

- "x" aspiration WITH respiratory distress
- "x" aspiration with pneumonia
- "x" Aspiration WITHOUT respiratory distress
- Other, please specify

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List.

Thank you,

NW-CDI_NICU-NEC

Dear Dr. _____

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

NEC: 777.5

One or more clinical signs:

1. Bilious or bloody emesis or aspirates;
2. Abd distention,
3. Blood in the stool.

One or more radiographic findings:

1. Pneumotosis intestinalis
2. Hepato-biliary gas
3. Pneumoperitoneum

Perinatal Intestinal Perforation: 777.6

Pneumoperitoneum (or focal perforation confirmed at laparoscopy) **not** associated with pneumotosis intestinalis, hepato-biliary gas, grossly bloody stools, or significant clinical shock and DIC.

*** In most cases it must be NEC or Perforation, not both.**

Based on your independent clinical judgment, please update documentation if the above indicators are clinically significant and can be further specified as:

NEC with pneumatosis, without perforation	777.52 Stage 2
NEC with perforation	777.53 Stage 3
NEC with pneumatosis and perforation	777.53 Stage 3
Perinatal Intestinal Perforation	777.6
Other / Not able to be determined	

Question? Why does this physician query include ICD codes with actual code descriptions?

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List.

Thank You,

NW-CDI_NICU-RDS

Dear Doctor,

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

a) PaO2 <50 in room air, central cyanosis in room air, a requirement for supplemental oxygen to maintain PaO2 >50, or a requirement for supplemental oxygen to maintain a pulse oximeter saturation over 85% within the first 24hrs of life.

b) CXR consistent with RDS within the first 24 hrs of life.

Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified:

Please specify:

Respiratory Distress Syndrome	Other, please specify
Acute hypoxic respiratory failure, specify cause if known	Undetermined

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List.

Thank You,

NW-CDI_NICU-PNA

Dear Doctor,

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Presumed pneumonia: CXR and symptoms indicate pneumonia, antibiotics for ≥ 96h, no pathogen in ETT or blood cultures.

Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified:

Please specify an organism if known:
- Presumed Pneumonia
(please specify: suspected bacterial or viral)
- Health-care associated pneumonia
- Ventilator-associated Pneumonia
- Aspiration Pneumonia
- Undetermined

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List.
Thank You,

NW-CDI_NICU-CRD

Dear Doctor,

A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

a) O2 requirement due to primary pulmonary disease at 36 wks (35+4to36+3) adjusted postmenstrual age in an infant with a **birthweight <1500 grams**. If the infant is alive but not in the PSVMC NICU at 36 weeks postmenstrual age then determine whether the infant is receiving oxygen therapy at the transfer hospital or at home.

b) Infants with **birthweights >1500 grams** and prolonged O2 needs (incl. home O2) **should be classified under their primary lung problem, e.g., MAS, CDH, NOT Chronic Lung Disease**

Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified:

Please specify:

- Bronchopulmonary dysplasia (aka Chronic respiratory disease arising in the perinatal period)
- Respiratory Distress Syndrome
- Other, please specify
- Undetermined

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank You,

---

NW-CDI_NICU-SIRS

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified:

- SIRS, noninfectious, without organ dysfunction

- SIRS, noninfectious, with organ dysfunction (if applicable, please specify the associated organ dysfunction)

- Other (please specify)
  SIRS: at least 3 of the following:
  –Fever (temperature >38.5°C)
  –Hypothermia (core temperature <36°C)
  –Heart rate >180 bpm
  –Tachypnea: >60 breaths/minute
  –Lethargy
  –Significant edema or positive fluid balance (>20 ml/kg over 24 h)
  –Hyperglycemia (plasma glucose >180 mg/dL)
  –Apnea > usual baseline

- No Clinical significance

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank you,

---

NW-CDI_NICU-SEPSIS

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.

_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified:

–SIRS, non-infectious
–Sepsis without organ dysfunction.
– Severe Sepsis with organ dysfunction. Please specify the associated organ dysfunction and organism, if known.
–Septic Shock
–Septicemia
–Other (please specify), or no clinical significance.

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank you,

---

NW-CDI_NICU ARF

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified:

Acute Renal Failure (ARF)
Acute Kidney Injury (AKI)
Other (please specify)
No Clinical Significance

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank you,

---

NW-CDI_General

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
_____ (clinical indicator) _____ was documented in _____ dated _____

Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified:

_____
_____
_____
Not Applicable / No Clinical Significance

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank you,

---

NW_CDI- CEREBRAL EDEMA

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
_____ (clinical indicator) _____ was documented in _____ dated _____
Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:

Brain / Cerebral Edema	**Hydrocephalus – Specify Non-Obstructive or Obstructive**
Brain Compression	**Other – Specify**
Unspecified	**Unknown**

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank You,

---

NW_CDI-NEUTROPENIA

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified as:

Drug-Induced Neutropenia	**Neutropenia Due to Infection**
Aplastic Anemia	**Leukemia**
Unspecified	**Other - Specify**

If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank you,

---

NW_CDI-PANCYTOPENIA

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
Based on your independent professional judgment, please document in your progress note or discharge summary if these clinical indictors can be further specified as:

Anti-Neoplastic Chemotherapy Induced Pancytopenia	**Other Drug-Induced Pancytopenia**
Aplastic Anemia	**Other Pancytopenia**
Clinically Insignificant	**Unknown**

If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank you,

---

NW_CDI-ANEURYSM

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
Based on your clinical judgment, can you further specify in your progress note a diagnosis to more accurately assign the correct diagnosis code:
Site (Please Specify): Abdominal Thoracic Thoracoabdominal Other
Type (Please Specify): With Rupture or Without Mention of Rupture
If applicable, please provide the appropriate diagnosis, include treatment plan and update the Problem List. Thank you,

---

NW_CDI-PVD

Dear Dr. _____
A review of the patient record found that documentation clarification is necessary to meet medical necessity, accuracy of coding and to reflect the severity of illness and risk of mortality for your patient.
_____(clinical indicator)_____ was documented in _____ dated _____
Based on your independent professional judgment, please clarify if a clinically significant diagnosis is related to the above clinical indictor:
Arteriosclerosis peripheral vascular disease (please specify: with rest pain, claudication, gangrene, ulcers) if applicable.
Arteriosclerosis of by-pass graft (please specify: autologous vein, non-autologous vein of biological by-pass graft) if applicable.
Chronic total occlusion of artery of extremities Polyneuropathy
Arterial embolism and thrombosis Unknown / Not Applicable
Is the condition secondary to another disease process: Diabetes, CHF, Congenital Defects, Arrhythmia?
If applicable, please provide the appropriate diagnosis, include treatment plan, and update the Problem List. Thank you,

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EXHIBIT 32

Clinical Diagnoses & KPHC Search Words "Synonyms"	•Document diagnoses in final progress note and/or discharge summary. For example, "Protein Calorie Malnutrition, Severe: followed by RD." •Document diagnoses that you are actively treating or are affecting the patient or patient care this hospitalization. •Rule-outs count in the Hospital: Diagnoses that are DOCUMENTED IN THE DISCHARGE SUMMARY as "Possible" "Probable" "Likely" "Suspected" "?" or "R/O" are ACCEPTABLE.	
SKIN ULCER / GANGRENE ULCER / CHRONIC ULCER **"ulcer p" "gang" "ulcer c"**	**Possible Clinical Indicators:** — Braden score of ≤ 18 — Bedbound, Wheelchair or SNF patients — Nutritionally or immunocompromised patients — Current or previous diagnosis of PCM — WOC Consult — Order for wound care — Nursing notes	**MD Documentation Tips:** •Document whether ulcers are **PRESENT ON ADMISSION** or **community acquired** •Document **TYPE and SITE of all ulcers (pressure, decubitus, etc), Stage if possible.** •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. DM, atherosclerosis, trauma, PCM)
PNEUMONIA / LUNG INFECTION **"pneumon"**	**Possible Clinical Indicators:** •Abnormal X-ray w/ indication of infection/infiltrate •Positive sputum culture •Organism-specific antibiotic •Evidence or H/O aspiration, dysphagia	**MD Documentation Tips:** •Document **TYPE** of pneumonia: aspiration, bacterial, viral, fungal •Document the **CAUSATIVE or SUSPECTED ORGANISM (ie: psuedomonas, myoplasma, etc)** •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. hypoxia, respfailure, septicemia, sepsis, etc.) • "Infiltrate" ≠ "PNA" •"Bacterial PNA ≠HCC" *Example: Empirically treating for suspected gram-negative PNA*
RENAL FAILURE **"acute renal f" "ckd"**	**Clinical Indicators:** **ARF: Acute rise in Creatinine in appropriate clinical context OR R.I.F.L.E. Spectrum:** •**Risk:** Inc Cr by 1.5x **or** Dec GFR > 25% **or** UO <0.5ml/kg/h x 6hr; •**Injury:** Inc Cr by 2x **or** Dec GFR > 50% **or** UO <0.5ml/kg/h x 12h; •**Failure:** Inc Cr by 3x **or** Dec GFR > 75% **or** UO <3ml/kg/h x 24h **or** UO = 0 x 12h **or** Cr ≥ 4 with an acute rise > 0.5 mg/dl **CRF or CKD: CKD1:** Kidney damage - Persistent proteinuria, structural kidney disease (cyst), nephritic, asymptomatic UA abnormal. or other radiological abnormalities with a normal GFR>90 **CKD 2:** GFR 60-89 and above CKD 1 structural findings, retinopathy **CKD 3:** GFR 30-59 **CKD 5:** GFR <15, patient is not on dialysis **CKD 4:** GFR 15-29 **ESRD:** GFR <15, patient is on RRT: HD or PD	**MD Documentation Tips:** •Document **ACUTE, CHRONIC or ACUTE ON CHRONIC** •Consider **ARF / AKI using RIFLE criteria** •Document **CKD STAGING 1 -5 using GFR scale** •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. DM, HTN, PCKD, transplant complication) •"Nephropathy" ≠ "CKD" •"Acute Renal insufficiency" ≠ "Acute Renal Failure" •"Azotemia" or "Uremia" ≠ "Renal Failure" •"Pre-Renal Renal Failure" ≠"Renal Failure"
PVD/PAD **"peri vas d" "pvd"**	**Possible Clinical Indicators / Symptoms:** •Ulcers, venous stasis, venous insufficiency, surgical H/O bypass •Ankle-Brachial index (ABI < 0.9) •May include rest pain after recumbence, numbness, tingling or weakness in legs	**MD Documentation Tips:** •Document **DIAGNOSIS of PVD** (excludes carotid, basilar and vertebral art stenosis) •Document the **PRESENCE and SITE** of any **DVT** or other **THROMBOSIS** •Document **DIAGNOSIS** of **Aortic Atherosclerosis or Aneurysm** from imaging • "Venous insufficiency" ≠ "PVD"
CANCER **"breast ca," "prostate", "colon ca"** **"metast" "hx ca"**	**Possible Clinical Indicators:** •**Primary Sites & any Invasive / Metastatic Sites** shown on imaging, biopsy, lab, path report •Active cancer is supported by tests, meds, treatments, palliative, &/OR hospice care.	**MD Documentation Tips:** •Document whether cancer is **ACTIVE** vs. **"HISTORY OF"** •Document **H/O Cancer by "NED": No Evidence of Disease.** •Document the **PRIMARY SITE** •Document the **METASTATIC SITE** •Document all **RELATED CONDITIONS** (i.e. path fractures, PCM or cachexia, decubiti, major depression)
HEMIPLEGIA / HEMIPARESIS / STROKE **"late effect" "CVA"**	**Clinical Indicators:** • LATE / RESIDUAL EFFECTS of CVA can include: – **Hemiplegia OR Hemiparesis** (Acute or Late Effect STROKE) – Evidence of unilateral weakness or hemiplegia (PT notes)	**MD Documentation Tips:** •Document **TYPE** of stroke (ischemic, hemorrhagic, etc) •Document whether **OLD vs. NEW** •Document all **LATE or RESIDUAL CONDITIONS** •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. coma, brain compression, cerebral edema, hemiparesis / hemiplegia, etc.) • "Weakness" ≠ "Hemiplegia"
FRACTURES **"fra" "after"**	**Possible Clinical Indicators:** •"Acute Fracture" = Abnormal X-ray stating Fx site •"Chronic Fracture" = Compression Fx w/ symptoms &/OR treatment •"Aftercare Fracture" = fractures already treated ≤ 90 days post Fx: No HCC •"H/O Fracture" = fracture is >90 days old, resolved: No HCC	**MD Documentation Tips:** •Document **OPEN vs. CLOSED & LOCATION** of all Fractures •Document whether Acute, Aftercare, Chronic Path Fx or H/O Fx •Document whether **EACH** fracture is **TRAUMATIC vs. PATHOLOGIC** •Document any/all **INTRACRANIAL INJURIES** •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. CA, osteoporosis, complications of Fx)
COMA / BRAIN COMPRESSION **"coma"**	**Clinical Indicators:** •Document "**COMA**" when pt. has: —Glasgow coma scale of ≤ 8 **OR** NIHSS score of 3 on question 1a (re: LOC) —No purposeful movement —is comatose —demonstrates only reflex responses to stimuli (i.e. pain) —has transient unresponsiveness (based on clinical judgment) •Document "**BRAIN COMPRESSION**" when pt has: – midline shift, – cerebral edema – mass effect – obstructive hydrocephalus	**MD Documentation Tips:** •If the **"COMA"** is resolved during the course of treatment, document "**COMA RESOLVED**" (based on clinical judgment, no time duration associated with 'coma' definition) •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. CVA, DM, respiratory failure) •No time duration associated with "Coma" definition. •A description of "comatose", "stupor" "unresponsive" "obtunded" ≠ Dx of "coma"

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SEPSIS / SEPTICEMIA **"sepsis"**	**Clinical Indicators:** **SIRS:** Any **TWO** of the following: – **WBC > 12K OR < 4K** – **T > 38 (100.4) OR < 36 (96.8)** – **Pulse or HR > 90** – **RR > 20** – **Bands > 10%** – **ALOC** **Sepsis:** •Any **TWO** of the above **SIRS** Indicators **AND** •A Diagnosis of **related current infection** **Bacteremia:** Positive blood culture (w/out fever)-No HCC **Septicemia: Bacteremia AND fever** > 38 (100.4) **Severe Sepsis:** •Documented **Sepsis AND** • **Acute organ dysfunction OR** • **Lactate >2** (Indicator for Severe Sepsis, not SIRS) **Septic Shock** •Documented **Sepsis** or **Severe Sepsis AND Hypotension**	**MD Documentation Tips:** •Document **APPROPRIATE DIAGNOSIS** (Septicemia, SIRS, Sepsis, Severe Sepsis, Septic Shock) •NOTE: Sepsis/SIRS diagnosis does not require a Positive Blood Cx. •Document **INDICATORS** for Diagnosis •Document **UNDERLYING INFECTION**, (known or suspected) •Document **UNDERLYING NON-INFECTIOUS CONDITION**, (known or suspected, i.e. pancreatitis, cholecystitis, burn, trauma, etc.) •"Urosepsis" ≠"Sepsis"; "Bacteremia" ≠"Septicemia" •"Septicemia" = "Sepsis" *Example: SIRS or Sepsis due to PNA or other infectious Process; SIRS due to Acute Pancreatitis, or other Non-infectious Process*
DIABETES W/ MANIFESTATIONS **"dm"** **"dm ckd" "dm 2"**	**Clinical Indicators:** •**Diabetic Renal Manifestation** —CKD, Nephropathy, renal insufficiency, proteinuria, microalbuminuria or abnormal GFR, high BUN or CR •**Diabetic Peripheral Circulatory Manifestation** —PVD, peripheral venous insufficiency or venous stasis •**Diabetic Neurological Manifestation** —Neuropathy or peripheral neuropathy	**MD Documentation Tips:** •**Document and LINK ALL other DM ASSOCIATED CONDITIONS**: – DM w/ DM PVD or CKD – DM w/ DM NEUROPATHY – DM w/ DYSLIPIDEMIA (low HDL<40 and high Tg>200; WNL on rx) – DM w/ ERECTILE DYSFUNCTION • "Nephropathy" ≠ "CKD"
PCM / CACHEXIA / MALNUTRITION **"pcm" "mal" "cac"**	**Clinical Indicators (Two (2) or more required):** —Either Albumin ≤ 3.0 g/dl **OR** Pre-albumin ≤ 12 mg/dl —Either Pressure ulcer ≥ Stage 2 **OR** any non-healing wound —Either BMI ≤18 **OR** Patient's current weight is < 90% of ideal body weight —**Both** >10% weight loss of usual body weight **AND** H/O poor oral intake Note: Labwork is a clinical indicator but it is NOT required to diagnose	**MD Documentation Tips:** •Read and Be Guided by RD Note •**Severe PCM:** requires 3 criteria. •Consider PCM in pts w/ CA, decubiti, on supplements &/or TPN • "Cachexia" = PCM HCC • "Cachectic" ≠ "Cachexia"; Failure to Thrive ≠Malnutrition
ARTIFICIAL OPENING **Feedings/Ostomies** **"osto"**	**Possible Clinical Indicators:** •Consider patients with – Enteral feedings – look for corresponding ancillary documentation w/out MD documentation – WOC nurse care for Ostomy – Surgical history of –Ostomy, w/o history of take-down	**MD Documentation Tips:** •Document **all artificial openings** for feeding or elimination •Does **NOT** include Tracheostomy •Document all **COMPLICATIONS** •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. PCM or cachexia, CA)
HYPOXIA / RESPIRATORY FAILURE & SHOCK **"chronic resp fail" "ARF" "hypox"**	**Clinical Indicators:** •**Hypoxia** –Hypoxia is a diagnosis captured based on MDs clinical assessment –Consider capturing "Hypoxia" if SaO2 ≤88% •**Chronic Respiratory Failure**: –PaO2 < 60 mm Hg with or w/o arterial partial pressure of PaCO2 > 50mm Hg **OR** –SaO2 ≤88% with or w/o arterial partial pressure of PaCo2 >50mm Hg while breathing air at sea level for >3mo. –Consider capturing "Chronic Resp Failure" when pt managed w/home O2. •**Acute Respiratory Failure**: –Consider capturing "Acute Resp Failure" if pt on mechanical ventilation, bipap, cpap, increased work of breathing, etc. •**Shock:** –Consider if treated w/ fluid boluses, transfusion and/or pressors to maintain hemodynamic stability	**MD Documentation Tips:** •Document **ACUTE, CHRONIC, or ACUTE ON CHRONIC** •Document "**HYPOXIA**" or "**HYPOXEMIA**" in appropriate patients •Document **RESPIRATORY DISTRESS** as **ACUTE** vs. **CHRONIC** •Document **CAUSE of shock** (i.e. hypovolemic,septic,cardiogenic,etc) •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. sepsis, coma, acute lung edema, V Fib, V Flutter) • "O2 Dependent" ≠ "Chronic Respiratory Failure" • "Hypoxemia" = "Hypoxia" • "Hypoxemic" or "Hypoxic" ≠ "Hypoxia" • "Hypoxia" = ARF HCC
HEART FAILURE **"heart fail"**	**Possible Clinical Indicators:** • Abnormal BNP • Abnormal X-ray with indication of pulmonary edema, pleural effusions • Low EF • Abnormal Systolic or Diastolic Function on ECHO • SOB / Peripheral edema / Anasarca / Treatment w/ diuretic	**MD Documentation Tips:** •Document **ACUTE, CHRONIC**, or **ACUTE ON CHRONIC** •Document whether **SYSTOLIC** or **DIASTOLIC FAILURE** •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. left heart failure, cardiomyopathy, pulmonary HTN, hypoxia, etc.) • "**Diastolic Dysfunction" ≠ "Diastolic Failure"**
ARRHYTHMIA **type in name of rhythm to locate**	**Possible Clinical Indicators:** •Abnormal EKG & / or telemetry strip reading •Abnormal Stress Test •Abnormal Holter Monitor •NOTE: Cannot capture HCC **:** If pacemaker or EPS procedure made patient asymptomatic and MD is not actively treating	**MD Documentation Tips:** •Document all **cardiac arrhythmias** such as PSVT, AFib, AFlutter •Document to **Confirm / Clarify EKG finding(s**)
MI / ANGINA **"myocar"**	**Possible Clinical Indicators:** •Abnormal EKG & / or telemetry strip reading **Angina, Stable or Unstable:** —If pt is asymptomatic and there is ongoing treatment for condition **OR** —If pt has signs or symptoms even if managed by medication **"Subsequent care for an MI" = occurred <8 weeks ago** vs. "**Old MI" = occurred > 8 weeks ago** •NOTE: Cannot capture HCC **:** If CABG, stent, or angioplasty made patient asymptomatic and MD is not actively treating	**MD Documentation Tips:** •Document all **MI diagnoses with the treatment or monitoring plans** •Document whether **ACUTE or OLD MI** (specify date if old) •Document any **POST-MI SYNDROME** •Document all **CORONARY OCCLUSIONS w/o MI** •Document any **DEMAND ISCHEMIA** •Document **TYPE OF ANGINA** as unstable vs. stable •If patient is asymptomatic on meds, consider "stable angina on specific med"
TRAUMATIC AMPUTATION / S/P AMPUTATION **"amput"** **Rev. 3- 22-11**	**Possible Clinical Indicators:** •Wheelchair or Bedbound •WOC consult •PT notes •RD notes	**MD Documentation Tips:** •Document **ALL** amputations •Document **SITE & LEVEL** of Amputation •Document **MECHANISM** (i.e. surgical, traumatic, crush, etc) •Document all **UNDERLYING & RELATED CONDITIONS** (i.e. PVD, DM, non-healing, infected, sepsis, gangrene)

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EXHIBIT 33

CDI Prioritization for Roll Out

July 2010

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Criteria

- Internal Audit results
- External Audit results
- HCC Recapture
- Staffing Candidates

- Note: If one Med Ctr in a pair was identified with opportunity, then other Med Ctr was included in roll out.

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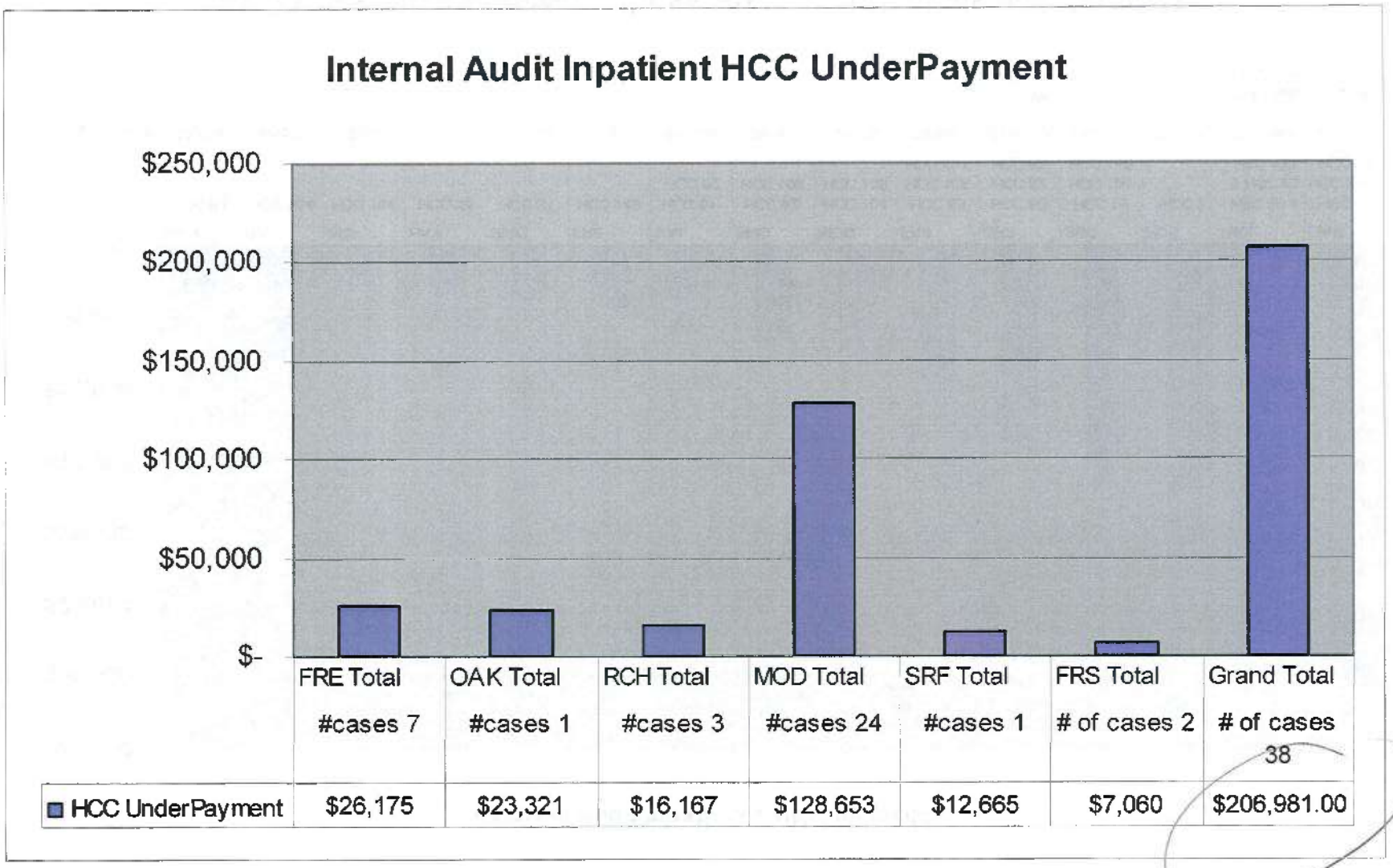

	FRE Total	OAK Total	RCH Total	MOD Total	SRF Total	FRS Total	Grand Total
	#cases 7	#cases 1	#cases 3	#cases 24	#cases 1	# of cases 2	# of cases 38
HCC UnderPayment	$26,175	$23,321	$16,167	$128,653	$12,665	$7,060	$206,981.00

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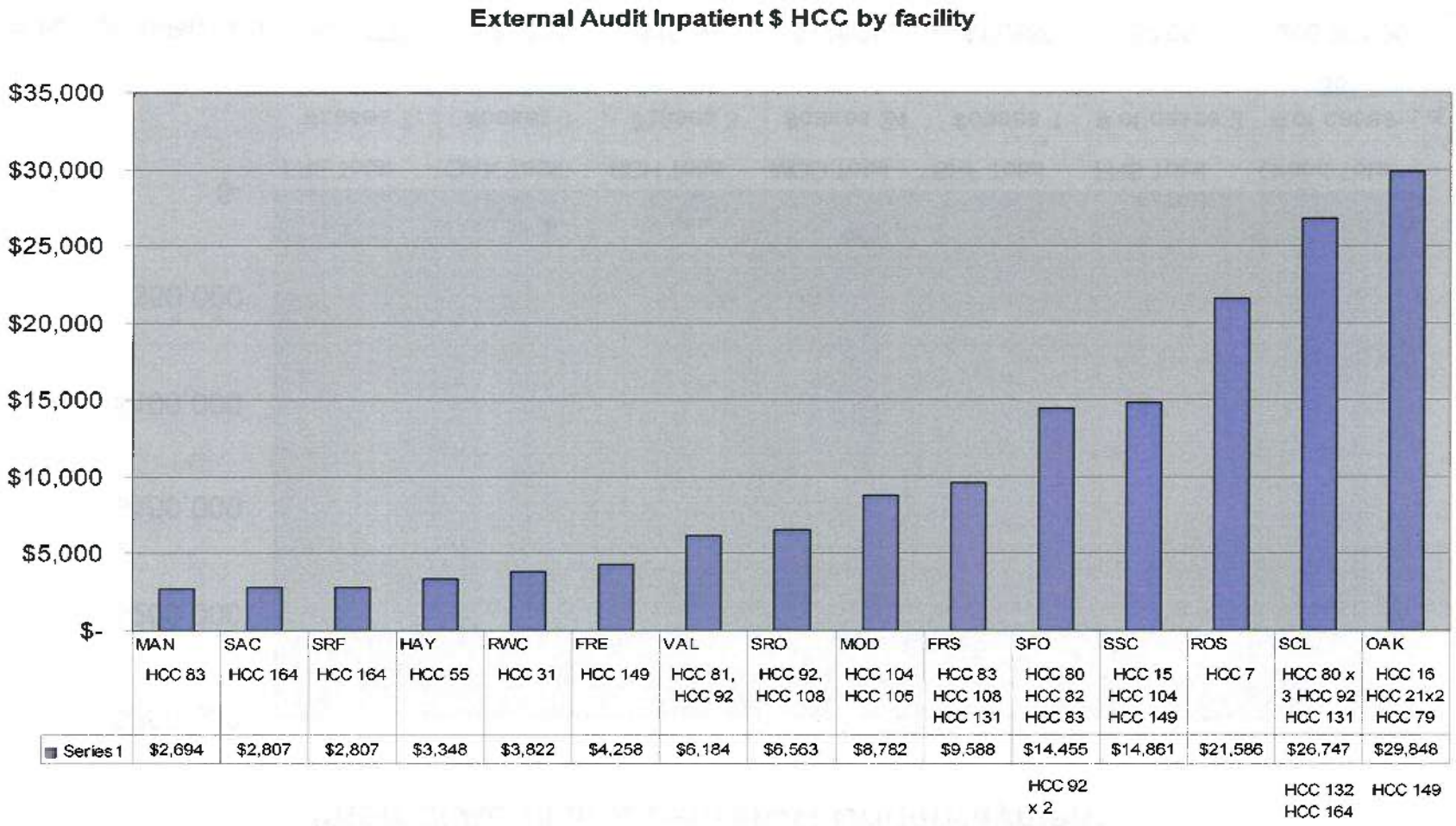

All 21 hospitals audited – these are only hospitals with findings.

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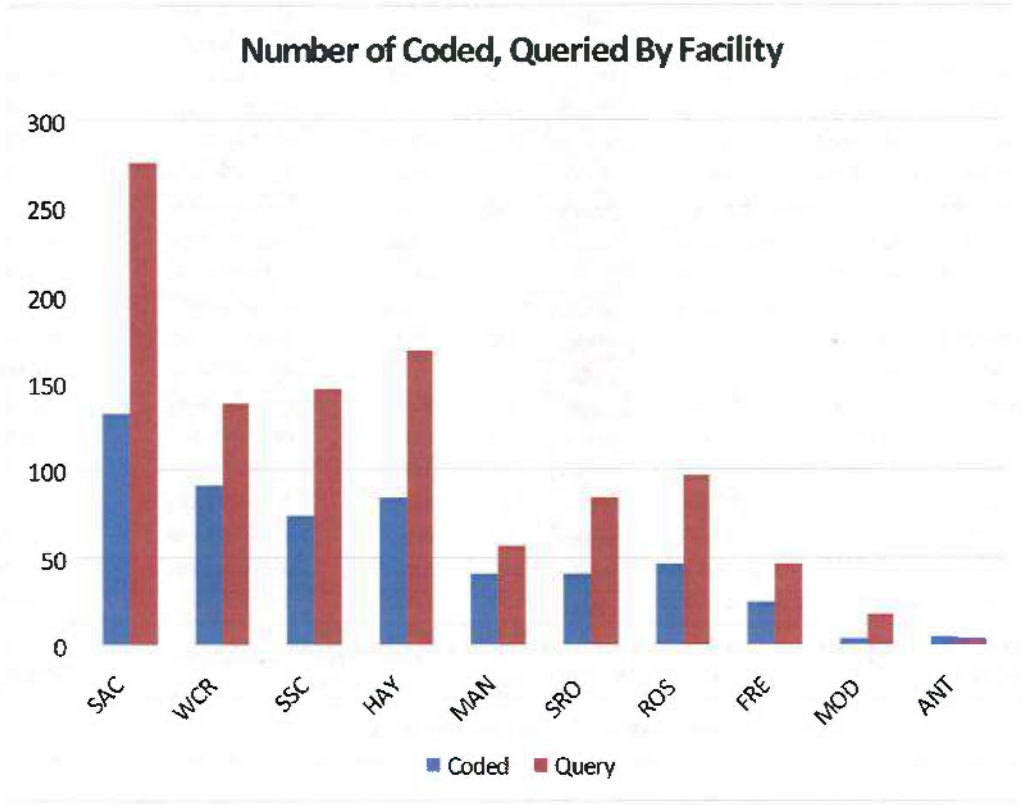
Facility Breakdown

HCC Recapture 2008



*Note variance may be due to when facilities went live on IP2. Review is only based on facilities with full EHR.

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Available Staffing

Clinical Documentation Integrity Program - Recruiting Tracking

		Candidate First Name	Candidate Last Name	Not Interested	Email Address	Date Resume Rec'd	Position of Interest	Clinical or HIM	Credential/ Degree	Source	Relo FROM: City & State	Phone Screen DATE	Medical Center
29	25	Janice	Bayol	Pending-med ctr		5/3/10	CDIC QA	HIM	RHIT,CCS,CPC,CPC-I	KP-not KP ee	Pacheco	5/12 @ 2	WCR
30	26	Donna	McIvor	Pending-med ctr		2/23/10	CDIC	Clinical	RN, MSN, BSN	KP - KFHP	San Jose	3/2 @ 2pm	SJO
31	27	Linda	Zwass	Pending-med ctr		12/1/09	CDIC	Clinical	RN, MS	KP	Millbrae	2/1 @ 2:30	RWC
32	28	Rhowena Defante	Arceo	Pending-med ctr		10/3/09	CDIC	Clinical	MD, CCS	KP	SCAL	2/12 @ 2pm	SRO
33	29	Nancy	Morales	Pending-med ctr		12/26/09	CDIC	Clinical	RN, BSN, CPC	KP - KFH	Fresno	1/18/10	SRO
34	30	Vicki	Polster	Pending-med ctr		1/4/10	CDIC	Clinical	RN, BSN	NHS	Auburn, CA	1/25 @ 3:30	ROS
35	31	Ugo	Nzeadibe	Pending-med ctr		1/8/10	CDIC	Clinical	RN, MSN	KP - KFH	Brentwood	1/19/10	ANT
36	32	Ann	Gubler	Pending-med ctr			CDIC	Clinical	RN	KP - KFH	Oakley	2/12 @ 4pm	ANT
37	33	Valerie	Goodwin	Pending-med ctr		2/16/10	CDIC	Clinical	RN	KP - KFH	Brentwood	3/2 @ 3	ANT
38	35	Gail	Worth	Pending-med ctr		2/11/10	CDIC QA	Clinical	RN,BSN,MPH	KP - KFH	Oakland	2/19 @ 4	WCR
39	36	Karyn (Denise)	Snipes	Pending-med ctr		1/26/10	CDIC	Clinical	RN, BSN,MPA	KP - KFH	Hayward	1/27 @ 4	HAY
40	37	Lateef	Ogunleye	Pending-med ctr		12/18/09	CDIC QA	Clinical	RN, BSN, MS	KP - KFH	Vacaville	3/1 @ 4	OAK
41	38	Joanna	Moore	Pending-med ctr		1/8/10	CDIC	Clinical	RN, MSN. CCM, CPHM	KP - KFH	Placerville	1/26 @ 3	SAC
42	39	Navdip	Gill	Pending-med ctr		1/8/10	CDIC	Clinical	RN	KP-not KP ee	Manteca	1/21/10	SAC
43	40	Deborah Ann	Wilkens	Pending-med ctr		1/12/2010	CDIC	Clinical	R.N., B.S.N.	KP-not KP ee	Stockton	2/1 @ 4	MOD
44	41	Becky	Mann	Pending-med ctr		6/1/10	CDIC	Clinical	RN	On Assign	Napa	6/11 @ 11	VAL
45	42	Kerry	Petersen	Pending-med ctr		6/9/10	CDIC	Clinical	RN BSN	Stern Assoc	Benecia	6/23 @ 11	VAL
46	43	Deborah	Sims	Pending - TPMG		3/8/10	CDIC QA	HIM	RHIT	KP-TPMG	Hayward	3/16 @ 2	
47	44	Chera	Perez	Pending - TPMG		5/18/10	CDIC	Clinical	RN	KP-TPMG	Turlock	6/3 @ 5:30	
48	45	Anita	Price	B candidate		12/15/09	CDIC	Clinical	RN, BSN, CCM	NHS	SAC	1/25 @ 4pm	ROS
49	46	Fraulein S.	Nelson	B candidate		12/16/09	CDIC	Clinical	RN, MSN	KP-not KP ee	Folsom,CA	2/1 @ 2	ROS
50	47	Ann Eliese	Wolff	B candidate		10/13/09	CDIC	Clinical	RN	KP - KFH	Brentwood	10/15/09	ANT
51	48	Ellen	Geohegan	B candidate		1/11/2010	CDIC	Clinical	RN, BS	KP	Santa Rosa	1/22/10	SRO
52	49	Geri	Tanimoto	B candidate		1/18/10	CDIC	Clinical	RN, MS	KP	SanLeandro	1/29 @ 4	OAK
53	50	Reshma	Sharma	B candidate		11/29/09	CDIC	Clinical	RN,MHA,BSN	KP	Modesto	12/18/09	MOD
54	51	Valerie	Toler	B candidate		1/8/10	CDIC	Clinical	RN, BA, LNC	KP	Hayward		HAY
55	52	Jane	Terman	B candidate		1/8/10	CDIC	Clinical	RN, CNOR, OHN	KP	OR		
56	53	Napoleon	Nazareno	B candidate		11/28/09	CDIC	Clinical	RN	KP	Hayward		

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CDI Priority Sites

- Walnut Creek & Antioch
- Roseville with Sacramento
- San Jose & Santa Clara
- Oakland & Richmond

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Clinical Documentation Integrity Program Staffing Waterfall Template v2.5 (26-Jul-10)

NO DATA ENTRY EXCEPT IN GREEN-SHADED COLUMNS				
Medical Center Use drop down menu (Column B) ONLY		CDI Start Date (MM/DD/YY)	New Hires Must Start No Later Than:	CDI "Go Live" Complete
SSC	South Sacramento (SSC)	7-Dec-09	7-Nov-09	6-Jan-10
SSF	South San Francisco (SSF)	15-Sep-10	16-Aug-10	15-Oct-10
SAC	Sacramento (SAC)	10-Nov-10	11-Oct-10	10-Dec-10
ROS	Roseville (ROS)	10-Nov-10	11-Oct-10	10-Dec-10
WCR	Walnut Creek (WCR)	10-Nov-10	11-Oct-10	10-Dec-10
ANT	Antioch (ANT)	10-Nov-10	11-Oct-10	10-Dec-10
SJO	San Jose (SJO)	12-Jan-11	13-Dec-10	11-Feb-11
SCL	Santa Clara (SCL)	12-Jan-11	13-Dec-10	11-Feb-11
OAK	Oakland (OAK)	12-Jan-11	13-Dec-10	11-Feb-11
RCH	Richmond (RCH)	12-Jan-11	13-Dec-10	11-Feb-11
FRE	Fremont (FRE)	23-Feb-11	24-Jan-11	25-Mar-11
HAY	Hayward (HAY)	23-Feb-11	24-Jan-11	25-Mar-11
SRO	Santa Rosa (SRO)	23-Feb-11	24-Jan-11	25-Mar-11
SRF	San Rafael (SRF)	23-Feb-11	24-Jan-11	25-Mar-11
FRS	Fresno (FRS)	6-Apr-11	7-Mar-11	6-May-11
MAN	Manteca (MAN)	6-Apr-11	7-Mar-11	6-May-11
MOD	Modesto (MOD)	6-Apr-11	7-Mar-11	6-May-11
SFO	San Francisco (SFO)	18-May-11	18-Apr-11	17-Jun-11
RWC	Redwood City (RWC)	18-May-11	18-Apr-11	17-Jun-11
VAL	Vallejo (VAL)	13-Jul-11	13-Jun-11	12-Aug-11
VAC	Vacaville (VAC)	13-Jul-11	13-Jun-11	12-Aug-11

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TAB 19

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Marcia Stein and Rodolfo Bone

UNITED STATES DISTRICT COURT

NORTHEN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, et al., Defendants.	CASE NO. 3:13-cv-03891-EMC SECOND AMENDED COMPLAINT BY RELATORS MARCIA STEIN AND RODOLFO BONE FOR VIOLATIONS OF THE FALSE CLAIMS ACT; REQUEST FOR JURY TRIAL
UNITED STATES OF AMERICA, *ex rel.* NASER AREFI, AJITH KUMAR, and PRIME HEALTHCARE SERVICES, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	CASE NO. 3:16-cv-01558-EMC SECOND AMENDED COMPLAINT BY RELATORS MARCIA STEIN AND RODOLFO BONE FOR VIOLATIONS OF THE FALSE CLAIMS ACT; REQUEST FOR JURY TRIAL

(Captions continued on next page)

UNITED STATES OF AMERICA, *ex rel.* MARCIA STEIN and RODOLFO BONE,

Plaintiffs,

vs.

KAISER FOUNDATION HEALTH PLAN, INC., a California corporation, KAISER FOUNDATION HOSPITALS, a California corporation, KAISER FOUNDATION HEALTH PLAN OF COLORADO, a Colorado corporation, KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC., a Georgia corporation, KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., a Maryland corporation, KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, an Oregon corporation, KAISER FOUNDATION HEALTH PLAN OF WASHINGTON, a Washington corporation, THE PERMANENTE MEDICAL GROUP, INC., a California corporation, SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, a business entity, form unknown, COLORADO PERMANENTE MEDICAL GROUP, a Colorado corporation, THE SOUTHEAST PERMANENTE MEDICAL GROUP, a Georgia corporation, HAWAII PERMANENTE MEDICAL GROUP, a Hawaii corporation, MID-ATLANTIC PERMANENTE MEDICAL GROUP, a Maryland corporation; NORTHWEST PERMANENTE, P.C., an Oregon corporation; GROUP HEALTH PERMANENTE, a Washington corporation, and KAISER PERMANENTE, a business entity, form unknown,

Defendants.

CASE NO. 3:16-CV-05337-EMC

SECOND AMENDED COMPLAINT BY RELATORS MARCIA STEIN AND RODOLFO BONE FOR VIOLATIONS OF THE FALSE CLAIMS ACT; REQUEST FOR JURY TRIAL

(Captions continued on next page)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA, *ex rel.* GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, INC., et al., Defendants.	CASE NO. 3:18-cv-01347-EMC SECOND AMENDED COMPLAINT BY RELATORS MARCIA STEIN AND RODOLFO BONE FOR VIOLATIONS OF THE FALSE CLAIMS ACT; REQUEST FOR JURY TRIAL
UNITED STATES OF AMERICA and STATE OF CALIFORNIA, *ex rel.* MICHAEL BICOCCA, Plaintiffs, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	CASE NO. 3:21-cv-03124-EMC SECOND AMENDED COMPLAINT BY RELATORS MARCIA STEIN AND RODOLFO BONE FOR VIOLATIONS OF THE FALSE CLAIMS ACT; REQUEST FOR JURY TRIAL
UNITED STATES OF AMERICA, *ex rel.* JAMES M. TAYLOR, Plaintiffs, v. KAISER PERMANENTE, INC., et al., Defendants.	CASE NO. 3:21-cv-03894-EMC SECOND AMENDED COMPLAINT BY RELATORS MARCIA STEIN AND RODOLFO BONE FOR VIOLATIONS OF THE FALSE CLAIMS ACT; REQUEST FOR JURY TRIAL

COME NOW, Plaintiffs and Qui Tam Relators Marcia Stein and Rodolfo Bone, individually and on behalf of the United States of America, and allege as follows:

JURISDICTION AND VENUE

1. Plaintiffs and Qui Tam Relators Marcia Stein and Rodolfo Bone (Relators) file this action on behalf and in the name of the United States of America (Government) seeking damages and civil penalties against the defendants for violations of 31 U.S.C. § 3729(a).

2. This Court's jurisdiction over the claims for violations of 31 U.S.C. § 3729(a) is based upon 31 U.S.C. § 3732(a).

3. Venue is vested in this Court under 31 U.S.C. § 3732(a) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3729(a) occurred in the Central District of California. Venue is also vested in this Court under 28 U.S.C. § 1391(b) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3729(a) occurred in the Central District of California.

THE PARTIES

4. Relators are citizens of the United States and residents of the State of California. Relators bring this action of behalf of the Government under 31 U.S.C. § 3730(b).

5. At all times relevant, defendants Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Foundation Hospitals (KFH) are and were corporations organized under the laws of California and transacted business in, among other places, the Central District of California.

6. At all times relevant, defendants Kaiser Foundation Health Plan of Colorado (KFHPCO), Kaiser Foundation Health Plan of Georgia, Inc. (KFHPGA), Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHPMAS), Kaiser Foundation Health Plan of the Northwest (KFHPNW), and Kaiser Foundation Health Plan of Washington (KFHPWA) are and were corporations organized under the laws of Colorado, Georgia, Maryland, Oregon and Washington, respectively.

7. KFHP, KFHPCO, KFHPGA, KFHPMAS, KFHPNW and KFHPWA are collectively referred to as "Kaiser Health Plans."

8. At all times relevant, defendant The Permanente Medical Group (TPMG) is and was a corporation organized under the laws of California.

9. At all times relevant, defendants Southern California Permanente Medical Group (SCPMG) and Kaiser Permanente (KP) are and were business organizations, forms unknown, and transacted business in, among other places, the Central District of California.

10. At all times relevant, defendant Colorado Permanente Medical Group (CPMG) is and was a Colorado corporation.

11. At all times relevant, defendant The Southeast Permanente Medical Group

(SEPMG) is and was a Georgia corporation.

12. At all times relevant, defendant Hawaii Permanente Medical Group (HPMG) is and was a Hawaii corporation.

13. At all times relevant, defendant Mid-Atlantic Permanente Medical Group (MAPMG) is and was a Maryland corporation.

14. At all times relevant, defendant Northwest Permanente, P.C. (NWP) is and was an Oregon corporation.

15. At all times relevant, defendant Group Health Permanente (GHP) is and was a Washington corporation.

16. Defendants TPMG, SCPMG, CPMG, SEPMG, HPMG, MAPMG, NWP, and GHP are collectively referred to as "Physician Medical Groups" or "PMGs."

17. Kaiser Permanente (KP) is a business entity, form unknown, that is, and at all times mentioned was, made up of three groups of interdependent entities, the Kaiser Health Plans, KFH and the PMGs, through an exclusive contractual relationship, that operates as one the nation's largest integrated health care delivery system focused on providing managed health care services to HMO beneficiaries and to seniors through the federal Medicare Advantage health care program. The Kaiser Health Plans provide, among other things, infrastructure and support in Information Technology (IT), Human Resources (HR), Compliance, Coding, Health Information Management (HIM), and Finance to KFH and its regional hospitals, medical centers and clinics, and to the PMGs and their regional medical groups and medical clinics. KFH provides hospital facilities and services to the Kaiser Health Plans' HMO and Medicare Advantage beneficiaries, and has various infrastructure functions and departments, including but not limited to HIM. The PMGs provide medical, diagnostic and physician services to the Kaiser Health Plans' HMO and Medicare Advantage beneficiaries.

18. In California, there are two regional medical groups: (a) defendant SCPMG, consisting of California physicians providing medical services to KP patients in the areas of Ventura County and all counties south thereof; and (b) defendant TPMG, consisting of

California physicians providing medical services to KP patients in all remaining counties north of Ventura County.

19. CPMG is a regional medical group consisting of physicians providing medical services in Colorado to KP patients.

20. SEPMG is a regional medical group consisting of physicians providing medical services in Georgia to KP patients.

21. HPMG is a regional medical group consisting of physicians providing medical services in Hawaii to KP patients.

22. MAPMG is a regional medical group consisting of physicians providing medical services in Maryland, Virginia and Washington, D.C. to KP patients.

23. NWP is a regional medical group consisting of physicians providing medical services is Oregon and Washington to KP patients.

24. GHP is a regional medical group consisting of physicians providing medical services in Washington to KP patients.

25. Relator Marcia Stein (Stein) is an AHIMA Registered Health Information Administrator (RHIA) and was employed by both the SCPMG and KFH. At SCPMG worked at Panorama City as the clinic records administrator and worked at KFH's Panorama City, California hospital as the Regional Director of KFH's Health Information Managers from about October 1987 until about May 2011. Health Information Managers are professionals with expertise in managing health information systems, and processing, analyzing and reporting information vital to the operations of hospitals, medical groups, medical clinics and health plans. Typically, Health Information Managers are also responsible for training physicians, health care professionals and coders on utilizing the available health information systems, electronic health records (EHR) and correct coding and documentation practices.

26. While employed at KFH Hospital-Panorama City, Stein reported to both the regional SCPMG and the KFH Hospital-Panorama City's managements. On behalf of SCPMG, Stein supervised a staff of over 100 full-time employees, including coders, billers, trainers, clinic staff and legal assistants (with regard to physician malpractice claims), and was

charged with implementing defendants' policies and procedures regarding medical record documentation and compliance, HIPAA security, and physician training and education. Stein attended monthly SCPMG Clinic Administrator and Regional Department meetings. Stein was also responsible for overseeing the Panorama City hospital's health information systems, coding, medical record documentation, HIPAA security, and related compliance issues, as well as being a contact person for various state and federal hospital data reporting questions or issues. Stein co-chaired the monthly regional HIM Director's meetings (for the Southern California Region), chairing the majority. Such meetings addressed coding and documentation problems with SCPMG senior leadership on behalf of other regional KFH HIM Directors.

27. Between 2010 and 2016, Rodolfo Bone (Bone) was a part employee of KFH at its South Bay hospital in Harbor City, California as a per diem coder. At the beginning of 2016 his position was moved to KFH's Southern California corporate offices in Pasadena, California where he continued as a per diem coder reporting to KFH's Regional Revenue Cycle. Beginning in 1996 and continuing until the present, Bone has been employed full time by Good Samaritan Hospital, located in Los Angles California, as a Coding Supervisor and Coding Auditor. Bone was born and raised in the Philippines where he graduated from medical school, and was and is licensed to practice medicine in the Philippines.

MEDICARE ADVANTAGE AND RISK ADJUSTMENT

28. At all times relevant, the United States (Government) funded the Medicare program, administered by the Centers for Medicare and Medicaid Services (CMS), which provides payment of healthcare services for, among others, Americans 65 years of age and older. Medicare provides an option, Medicare Advantage (MA), in which eligible Medicare beneficiaries can enroll with a health plan or managed care organization (collectively, "MAO") contracted with CMS for a capitated rate paid by CMS that generally provides at least those services provided to standard fee-for-service (FFS) Medicare beneficiaries. (*See,* 42 U.S.C. § 1395w-21(a).)

29. At all times relevant, each of the Kaiser Health Plans had a MA contract with CMS, the federal agency that administers the Medicare program, to provide MA benefits to

eligible enrollees. Eligible MA enrollees selected the Kaiser Health Plan in their locale and selected a primary care physician from a directory of PMG physicians near the enrollees' residence. The revenues from these MA contracts were a significant source of revenues for defendants. The revenues the PMGs received for the MA enrollees they serviced were also the primary source of funding for any physician bonuses that were paid.

30. At all times relevant, Section 1853(a)(3) of the Social Security Act [42 U.S.C. § 1395w-23(a)(3)] required the Government's Centers for Medicare and Medicaid Services (CMS) to risk adjust payments to Medicare Advantage organizations (MAOs), such as the Kaiser Health Plans. In general, the risk adjustment methodology relied on enrollee diagnoses, as specified by the International Classification of Disease, Ninth Revision Clinical Modification (ICD-9) Guidelines (ICD-9 Guidelines), to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee. Diagnosis codes (ICD-9 codes) collected from physicians and related information (collectively, "risk adjustment data") submitted by MAOs, such as the Kaiser Health Plans, to CMS were used to develop Hierarchical Condition Category (HCC)[1] risk scores that are used by CMS to risk adjust the capitated payment rates paid by the Government to that particular MAO. The HCC risk scores compensated a MAO with a population of patients with more severe illnesses than normal through higher capitation rates. Likewise, a MAO with a population of patients with less severe illnesses than normal would see a downward adjustment of its capitation rates because it was servicing a healthier than normal population of patients. By risk adjusting MAO payments, CMS attempts to make appropriate and accurate payments for enrollees with differences in expected healthcare costs. Risk adjustment data records the health status and demographic characteristics of an enrollee.

31. In order to obtain an HCC risk adjustment score for a MA enrollee for a given year, the enrollee must have an encounter with a medical provider or examiner that generates

[1]Not all diagnoses result in a HCC risk score. Only certain diagnosis codes or combinations thereof result in HCC risk scores. CMS reviews and publishes the list of relevant ICD-9 diagnosis codes and their related HCC coefficients annually. A HCC risk score will vary upon the diagnosis codes or combinations thereof according to a matrix determined by the Government.

a diagnosis code or codes, which were timely submitted to CMS. If a MA enrollee does not have a reported encounter with a medical provider or examiner that generates a diagnosis code or codes during the year, the following year, CMS will pay the MAO a capitated rate for that MA enrollee as though s/he was perfectly healthy, even though in prior years the MA enrollee had a number of diagnoses that resulted in significant HCC risk adjustment scores and correspondingly high capitation rates.

32. Risk adjustment data (RAD) submitted by or on behalf of a MAO to CMS must be supported by properly documented medical records from the encounter that led to the RAD. 42 C.F.R. §§ 422.310(c)(2) and (d), 422.504(l); Medicare Managed Care Manual, Ch. 7, § 40 [Medicare Advantage Organizations "must . . . [e]nsure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes must be documented in the medical record and must be documented as a result fo a face-to-face visit. . . ."]; *see also,* 79 Fed.Reg. No. 100, 29844, 29923 (May 23, 2014) ["Further, CMS has required for many years that diagnoses that MA organizations submit for payment be supported by medical record documentation."] In order to be a properly documented medical record, the medical record entries must, among other things, (1) be the result of a MA enrollee's face-to-face encounter with a medical provider or examiner legally authorized to perform the service rendered under applicable Medicare laws, regulations and rules,[2] (2) that accurately and truthfully documents the findings necessary to support the medical diagnoses by the medical provider/examiner in accordance with applicable Medicare laws, regulations and rules,[3] and (3) signed by the

[2] *See,* Medicare Managed Care Manual, Ch. 7, § 40 ["All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. . . . "]; 42 U.S.C. § 1395x(r) , (aa)(5)(A), (aa)(6); 42 C.F.R. §§ 410.20(b), 410.74(a)(2), 410.75(b)-(c), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d).

[3] 42 C.F.R. §§ 422.310(c)(2) and (d), 422.504(l)(2)-(3); CMS Pub.100-08, Medicare Program Integrity Manual, Ch. 3, §3.3.2.5; International Classification of Disease 9th Revision Guidelines (ICD-9), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d), and Medicare Managed Care Manual, Ch. 7, § 40 ["The diagnosis must be coded according to International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting."]

medical provider/examiner as required by Medicare.[4] Further, the diagnoses must be coded in accordance with all applicable national guidelines, including but not limited to International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting, and the American Health Information Management Association (AHIMA) national guidelines for ethical coding.[5] AHIMA is a member of the ICD9CM and the ICD10CM Cooperating Parties, thus their practice briefs are considered "industry standards." Failure to meet any of these required elements results in the medical record not being properly documented and being unable to support RAD arising therefrom and invalidating the submission of such RAD (i.e., ICD-9 diagnosis codes).

33. MAOs do not typically submit claims for services rendered to CMS in the traditional FFS sense. The capitation payments are paid in advance, and by accepting the capitated payments, MAOs agree to be at risk for all of the health care costs for the MA enrollees assigned to it. Capitation payments are made prospectively with the data for the current calender year being used to risk adjust the capitation payments for that specific MA enrollee in the subsequent calender year. Instead of submitting traditional FFS claims, MAOs submit RAD which are used by CMS to calculate and risk adjust the capitation payments paid by CMS to the MAOs for each MA enrollee. Because the capitation payments are adjusted based upon the MAOs' submission of RAD, the submission of RAD is considered by the Government as the submission of claims for payment to CMS for purposes of enforcing civil and criminal penalties for making false claims under Social Security Act §§1128A [42 U.S.C. § 1320a–7a], 1128 B [42 U.S.C. § 1320a–7b] and the False Claims Act, 31 U.S.C. § 3729.

34. CMS has made it clear that MAOs, such as the Kaiser Health Plans, "must be

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[4]Medicare Program Integrity Manual, Ch. 3, §3.3.2.4, made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d).

[5]42 C.F.R. § 422.310(d)(1) ["MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. . . ."]; Medicare Managed Care Manual, Ch. 7, § 40 ["The diagnosis must be coded according to International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting."]; AHIMA 2009, Amendments, Corrections ans Deletions in the electronic Health Record: Toolkit, pp. 1-8, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678; Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A)-(B).

continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and "are expected to have effective and appropriate payment evaluation procedures and effective compliance programs as a way to avoid receiving or retaining overpayments." Additionally, "we [CMS] have always expected that MA organizations or Part D sponsors implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29,884, 29,921, 29,923-29,924 (May 14, 2014).)

35. The MA program requires MAOs provide, at a minimum, all of the benefits available under original Medicare (Parts A and B). The MA program incorporates into it all of the coverage determinations, rules and regulations of Medicare Parts A and B unless such regulations are specifically altered or superceded by the Medicare Part C regulations that specifically govern the MA program.

36. As will be explained in detail below, at various times during and between 2010 and the present, the defendants submitted false and fraudulent claims to CMS in violation of 31 U.S.C. § 3729(a) by (a) making and submitting to CMS false, inaccurate and exaggerated diagnoses for sepsis that were not supported by properly documented medical records, (b) making and submitting to CMS false, inaccurate and exaggerated diagnoses for malnutrition that were not supported by properly documented medical records, (c) making and submitting to CMS false, inaccurate and exaggerated diagnoses for aortic atherosclerosis that were not supported by properly documented medical records, (d) making and submitting to CMS diagnoses resulting from improper and unethical leading physician queries, (e) performing medical record reviews designed to only identify and report to CMS previously unreported diagnosis codes that concealed and failed to withdraw from CMS previously reported diagnosis codes that were unsupported by the reviewed medical records, and (f) providing medically unnecessary and non-covered routine physical examinations in order to identify and submit invalid RAD for use in calculating Kaiser Health Plans' capitation payments to CMS.

37. Although the majority of Kaiser's Medicare patients are beneficiaries under the MA program, approximately 20% of Kaiser's Medicare patients are beneficiaries under

original fee-for-service (FFS) Medicare, i.e., Medicare Part A and/or Part B. Defendants' fraudulent misconduct alleged below concerning sepsis and malnutrition, (briefly mentioned in paragraph 36(a)-(b)) involved Kaiser's FFS Medicare patients and MA patients. Inpatient hospital facilities, such as KFH, bill CMS for FFS Medicare services by mapping ICD-9 and later ICD-10 diagnosis codes, into diagnostic related groups (DRGs), major complications and co-morbidities (MCCs) each of which is assigned a monetary value by CMS, depending in part, on the county where the hospital is located. In FFS Medicare hospital billing, DRGs are primary diagnoses and MCCs are secondary diagnoses. Some but not all MCCs cause an increase in the DRG's value.

SEPSIS

38. The current lay-person definition of sepsis and sepsis with acute organ failure (collectively, "Sepsis") is "Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs." (The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3), *JAMA*, (February 23, 2016) Vol. 315, No. 8, 801, 807.) "Sepsis is not a specific illness but rather a syndrome encompassing a still-uncertain pathobiology. At present, it can be identified by a constellation of clinical signs and symptoms in a patient with suspected infection." (*Id.* at 803.) Sepsis is characterized by "signs of inflammation (vasodilator, leukocyte accumulation, increased micro vascular permeability) occurring in tissues that are remote from the infection. Systemic inflammatory response syndrome (SIRS) is an identical clinical syndrome that complicates a noninfectious insult (e.g., acute pancreatitis, pulmonary contusion). . . . This response can lead to multiple organ dysfunction syndrome (MODS), which is the cause of the high mortality associated with these syndromes." (Sepsis Definitions: Time for Change, *Lancet,* (March 2, 2013), Vol. 381, No. 9868, 774–775 (See, http://doi.org/10.1016/S0140-6736(12)61815-7).)

39. The term Sepsis is usually reserved for patients that need to be admitted to the hospitals intensive care unit (ICU). (See, Sepsis Definition: Time For Change, *Lancet* (March 2, 2013) Vol. 381, No. 9868, pp. 774–775.) Patients who develop Sepsis face a substantial likelihood of death as it is one of the main causes of death among hospital patients. Sepsis has

been estimated to be the cause or related to of as many as 1 out of every 2 to 3 in-patient hospital deaths. (Hospital Deaths in Patients With Sepsis From 2 Independent Cohorts, *JAMA,* (July 2, 2014) Vol. 312, No. 1, 90-92 at p. 90. (See, http://jama.jamanetwork.com/article.aspx?articleid=1873131).) During 2009, the national mean length of stay for patients who had Sepsis as their principal diagnosis was 8.8 days and 15.8 days for patients with Sepsis as a secondary diagnosis. (Agency for Healthcare Research and Quality (AHRQ), HealthCare Cost and Utilization Project (H-CUP), Statistical Brief #122, p. 4 (October 2011).)

40. During 1991, the American College of Chest Physicians (ACCP) and the Society of Critical Care Medicine (SCCM) convened a Sepsis "Consensus Conference" the purpose of which, "[I]s to propose a conceptual framework for future studies of the clinical phenomenon of organ system dysfunction in critical illness, and to lay the foundations for common terminology and criteria to describe the syndrome." (The ACCP/SCCM Consensus Conference Statement - 1991, *Chest*, (June 1992) Vol. 101, 1644, 1648.) In other words, to provide some broad definitions of Sepsis so that researches could conduct effective clinical trials. (*See,* 2001 International Sepsis Definitions Conference, *Intensive Care Med.,* (March 28, 2003) Vol. 29, 530, 531.) The 1991 Consensus Conference introduced into common parlance the term "systemic inflammatory response syndrome" (SIRS). The term provided a reference for the complex findings that result from a systemic activation of the innate immune response, regardless of cause. (*Id*.) "This systemic inflammatory response can be seen following a wide variety of insults and includes, but is not limited to, more than one of the following clinical manifestations:

– Body temperature higher than 38°C or lower than 36°C

– Heart rate higher than 90/min

– Hyperventilation evidenced by respiratory rate higher than 20/min or PaCO2lower than 32 mmHg

– White blood cell count higher than 12,000 cells/ µl or lower than 4,000/ µl

These physiologic changes should represent an acute alteration from baseline in the absence of other known causes for such abnormalities. . . ." (The ACCP/SCCM Consensus Conference

Statement - 1991, *Chest*, (June 1992) Vol. 101, 1644, 1645.) The SIRS concept has been globally adopted by clinical investigators resulting in approximately 800 research articles about SIRS and/or Sepsis between 1992 and 2002.

41. The 1991 Consensus Conference introduced the concept that Sepsis is the body's inflammatory response to infection. The conference concluded that patients with elevations in at least two of four variables that are indicators of inflamation (temperature, heart rate, respiratory rate, and white blood cell count) were suspect of having SIRS, and that patients with elevations in at least two of the four variables and an infection were potential indicators of sepsis. However, the Consensus Conference instructed physicians **not** to use the SIRS criteria plus infection as a diagnostic standard, "To help identify these manifestations as sepsis, it should be determined whether they are a part of the direct systemic response to the presence of an infectious process. Also, the physiologic changes measured should represent an acute alteration from baseline **in the absence of other known causes for such abnormalities**." (Emphasis added; The ACCP/SCCM Consensus Conference Statement - 1991, *Chest,* (June 1992) Vol.101, 1644, 1646.)

42. In 2001, the definitions of sepsis and SIRS were revisited at the International Sepsis Definitions Conference sponsored by the ACCP, SCCM, the European Society of Intensive Care Medicine (ESICM), the American Thoracic Society (ATS), and the Surgical Infection Society (SIS). The 2001 International Sepsis Definitions Conference ("2001 Conference") goals included identification of ways to improve the current sepsis definitions and to identify methodologies for increasing the accuracy, reliability, and/or clinical utility of the diagnosis of sepsis. (2001 International Sepsis Definitions Conference, *Intensive Care Med.,* (March 28, 2003) Vol. 29, 530, 531.) The 2001 Conference addressed at length the short-comings of the then current sepsis and SIRS definitions. The SIRS criteria had been found to have no practical use to a clinician for diagnosing Sepsis and concluded, among other things, "[T]he specific criteria proposed in the 1992 consensus definitions are widely considered to be too nonspecific to be of utility in diagnosing a cause of the syndrome or in

identifying a distinct pattern of host response."[6] (2001 International Sepsis Definitions Conference, *Intensive Care Med.*, (2003) Vol. 29, 530, 532.) The final Report from the 2001 Conference further concluded, "Unfortunately a clinically useful set of criteria for diagnosing sepsis and related conditions will necessarily be somewhat arbitrary. There is no 'gold standard' (such as the infarcted myocardium) against which the diagnostic criteria can be calibrated." (*Id.* at 532.)

43. Although the 2001 Conference did not result in a new definition of sepsis, it clarified that SIRS criteria were not intended to be used as a physician diagnostic tool but rather a starting point for researchers to identify clinical trials participants. (*Id.* at 532.) In response to the limitations noted of the SIRS definition, the 2001 Conference Report stated that clinical findings such as, "[H]emodynamic instability, arterial hypoxemia, oliguria, coagulopathy, and altered liver function tests among the list of criteria that can be used to establish the diagnosis of sepsis." (*Id.* at 533.) The Report included an expansive list of possible signs, symptoms and potentially sceptic values, grouped into five main categories, General Parameters, Inflammatory Parameters Hemodynamic Parameters, Organ Dysfunction Parameters, and Tissues Perfusion Parameters, to aid physicians in making and confirming Sepsis as opposed to less severe medical conditions.[7] (*Id.* at 533-34.)

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[6]The 2001 International Sepsis Definitions Conference cited the work of J.C. Marshall who concluded, "The four criteria that define SIRS are non-specific measures of physiologic severity, rather than distinctive manifestations of a disease process....However, the complexity of the biologic processes involved suggest that a clinical syndrome of systemic inflammation is of no more use to the clinician than a clinical syndrome of cancer." (SIRS and MODs: What is Their Relevance to the Science and Practice of Intensive Care, *Shock,* (December 2000) Vol. 12, No. 6, 586-9.

[7]The complete list of Sepsis diagnostic criteria was stated as Infection documented or suspected and some of the following:

> General parameters
> Fever (core temperature >38.3°C) Hypothermia (core temperature <36°C Heart rate >90 bpmor >2 SD above the normal value for age Tachypnea: >30 bpm Altered mental status Significant edema or positive fluid balance (>20 ml/kg over 24 h) Hyperglycemia (plasma glucose >110 mg/dl or 7.7 mM/l) in the absence of diabetes
>
> Inflammatory parameters
> Leukocytosis (white blood cell count >12,000/µl) Leukopenia (white blood cell count <4,000/µl) Normal white blood cell count with >10%

44. The Report emphasized that its expanded list of clinical findings were not specific to sepsis and therefore, like the SIRS criteria, the list could not be used as a diagnostic standard in all cases. The physician still had to determine if a medical condition other than sepsis was the cause of the patient's symptoms and/or elevated values before diagnosing sepsis or sepsis acute organ failure, when applicable, and separately determine if such organ failure was a result of Sepsis or some other cause. Other medical conditions besides Sepsis can also account for increases in the 2001 Conference criteria including, but not limited to, post operative surgery recovery, minor respiratory infections, minor urinary tract infections, trauma as well as certain medications. The Report stressed, "It is important that as a practitioner 'checks off the boxes' to establish the diagnosis of sepsis; only findings that cannot be easily explained by other causes should be included." *Id.* "Most clinicians do not refer to patients as septic when they develop an uncomplicated mild upper-respiratory viral infection with slight fever and tachycardia, (i.e., a faster than normal heart rate.)" (Sepsis Definitions: Time For Change, *Lancet*, March 2, 2013, Vol. 381, No. 9868, 774–775.)

45. Between 2001 and 2010 several organized approaches to identify and treat Sepsis were proposed. The two most prominent of these organized treatment approaches were Early Goal-Directed Therapy for the treatment of Sepsis and Sceptic Shock (EGDT) published in the New England Journal of Medicine (N Engl J Med (November 8, 2001) Vol. 345, 1368-

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> immature forms Plasma C reactive protein>2 SD above the normal value Plasma procalcitonin >2 SD above the normal value
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> Hemodynamic parameters
> Arterial hypotensionb (systolic blood pressure <90 mmHg, mean arterial pressure <70, or a systolic blood pressure decrease >40 mmHg in adults or <2 SD below normal for age) Mixed venous oxygen saturation >70%b Cardiac index >3.5 l min−1 m−2c,d
>
> Organ dysfunction parameters
> Arterial hypoxemia (PaO2/FIO2 <300) Acute oliguria (urine output <0.5 ml kg−1 h−1 or 45 mM/l for at least 2 h) Creatinine increase ≥0.5 mg/dl Coagulation abnormalities (international normalized ratio >1.5 or activated partial thromboplastin time >60 s) Ileus (absent bowel sounds) Thrombocytopenia (platelet count <100,000/μl) Hyperbilirubinemia (plasma total bilirubin >4 mg/dl or 70 mmol/l)
>
> Tissue perfusion parameters
> Hyperlactatemia (>3 mmol/l) Decreased capillary refill or mottling

1377), and continuing since 2002, the Surviving Sepsis Campaign, a joint collaboration of the Society of Critical Care Medicine and the European Society of Intensive Care Medicine. The Surviving Sepsis Campaign (SSC) published and continuously updated Surviving Sepsis Bundles that outline the basic treatment protocols along with detailed treatment guidelines to provide institutions and physicians with a coordinated effort to measure and manage each of the five parameters for diagnosing Sepsis identified in the 2001 Conference (i.e., General Parameters, Inflammatory Parameters Hemodynamic Parameters, Organ Dysfunction Parameters, and Tissues Perfusion Parameters).

46. The SSC Surviving Sepsis Bundle states:

TO BE COMPLETED WITHIN 3 HOURS:

1) Measure lactate level
2) Obtain blood cultures prior to administration of antibiotics
3) Administer broad spectrum antibiotics
4) Administer 30 ml/kg crystalloid for hypotension or lactate 4mmol/L

"Time of presentation" is defined as the time of triage in the emergency department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements of severe sepsis or septic shock ascertained through chart review.

TO BE COMPLETED WITHIN 6 HOURS:

5) Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) ≥65 mm Hg
6) In the event of persistent hypotension after initial fluid administration (MAP < 65 mm Hg) or if initial lactate was ≥4 mmol/L, re-assess volume status and tissue perfusion and document findings according to Table 1.
7. Re-measure lactate if initial lactate elevated.

TABLE 1

DOCUMENT REASSESSMENT OF VOLUME STATUS AND TISSUE PERFUSION WITH:

EITHER:

• Repeat focused exam (after initial fluid resuscitation) including vital signs, cardiopulmonary, capillary refill, pulse, and skin findings.

OR TWO OF THE FOLLOWING:

• Measure CVP
• Measure ScvO2
• Bedside cardiovascular ultrasound

• Dynamic assessment of fluid responsiveness with passive leg raise or fluid challenge. (http://www.survivingsepsis.org/Bundles/Pages/default.aspx.)

47. The SSC guidelines and EGDT each contemplate that physicians timely diagnose Sepsis, take multiple blood samples prior to the administration of antibiotics for obtaining an accurate blood culture, monitor and managing the patients fluid retention, monitor arterial pressure via central venous catheter (i.e. an arterial catheter placed in the Vena Cava artery) administer IV fluids, measure and adjust lactate levels (a precursor to organ failure), and administer various medications including, but not limited to, antibiotics to fight the infection, and vasopressors and corticosteroids, as needed, to manage fluid retention and prevent organ failure.[8] (Early Goal-Directed Therapy for the treatment of Sepsis and Sceptic Shock, *N Engl J Med,* (November 8, 2001) Vol. 345, 1368-1377; http://www.survivingsepsis.org/Guidelines/Pages/default.aspx.) Typically, MA enrollees that have a central venous catheter inserted are admitted to or already in the ICU.

48. The SSC's detailed treatment guidelines, provided in conjunction with the Surviving Sepsis Bundles, include but are not limited to: Initial Resuscitation and Infection Issues; Hemodynamic Support and Adjunctive Therapy; Blood Product, Immunoglobulins and Selinum Administration; Mechanical Ventilation of Sepsis-Induced Acute Respiratory Distress Syndrome (ARDS); Sedation, Analgesia, and Neuromuscular Blockade; Glucose Control; Renal Replacement Therapy; Bicarbonate Therapy; Deep Vein Thrombosis Prophylaxis; Stress Ulcer Prophylaxis; and Nutrition to address various patient responses and provide treatment options. (Id.) Administering such complex Sepsis treatments routinely take place in the hospital's ICU. (*Id.*)

49. Based on the 2001 Conference's final report, during 2003 the ICD-9 Guidelines and the ICD-9 codes were modified to include the 2001 International Sepsis Definition Conference's expanded list of sepsis and sepsis with acute organ failure, resulting in a more expansive and detailed diagnostic and coding scheme for properly documenting and coding

[8] In 2015, based on the best available evidence, the Surviving Sepsis Bundle was updated making the use of a central venous catheter to monitor blood oxygen or pressure levels optional instead of required.

Sepsis. The ICD-9 Guidelines explain in detail the precise sequence of steps required to properly code the various stages of Sepsis, including but not limited to, sepsis, sepsis with organ dysfunction, sepsis with multiple organ dysfunction, sepsis caused by various types of infections, and septic shock. (*ICD-9-CM Official Guidelines for Coding and Reporting*, §I.C.1.b.1.-12.) Further, the ICD-9 Guidelines repeatedly stress that coders will likely have to query physicians when documenting Sepsis to trigger proper documentation that supports the Sepsis diagnosis due the complex nature of those diseases.[9] While the ICD-9 Guidelines explain the minium information required for coders to properly record a particular ICD-9 diagnosis code, it does not explain to the physician all of the steps and criteria for making a particular diagnosis. It is not uncommon for the medical standard of care to be more detailed and complex than the ICD-9 Guidelines.

50. On or about February 23, 2016, JAMA published the Report of The Third International Sepsis Definitions Conference. This Third Sepsis Definitions Conference (Sepsis-3) adopted a new definition of Sepsis that was consistent with the current state of the medical practice and research since the 2001 Conference. "The task force sought to differentiate sepsis from uncomplicated infection and to update definitions of sepsis and septic shock to be consistent with improved understanding of the pathobiology.... The sepsis illness concept is predicated on infection as its trigger, acknowledging the current challenges in the microbiological identification of infection. . . . The task force recognized that sepsis is a syndrome without, at present, a validated criterion standard diagnostic test." (The Third International Consensus Definitions for Sepsis and Septic Shock, *JAMA* (Feb. 2016) Vol. 315, No. 8, 801, 803.) The new sepsis definition from Sepsis-3 was stated as:

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[9]The ICD-9 Guidelines state, "Due to the complex nature of sepsis and severe sepsis, some cases may require querying the provider prior to assignment of the codes." §I.C.1.b.1.c. "If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign code 995.92, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider." §I.C.1.b.5. "Sepsis or severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether the sepsis or severe sepsis was present on admission, the provider should be queried." §I.C.1.b.2.c.

> In lay terms, sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs.
>
> Patients with suspected infection who are likely to have a prolonged ICU stay or to die in the hospital can be promptly identified at the bedside with qSOFA, ie, alteration in mental status, systolic blood pressure 100 mm Hg, or respiratory rate 22/min.
>
> Septic shock is a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality.
>
> Patients with septic shock can be identified with a clinical construct of sepsis with persisting hypotension requiring vasopressors to maintain MAP 65 mm Hg and having a serum lactate level >2 mmol/L (18 mg/dL) despite adequate volume resuscitation. With these criteria, hospital mortality is in excess of 40%. Abbreviations: MAP, mean arterial pressure; qSOFA, quick SOFA; SOFA: Sequential [Sepsis-related] Organ Failure Assessment. (*Id*. at 805.)

The Sepsis-3 Report concludes that, "The current use of 2 or more SIRS criteria to identify sepsis was unanimously considered by the task force to be unhelpful. Changes in white blood cell count, temperature, and heart rate reflect inflammation, the host response to 'danger' in the form of infection or other insults. The SIRS criteria do not necessarily indicate a dysregulated, life-threatening response. SIRS criteria are present in many hospitalized patients, including those who never develop infection and never incur adverse outcomes." (*Id*.) This conclusion is very similar to the conclusions published from the 2001 Conference. (2001 International Sepsis Definition Conference, *Intensive Care Med.* (2003) Vol. 29, 530, 532-4.) A further change was to abandon the use of the term "severe sepsis," i.e., sepsis with organ dysfunction, because all sepsis cases are severe due to their potential to cause death. Lastly, the Sepsis-3 Report recognized that Septic Shock, i.e., sepsis involving multiple organ failure, has an even higher likelihood of patient death than sepsis. In an e-mail to its staff dated March 8, 1016, KFHP unequivocally rejected the modern Sepsis-3 definitions and diagnostic recommendations.

DEFENDANTS' FRAUDULENT MISCONDUCT

51. During or about 2009, KFH in conjunction with TPMG and SCPMG adopted and implemented early treatment protocols purportedly to identify and treat all patients suspected of having Sepsis. These Sepsis treatment protocols where subsequently adopted by all PMGs. The Sepsis treatment protocols KHF, TPMG and SCPMG implemented where intentionally

over-broad to ensure that all patients with Sepsis were timely diagnosed and treated. However, KFH's overly-broad Sepsis treatment protocols also resulted in over-diagnosing Sepsis in patients that had presented with uncomplicated mild upper-respiratory viral infection and/or urinary tract infections, with slight fever and tachycardia, (i.e., a faster than normal heart rate). Such patients where not suffering from Sepsis, Sepsis with organ dysfunction, nor severe Sepsis. SCPMG and KFH's Sepsis treatment protocols did not provide any process to correct any false-positive Sepsis diagnoses made by TPMG and/or SCPMG physicians. Efforts by coders employed by KFH, SCPMG or TPMG to correct such over-diagnosed and false Sepsis diagnoses were overruled and/or disallowed by TPMG and SCPMG physicians. None of the falsely diagnosed Sepsis patients where admitted to the hospital as inpatients nor the ICU. Instead, such falsely diagnosed Sepsis patients were held in the emergency room's observation beds for a period of up to 72 hours before being sent home. However, most were sent home within 48 hours or less.

52. During and between approximately 2010 to the present, SCPMG, TPMG, KFH and KFHP participated in a fraudulent scheme to up-code and falsely diagnose MA enrollees with sepsis and/or severe sepsis, i.e., sepsis with acute organ failure, (collectively referred to as "Sepsis") when Sepsis was not present. Such false Sepsis diagnoses were made in order to increase the risk adjustment scores for the MA enrollees so diagnosed and thereby increase CMS's capitation payments to KFHP, TPMG and SCPMG. This scheme was also promoted by KFH to falsely lower KFH's reported Sepsis mortality rates thereby improve KFH's reputation and prestige as a quality hospital provider. This fraudulent scheme concerned the identification and treatment of Sepsis for KFHP's MA enrollees that presented in the emergency room (ER) of KFH hospitals and was accomplished by (a) KFHP, PMG and SCPMG and KFH implementing unwritten policies that prohibited coders employed by , KFH, SCPMG and/or TPMG, (collectively referred to as "Kaiser's coders") from performing physician queries for Sepsis diagnoses as required by the ICD-9 Guidelines, (b) implementing unwritten policies requiring Kaiser's coders to code ICD-9 diagnosis codes for Sepsis based solely on the physician's instructions to code Sepsis instead of relying on the supporting clinical

findings documented in the medical record, (c) using an improper Sepsis diagnostic standard that overstated the frequency of Sepsis diagnoses, (d), aggressively diagnosing Sepsis as part of a strategy to lower the reported Sepsis mortality rate at KFH hospitals throughout California, and (e) KFHP, TPMG and SCPMG, as an express condition of receiving capitation payments from CMS, routinely and annually falsely certifying that such ICD-9 diagnosis codes for Sepsis were accurate, complete and truthful to their best knowledge, information and belief, required by CMS as a condition of receiving payment, when KFHP, TPMG and SCPMG knew or should have known that such certifications were false.

53. During or about 2008 and 2009, TPMG and SCPMG adopted unwritten policies instructing Kaiser's coders to code Sepsis based upon a physician's instruction to code Sepsis and prohibiting Kaiser's coders from performing coding queries regarding Sepsis diagnoses. Kaiser's coders are required to perform coding queries by the ICD-9 Guidelines and AHIMA's Ethical Coding Guidelines when such queries are needed to trigger clinical documentation required to properly support or to properly rule out a Sepsis diagnosis.

54. In 2009, several KFHP HIM directors from Southern California KFH hospitals including the HIM Director for KFH Hospital-Woodland Hills, Vivian Wachs, Registered Health Information Technician (RHIT), informed Stein, co-chair of the Southern California Region monthly HIM meetings, and all of the HIM Directors in attendance, that their local SCPMG physician leadership was insisting that Sepsis be coded at the physician's discretion and without supporting clinical findings properly documented in the medical record as required by the ICD-9 Guidelines and by CMS. (42 C.F.R. §422.310(b)-(d); CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq.) In response, Stein requested and was granted permission by Dr. Kirk Tamaddon, SCPMG's Chief Regional Physician Liaison, who chaired the SCPMG regional meetings, to make a presentation on Sepsis coding guidelines and Sepsis medical record documentation requirements at the October 2009, SCPMG physician leadership meeting.[10] In addition to Dr. Tamaddon, the meeting was attended by at several

[10]Physician Liaisons are responsible for implementing monitoring and communicating to physicians and staff the PMG's regional directives regarding coding and documentation.

SCPMG Regional Medical Directors, and several Regional Operational Directors, approximately 15 SCPMG Physician Liaisons and/or physician representatives and 20 SCPMG Data Quality Managers and Encounter Coding Specialists.

55. Stein's presentation explained, among other things, that all of the symptoms and clinical findings that supported a diagnosis of Sepsis and all clinical findings and test results that support a diagnoses of organ dysfunction caused by Sepsis had to be documented in the medical records. Additionally, because of the complexity of the diagnoses, it was likely that Kaiser's coder needed to clarify the clinical findings and symptoms by making queries to physicians intended to trigger clarifying responses of the medical record's supporting documentation. Shortly after Stein finished her presentation, Dr. Albert Dreskin, SCPMG's Woodland Hill's Physician Liaison, informed the attendees to disregard the presentation Stein had just given, falsely asserting that SCPMG physicians had no requirement to provide additional clinical documentation for a Sepsis diagnoses because Sepsis was a clinical decision therefore all that was required was for the physician to write Sepsis. Dr. Dreskin concluded his remarks by reminding the attendees that diagnosing Sepsis was worth a lot of money to the defendants because it increased the MA enrollees' risk adjustment scores. In fact, the submission of the ICD-9 diagnosis code for sepsis resulted in a HCC risk score of.754 which increased the capitation payments for each such diagnosed MA enrollee by approximately $8,500 for the next year.

56. Following the October 2009 SCPMG physician leadership meeting and continuing through to the present, SCPMG physician and coding leadership routinely insisted that Sepsis be coded whenever the physician wrote the word Sepsis in the medical record and prohibited Kaiser's coders from making coding queries to clarify the supporting medical record documentation. Such coding instructions and query restrictions violate ICD-9 Guidelines and AHIMA ethical coding guidelines. The blatantly improper coding practice was unique to the defendants' coding and documentation of Sepsis. Kaiser's coders did not have such coding instructions or query restrictions with regards to any other diagnoses. Stein witnessed these improper Sepsis coding policies at KFH Hospital-Panorama City and was informed by other

HIMs that such polices were adopted by the defendants throughout KP's Southern California region.

57. Throughout the term of his employment at KFH Hospital-South Bay, Bone had been instructed that he was **not** to query physicians regarding Sepsis diagnoses and was required to code Sepsis as instructed by the physician regardless of the medical record documentation. Bone had learned from other coders that such Sepsis coding instructions and query restrictions had been adopted by the defendants throughout KP's Southern California region. Stein and Bone are informed and believe, and upon such information and belief alleges, that the SCPMG's policy to prohibit physician queries of Sepsis diagnoses and to require Kaiser's coders to code Sepsis based on the physician's instructions (as opposed to the supporting clinical findings documented in the medical record) originated with TPMG and then was implemented by SCPMG during or about 2009.

58. As part of KP's national agenda to lower its reported Sepsis mortality rates at KFH hospitals, during or about 2009, KFHP and TPMG implemented Sepsis identification and treatment protocols that were then implemented by SCPMG on or about 2011 and eventually by all PMGs. These Sepsis treatment protocols were purportedly based upon the EGDT treatment protocols. These Sepsis diagnostic criteria improperly used the Sepsis definition promulgated at the 1991 Consensus Conference, i.e., Sepsis is SIRS plus infection, as a diagnostic standard, even though by 2009 it was well established the SIRS criteria could not be properly used as a diagnostic standard. Specifically, defendants' Sepsis diagnostic standard required an elevated value in two or more SIRS criteria plus an infection to diagnose Sepsis.

59. As discussed above in paragraph 40, the 1991 Sepsis definition was adopted to assist researchers identify subjects to participate in clinical trials and promote Sepsis research. By 2001 it was well established that Sepsis could not be diagnosed just be using the SIRS criteria plus infection (i.e., whenever two or more SIRS criteria were elevated and the patient had an infection) because such criteria applies to many patients who are suffering less severe conditions than Sepsis. Instead, the SIRS criteria potentially diagnosed Sepsis only when no other possible explanation or medical condition that accounted for the elevated levels. (The

ACCP/SCCM Consensus Conference Statement - 1991, *Chest,* June 1992, Vol.101, 1644, 1646.) The 2001 Conference published an expanded list of criteria to diagnose Sepsis but concluded that these criteria, like the SIRS criteria, were not specific to Sepsis so such criteria could not be adopted as a diagnostic "gold standard" that could be used conclusively in every instance. The physician still had to make a judgment call to determine if the symptoms were the result of the patient having a life threatening inflammatory response to infection that potentially threatened to shut down organs resulting in death, i.e., Sepsis, or had some less severe medical condition that explained the abnormal criteria values.

60. Defendants, in adopting a diagnostic standard based on two elevated SIRS criteria, ignored the then current standard of medical care by not including the well accepted expanded criteria from the 2001 Conference to diagnose Sepsis and to diagnose Sepsis with acute organ failure. (2001 International Sepsis Definitions Conference, *Intensive Care Med.* (2003) Vol. 29, 530, 532.) Defendants' Sepsis diagnostic standard also disregards the 2001 Conference's conclusions which unequivocally stated that the SIRS criteria were overly broad, too sensitive and nonspecific for sepsis making them unsuitable for use as a diagnostic standard. A conclusion that also was well accepted by the then concurrent and future medical literature.

61. Despite these flaws, Defendants nonetheless adopted the SIRS criteria as a diagnostic standard for KP's national Sepsis program knowing that using the SIRS diagnostic standard results in false and inaccurate Sepsis diagnoses. KP's physician training materials regarding diagnosing Sepsis failed to instruct KP's physicians **not** to diagnose Sepsis if the elevated SIRS criteria were due to a condition other than Sepsis, failed to instruct physicians to perform timely blood draws, i.e., prior to the administration of antibiotics, so accurate blood cultures are obtained (required to identify blood-born pathogens) and fails to discuss or incorporate any of the additional Sepsis diagnostic criteria from the 2001 International Sepsis Definitions Conference that physicians are suppose to use in making a Sepsis diagnosis.

62. SCPMG's, TPMG's and KP's adoption of improper Sepsis specific coding policies, (i.e., policies that required Kaiser's coders to code Sepsis based on the physician's

instruction and also prohibited Kaiser's coders from making coding queries regarding Sepsis diagnoses), ensured that the Kaiser Health Plans submitted false and inaccurate Sepsis diagnoses to CMS as valid RAD. Such improper coding policies were and are unique to Sepsis for SCPMG, TPMG and KFH and violated the ICD-9 Guidelines and AHIMA ethical coding Guidelines. For all other syndromes, diseases, illnesses or injuries, Kaiser's coders were able to perform coding queries without restrictions. Sepsis was the only diagnoses that Kaiser's coders were not allowed to use coding queries to clarify the supporting documentation in the medical record.

63. During and between 2010 and 2014, while working at KFH Hospital-South Bay, Bone coded approximately three to four Sepsis diagnoses a week for MA enrollees that were not admitted to the ICU or the hospital but were discharged home after being put in an emergency room observation bed for between 3 to 48 hours. Frequently, such MA enrollees were not treated aggressively for Sepsis per KP's Sepsis treatment protocols, including but not limited to, failing to insert a central venous catheter and failing to perform blood draws prior to the administration of antibiotics to obtain blood cultures. During this time period, Bone also routinely coded Sepsis diagnoses for MA enrollees who were not admitted to the ICU but were admitted to the hospital for a brief stay of up to three days. Such MA enrollees typically were not treated aggressively for Sepsis per KP's Sepsis treatment protocols, including but not limited to, failing to insert a central venous catheter and failing to perform blood draws prior to the administration of antibiotics to obtain blood cultures. Bone observed, that the medical records of MA enrollees diagnosed with Sepsis, but not admitted to the hospital and MA enrollees admitted to the hospital for a brief stay but were not treated for Sepsis aggressively, did not have sufficient clinical findings documented in their medical records that supported the Sepsis diagnoses.

64. The fact that MA enrollees that were diagnosed with Sepsis in the ER but discharged without being admitted to the ICU or the hospital is a strong indication that such MA enrollees did not have Sepsis, and that such Sepsis diagnosis and coding were false. It is not credible that an MA enrollee is diagnosed with sepsis and/or sepsis with acute organ failure

does not require an admission to the ICU for treatment let alone is discharged without ever being admitted to the hospital. Rather, such MA enrollees did not have Sepsis and the ER observations confirmed this fact allowing the physician to confidently send the MA enrollee home without admission to the hospital or ICU.

65. As a result of KP's emphasis on diagnosing Sepsis and adopting an improper and overly broad Sepsis diagnostic standard, the number of Sepsis diagnoses by PMG and SCPMG physicians, between 2009 and 2013, increased dramatically at all California KFH hospitals; as much as, between 200% to 300% at some facilities. This increase in the number of Sepsis diagnoses had the effect of dramatically lowering KFH California Hospital's reported Sepsis mortality rates. The reported Sepsis mortality rates were a ratio comparing the number of Sepsis cases diagnosed at KFH Hospitals to the number of patients that expired as a result of having Sepsis. As such, the reported Sepsis mortality ratio was easy to manipulate by increasing the number of Sepsis diagnoses with false Sepsis diagnoses. By 2013, KP claimed that its reported Sepsis mortality rate had dropped to approximately 9% and its average length of stay for such cases had dropped to 3.5 days. . (An Innovative Approach to Sepsis Prevention Saves Lives, (Dec 6, 2013) https://businesshealth.kaiserpermanente. org/insights /sepsis-prevention.) KP's reported Sepsis mortality rate and average length of stay during 2010 through 2013 are unrealistic numbers and an indication that the Kaiser Health Plans submitted false Sepsis diagnoses. As discussed below in greater detail, at least one KP physician complained, challenging the validity of KP's reported sepsis mortality rates. A recent landmark study comparing the difference in effectiveness between EGDT treatment protocols and traditional treatment methods, when properly implemented using hospital systems with best practices, achieved sepsis mortality rates of 19%-20%. (A Randomized Trial of Protocol-Based Care for Early Septic Shock, The ProCESS Investigators, *N Engl J Med* (July 24, 2014); Vol. 370, 1683, 1690.) For 2010, the national mean length of stay for MA enrollees with Sepsis as a primary diagnosis was 9 days and 15 days for those with Sepsis as a secondary diagnosis. (AHRQ, H-CUP Statistical Brief #122, p.4 (October 2011).)

66. In November 2010, KP's management identified KFH Hospital-Panorama City

as being an outlier for its reported Sepsis mortality rates of 25% despite noting, that all by all other quality measures, the facility was one of KFH's very best hospitals. The e-mail instructed executives responsible for KFH Hospital Panorama City to solve this problem by identifying more cases of Sepsis. Dr. Chiara Conrado, KFH-Panorama City Hospital's Pulmonary and Intensive Care Specialist, responded complaining that the sepsis mortality rates from other KFH facilities was not believable, that the data used was not verified for accuracy, that Kaiser's coders and physicians incorrectly diagnose and code sepsis and that the KP's reported Sepsis mortality rates for 2010 were lower than what other significant studies achieved and therefore KP's data was not credible.

67. Dr. Conrado received no response to her complaints. At all times relevant defendants were required to maintain an effective compliance program designed to identify and ameliorate Medicare fraud waste and abuse (FWA). (42 C.F.R. §422.503(b)(4)(vi); Medicare Managed Care Manual, Ch.21 §§30-50 et seq.) Pursuant to statutory and CMS requirements, defendants' compliance officer was required to initiate a timely investigation into Dr. Conrado's accusations regarding the potential Medicare FWA issues raised by Dr. Conrado's complaints but failed to do so. (42 C.F.R.§422.503(b)(4)(vi); CMS Publication 100-16, Medicare Managed Care Manual, Ch. 21 §Ch.21 §50.7.1.)[11] [12]

68. KP's use of an overly broad and improper Sepsis diagnostic standard imposes on KFHP, TMPG, SCPMG and KFH, a duty to exercise reasonable diligence to identify, and redact false and incorrect Sepsis diagnoses from the RAD submitted to CMS. This duty is an integral part of the Medicare Advantage's regulatory framework intended to help MAOs, such

[11] 42 C.F.R. §422.504(b)(4)(vi) states in part: [Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse.]

[12] Medicare Managed Care Manual, Ch.21 §50.7.1 – Conducting a Timely and Reasonable Inquiry of Detected Offenses, states in part, "Sponsors must conduct a timely and well-documented reasonable inquiry into any compliance incident or issue involving potential Medicare program noncompliance or potential FWA. . . . It may be discovered through a hotline, a website, an enrollee complaint. . . . Regardless of how the noncompliance or FWA is identified, sponsors must initiate a reasonable inquiry as quickly as possible, but not later than 2 weeks after the date the potential noncompliance or potential FWA incident was identified."

as KFHP, avoid the submission of false and fraudulent claims to CMS and avoid the receipt and retention of improper overpayments from CMS. (42 C.F.R. §§ 422.326(c), 422.503(b)(4)(iv), 422.504(l)(2); CMS Publication 100-16, Medicare Managed Care Manual, Ch.7 §40 et seq. and Ch.21 §§30-50 et seq.; 79 Fed.Reg. 29844, 29923-24 (March 23, 2014).)

69. KFHP failed to use reasonable diligence in its selection of its Sepsis diagnostic standard and also by failing to identify and redact false and unsupported Sepsis diagnoses from the RAD submitted to CMS. As an express condition of receiving its monthly capitation payments on behalf of MA enrollees, KFHP certified based on its best knowledge, information and belief that the RAD it submitted to CMS was accurate, truthful and complete. (42 C.F.R. §422.504(l)(2).) Because KFHP did not attempt to identify and redact the potentially false and fraudulent Sepsis diagnoses obtained from its contracted medical groups, KFHP's statutorily required certifications were false. KFHP's best knowledge, information and belief were that many of the Sepsis diagnoses were inaccurate, untruthful and incomplete, and were not supported by the clinical documentation in the medical record as required by CMS. (CMS Publication 100-16, Medicare Managed Care Manual, Ch.7 §40 et seq.) Furthermore, without a process to identify known potentially inaccurate Sepsis diagnoses, KFHP had no legitimate basis for making such a certification. (See, 79 Fed.Reg. 29844, 29923-24 (March 23, 2014).)

70. During and between approximately 2008 until the present, KFH hospital facilities, including all those in California, utilized the above described, false sepsis diagnoses and documentation practices to up-coded its FFS Medicare hospital claims that KHF submitted to CMS on behalf of FFS Medicare patients. The false and fraudulent sepsis ICD-9 and later ICD-10 diagnosis codes where mapped to the KFH's hospital's master claim bill, CMS form UB-04 as DRG 871 or 872 and submitted to CMS, resulting in a false and fraudulent claims in violation of the FCA. Each such false sepsis claim resulted in KFH receiving approximately $7000 to $12,000 of additional revenue from CMS.

71. Stein is informed and believes and upon such information and belief alleges, that between 2010 until her departure in 2011, the Kaiser Health Plans, KFH and PMGs adopted and implemented the Sepsis diagnosis, coding and treatment policies described above and in

paragraphs 53 through 58 as national policies and procedures.

72. Bone is informed and believes, and upon such information and belief alleges, that throughout the term of his employment (2010 until the present) the Kaiser Health Plans, KFH and PMGs adopted and implemented the unwritten Sepsis diagnosis, coding and treatment policies described above and in paragraphs 53 through 58 as national policies and procedures.

MALNUTRITION

73. During and between approximately 2006 until on or about December 11, 2013, SCPMG, TPMG, KFH and KFHP participated in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA enrollees in order to increase the risk adjustment scores for the MA enrollees so diagnosed. This fraudulent scheme was conducted at all KFH Hospitals throughout California and involved the diagnoses and coding of malnutrition and severe malnutrition based upon assessments performed by dieticians employed by KFH. The KFH dietician used a rubber stamp on the MA enrollee's medical record indicating that in his/her opinion the MA enrollee suffered from malnutrition or severe malnutrition. SCPMG and TPMG physicians then countersigned the stamp in the MA enrollees' medical record. Based solely on the presence of the physician's countersignature of the dietician's rubber stamp, KFH coders recorded the ICD-9 diagnosis codes for malnutrition or severe malnutrition as indicated by the rubber stamp. KFHP submitted to CMS these malnutrition and severe malnutrition ICD-9 diagnosis codes as RAD for use in calculating that MA enrollees' risk adjustment scores, which increased CMS's capitated payments to defendants.

74. Valid RAD must be the result of a face-to-face encounter with a physician or other qualified clinician that has been identified by CMS as an acceptable source of RAD. (CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq., §120.1.1, Table 19; 42 C.F.R. 422.310(b)-(d).) In order for RAD to be valid for submission to CMS, each ICD-9 diagnosis code submitted must have the appropriate clinical findings documented in the MA enrollee's medical record. (CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq.; 42 C.F.R. § 422.310(b)-(d).) KFH Hospitals' use of the dietician's stamp for

diagnosing and documenting malnutrition fails on both accounts, there is no face-to-face-encounter with a qualified physician where the physician makes a diagnoses of malnutrition, nor does the dietician's rubber stamp substitute for physician documenting in the medical record a diagnosis of malnutrition or the clinical indicators and clinical findings reviewed and observed necessary to support the malnutrition or severe malnutrition diagnosis.

75. The Medicare Managed Care Manual, Ch. 7, §120.1.1, Table 19, lists physician speciality types and other clinicians that are acceptable sources of RAD. Dieticians are not included in this list. KP's dieticians cannot make medical diagnosis on behalf of MA enrollees. The physicians' countersignatures of the dietician's stamp does not constitute a valid physician diagnosis or medical record documentation of such.

76. Kaiser's coders did not record the ICD-9 diagnosis code for malnutrition or severe malnutrition when the physician's countersignature was missing from the stamp. In those instances, the medical record was routed back to the physician for his/her countersignature. Physician's counter-signatures that were initially missing from the dieticians's stamp were routinely "rubber stamped" without question and countersigned but no entry showing that the physician made a diagnosis of malnutrition was made in the medical record itself.

77. The ICD-9 code book contains the following malnutrition diagnosis codes: 260 Kwashiorkor; 261 Nutritional marasmus; 262 Other severe, protein-calorie malnutrition; 263.0 Malnutrition of moderate degree; 263.1 Malnutrition of mild degree; 263.2 Arrested development following protein-calorie malnutrition; 263.8 Other protein-calorie malnutrition; and 263.9 Unspecified protein-calorie malnutrition. Each of these distinct ICD-9 diagnosis codes for malnutrition require specific and appropriate supporting clinical findings in order to be properly documented and submitted as a valid diagnoses and valid RAD.

78. Clinical findings, such as the number of folds in the patients' skin, the size of their triceps, their body mass index, weight changes over time, dietary intake, wasting of muscle and debility, albumin and pre-albumin blood test, digestive difficulties or digestive diseases, absorption problems, eating disorders and feeding method (i.e. oral or tubal feeding)

are examples of clinical findings that treating physicians were required to record in the MA enrollees' medical record as the result of a face-to-face encounter as part of documenting a diagnosis of malnutrition or severe malnutrition. Without appropriate clinical findings, Kaiser's coders were unable to determine which malnutrition ICD-9 diagnosis code to record.

79. During on or about December 13, 2013, KFH disseminated instructions prohibiting the continued practice of allowing physicians to countersign a dieticians stamp as a method of diagnosing and documenting malnutrition. The instruction states, among other things, "It is not appropriate to have physicians counter-sign the dieticians stamp as a means of establishing the diagnosis by the physician." (Citing, CMS 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Resource Guide.) KHF and KFHP's new policy required the treating physician to document the appropriate clinical findings in the MA enrollees' medical records to support malnutrition diagnoses.

80. 42 C.F.R. § 422.326, the Medicare Advantage Overpayment Report and Return regulation, requires KFHP to notify CMS within 60 days from the time it knew or should have known that it received an overpayment and make arrangements with CMS for the return of such overpayments. KFHP violated 42 C.F.R. § 422.326 by failing and refusing to exercise reasonable diligence with respect to the identification and return of overpayments resulting from the improper diagnosing, documenting and coding of malnutrition and severe malnutrition of its MA enrollees as described above. Failing to notify CMS of the receipt of an overpayment within 60 days is an obligation under the False Claims Act and subjects KFHP to FCA liability under 31 U.S.C. §3729(a). KFHP's and/or the other defendants' policy change regarding the diagnoses, documentation and coding of malnutrition is evidence that KFHP was aware that it submitted invalid malnutrition RAD to CMS that resulted in the receipt and retention of overpayments during prior periods.

81. During and between 2006 and at December 11, 2013, KFHP, SCPMG, TPMG and KFH knowingly submitted or caused to be submitted false and fraudulent malnutrition diagnoses to CMS as valid RAD for use in calculating KFHP's capitation payments. Such submissions of false malnutrition diagnoses resulted in false and fraudulent claims in violation

of the FCA. The impact of KFHP's false malnutrition diagnoses and upcoding is profound. In Los Angeles County, each fraudulent diagnosis of malnutrition increased the subsequent CMS's capitation payments for that MA enrollee by approximately $9,000 per year. During the time frame referenced above, KFHP submitted to CMS tens of thousands of such fraudulent malnutrition diagnoses on behalf of KFHP's MA enrollees.

82. During and between 2006 until approximately December 11, 2013, KFH hospital facilities, including all those in California, allowed physicians to improperly countersign dieticians stamps as a means of diagnosing and documenting malnutrition for Medicare FFS patients. The false and fraudulent malnutrition ICD-9 diagnosis codes where mapped to the KFH's hospital's master claim bill, CMS form UB-04 as MCCs (i.e., secondary diagnoses, increasing the DRG's value) and submitted to CMS, resulting in false claims in violation of the FCA. KFH received between $1,000 to $5,000 of additional revenue per patient discharge from CMS as a result of the false malnutrition claims. KFHP nor KFH made no effort to notify CMS of overpayments that resulted from the submission of such false and fraudulent Medicare FFS malnutrition claims, although per 42 C.F.R. §401.305, KFHP was obligated to report and timely return such overpayments.

83. Stein and Bone are informed and believe, and upon such information and belief allege, that the above-described improper diagnosis, coding and documentation practices for malnutrition described above in paragraphs 73 through 82 are, and since 2006 were, national polices and performed in the same improper manner nationwide by Kaiser Health Plans, KFH and the PMGs.

AORTIC ATHEROSCLEROSIS

84. Aortic atherosclerosis is a chronic condition that results in the build up of arterial plaque or fatty deposits in the patient's aorta. Treatment typically involves a medication regimen of statin family drugs (also used to lower cholesterol) and life style changes, such as diet and exercise. Severe cases can cause fatal episodes of coronary artery disease, while less severe conditions can be tolerated by some patients as long as the disease does not rapidly progress. Aortic atherosclerosis can be detected and diagnosed from a typical chest x-ray.

85. During and between 2007 until on or about April 4, 2016, KFH and the Kaiser Health Plans instructed their coders to code the ICD-9 and later ICD-10 diagnosis code associated with aortic atherosclerosis (AA) any time there was an X-Ray report indicating that AA was present and also anytime that a physician noted the presence of AA or listed AA in the patient's medical record. This instruction applied to MA patients admitted to Kaiser inpatient facilities in, among other states, California. Pursuant to these instructions, KFH coders coded KFH's MA patients with an AA diagnosis based simply upon an X-ray or the physician's notation of AA in the medical record, without the medical record reflecting that the patient was treated for his/her AA condition. These instructions directly contradict CMS's instructions set forth in the 2008 Risk Adjustment Data Technical Assistance For Medicare Advantage Organizations, RESOURCE GUIDE, (the "CMS 2008 Resource Guide") available at, https://www.csscoperations.com/internet/csscw3_files.nsf/F/CSSC%20Archive2008%20Resource%20Guidea.pdf/$FILE/2008%20Resource%20Guidea.pdf. The CMS 2008 Resource Guide clearly prohibits coding risk adjustment data from X-rays stating in part, "MA organizations **must not submit documentation from laboratory and diagnostic radiology services as a standalone medical record for data validation.** This type of medical documentation is insufficient for coding purposes." (Emphasis added.) CMS 2008 Resource Guide at p. 16.

86. Kaiser's coding and documentation of AA was not in compliance with the ICD-9 and later ICD-10 Coding and Documentation Guidelines, which requires the patient to have received treatment for a chronic condition, such as AA, in order to validly code the ICD-9 or ICD-10 diagnosis code for such chronic condition, and prohibits coding based upon an abnormal test result, such as from an x-ray. The bare notation of AA in the medical record or noting the presence of AA without documentation of the medical services provided to treat the AA condition is insufficient documentation to support the submission of an AA diagnosis code to CMS, as RAD for use in calculating KFHP's capitation payments. As a result of the foregoing, KFHP submitted RAD that included the improperly diagnosed and documented AA for use in calculating KFHP's capitation payments. The submission of such RAD to CMS

resulted false and fraudulent claims in violation of the FCA. AA has a HCC risk score of approximately .300 resulting in increased prospective capitation payments of approximately $2000-$3000 for each enrollee for which KFHP submitted improperly diagnosed or documented AA RAD.

87. On or about April 4, 2016, KFH issued the following instructions regarding the coding of AA:

> After having gone through a clinical review at the time of updating the list of examples of systemic conditions, AA was determined not to meet the definition of a systemic condition and does not appear on the final list of examples of systemic conditions. The clinician must do more than just list this condition. There must be documentation to show how it impacted the current encounter. It will be up to the region to decide if they want to query the provider about this condition when it is only listed. Without a query and additional documentation from the provider to show it impacted the encounter it cannot be coded.

88. After April 4, 2016 instruction regarding coding and documentation of AA was disseminated, the ICD-10 diagnosis code for AA were recorded by Kaiser coders when medical record documented treatment for AA, as opposed to the condition simply being identified. This change is consistent with the ICD-10 Coding and Documentation Guidelines, Section III(B) and Section IV(I) Chronic Diseases, which states:

> Section III(B) Abnormal Findings - "Abnormal findings and other diagnostic results are not coded and reported unless the provider indicates their clinical significance."
>
> Section IV(I) Chronic Diseases - "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)"

89. Prior to the April 4, 2016 instruction, KFH and the Kaiser Health Plans regularly monitored the coding of AA for their hospital patients to ensure that every time AA was noted in the medical record, AA was coded by Kaiser's coders, but did not ensure that such AA coded diagnoses met the requirements for coding AA under the ICD-9 and later the ICD-10 Coding and Documentation Guidelines. On at least two occasions during the course of Bone's employment, KFH's internal auditors notified him that he failed to properly code AA diagnoses where the only documentation in the medical record was that AA had been observed as a result

of a chest x-ray, but no treatment for AA had been documented. Bone was required to fix the problem by coding the ICD-9 diagnosis code for AA for such encounters.

90. All RAD to be submitted to CMS for use in calculating the Kaiser Health Plans' capitation payments must be the result of face-to-face physician encounters that are supported by properly documented medical records. All medical record documentation must be performed in accordance with ICD-9 and later ICD-10 Coding and Documentation Guidelines. (Medicare Managed Care Manual, Ch. 7 §40, et seq.) As a result of the foregoing, all of the ICD-9 and/or ICD-10 diagnosis codes for AA, that where inaccurately coded, including but not limited to, because there was no medical documentation of the patient receiving contemporaneous treatment for AA, are invalid to submit to CMS as RAD for use in calculating Kaiser's capitation payments and result in the submission of false claims.

91. Kaiser made no attempt to determine the amount of the overpayments it received from CMS resulting from the submission of falsely diagnosed and improperly documented AA diagnoses and failed to notify CMS of the receipt of overpayments nor attempt to refund the same as required by 42 C.F.R §422.326. .

REFRESH FRAUDS

92. As will be explained in greater detail below, between 2010 and the present, KFHP, KFH, TPMG and SCPMG and the remaining PMGs submitted or caused to be submitted false and fraudulent RAD resulting from KFHP's practice of "refreshing" missing HCC diagnosis codes. These frauds were accomplished by (a) routinely and intentionally making improper late medical record entries, (b) amending the medical record without valid face-to-face encounters, (c) failing to include the supporting clinical documentation in the amended medical record required to support the new HCC diagnosis codes, (d) performing improper written leading physician queries, (e) improperly making diagnoses from problem lists, (f) concealing the frauds by illegally destroying the written queries, and (g) deceiving MA enrollees to obtain medically unnecessary and non-covered medical services.

93. At all times relevant, CMS allowed MAOs an additional period of time (Data Lag Period) after the end of the payment year to submit additional valid RAD and withdraw

previously submitted invalid RAD arising from services rendered during that payment year. The end of the Data Lag Period was the final RAD cutoff date after which CMS no longer accepted any new or withdrawn RAD for that payment year, and CMS used the RAD for that payment year to risk adjust the MAO's capitation payments for the next payment year. When the HCC risk adjustment model was relatively new, the Data Lag Period was two years after the end of the payment year. Over time, CMS shortened the Data Lag Period to 13 months after the end of the payment year.

94. After the end of the payment year, but before the end of the Data Lag Period, MAOs such as KFHP can retrospectively review the medical records of its MA enrollees to ensure that the RAD submitted to CMS was properly supported by medical records and withdraw unsupported diagnosis codes. MAOs can also submit to CMS previously unreported HCC diagnosis codes if the medical record supports such additional diagnoses, or in certain cases, make an amendment to the medical record based on the last face-to-face encounter the physician had during the payment year if the physician has a recollection of the face-to-face encounter and there is sufficient clinical findings in the existing medical record to make such a diagnoses.

95. Beginning in 2006 and continuing to the present, TPMG and SCPMG and the other PMGs implemented separate programs designed to identify "missing" HCC diagnosis codes and have the physicians "refresh" the missing HCC diagnoses. TPMG and SCPMG considered HCC diagnoses to be missing when the HCC diagnoses had been submitted to CMS as RAD arising from services rendered during the last closed payment year, but had not been submitted in the subsequent payment year, subject to a pending Data Lag Period (e.g., if 2010 was the last closed payment year, 2011 is the subsequent payment year with a Lag Data Period pending between January 1, 2012 through January 31, 2013). TPMG and SCPMG separately monitored the success of their respective programs to increase the number of HCC related diagnoses that were submitted to CMS and then shared information regarding best practices. TPMG achieved its upcoding objectives by using complex computer technology such as convergent medical terminology (CMT) and data mining algorithms to build upcoding into

the coding process then carefully tracked the ongoing implementation of its data mining results to ensure its HCC coding objectives were achieved. SCPMG developed a simpler approach that did not use CMT or complex data mining algorithms. Instead, SCPMG upcoding relied primarily on using improper leading written and verbal coding queries to instruct physicians to add high value HCC related diagnoses to their patients medical records. This allowed SCPMG coders to instruct SCPMG physicians to add via addendums, missing HCC related ICD-9 and ICD-10 diagnosis codes to their patients medical records. The use of such leading coding queries is a very efficient and effective way to increase the patient's HCC score and related capitation payments; however, it is also deemed an illegal practice that results in fraudulent and improper medical record documentation.

96. During on or about 2009, plaintiff and Relator Marcia Stein attended a conference sponsored by SCPMG at its Regional Office in Pasadena California. In attendance were representatives from TPMG and all other PMGs both in person and via teleconferencing. The purpose of the meeting was to share best practice information with the PMGS for capturing missing HCC related diagnoses. SCPMG's use of leading written and verbal leading coding queries had clearly achieved the best results of all the PMGs regarding the quantity of additional HCC related diagnoses captured and submitted to CMS. Many out of state PMGs expressed an interest in having SCPMG help them implement similar programs for their PMG. Based upon this meeting, Stein is informed and believes and thereupon alleges that a majority of the PMGs adopted SCPMG's tactics of utilizing improper written and verbal leading queries to fraudulently document missing HCC related ICD-9 and ICD-10 diagnosis codes for submission to CMS as RAD. SCPMG's increase in HCC diagnosis codes submitted to CMS as RAD from improper leading queries dramatically increased their patients' RAD and resulted in several hundred million dollars of increased revenue for KP. This number increased as more PMGs incorporated SCPMG's improper leading query practice into their process for capturing missing HCCs.

97. The refresh process started with KFHP's contracted medical groups compiling a "hit-list" of high value HCC risk adjustment scores and their related ICD-9 diagnosis codes

("HCC diagnoses") from which to work from. The hit-list included, but was not limited to, all of the complications related to diabetes, and the different manifestations and complications of coronary disease, chronic kidney disease, old myocardial infarction, and cancer. Each year, TPMG, SCPMG and other PMGs performed a computer searches to data-mine the RAD submissions from the last closed payment year to identify the MA enrollees with a history of hit-list HCC diagnoses, and used those results to identify missing HCC related diagnoses. SCPMG's coders then sent written leading queries to the MA enrollees' attending physicians with a list of the missing HCC diagnoses. The leading physician queries instructed the SCPMG physicians to "refresh" (i.e., add) the missing HCC diagnosis to a particular MA enrollee's medical record. SCPMG's coders would follow up with verbal queries during one-on-one meetings with SCPMG physicians to ensure that the hit-list HCC diagnoses were added by a signed addendum. Most SCPMG physicians readily complied with SCPMG coders' requests to add the hit-list HCC diagnoses identified in the leading queries.

98. All RAD that MAOs, such as the Kaiser Health Plans, submit to CMS must be the result of a face-to-face physician encounter and must be supported by a medical record documented in accordance with ICD-9 Guidelines. (Medicare Managed Care Manual, Ch. 7 §40 et seq.; 42 C.F.R. §422.310(d).) An addendum is new documentation used to add information to an original entry. Addenda should be timely and bear the current date and reason for the additional information to an original entry. (AHIMA (2015) Amendments, Corrections and Deletions in the Electronic Health Record Tool Kit, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678.)

99. CMS's rule governing late medical entries states, "All services provided to beneficiaries **are expected to be documented in the medical record at the time they are rendered**. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service." (Emphasis added.) (Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A) and made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b),

422.310(d).) Similarly, AHIMA Guidelines state, "When documenting an omission, validate the source of additional information as much as possible. Late entries should be documented as soon as possible. While there is no time limit for writing a late entry, the more time that passes, the less reliable the entry becomes."[13] (AHIMA (2015) Maintaining a Legally Sound Health Record: Paper and Electronic, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_028509.hcsp?dDocName=bok1_028509.)

100. The "refreshed" HCC diagnoses were invalid as RAD for submission to CMS by the Kaiser Health Plans because they violated the requirements described in the preceding two paragraphs. First, the refreshed HCC diagnoses were not the result of a face-to-face encounter. In order to document an omission via a late entry amendment, the physician must have a specific recollection of the subject face-to-face encounter with the MA enrollee. As the encounters being "refreshed" were between 6 to 12 months before the hit-list addenda were added to the medical records, the physicians did not have specific detailed recollections of the encounter required to add clinical findings in support of hit-list HCC diagnoses being added.

101. Second, the addenda themselves were not supported by required clinical documentation in the medical record in accordance with ICD-9 Guidelines. This is apparent on the face of the addenda which consist of just the addition of the hit-list HCC diagnoses, signed and dated by the physician. Physicians who executed the addenda did not review the medical record entries (i.e., the portion being amended) to confirm that the medical record contained the necessary clinical findings to support the new HCC diagnoses, nor did they include language in the addenda that identified the reasons for the late entry nor any required clinical findings to support adding the new HCC diagnoses as required by the ICD-9 and AHIMA coding and documentation guidelines. The mere conclusion of the new HCC diagnoses, without the supporting clinical findings necessary to support the conclusion, is not an acceptable method of medical record documentation. Additionally, such incomplete documentation does not indicate that it is "related to a service that was provided" during the

[13]For reference, 42 C.F.R. § 482.24(c)(4)(viii) requires hospitals to complete the medical record entries of the final diagnoses within 30 days of discharge.

prior encounter as required by CMS's rule for late entries. (Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A).) Therefore, such improperly "refreshed" HCC diagnoses codes should not have been submitted to CMS as RAD.

102. Typically, the hundreds of employee physicians, including but not limited to Drs. Steven Steinberg, Margabanhu Ramanathan, Edward Brosnan, David Wong, Sivakumar, and Young Cho, who worked for KFHP's contracted medical groups, responded to the leading queries by signing any "refresh" addenda that their employers requested via the leading physician queries and problem lists.

103. The addenda refreshing HCC diagnoses were also invalid because they (a) failed to provide an explanation regarding why the late entry needed to be made as required by the AHIMA standards for making addenda, (b) failed to identify the services rendered during the subject encounter that the refreshed HCC diagnoses are related to as required by CMS's rules for late entries, and (c) failed to identify the clinical findings required to support the new HCC diagnosis codes as required by the ICD-9 Guidelines.

104. "To support why a query was initiated, all queries must include the clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested."[14] (AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p.2; http://ahima.org/library.) The Kaiser's coders' queries used for refreshing missing HCC diagnoses did not contain any clinical indicators or explanations in support of why they was initiated. Kaiser's coders only reviewed the problem list of missing HCC diagnoses and the prior year's medical record visit to confirm that the HCC diagnoses identified by the computer data mining was present. The medical record visit to be refreshed was not reviewed by the Kaiser's coders and thus they had no basis to make the queries.

105. Defendants' refreshing of HCC diagnoses relied on using invalid, leading physician queries that instructed physicians which HCC diagnoses to add to the medical records. "A leading query is one that is not supported by the clinical elements in the health

[14]AHIMA is a member of the ICD9CM and the ICD10CM Cooperating Parties, thus their practice briefs are considered "industry standards" for coding and query policy and procedure.

record and/or directs a provider to a specific diagnosis or procedure." (AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p. 2; http://ahima.org/library.) AHIMA sets the national standards regarding coding and documentation, and as such its policies are incorporated into the medical record documentation requirements by CMS. (42 C.F.R. § 422.310(d).) The AHIMA guidelines do not allow leading queries because they result in inaccurate and/or false medical record documentation. After the leading queries were used by TPMG and SCPMG physicians, the queries were illegally destroyed.

106. At all times mentioned, CMS required the Defendants to maintain the medical record on some type of retrievable format for at least ten years. No part of the medical record is supposed to be destroyed. CMS and AHIMA requirements make it clear that if the physician query results in adding new diagnoses, then the query becomes part of the medical record and must be maintained for use in auditing the validity of the diagnoses contained therein. (Medicare Quarterly Compliance Newsletter, Vol 2, Issue 3 at p. 13 (April 2012); https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medqtrlycomp_newsletter_icn907927.pdf.) Further, AHIMA Guidelines strongly recommend that the queries to physicians be preserved as part of the medical record and if a different policy is adopted, then the query must be maintained as business record. (AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p. 4; http://ahima.org/library.)

107. At all times mentioned, KFH's medical record retention policy included Kaiser's coders' queries as part of the medical record. At al times mentioned, the Kaiser Health Plans allowed their contracted medical groups, including TPMG and SCPMG, to adopt different and conflicting medical record retention policies that improperly failed to preserve Kaiser's coders' queries as part of the medical record or as a business record. Instead, Kaiser's coders' queries were destroyed immediately after the queries had been reviewed by the physicians. The Kaiser Health Plans always had the ability to require their exclusively contracted medical groups, including TPMG and SCPMG, to adopt unified policies for medical record retention, query

practices, late entries into the medical records and medical record documentation. CMS's regulations mandates that the Kaiser Health Plans' contracts contain such rights and provisions. (42 C.F.R. § 422.504(i)(3)(iii).)

108. Realtors are informed and believe, and based upon such information and belief allege, that the Kaiser Health Plans knowingly allowed its exclusively contracted medical groups, including TPMG and SCPMG, to adopt conflicting policies for using leading queries, preserving queries as part of the medical record, making late entries and amendments to the medical record, and medical record documentation expressly for the purpose of committing the Medicare frauds described in this complaint.

109. During or about 2006, several HIM managers, such as Sarah Lynch, the HIM Director KFH-Hospital, Orange County, and Jennifer Squires, Encounter Coding Manager, vigorously protested the required use of leading queries and their immediate destruction after the physicians had "refreshed" the medical record. Ms. Lynch was informed by her supervisor, that SCPMG and Kaiser requested that Ms. Lynch be terminated for complaining about the use and destruction of leading queries and was informed by her supervisor that in order to avoid termination Ms. Lynch had to refrain from further complaints regarding these issues. Ms. Lynch's complaints regarding leading queries and destruction of medical records should have triggered a compliance investigation by the Kaiser Health Plans to identify the Medicare FWA caused by the leading Kaiser coders' queries complained of and issued appropriate corrective action plans. (42 C.F.R. § 422.503(b)(4)(vi); Medicare Managed Care Manual, Ch. 21 §30-50, et seq.)

110. In a number of instances, the MA enrollees had not been seen by their PCP during the open payment year and/or had not been seen during the current year. These MA enrollees' medical records could not be refreshed with a late entry addenda because there was no face-to-face encounter, and therefore no medical record entry during the relevant time period to amend. TPMG and SCPMG contacted these MA enrollees and falsely informed them that they needed to schedule a follow-up visit with their primary care physician (PCP). In addition, there were MA enrollees who had been seen during the open payment year, but for whom no HCC

diagnoses were identified during those encounters. These MA enrollees were also scheduled for a follow up visit for the sole purpose of identifying HCC diagnoses to submit to CMS.

111. The RAD obtained from the physician followup encounters to refresh the MA enrollees' hit-list HCC diagnoses were invalid because the RAD was obtained from medically unnecessary and uncovered services. Among the services that are specifically excluded from original Medicare are routine physicals and medically unnecessary services. (42 C.F.R. § 411.15(a)(1),(k), and made applicable to Medicare Advantage by 42 C.F.R. § 422.101(b)(1)-(2).) The improper followup visits that the Kaiser Health Plans and their contracted medical groups, including TPMG and SCPMG performed, were in fact routine physicals or otherwise medically unnecessary services because the MA enrollees were deceived into having the exam, the MA enrollees had no medical complaint that required followup, and the true secret purpose of the visit was specifically to "refresh" certain hit-list HCC diagnoses that the Kaiser Health Plans had identified. The Kaiser Health Plans cannot submit to CMS improperly obtained, non-covered and excluded services as valid RAD. (42 C.F.R. § 422.310(c).)

112. Although the Kaiser Health Plans cover routine physicals as a supplemental benefit, such coverage is limited to exams that are, "[M]edically appropriate preventative care in accordance with generally accepted professional standards of practice." The Kaiser Health Plans' Evidence of Coverage (2011) at p. 51, available at: https://www.sjretirement.com/Uploads/PF/2011%20Kaiser %20Hawaii %20KPSA% 20EOC.pdf.) As will be explained in greater detail below, because the purpose of the visit was to deceitfully obtain hit-list HCC diagnoses, the refresh followup visits do no meet The Kaiser Health Plans' coverage criteria under its supplemental benefits. Further, the services the MA enrollees received during such physician encounters to "refresh" their prior HCC diagnoses were not documented as a covered routine physical by the Kaiser Health Plans, TPMG, SCPMG and the other PMGs, but were falsely documented as some other type of consultative visit. Because the MA enrollees' physician visits to refresh old HCC diagnoses were medically unnecessary, the services were not covered under the Kaiser Health Plans' MA plans, and the Kaiser Health Plans could not legally submit RAD to CMS arising from such services.

113. On or about, 2006 Stein was present at a meeting with SCPMG regional physician leadership from the Panorama City Medical Clinic, including but not limited to Drs. Zollner, Hoffman, Steinberg, and Candac Lumeg. Present by telephone were the SCPMG physician leaders, from the Santa Clarita Medical Clinic. The purpose of the meeting was to discuss the data-mining results provided by SCPMG's Pasadena headquarters that identified MA enrollees who needed a current physician encounter in order for their HCC diagnoses to be refreshed. A telephone call script had been provided by defendants that was used to schedule the appointments with the MA enrollees and was read out loud for the meeting participants. The call script informed the MA enrollees that they needed to come in for a follow up visit for the HCC condition that had been identified by defendants. This statement was false. The SCPMG physician leaders candidly admitted that the follow-up exams were medically unnecessary and being used as pretext; the true purpose of the visits was for the PCPs to refresh the hit-list HCC diagnoses.

114. During this meeting it was decided that Mary Stefanec, RN, Department Administrator for Internal Medicine, would be responsible for supervising staff to contact the identified enrollees assigned to physicians located at the SCPMG medical clinics in Panorama City and convince such MA enrolles to come in for the purported follow-up visits. Similar meetings were schedule throughout California.

115. None of the MA enrollees were informed the that the true purpose of the visit was for the Kaiser Health Plans' contracted medical groups to "refresh" prior HCC diagnoses so that the Kaiser Health Plans would receive a higher capitation payment from CMS. Instead, the MA enrollees were deceived into scheduling medically unnecessary routine physicals by being falsely informed that their medical condition required a follow-up visit. These untrue MA enrollee solicitations violated CMS's regulations that prohibit making untrue or misleading statements to enrollees. (42 C.F.R. § 422.752(a)(5)(ii).)

116. Beginning in 2006 and continuously thereafter, Kaiser Health Plans, KFH and the PMGs annually scheduled tens of thousands of MA enrollee visits for the purpose of "refreshing" prior hit-list HCC diagnoses by falsely claiming such visits were medically

necessary follow-up visits. The true purpose of the MA enrollees' medical appointments was for the Kaiser Health Plans' contracted medical groups to collect HCC diagnoses for submission to CMS by the Kaiser Health Plans. The untruthful statements to the MA enrollees constituted a false statement material to a false or fraudulent claim in violation of 31 U.S.C. § 3729(a)(1)(B).

FIRST CLAIM FOR RELIEF

(Violation of 31 U.S.C. §3729(a) against all Defendants: False Sepsis Claims)

117. Relators reallege and incorporate by reference paragraphs 1 through 72 of this complaint as though fully set forth at length.

118. At all times mentioned during the six years prior to the filing of this action and continuing, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

119. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A) and (B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

120. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by conspiring to violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

121. Defendants the Kaiser Health Plans knew or should have known that they had improperly received and retained excessive payments for Medicare FFS patients for whom the Kaiser Health Plans submitted to CMS Sepsis diagnoses that were routinely falsely and

fraudulently diagnosed, coded and lacked adequate supporting medical record documentation, in violation of 42 C.F.R. § 401.305. Such falsely diagnosed Sepsis patients were not admitted to the hospital nor the ICU, but held in an emergency room observation bed for up to 72 hours and then sent home.

122. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 401.305.

123. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 401.305.

124. Defendants the Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS Sepsis diagnoses that were routinely falsely and fraudulently diagnosed, coded and lacked adequate supporting medical record documentation, in violation of 42 C.F.R. § 422.326.

125. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

126. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

127. The Kaiser Health Plans are, and at all times mentioned were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) Because the Kaiser Health Plans adopted overly broad Sepsis diagnostic standards, they had an obligation to establish a process to identify and redact or withdraw

incorrect Sepsis diagnosis codes from the RAD they submitted to CMS. The Kaiser Health Plans did not adopt any such process to identify and redact or withdraw incorrect Sepsis ICD-9 diagnosis codes from the RAD they submitted to CMS and failed to do so. As a result of the Kaiser Health Plans' failure and refusal to reasonably attempt to meet this obligation, it had no legitimate basis for certifying that the Sepsis ICD-9 diagnosis codes it submitted to CMS were accurate, complete and truthful RAD.

128. Defendants were obligated to conduct a Medicare FWA investigation in response to Dr. Conrado's repeated complaints that sepsis was being inaccurately diagnosed and coded. The Kaiser Health Plans and their first tier contracted entities failed and refused to conduct such a compliance investigation, rendering the Kaiser Health Plans' compliance program, as it pertains to the submission of false Sepsis diagnosis codes, ineffective. Because the Kaiser Health Plans had an ineffective compliance program, they had no legitimate basis on which to certify the accuracy, completeness and truthfulness of the Sepsis ICD-9 diagnosis codes they submitted as RAD to CMS between 2010 to the present. (42 C.F.R. §§ 422.503(b)(4)(vi), 422.504(i)(3)(iii)&(l); Medicare Managed Care Manual, Ch. 21 §50.7.1; 79 Fed.Reg. 29884, 29923-24 (May 14, 2014).)

129. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for Sepsis that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid defendant Kaiser Health Plans at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

130. At all times mentioned during the six years prior to the filing of this action, the

Kaiser Health Plans routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(G) by knowingly concealing or knowingly and improperly avoiding or decreasing their obligation to pay or transmit to the Government the overpayments made by CMS as a result of the submission of false and unsupported Sepsis diagnoses to CMS.

131. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the ICD-9 diagnosis codes for Sepsis submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

132. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

133. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

134. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

SECOND CLAIM FOR RELIEF

(For violations of 31 U.S.C. § 3729(a) against all Defendants: False Malnutrition Claims)

135. Relators reallege and incorporate by reference paragraphs 1 through 37 and paragraphs 73 through 83 of this complaint as though fully set forth at length.

136. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health

Plans obtain overpayments from CMS.

137. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A) and (B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

138. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by conspiring to violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

139. At all times mentioned during the six years prior to the filing of this action, defendant Kaiser Health Plans and defendant KFH knew or should have known that they had improperly received and retained excessive FFS Medicare payments for Medicare beneficiaries for whom the Kaiser Health Plans and K Foundation Hospitals submitted to CMS malnutrition diagnoses that were routinely and repeatedly falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 401.305.

140. At all times mentioned, the Kaiser Health Plans and Kaiser Foundation Hospitals failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 401.305.

141. At all times mentioned, the Kaiser Health Plans and the Kaiser Foundation Hospitals acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 401.305.

142. At all times mentioned during the six years prior to the filing of this action, defendant Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS malnutrition diagnoses that were routinely and repeatedly falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record

documentation in violation of 42 C.F.R. § 422.326.

143. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

144. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

145. The Kaiser Health Plans are, and at all times mentioned were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) KFHP had an obligation to establish a process to identify and redact or withdraw incorrect or unsupported malnutrition diagnosis codes from the RAD it submitted to CMS. KFHP did not adopt any such process to identify and redact or withdraw incorrect or unsupported malnutrition ICD-9 diagnosis codes from the RAD it submitted to CMS and failed to do so. As a result of KFHP's failure and refusal to reasonably attempt to meet this obligation, it had no legitimate basis for certifying that the malnutrition ICD-9 diagnosis codes it submitted to CMS were accurate, complete and truthful RAD.

146. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for malnutrition that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid defendant KFHP at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims,

concealments and use of false records and statements to get such false claims approved and paid by CMS.

147. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the ICD-9 diagnosis codes for malnutrition submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

148. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

149. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

150. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

THIRD CLAIM FOR RELIEF

(For violations of 31 U.S.C. § 3729(a) against all Defendants: False Aortic Atherosclerosis Claims)

151. Relators reallege and incorporate by reference paragraphs 1 through 37 and paragraphs 84 through 91 of this complaint as though fully set forth at length.

152. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

153. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A)&(B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

154. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by (a) conspiring violate 31 U.S.C. § 3729(a)(1)(A) and/or (B). At all times mentioned during the six years prior to the filing of this action, defendant Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS aortic atherosclerosis diagnoses that were routinely and repeatedly falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 422.326.

155. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

156. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

157. The Kaiser Health Plans are, and at all times mentioned were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) KFHP had an obligation to establish a process to identify and redact or withdraw incorrect or unsupported malnutrition diagnosis codes from the RAD it submitted to CMS. KFHP did not adopt any such process to identify and redact or withdraw incorrect or

unsupported aortic atherosclerosis ICD-9 diagnosis codes from the RAD it submitted to CMS and failed to do so. As a result of KFHP's failure and refusal to reasonably attempt to meet this obligation, it had no legitimate basis for certifying that the aortic atherosclerosis ICD-9 diagnosis codes it submitted to CMS were accurate, complete and truthful RAD.

158. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for aortic atherosclerosis that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid defendant KFHP at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

159. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the ICD-9 diagnosis codes for aortic atherosclerosis submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

160. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

161. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

162. Relators are also entitled to recover their attorney's fees, costs and expenses from

defendants pursuant to 31 U.S.C. § 3730(d).

FOURTH CLAIM FOR RELIEF

(For violations of 31 U.S.C. § 3729(a) against all Defendants: False Refresh Claims)

163. Relators reallege and incorporate by reference paragraphs 1 through 37 and paragraphs 92 through 116 of this complaint as though fully set forth at length.

164. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

165. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A) and (B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

166. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by conspiring to violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

167. At all times mentioned, defendant the Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS HCC diagnoses that were routinely and repeatedly falsely and fraudulently "refreshed", diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 422.326.

168. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R.

§ 422.326.

169. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

170. The Kaiser Health Plans are, and at all times mentioned during the six years prior to the filing of this action were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) The Kaiser Health Plans had an obligation to establish a process to identify and redact or withdraw incorrect or unsupported "refreshed" HCC diagnosis codes from the RAD it submitted to CMS. The Kaiser Health Plans did not adopt any such process to identify and redact or withdraw incorrect or unsupported "refreshed" ICD-9 diagnosis codes from the RAD they submitted to CMS and failed to do so. As a result of the Kaiser Health Plans' failure and refusal to reasonably attempt to meet this obligation, they had no legitimate basis for certifying that the "refreshed" ICD-9 diagnosis codes they purportedly added to their MA enrollees' medical records and submitted to CMS were accurate, complete and truthful RAD.

171. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for improperly and invalid "refreshed" ICD-9 diagnosis codes that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid the Kaiser Health Plans at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false

records and statements to get such false claims approved and paid by CMS.

172. At all times mentioned during the six years prior to the filing of this action and continuing, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the "refreshed" ICD-9 diagnosis codes submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

173. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

174. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

175. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs and Qui Tam Relators pray for relief as follows:

FOR THE FIRST CLAIM FOR RELIEF

1. Treble the Government's damages according to proof;

2. Civil penalties according to proof;

3. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE SECOND CLAIM FOR RELIEF

4. Treble the Government's damages according to proof;

5. Civil penalties according to proof;

6. A relator's award of up to 30% of the amounts recovered by or on behalf of the

Government;

FOR THE THIRD CLAIM FOR RELIEF

7. Treble the Government's damages according to proof;

8. Civil penalties according to proof;

9. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE FOURTH CLAIM FOR RELIEF

10. Treble the Government's damages according to proof;

11. Civil penalties according to proof;

12. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR ALL CLAIMS FOR RELIEF

13. Attorney's fees, expenses, and costs; and

14. Such other and further relief as the Court deems just and proper.

THE ZINBERG LAW FIRM
A Professional Corporation

HANAGAMI LAW
A Professional Corporation

Dated: Nov 12, 2021

By: _____
William K. Hanagami
Attorneys for Plaintiffs and Qui Tam Relators,
Marcia Stein and Rodolfo Bone

REQUEST FOR JURY TRIAL

Plaintiffs and Qui Tam Relators hereby request a trial by jury.

THE ZINBERG LAW FIRM
A Professional Corporation

HANAGAMI LAW
A Professional Corporation

Dated: Nov 12, 2021

By: _____
William K. Hanagami
Attorneys for Plaintiffs and Qui Tam Relators,
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TAB 20

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK, Plaintiff, v. KAISER PERMANENTE, et al., Defendants.	Case No. 3:13-cv-03891-EMC **UNITED STATES' COMPLAINT-IN-INTERVENTION**

(captions continued on next page)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR, and PRIME HEALTHCARE SERVICES, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **UNITED STATES' COMPLAINT-IN-INTERVENTION**
UNITED STATES OF AMERICA ex rel. MARCIA STEIN AND RODOLFO BONE, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **UNITED STATES' COMPLAINT-IN-INTERVENTION**
UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:18-cv-01347-EMC **UNITED STATES' COMPLAINT-IN-INTERVENTION**

(captions continued on next page)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiff, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **UNITED STATES' COMPLAINT-IN-INTERVENTION**
UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:21-cv-03894-EMC **UNITED STATES' COMPLAINT-IN-INTERVENTION**

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The United States of America ("United States" or "Government") brings this action against Defendants Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C. (collectively, "Kaiser" or "Defendants"), to recover treble damages and civil penalties for violations of the False Claims Act ("FCA"), 31 U.S.C. §§ 3729-33, and conspiracy to violate the FCA, and damages and other relief for common law claims of payment by mistake and unjust enrichment. Having filed a notice of intervention pursuant to 31 U.S.C. § 3730(b)(4)(A), the United States alleges for its complaint-in-intervention ("Complaint") as follows:

I. PRELIMINARY STATEMENT

1. Beginning sometime prior to 2009 and continuing through at least 2018, Kaiser engaged in a coordinated scheme to unlawfully obtain payments from the Medicare Part C program, also called Medicare Advantage. Kaiser obtained these payments by systematically altering patient medical records to add diagnoses that either did not exist or were unrelated to the patient's visit with the Kaiser physician. Kaiser altered the patients' medical records to add these diagnoses retrospectively—*after* the patient medical visit—using a mechanism called an addendum. Often, these addenda were added months or even a year or more after the visit. In many cases, patients were not even told that they supposedly had the diagnoses that Kaiser had added to their medical records. Kaiser knew that it could not lawfully submit diagnoses that were unrelated to the patient's visit, but it nevertheless routinely used these diagnoses to obtain additional payments from Medicare. Between 2009 and 2018, Kaiser added roughly half a million diagnoses using addenda. Kaiser submitted the diagnoses from these addenda to the Centers for Medicare and Medicaid Services ("CMS") and received additional Medicare payments in the range of $1 billion from these diagnoses.

2. As Medicare Advantage ("MA") Organizations, Kaiser's Health Plans were responsible for covering the costs of medical services for the Medicare patients enrolled in Kaiser's MA plans. Kaiser's Health Plans, in return, received monthly payments from CMS for each patient for whom Kaiser provided such coverage. CMS adjusts these payments for various "risk" factors that affect expected healthcare expenditures, to ensure that MA Organizations are paid more for sicker enrollees expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower costs.

To make these adjustments, CMS relies on "risk adjustment" data, including medical diagnosis codes, collected from MA Organizations. This payment model creates powerful incentives for MA Organizations like Kaiser's Health Plans to exaggerate the expected healthcare costs for their enrollees by "over-reporting" diagnosis codes. *See infra* ¶¶ 20-22, 52-72.

3. Kaiser knew that, pursuant to this risk-adjustment system, the amount of payment that CMS made to Kaiser for a Medicare Advantage patient depended directly on the diagnoses that Kaiser submitted to CMS for that patient. In fact, internally, executives repeatedly stressed the importance of these risk-adjustment payments to the financial health of Kaiser, emphasizing that "risk adjustment is by far the biggest lever we have to change our revenue from Medicare. If we don't do this well, our financial health could be seriously impacted." Kaiser touted that its structure gave it a strategic advantage over other health plans in obtaining risk-adjustment revenue because Kaiser's health plans were integrated with its physician groups "under one roof" and coordinated with each other. Kaiser's risk-adjustment programs were highly successful at achieving Kaiser's goal of increasing Medicare Advantage risk-adjustment revenue. *See infra* ¶¶ 28-40, 100-20.

4. The allegations in this complaint concern one of the ways that Kaiser increased its diagnoses and therefore its risk-adjustment revenue—by systematically creating retrospective addenda to medical records of patients' visits with physicians. Kaiser would mine a Medicare Advantage patient's medical file for potential additional diagnoses, regardless of their relevance to the visit. Kaiser would then seek to have the physician add the new diagnoses to the medical record retrospectively using an addendum, as if the new diagnoses had been addressed in some way during the patient visit when in fact they had not been. The driver was money: so that Kaiser could submit these improper diagnoses to CMS for payment. Indeed, Kaiser employed these initiatives only for diagnoses and patients for whom Kaiser could receive a risk-adjustment payment. *See infra* ¶¶ 121-32.

5. During all relevant times, CMS has imposed specific standards regarding which diagnoses could be submitted for risk-adjustment payment. Among other limitations, diagnoses could be submitted only if they conformed to the International Classification of Diseases ("ICD") Official Guidelines for Coding and Reporting (the "ICD Guidelines"). The ICD Guidelines limited reportable diagnoses to those that required or affected patient care treatment or management at the visit. In other

words, only those conditions that specifically mattered to the patient care, treatment, or management that the physician actually provided at the visit could be submitted to CMS for payment. *See infra* ¶¶ 73-87.

6. Kaiser knew and understood these standards, and knew that any diagnoses submitted for payment had to comply with these standards. Kaiser's own internal compliance materials stated that diagnoses submitted for payment must comply with these specific standards. Kaiser knew that it could not submit diagnoses for payment that were irrelevant to the visit. *See infra* ¶¶ 88-96.

7. Kaiser nevertheless systematically violated these standards as it pursued various risk-adjustment initiatives that routinely resulted in the creation of addenda to retrospectively add diagnoses to patient medical records. These initiatives included "data mining" and "chart review," where Kaiser would utilize automated algorithms and/or human reviewers to identify new diagnoses for a patient. Such never-before-diagnosed conditions should rarely, if ever, have resulted in addenda because these diagnoses were, almost by definition, not relevant to the visit. Yet Kaiser routinely added these diagnoses to medical records using addenda and submitted them for payment, often without even telling patients about these brand-new diagnoses. Kaiser also employed a related data-mining program called "refresh," where Kaiser would mine patient medical files to find old diagnoses that had not yet been diagnosed in the current service year. If a physician failed to address any of these old diagnoses at a patient visit, the physician would be provided a list of these "missed opportunities"—i.e., opportunities for risk-adjustment payment—to create an addendum to retrospectively add these diagnoses to the medical record. Kaiser's efforts focused especially on diagnoses it knew were lucrative, and Kaiser routinely ignored the requirement that every diagnosis must have required or affected patient care, treatment, or management at the visit in order to be submitted for payment. *See infra* ¶¶ 133-83.

8. Kaiser regularly brought these mined diagnoses to the physician's attention for addition to the patient's medical record using a tool called a "query"—which in the healthcare industry is a communication tool used to clarify documentation in the health record. Queries present significant risks for improper diagnosis coding, and there are national standards guiding and limiting the use of queries. The standards include that a query cannot be leading (i.e., cannot direct a provider to a specific diagnosis) and cannot discuss financial impact. But Kaiser routinely violated the national query standards and used queries not to clarify medical records, but instead for the purpose of pressing

physicians to retrospectively add new diagnoses via addenda that had nothing to do with the visit, so that Kaiser could then seek payment from CMS for these diagnoses. *See infra* ¶¶ 185-216.

9. Kaiser employed numerous tactics to pressure physicians to improperly add these diagnoses. In addition to improper queries, Kaiser required its physicians to meet certain metrics related to its risk-adjustment program. Kaiser meticulously tracked and monitored these metrics across physicians, facilities, and regions. Physicians who scored high were praised and rewarded. Those who did not would often be required to meet with supervisors about their risk-adjustment performance and could face financial consequences. As each year drew to a close, some employees referred to Kaiser's rush to capture as many diagnoses as possible as the "dash for cash." Kaiser employed numerous other tactics, such as "coding parties," where it would gather physicians in a room and expect them to work through lists of diagnoses and add these diagnoses to the records of their patient visits. *See infra* ¶¶ 217-68.

10. Kaiser knew that its addenda practices were widespread and unlawful. Kaiser ignored numerous red flags and internal warnings that it was violating Medicare rules, including concerns raised by its own physicians that these were false claims and audits by its own compliance office identifying the issue of inappropriate addenda. As Relator Randi Osinek (a Kaiser certified medical coder) reported to several Kaiser executives in 2011: "over 50% of the physicians tell me they feel that they are being '<u>forced</u>' to add diagnoses that they did not consider[], evaluate[], and/or treat. Especially since they feel their bonuses are being impacted." (Emphasis in original.) *See infra* ¶¶ 269-331.

11. Through these coordinated and systematic efforts to have physicians create retrospective addenda to patient medical records with diagnoses that did not exist or were unrelated to the medical visit, Kaiser improperly submitted thousands upon thousands of diagnoses to CMS as claims for payment. Based on these unlawful false claims, Kaiser improperly obtained and retained hundreds of millions of dollars in risk-adjustment payments from CMS, in violation of both the FCA and the common law. If CMS had known that Kaiser was submitting fraudulent diagnosis codes, CMS would have refused to make risk-adjustment payments based on the improper coding and/or taken other appropriate actions to ensure that Defendants did not receive or retain risk-adjustment payments to which they were not entitled, including by recouping payments through administrative processes,

payment adjustments, or obtaining repayments in enforcement actions.

II. PARTIES

A. Plaintiff and Relators

12. Plaintiff is the United States of America, suing on behalf of the Department of Health and Human Services ("HHS"), which includes its operating division, CMS. At all times relevant to this Complaint, CMS administered the MA Program and made risk-adjustment payments under the MA Program. The United States filed its notice of intervention in this consolidated action on July 27, 2021. *See* 31 U.S.C. § 3730(b)(4)(A).

13. Relator Randi Osinek filed an action alleging violations of the FCA on behalf of herself and the United States Government pursuant to the *qui tam* provisions of the FCA on August 22, 2013. *See* 31 U.S.C. § 3730(b). Randi Osinek is a citizen of the United States and a resident of the State of Oregon. Randi Osinek, a certified medical coder, worked for Defendant The Permanente Medical Group as a Data Quality Trainer and Audit Manager at Kaiser's San Rafael, California facility.

14. Relator James Taylor, M.D. filed an action alleging violations of the FCA on behalf of himself and the United States Government pursuant to the *qui tam* provisions of the FCA on October 22, 2014 in the District of Colorado. His action was transferred to the Northern District of California on May 11, 2021. Dr. Taylor is a citizen of the United States and a resident of the State of Colorado. Dr. Taylor worked for Defendant Colorado Permanente Medical Group from 1995 through 2015, most recently as the Medical Director of Revenue Cycle/Claims, where his responsibilities included revenue cycle risk adjustment programs and coding governance and compliance. Dr. Taylor also previously served as Chair of the Board of Directors of Defendant Colorado Permanente Medical Group.

15. Relators Naser Arefi, Ajith Kumar, and Prime Healthcare Services, Inc. ("Prime") filed an action alleging violations of the FCA on behalf of themselves and the United States Government pursuant to the *qui tam* provisions of the FCA on September 4, 2015. Naser Arefi is a citizen of the United States and a resident of the State of California. Naser Arefi worked for Defendant The Permanente Medical Group, Inc. as a Clinical Documentation Specialist from 2011 to 2014. Ajith Kumar is a citizen of the United States and a resident of the State of California. Ajith Kumar was Vice President of Reimbursement Management at Prime. Prime owns and operates 45 acute care hospitals,

including 15 in California.

16. Relators Marcia Stein and Rodolfo Bone filed an action alleging violations of the FCA on behalf of themselves and the United States Government pursuant to the *qui tam* provisions of the FCA on May 16, 2016, and filed an amended complaint on November 3, 2016. Marcia Stein is a citizen of the United States and a resident of the State of California. From 1987 to 2011, Marcia Stein worked for Kaiser Foundation Hospitals as a Regional Health Information Manager. In that role, she trained physicians and other medical professionals on correct coding and documentation practices. Rodolfo Bone is a citizen of the United States and a resident of the State of California. Rodolfo Bone is a medical graduate who worked as a part-time coder for Kaiser Foundation Hospitals.

17. Relators Gloryanne Bryant and Victoria Hernandez filed an action alleging violations of the FCA on behalf of themselves and the United States Government pursuant to the *qui tam* provisions of the FCA on March 1, 2018. Gloryanne Bryant is a citizen of the United States and a resident of the State of California. Prior to her retirement in 2017, Gloryanne Bryant was the National Director of the Coding Quality Group for Defendant Kaiser Foundation Health Plan. Victoria Hernandez is a citizen of the United States and a resident of the State of California. Victoria Hernandez worked for Defendant The Permanente Medical Group, Inc. from 1995 to 2015 and held various positions, including Regional Director for Auditing and Coding.

18. Relator Michael Bicocca, M.D. filed an action alleging violations of the FCA on behalf of himself and the United States Government pursuant to the *qui tam* provisions of the FCA on February 10, 2020 in the Eastern District of California. His action was transferred to the Northern District of California on April 28, 2021. Dr. Bicocca is a citizen of the United States and a resident of the State of California. Prior to his retirement in December 2019, Dr. Bicocca was the Chief of Pain Management for three Kaiser hospitals in California and a practicing physician at Defendant The Permanente Medical Group's office in South Sacramento, California.

B. Defendants

19. The Defendants are part of Kaiser Permanente, an integrated health-care consortium comprised of three components: health plans ("Health Plans"); physician medical group practices (referred to as "Permanente Medical Groups"); and hospitals. This Complaint concerns Kaiser's Health

Plans and Permanente Medical Groups in Northern California, Southern California, and Colorado.

1. Kaiser Health Plans

20. Defendants Kaiser Foundation Health Plan, Inc. ("the Health Plan") and its wholly owned subsidiary, Kaiser Foundation Health Plan of Colorado ("the Colorado Health Plan"), are Kaiser Health Plans that have executed contracts with CMS to be MA Organizations and provide MA plans.

21. Defendant the Health Plan is headquartered in Oakland, California. The Health Plan has contracted with CMS to provide MA plans in California, covering Kaiser's Northern California and Southern California regions.

22. Defendant the Colorado Health Plan is also headquartered in Oakland, California. The Colorado Health Plan has contracted with CMS to provide MA plans in Colorado, covering Kaiser's Colorado region.

2. Permanente Medical Groups

23. Defendants The Permanente Medical Group, Inc. ("N. California Medical Group"), Southern California Permanente Medical Group, a California partnership ("S. California Medical Group"), and Colorado Permanente Medical Group, P.C. ("Colorado Medical Group") are regional Permanente Medical Groups that contract exclusively with the Health Plan (or the Colorado Health Plan in the case of the Colorado Medical Group) to provide medical services to patients who enroll in Kaiser healthcare plans, including patients who enroll in Kaiser's MA plans. Collectively, the N. California Medical Group, the S. California Medical Group, and the Colorado Medical Group provide medical services to over one million MA beneficiaries in California and Colorado.

24. Defendant the N. California Medical Group is headquartered in Oakland, California and employs approximately 9,500 physicians. The N. California Medical Group provides medical services for Kaiser's Northern California region.

25. Defendant the S. California Medical Group is headquartered in Pasadena, California, and employs approximately 7,800 physicians. The S. California Medical Group provides medical services for Kaiser's Southern California region.

26. Defendant the Colorado Medical Group is headquartered in Denver, Colorado, and employs approximately 1,100 physicians. The Colorado Medical Group provides medical services for

Kaiser's Colorado region.

27. Kaiser's Permanente Medical Groups, including the N. California Medical Group, the S. California Medical Group, and the Colorado Medical Group, have a national leadership and consulting organization, the Permanente Federation LLC ("Permanente Federation"). The Permanente Federation is run by the leadership of the Permanente Medical Groups.

3. Kaiser's integrated and collaborative risk-adjustment operations

28. Kaiser's Health Plans, Permanente Medical Groups, and hospitals publicly hold themselves out and do business collectively as an integrated healthcare provider called "Kaiser Permanente." Kaiser Permanente publicly declares that its Health Plans, Permanente Medical Groups, and hospitals are "under one roof," and that "[t]he interconnectedness and interdependence of the hospitals, health plan, and medical groups that make up Kaiser Permanente have advanced our efforts to operate seamlessly as an enterprise."

29. Kaiser's Health Plans and Permanente Medical Groups use an integrated system for storing patient electronic medical records, KP HealthConnect. Both the Kaiser Health Plans and the Permanente Medical Groups directly access patient medical records through KP HealthConnect.

30. The coordination touted by Kaiser extended to its efforts to increase risk-adjustment revenue from the MA Program. Kaiser's internal Medicare Risk Adjustment Manual highlighted that "[c]ollaboration is the key to the success of the Medicare Risk Adjustment program at Kaiser Permanente." Many offices and individuals from the Kaiser Health Plans and the Permanente Medical Groups were collectively involved in Kaiser's submission of risk-adjustment claims to CMS.

31. Internal Kaiser documents and training materials discussed how "[w]e at KP have a strategic advantage to be successful under Medicare risk adjustment compared to other health plans because of our integrated structure, our partnership with the Permanente Medical Groups, and our electronic medical record, KP HealthConnect. We are better poised to know about and to manage chronic conditions better than anyone else."

32. According to Kaiser's internal Risk Adjustment Manual, Medicare risk-adjustment work at Kaiser is "governed by several groups and has many stakeholders." The "governing parties" include the "National Medicare Leadership Team," the "National Medicare Finance Advisory Council," the

Chief Financial Officer, and the Executive Director of the Permanente Federation. "[D]ue to the importance of this work to financial performance and compliance," the many "stakeholders" include: "Sales and Marketing, Regional and National Controllers, the CFOs, Permanente Medical Groups, Pricing and Actuarial, Revenue Cycle, Compliance, Government Relations, and Regional Presidents."

33. By way of example, in 2009, the "Executive Sponsors" of the "National KP Risk Adjustment Initiative" were Kathy Lancaster (Executive Vice President and Chief Financial Officer of the Health Plan) and Jack Cochran (Executive Director of the Permanente Federation). The National Leads were Diane Morissette (National Director for Medicare Risk Adjustment, National Medicare Finance for the Health Plan) and Dr. Simon Cohn (Associate Executive Director of the Permanente Federation).

34. Kaiser's National Medicare Finance department is housed within the Health Plan and employs dozens of individuals with expertise in cost reimbursement, risk management, finance and accounting, and systems and project management. There is also a special Risk Adjustment Team, whose analysts help interpret Medicare risk-adjustment trends and data and also perform risk-score forecasting. A dedicated part of the team focuses on "coordinating efforts across the regions, sharing successful practices among the regions, distilling information, and communicating results to leadership."

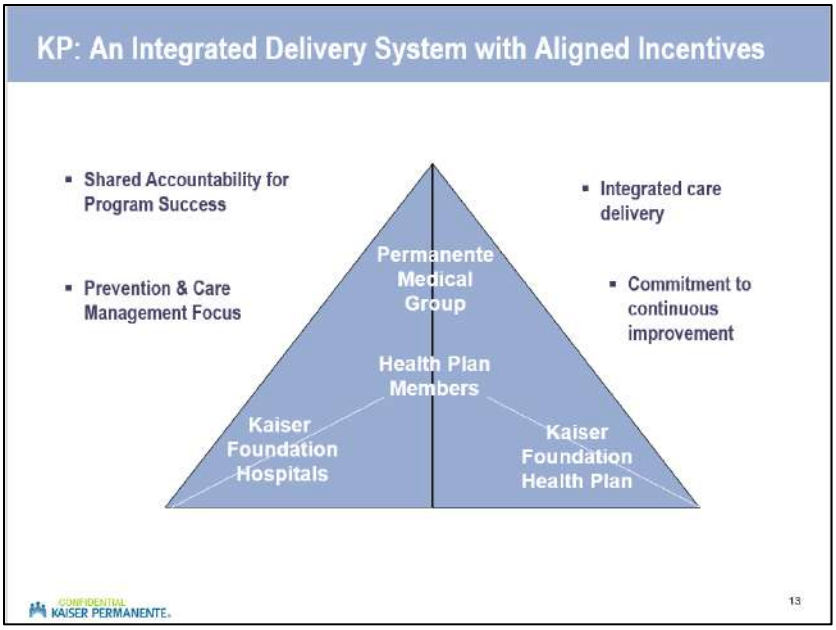
35. The Medicare Risk Adjustment Regional Reporting Group ("Medicare Regional Reporting Group") is a "community" that coordinates how both the Kaiser Health Plans and the Permanente Medical Groups implement Medicare risk-adjustment initiatives, and includes coders, physicians, programmers, analysts, legal and compliance advisors, project managers, statisticians, forecasters, accountants, strategists, government-relations influencers, and business-line leaders from both the Kaiser Health Plans and the Permanente Medical Groups. The Medicare Regional Reporting Group is co-led by the National Director for Risk Adjustment in Kaiser's National Medicare Finance department and the Associate Executive Director of the Permanente Federation.

36. Kaiser's National Medicare Finance department supports the semi-annual Medicare Regional Reporting Group conference that brings together Health Plan employees and Permanente Medical Group physicians from multiple regions to "increase their knowledge of Medicare risk adjustment, share best practices, and improve consistency and coordination."

37. Kaiser's National Compliance, Ethics & Integrity Office ("National Compliance Office") is also housed within the Health Plan. Kaiser's National Compliance Office is led by the senior vice president and Chief Compliance Officer of the Health Plan. The Chief Compliance Officer reports directly to the Chief Executive Officer and the Board of Directors of Kaiser. While it is housed within the Health Plan, the National Compliance Office provided training to coders and physicians in the Permanente Medical Groups. It also conducts audits of the Permanente Medical Groups, including audits of the Permanente Medical Groups' coding of patient diagnoses.

38. Each Kaiser region's Health Plan (e.g., Colorado) also has a Regional Compliance Officer and a regional Compliance Committee. These regional Compliance Committees oversee compliance activities, including with respect to Medicare Advantage.

39. The following diagram from an internal Kaiser training depicts the integrated nature of Kaiser's operations:



40. Because of the interconnected and interdependent nature of Kaiser, each of the Defendants—the Health Plan, the Colorado Health Plan, the N. California Medical Group, the S. California Medical Group, and the Colorado Medical Group—collaborated on their mutual Medicare risk-adjustment efforts.

III. JURISDICTION AND VENUE

41. This Court has subject-matter jurisdiction over this action pursuant to 28 U.S.C. § 1345 because the United States is the Plaintiff. In addition, the Court has subject-matter jurisdiction over the FCA claims for relief under 28 U.S.C. §§ 1331 and 1345 and 31 U.S.C. § 3732(a)-(b).

42. This Court has personal jurisdiction over the Defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides in, transacts business in, or has committed the alleged acts in this District. Moreover, all of the Defendants have extensive contacts with California. *See also* Fed. R. Civ. P. 4(k)(1)(C) (providing that serving a summons or filing a waiver of service establishes personal jurisdiction over a defendant "when authorized by federal statute").

43. Venue also lies in this District pursuant to 28 U.S.C. § 1391(b)-(c) and 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides in, and transacts business in this District, a substantial part of the events or omissions giving rise to the claims occurred in this District, and/or all of the Defendants are subject to the Court's personal jurisdiction under the FCA.

44. Intradistrict assignment to the San Francisco or Oakland Division is proper under Civil L.R. 3-2(c) because Defendants the Health Plan, the Colorado Health Plan, and the N. California Medical Group are all headquartered in Oakland and a substantial part of the events or omissions that give rise to the claims occurred therein.

IV. THE FALSE CLAIMS ACT

45. The FCA is the primary civil remedial statute designed to deter fraud upon the United States and reflects Congress's objective to "enhance the Government's ability to recover losses as a result of fraud against the Government." S. Rep. No. 99-345, at 1 (1986), 1986 U.S.C.C.A.N. 5266.

46. A defendant violates the FCA when it "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval." 31 U.S.C. § 3729(a)(1)(A). Under the FCA, a claim includes a request for money. *Id.* § 3729(b)(2). Further, a claim is "false or fraudulent" under the FCA if the entity or person submitting the claim was not entitled to payment.

47. After the 2009 amendments to the FCA by the Fraud Enforcement and Recovery Act of 2009 ("FERA"), Pub. L. No. 111-21 (May 20, 2009), a defendant violates the FCA when it "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)(B).

48. Conspiracy to violate Sections 3729(a)(1)(A) and (a)(1)(B) is also actionable under the FCA.

49. Under the FCA, the terms "knowing" and "knowingly" mean that the defendant had actual knowledge of or acted in deliberate ignorance or reckless disregard of information relating to the truth or falsity of its claims for payment or its false records or statements. 31 U.S.C. § 3729(b)(1)(A). The FCA does not require proof that the defendant had specific intent to defraud the Government. *Id.* § 3729(b)(1)(B). The terms "knowing," "knowingly," "knowledge," "knows," and "knew," as used in this Complaint, have the meaning ascribed to them by the FCA.

50. The term "material," as used in the FCA, "means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

51. The FCA imposes liability of treble damages plus a civil penalty for each false claim in an amount (as pertinent here) not less than $5,500 and not more than $11,000 for claims submitted prior to August 1, 2016; not less than $10,781 and not more than $21,563 for claims submitted between August 1, 2016 and February 3, 2017; and as appropriately statutorily adjusted for inflation each successive year under the Bipartisan Budget Act of 2015, Pub. L. No. 114-74, § 701, 129 Stat. 584, 599-601 (2015). *See* 28 C.F.R. § 85.5 (identifying applicable inflation adjustments on an annual basis); 31 U.S.C. § 3729(a)(1).

V. THE MEDICARE ADVANTAGE PROGRAM AND ITS RISK-ADJUSTMENT PAYMENT SYSTEM

A. Medicare Part C and risk-adjustment payments to MA Organizations

52. Medicare is a federally operated health insurance program administered by CMS for individuals 65 and older and the disabled. *See* 42 U.S.C. §§ 1395c *et seq*. There are four parts to the Medicare Program: Part A primarily covers inpatient and institutional care; Part B primarily covers outpatient care; Part C is the Medicare Advantage Program at issue in this case; and Part D is prescription drug coverage.

53. A Medicare beneficiary may choose what is commonly referred to as "traditional" Medicare. Under Medicare Parts A and B, the Government reimburses healthcare providers using a fee-

for-service system, in which providers submit claims to CMS for healthcare services actually rendered, such as a provider office visit or hospital stay. CMS then pays the providers directly for each service based on payment rates predetermined by the Government.

54. Alternatively, under the MA Program, a Medicare beneficiary can opt out of the traditional Medicare Program (Parts A and B) and instead enroll in an MA plan managed by an MA Organization. *See* Subchapter XVIII of the Social Security Act, 42 U.S.C. §§ 1395w-21 to 1395w-28.

55. MA Organizations are insurers who contract with CMS to provide healthcare plans called MA plans to people who are eligible for Medicare Part C. *See* 42 U.S.C. §§ 1395w-21-1395w-28. MA plans must provide Medicare beneficiaries all the services that they are entitled to receive from the traditional Medicare program, at a minimum, subject to limited exceptions. Defendants the Health Plan and the Colorado Health Plan are MA Organizations that administer Kaiser's MA plans in California and Colorado.

56. A Medicare beneficiary who enrolls in an MA plan is considered a member of and enrollee in that plan.[1]

57. CMS reimburses MA plans differently than traditional Medicare. Under Medicare Part C, the Government pays each MA Organization a predetermined base monthly amount for each enrollee in their MA plans. This monthly payment is known as a "per-member, per-month" payment and varies for each MA plan depending on various factors. *See* 42 U.S.C. § 1395w-23 (Payments to Medicare+Choice Organizations[2]); *see also* 42 C.F.R. Part 422 Subpart F (Submission of Bids, Premiums, and Related Information and Plan Approval); 42 C.F.R. Part 422 Subpart G (Payments to Medicare Advantage Organizations).

58. Additionally, since 2000, Congress has required that CMS adjust the "per-member, per-month" base payment for each MA plan beneficiary to account for: (1) demographic factors such as age

[1] In this Complaint, the terms beneficiaries, members, enrollees, and patients are used interchangeably and mean the same thing, i.e., individuals enrolled in MA plans.

[2] Medicare+Choice was the predecessor to the Medicare Advantage Program. Any provisions, such as 42 U.S.C. § 1395w-23, that reference Medicare+Choice are "deemed a reference to 'Medicare Advantage' and 'MA.'" *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-73, § 201(b), 117 Stat. 2066, 2176 (Dec. 8, 2003) (codified at 42 U.S.C. § 1395w-21 note).

and gender (among others) and (2) health status. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i). This is known as risk adjustment. Each beneficiary's risk score acts as a multiplier that is applied to the MA plan's base rate to determine the overall monthly payment for the beneficiary. *See* 42 U.S.C. § 1395w-23(a)(1)(G); *see also* 42 C.F.R. § 422.308(e).

59. HHS has the authority to determine the risk-adjustment methodology. *See* 42 U.S.C. § 1395w-23(a)(1)(C). For Medicare Advantage, since 2004, HHS has used a model called the CMS Hierarchical Conditions Category ("CMS-HCC") model, which determines each patient's risk score by accounting for the patient's demographic factors and health status. *See* 42 C.F.R. § 422.308(c); *see also* 42 U.S.C. § 1395w-23(a)(1)(C)(i).

60. The CMS-HCC model is prospective in the sense that it uses diagnoses made in a base year (the "service year"), along with demographic information (such as age and gender, among others), to predict costs for Medicare benefits and adjust payments for the following year (the "payment year"). The diagnoses included in the CMS-HCC model are a subset of diagnosis codes from the International Classification of Diseases. The diagnoses in the CMS-HCC model generally include major, severe, and/or chronic medical conditions.

61. HHS has adopted the ICD and its accompanying ICD Guidelines as the standard for medical record documentation, including the identification of diagnosis codes for health conditions. *See* 45 C.F.R. §§ 162.1002(a)(1), (b)(1), (c)(2), (c)(3) ("The Secretary [of HHS] adopts . . . the official ICD-10-CM Guidelines for coding and reporting"). At all relevant times, CMS regulations have therefore required MA Organizations to "submit data that conform to" the ICD Guidelines. 42 C.F.R. § 422.310(d)(1) (requiring MAOs to submit data in conformity with "all relevant national standards"); *see also* CMS, *Medicare Managed Care Manual*, Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004); CMS, *Medicare Managed Care Manual*, Chapter 7 § 40 (Rev. 118, Sept. 19, 2014).

62. ICD diagnosis codes are alphanumeric codes used by healthcare providers, insurance companies, and public health agencies to represent medical conditions; every disease, injury, infection, and symptom has its own code. The applicable ICD diagnosis codes are set forth in the International Classification of Diseases, Ninth Revision, Clinical Modification ("ICD-9") through October 1, 2015, and thereafter in the International Classification of Diseases, Tenth Revision, Clinical Modification

("ICD-10"). *See* 45 C.F.R. § 162.1002 (listing dates for use of Medical data code sets). The particular ICD Guidelines provisions relevant to the allegations in this Complaint have remained the same.[3] The Health Insurance Portability and Accountability Act ("HIPAA") and HHS regulations broadly mandate the use of the ICD, including the ICD Guidelines, across the healthcare industry.

63. The CMS-HCC model relies upon the ICD diagnosis codes and the ICD Guidelines. The ICD diagnosis codes included in the CMS-HCC model are grouped into categories of clinically related medical diagnoses that comprise the HCCs (i.e., the categories). For example, various cancer diagnosis codes are grouped together (e.g., colorectal and bladder cancers). The CMS-HCC model organizes related conditions into hierarchies based on disease severity and expected cost. For example, various cancer HCCs are in the same hierarchy, with the HCC associated with metastatic cancer diagnosis codes as the most severe. If a patient is diagnosed with conditions (diagnosis codes) that correspond to more than one HCC in a hierarchy, only the most severe HCC is kept and any lower-ranking HCCs are dropped.

64. For a given payment year, an MA plan beneficiary might have zero HCCs or might have one or more HCCs, depending on whether the beneficiary had any diagnoses from the service year that correspond to an HCC. Some examples of HCC codes are diabetes with chronic complications (HCC 18), protein-calorie malnutrition (HCC 21), congestive heart failure (HCC 80), and vascular disease (HCC 108).[4]

65. Each HCC is assigned a coefficient. CMS calculates a beneficiary's risk score by adding the coefficients associated with each of the beneficiary's applicable demographic characteristics (such as age and gender) and the applicable HCCs, if any, that apply to the beneficiary.[5] A risk score of 1.0 reflects the average expected Medicare-incurred expenses. A risk score of 0.75 reflects expected costs

[3] Because the relevant guidelines have remained the same, the Complaint will not reference any particular version of the ICD Guidelines. All ICD Guidelines for the relevant years are available at https://www.cdc.gov/nchs/icd/icd9cm.htm and https://www.cdc.gov/nchs/icd/icd10cm.htm.

[4] CMS has adjusted the CMS-HCC model over time, utilizing different versions. The numerical examples of HCC codes cited in this paragraph are from the Version 22 model.

[5] CMS makes several further adjustments to the risk score before reaching a final calculation. *See* CMS, *Medicare Managed Care Manual*, Chapter 7 § 100 (Rev. 114, June 7, 2013). These adjustments are not relevant to the allegations in the Complaint.

for a particular beneficiary that are 25% less than the estimated average costs for enrollees in the MA plan, and a risk score of 1.25 reflects expected costs that are 25% greater than the estimated average costs for enrollees in the MA plan.

66. CMS uses these risk scores to adjust the base monthly payment for each MA plan beneficiary. As noted, each patient's risk score is based upon diagnosis codes submitted from medical visits in the "service year." CMS uses those service-year calculations to determine the monthly payments to the MA organizations in the following year (the "payment year"). Each MA plan beneficiary's risk score is calculated each year.

67. To understand the operation of the CMS-HCC model, imagine a hypothetical patient whose "demographic" characteristics—i.e., age, sex, and institutional and disability statuses—were assigned a coefficient of 0.60. If this patient had no diagnosed diseases, an MA plan would be paid 60% of its base rate (which is keyed to the average beneficiary) for covering this patient. If the imagined patient had one diagnosis in the service year that mapped to an HCC, the CMS-HCC model would add the risk-adjustment coefficient for that HCC. For example, if that HCC had a risk-adjustment coefficient of 0.30, the patient would then have a risk score of 0.90, and the MA plan would be paid 90% of its base rate in the payment year for covering this patient. If this patient had a second diagnosis that mapped to another HCC, CMS would add the risk adjustment coefficient for that HCC as well. So if that second HCC had a risk adjustment coefficient of 0.20, the patient would then have a risk score of 1.10, and the MA plan would be paid 110% of its base rate in the payment year for covering this patient. If we assume the base payment amount for the patient was $10,000, the first diagnosis would cause CMS to pay out $3,000 more in risk adjustment payments, and the second diagnosis would cause CMS to pay out an additional $2,000 in risk adjustment payments.[6]

68. The CMS-HCC model relies upon MA Organizations and authorized physicians to correctly document and submit ICD diagnosis codes for their patients pursuant to the ICD Guidelines. When a Medicare Advantage insurer reports to CMS a relevant diagnosis for a covered patient, that

[6] As noted above, CMS makes several technical adjustments to the risk score not relevant to the allegations in the Complaint. For purposes of this example, all adjustments are incorporated within the hypothetical coefficients.

reported diagnosis directly increases the amount that CMS pays the insurer for providing coverage. A higher risk score translates into higher payments by CMS to the MA Organization. Thus, the risk-adjusting diagnosis codes that correspond to HCCs directly impact how much money CMS pays an MA Organization. The CMS-HCC model does not predict any costs associated with a patient simply having a condition or having been diagnosed with a condition in the past. Rather, as explained above, the CMS-HCC model predicts expected costs based upon particular ICD diagnoses coded in conformance with the ICD Guidelines in the service year.

69. CMS, through its regulations and guidance, has made clear to MA Organizations and healthcare providers, including physicians, that it relies on the risk-adjusting diagnosis codes to determine and make accurate payments for each patient enrolled in the MA Program. "Accurate risk-adjusted payments rely on the diagnosis coding derived from the member's medical record." *See, e.g.*, 42 C.F.R. § 422.504(*l*); CMS, *2013 National Technical Assistance Risk Adjustment 101 Participant Guide* 13 (2013).

70. During the relevant time period, MA Organizations submitted risk-adjustment data, including diagnosis codes, through two electronic systems administered by CMS: the Risk Adjustment Processing System ("RAPS") and the Encounter Data Processing System ("EDPS"). Up to 2014, CMS calculated risk-adjustment payments based solely on data submitted through RAPS. Starting in 2015, CMS has calculated risk-adjustment payments using a combination of data submitted through RAPS and EDPS.

71. Each RAPS and EDPS submission by an MA Organization is a claim for payment because the reported diagnosis codes factor directly into CMS's risk-adjustment calculations and into the resulting payments made by CMS to the MA Organization.

72. MA Organizations can delete or "redact" diagnoses from both the RAPS and EDPS databases to remove erroneous, invalid, unsupported, or otherwise improper diagnosis codes previously submitted to CMS. After a diagnosis is deleted or redacted, CMS's electronic-processing system recalculates the payment.

B. Standards governing risk-adjustment payments

73. CMS has the authority to issue rules to implement and regulate Medicare Part C. *See*

42 U.S.C. § 1395w-26(b). CMS has promulgated regulations governing the Medicare Advantage Program, including numerous regulations imposing obligations and responsibilities on MA Organizations. 42 C.F.R. Part 422.

74. Further, in order to participate in the MA Program, MA Organizations such as Kaiser's Health Plans must enter into and execute a written contract with CMS for the MA plans they operate. 42 U.S.C. § 1395w-27(a); 42 C.F.R. Part 422, Subpart K. Pursuant to 42 C.F.R. § 422.505, these contracts are renewed annually unless CMS or the MA Organization provides a notice of intention not to renew. As relevant here, the Health Plan and the Colorado Health Plan executed such contracts with CMS for the MA plans they operated.

75. These contracts impose numerous obligations. Among others, the contracts require an MA Organization to operate its MA plans in compliance with the requirements of the contract, applicable federal law and regulations, and CMS's policies, including CMS's Medicare Managed Care Manual. Furthermore, the MA Organization must certify the accuracy, completeness, and truthfulness of the data it submits to CMS. 42 C.F.R. § 422.504(*l*).

76. Entities—like physician groups—enter into agreements with MA Organizations to provide health care services to MA plan beneficiaries. These entities are called first tier and downstream entities. *See, e.g.*, 42 C.F.R. § 422.500 ("*First tier entity* means any party that enters into an acceptable written arrangement with an MA Organization or contract applicant to provide administrative services or health care services for a Medicare eligible individual."); *id.* ("*Downstream* entity means any party that enters into an acceptable written arrangement below the level of the arrangement between an MA Organization (or contract applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services."); *see also, e.g.*, 42 C.F.R. § 422.504(i) (listing some of the obligations).

77. First tier and downstream entities—such as the Permanente Medical Groups—must, among other things, agree in their contracts with the MA Organization to terms that commit them to comply with the MA Organization's contractual obligations to CMS, 42 C.F.R. § 422.504(i)(3)(iii), and agree to "comply with all applicable Medicare laws, regulations, and CMS instructions," *id.* § 422.504(i)(4)(v). Furthermore, if the entity generates data relating to an MA Organization's claims for

payment, it must certify the accuracy, completeness, and truthfulness of that data. *Id.* § 422.504(*l*)(3). The Defendant Permanente Medical Groups have each executed contracts agreeing to these and other obligations related to the MA Program.

78. CMS imposes, and Kaiser Health Plans have contractually agreed to, numerous obligations with respect to diagnosis codes submitted to obtain risk-adjustment payments. As most relevant to this Complaint:

79. *First*, given the material impact of diagnoses in calculating the Government's payments, MA Organizations must ensure that diagnosis codes submitted for risk-adjustment payments are accurate, complete, and truthful. MA Organizations must attest to the validity of their risk-adjustment data, including diagnoses, in a Risk Adjustment Attestation submitted to CMS each year. Specifically, the chief executive officer, chief financial officer, or an individual delegated with authority to sign on behalf of one of these officers and who reports directly to such officer, must certify that the risk-adjustment data that the MA Organization submitted to CMS is accurate, complete, and truthful. *See* 42 C.F.R. § 422.504(*l*); CMS, *Medicare Managed Care Manual*, Chapter 11 § 130 (Rev. 79, Feb. 17, 2006). In its contracts with CMS, Kaiser (like other MA Organizations) agreed that: "[a]s a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G," it must attest to "the accuracy, completeness and truthfulness of the data identified on these attachments." CMS's regulations further specify that the MA Organization's submission of its such attestations regarding "the accuracy, completeness, and truthfulness" of this data is "a condition for receiving a monthly payment" from CMS. 42 C.F.R. § 422.504(*l*).

80. *Second*, diagnosis codes submitted for risk-adjustment payments are valid only if they are documented in the medical record as a result of a face-to-face visit between a patient and physician.[7] *See, e.g.*, CMS, *Medicare Managed Care Manual*, Chapter 7 § 40 (Rev. 118, Sept. 19, 2014) ("All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit."); CMS, *Medicare Managed Manual*, Chapter 7 § 111.3 (Rev. 57, Aug. 13,

[7] The Medicare Managed Care Manual provides a table of Acceptable Physician Specialty Types. *See* CMS, *Medicare Managed Care Manual*, Chapter 7 Table 19 (Rev. 118, Sept. 19, 2014). The type of physician is not at issue in this Complaint; this Complaint will therefore refer simply to "physician."

2004) ("Physician risk adjustment data is defined as diagnoses that are noted as a result of a face-to-face visit by a patient to a physician (as defined above) for medical services.").

81. *Third*, diagnosis codes submitted for risk-adjustment payments must be in conformance with the ICD, including the ICD Guidelines. *See, e.g.*, 45 C.F.R. § 162.1002(a)(1)(i), (b)(1), (c)(2)(i) (establishing the ICD, including the ICD Guidelines, as the national standard for diagnosis coding); 42 C.F.R. § 422.310(d)(1) ("MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards."); CMS, *Medicare Managed Care Manual*, Chapter 7 § 40 (Rev. 118, Sept. 19, 2014) ("The diagnosis must be coded according to *International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting*."); CMS, *Medicare Managed Care Manual*, Chapter 7 § 40 (Rev. 114, June 7, 2013); CMS, *Medicare Managed Manual*, Chapter 7, Exhibit 30 (Rev. 57, Aug. 13, 2004); 42 C.F.R. § 422.504(h)(2) (requiring MA Organizations to comply with HIPAA simplification rules at 45 C.F.R. part 162, which includes the adoption of the ICD and ICD Guidelines as the national standard); ICD Guidelines, Preamble ("These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. . . . Adherence to these guidelines when assigning ICD-10-CM diagnosis codes is required under [HIPAA].").

82. The ICD Guidelines impose numerous requirements and limitations on what diagnoses may be coded in a particular visit and in a particular setting. Those Guidelines differ with respect to when diagnoses can be coded for non-outpatient and outpatient visits. *Compare* ICD Guidelines §§ II, III (non-outpatient guidelines), *with* § IV (outpatient guidelines). This Complaint concerns outpatient visits, which are covered by Section IV of the ICD Guidelines.

83. For an outpatient visit (sometimes referred to as an encounter), the ICD Guidelines only permit the coding of documented conditions that both exist at the visit *and* that "require or affect patient care treatment or management." ICD-10 Guidelines § IV.J; ICD-9 Guidelines § IV.K.[8] In other words,

[8] The ICD Guideline provisions discussed in this Complaint are identical in all relevant editions of the ICD-9 and ICD-10 Guidelines; the subsection letter changed because one subsection not relevant to the Complaint was removed for the ICD-10.

it is not enough that a condition merely exists; the condition must have specifically mattered to patient care, treatment, or management.

84. The ICD Guidelines state that "[c]hronic diseases treated on an ongoing basis may be coded and reported as many times as the patient received treatment and care for the condition(s)." ICD-10 Guidelines § IV.I; ICD-9 Guidelines § IV.J. As CMS explained in a 2013 Participant Guide: "For a chronic condition to be accepted for risk adjustment, the patient must have a face-to-face visit each year with a provider/physician who assesses and documents that condition." CMS, *2013 National Technical Assistance Risk Adjustment 101 Participant Guide* 17 (2013).

85. For example, even if an MA organization knows that a patient was diagnosed in a prior year with a chronic condition that tends not to go away, the MA organization may not submit the diagnosis for payment for the current year unless the physician has a face-to-face visit with the patient in the current year and the chronic condition required or affected care, management, or treatment during that patient visit.

86. The ICD Guidelines further provide that if a patient does not have a medical condition at the time of a visit, it may not be coded. Moreover, uncertain conditions—such as probable, suspected, questionable, working diagnoses, etc.—may not be coded. *See* ICD-10 Guidelines § IV.H; ICD-9 Guidelines § IV.I. Prior conditions may be coded only with special ICD "history codes" if the prior condition has an impact on current care or treatment. *See* ICD-10 Guidelines § IV.J; ICD-9 Guidelines § IV.K.

87. In sum, the diagnosis codes that MA Organizations submit to CMS for risk-adjustment purposes must be:

a. established by a qualified physician;

b. based on a face-to-face medical visit between the patient and physician;

c. documented in the medical record; and

d. coded in compliance with the ICD Guidelines, including the limitation that the condition must have required or affected patient care, treatment, or management for the visit.

VI. KAISER KNEW THE CMS STANDARD FOR SUBMISSION OF RISK-ADJUSTMENT DIAGNOSES

88. Kaiser knew that diagnoses submitted to CMS for risk-adjustment purposes must be: (a) established by a qualified physician; (b) based on a face-to-face medical visit between the patient and physician; (c) documented in the medical record; and (d) coded in compliance with the ICD Guidelines, including the limitation that the condition must have required or affected patient care, treatment, or management for the visit.

89. As far back as 2008, Kaiser issued a "Program Advisory" (the "2008 Risk Adjustment Program Advisory") to all its regions that was "intended to clarify the minimum amount and type of documentation necessary to support the diagnoses submitted to [CMS] as Medicare Advantage risk adjustment data." The designated points of contact for the 2008 Risk Adjustment Program Advisory were: Dr. Simon Cohn (Associate Executive Director for the Permanente Federation); Gina Reese (Senior Counsel for Kaiser Foundation Hospitals and Health Plans); and Janet Franklin (at the time, a Practice Leader, Coding Compliance, with the National Compliance Office).

90. The 2008 Risk Adjustment Program Advisory demonstrates that Kaiser knew the CMS standard for submission of risk-adjustment diagnoses. Specifically, it stated that:

a. "Diagnoses submitted as physician risk adjustment data must be recorded by a 'physician'";

b. "[R]isk adjustment data must be obtained as the result of a face-to-face visit by the physician . . . with the patient" (emphasis in original);

c. "For the outpatient or physician office visit note, it is acceptable to submit risk adjustment data for diagnoses documented in the history, physical or assessment portion of the medical record that is directly associated with the date of the face-to-face encounter with the patient"; and

d. "**Documentation Must Comply with ICD-9-CM Coding Guidelines**" and "[t]here must be an implicit or express indication that the physician **considered**, **addressed** or **evaluated** the coded diagnosis during the patient encounter. . . . [I]f the physician does not actually consider the condition during the visit, then the

physician should not document the diagnosis in the medical record for that visit and that diagnosis should not be submitted to CMS as risk adjustment data." (Emphasis in original.)

91. A 2010 Medicare Regional Reporting Group presentation to all Defendants stated that the physician must have considered, addressed, or evaluated the condition during the patient visit. "Each encounter must be evaluated separately and the condition's impact to care must be evident. This is in keeping with Coding Clinic and as iterated [sic] by CMS in their participant guide." The presentation then cited the specific provision in the ICD Guidelines requiring that the condition must require or affect patient care, treatment, or management in order to be coded.

92. A 2014 Medicare Regional Reporting Group presentation reiterated these requirements: "Documentation must comply with the ICD-9-CM Coding Guidelines." To be coded, the condition must be "[e]valuat[ed], treat[ed] or affect care," must be the "result of face-to-face encounter" with an acceptable physician, and "must have occurred in the applicable year."

93. In 2015, Kaiser issued an updated version of the Program Advisory (the "2015 Risk Adjustment Program Advisory"), with similar guidance. As with the 2008 Risk Adjustment Program Advisory, the 2015 Risk Adjustment Program Advisory was "intended to provide guidance about the documentation necessary to support the diagnoses reported by physicians and diagnoses codes submitted by Kaiser Foundation Health Plans to [CMS] for physician encounter risk adjustment data." The designated points of contact for the 2015 Risk Adjustment Program Advisory were: Dr. Simon Cohn; Paula Ohliger (Senior Counsel for the Health Plan); and Janet Franklin (at that time, a Compliance Manager for Risk Adjustment with the National Compliance Office).

94. Specifically, the 2015 Risk Adjustment Program Advisory states that "CMS requires that diagnoses submitted for risk adjustment be" made:

a. By "a physician deemed acceptable for risk adjustment";

b. "[A]s a result of a face-to-face encounter";

c. "[D]ocumented in the medical record"; and

d. "**Documentation Must Comply with ICD-9-CM Coding Guidelines**. . . . Generally, physicians should document all conditions that coexist at the time of

> the encounter/visit, and require or affect the physician's care, treatment or management of the patient. . . . [I]f the physician does not actually consider the condition during the encounter or the diagnosis did not impact that encounter then the physician should not document the diagnosis in the medical record for the visit and that diagnosis should not be submitted to CMS as risk adjustment data." (Emphasis in original.)

95. Various employees, including those from the National Compliance Office, confirmed Kaiser's awareness of these requirements. As Janet Franklin testified, "in order to submit a diagnosis that impacted reimbursement, you had to meet the coding rules that showed that it impacted—that there was monitoring, evaluation, assessment, treatment, or some kind of impact to the encounter that day."

96. Internal Kaiser training documents also stressed the importance of the compliance "Golden Rule" regarding coding for patient diagnoses: "'If it's not documented by the physician, it didn't happen.' . . . In compliance and in coding, there is no deviation from this principle. We can't code it if it isn't documented, and we can't bill for it."

VII. KAISER KNOWINGLY SUBMITTED OR CAUSED TO BE SUBMITTED FRAUDULENT DIAGNOSIS CODES

97. Despite its obligations to the contrary, Kaiser knowingly submitted or caused to be submitted diagnoses that had no relevance to the patient visit and sometimes did not exist at all and sought risk-adjustment payments based on such fraudulent diagnoses. Kaiser knew that it could submit only those diagnoses that required or affected care, treatment, or management for a patient visit. Yet Kaiser knowingly submitted or caused to be submitted thousands upon thousands of diagnoses that it knew had nothing to do with those visits and were not addressed or considered in any way at the patient visits.

98. Kaiser generated such diagnoses through the use of medical record addenda—changes to the medical record after the patient visit, often months or even a year or more after the visit—to add unrelated diagnoses identified through one of Kaiser's risk-adjustment programs. Kaiser mined patient records for anything that might support a risk-adjusting diagnosis and then had the physician retrospectively create an addendum to the medical record to make it appear as if the diagnosis was part

of the original patient visit, regardless of whether it actually was.

99. Defendants all knew that the purpose of these programs was to add diagnoses that the Health Plan and the Colorado Health Plan could submit to CMS to falsely claim entitlement to hundreds of millions of dollars in additional risk-adjustment payments, which the Health Plans then shared with the Permanente Medical Groups. Indeed, the Defendants routinely tracked these programs in great detail to identify the diagnoses added, money earned, and return on investment. Meanwhile, Permanente Medical Group physicians often did not tell their patients that they supposedly had the diagnoses for which the Kaiser Health Plans claimed payment.

A. Kaiser recognized the importance of Medicare revenue and implemented national initiatives to increase patient risk scores.

100. Kaiser recognized and emphasized internally that Medicare Advantage, and in particular risk-adjustment payments from diagnoses, were (and are) critical to Kaiser's business. Internal Kaiser documents stressed repeatedly how "Medicare is important to KP," how "Medicare is KP's largest single payor," and how Medicare is a "[s]ignificant contributor to operating income." Kaiser's internal analyses reflected that although Medicare accounted for roughly 10% of Kaiser's members, Medicare accounted for more than 30% of Kaiser's total revenue. And risk-adjustment payments (i.e., CMS payments based upon risk-adjustment diagnoses) accounted for more than half of all of Kaiser's Medicare revenue.

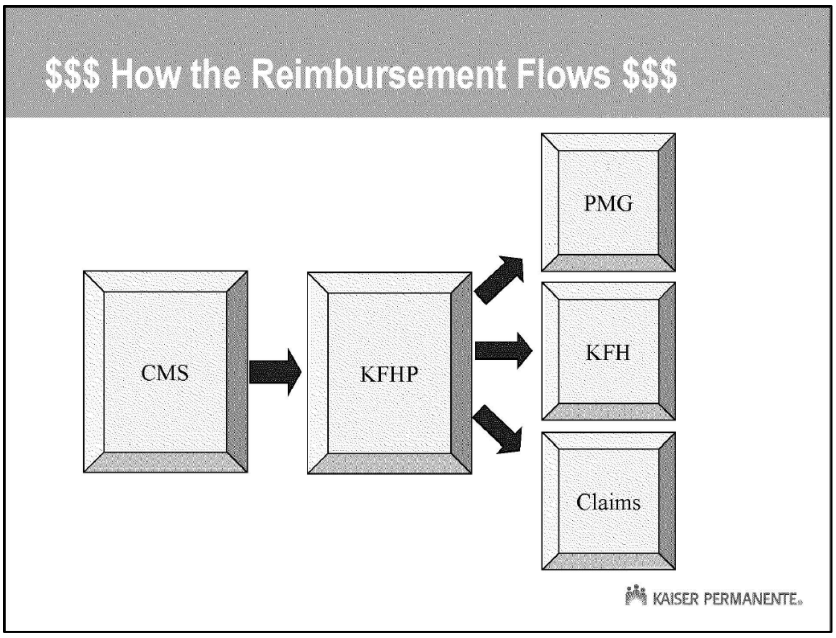
101. In his speaker notes for a National Compliance Office summit meeting, Dr. Simon Cohn (Associate Executive Director of the Permanente Federation) explained: "So why are we talking to you about this [Medicare Risk Adjustment] again? … because of KP[']s critical dependencies on Medicare Revenue—risk adjusted revenue—which is almost 1/3 of program revenue and the only thing we are currently making a margin on—the more you know about this the better."

102. As Diane Morissette (National Director for Medicare Risk Adjustment, National Medicare Finance for the Health Plan) explained to the Medicare Regional Reporting Group, including representatives from all of the Defendants, in 2010: "Why a focus on risk adjustment . . . that's enough to warrant its own 2-day meeting? Because risk adjustment is by far the biggest lever we have to change our revenue from Medicare. If we don't do this well, our financial health as a company could be

seriously impacted."

103. Revenue from the Medicare Advantage program was shared among the Kaiser entities. As one set of internal Kaiser training materials put it, "Many management consultants will advise people to 'follow the money', so let's do that here. In Medicare Advantage, Medicare or 'CMS' pays Kaiser Foundation Health Plan to cover Medicare covered benefits for our Medicare Advantage members. Our Health Plan, in turn, pays the Permanente Medical Groups, Kaiser Foundation Hospitals, and various external providers through claims to care for our members."

104. The same Kaiser internal training depicted the flow of money in the following way:



105. Recognizing the importance of risk adjustment as a revenue driver, Kaiser's National Medicare Leadership Team, National KP Risk Adjustment Initiative, National Medicare Finance department, and the Medicare Regional Reporting Group were all key players involved in risk-adjustment activities at Kaiser. Kaiser's National Medicare Finance department assigned one or more persons from its ranks to lead each region's risk-adjustment efforts. National Medicare Finance's region leads collaborated with the regional Permanente Medical Groups to ensure coordination, identify and analyze potential opportunities to increase risk-adjustment revenues, and share information across regions. If particular regions had successful initiatives that increased their risk scores, Kaiser's National Medicare Finance department would work with other regions to duplicate those efforts. The Medicare

Regional Reporting Group shared information across all Kaiser entities and regions regarding risk adjustment, including so that successful initiatives could be shared and duplicated.

106. Internally, Kaiser touted that it had a "strategic advantage" in Medicare risk adjustment because of its integrated structure. This structure enabled Kaiser to coordinate its efforts between each of its entities and across regions. The National KP Risk Adjustment Initiative and the various working groups it spawned, as well as Kaiser's National Medicare Finance department, ensured this high level of coordination.

107. Key to Kaiser's ability to coordinate risk-adjustment activities among the Kaiser Health Plans and the Permanente Medical Groups was the fact the Kaiser Health Plans and the Permanente Medical Groups actively monitored and shared risk-adjustment data, including diagnosis documentation.

108. Kaiser's National Medicare Finance department tracked numerous metrics. Risk scores were compared across regions, trended over time, tracked against forecasts, and compared to benchmarks. Volumes of diagnoses were tracked and compared across time, regions, and against expected thresholds. The number of diagnoses per visit, visits per member, HCCs per member, HCC frequencies, and number of un-refreshed diagnoses were all tracked within Kaiser's National Medicare Finance department.

109. A variety of reports on all of these metrics were distributed to individuals throughout the Kaiser Health Plans and Permanente Medical Groups involved with Medicare risk adjustment, as well as posted to the internal "KP Medicare Risk Adjustment Website," the purpose of which was to "provide one central location as a resource to staff across the regions who are working on Medicare Risk Adjustment."

110. In addition to the various risk-adjustment reports, the KP Risk Adjustment Website contained presentations from Medicare Regional Reporting Group conferences, training materials, compliance policies, and National Compliance Office work plans.

111. As Kaiser's internal Risk Adjustment Manual further explains: "[a]ccuracy and completeness of diagnosis documentation, coding and data submission is tracked monthly by reviewing a full suite of reports that are produced by [Management Information & Analysis], reviewed by National Medicare Finance and the Permanente Federation and consolidated into a monthly summary of reports.

In addition, as soon as new monthly risk score results are available, a Medicare Risk Adjustment flash report is distributed to CFOs, Medicare Risk Adjustment regional leads, National Medicare Finance managers and other key stakeholders."

112. An additional function of Kaiser's National Medicare Finance department was to work with each region to develop a "risk adjustment improvement plan." The plans covered seven areas relating to "completeness and accuracy of documentation, coding and data submission." These plans "are developed early in the year and are evaluated quarterly. Gaps that are identified are worked through to resolution with the Region and successful practices that are identified are highlighted and shared with other Regions."

113. In addition to monthly meetings, the Medicare Regional Reporting Group held semi-annual conferences to ensure that key leaders and staff involved in Medicare risk adjustment were updated with the latest information from CMS, reviewed risk score trends and accuracy rates, and learned new tools to allow them to work more efficiently and effectively. The Medicare Regional Reporting Group conferences were also an important opportunity to share successful practices, such as "[n]ew and promising regional initiatives to improve completeness and/or accuracy of risk adjustment data."

114. In addition, the "KP Risk Adjustment Data Leads" for all regions and representatives from the national risk-adjustment reporting team meet weekly to "share new risk adjustment information, discuss and resolve data submission issues, and share successful practices." "Data Leads often adopt each others' initiatives, especially as KP regions move toward common sources for risk adjustment data. Best practices and lessons learned are discussed, with a focus on moving toward common national practices to the greatest extent possible."

115. Kaiser made clear that it expected results and would hold employees accountable for achieving them. In a 2006 Medicare Regional Reporting Group presentation regarding Improving Diagnosis Capture for Medicare Risk-Adjusted Payment, Diane Morissette and Dr. Simon Cohn stated that there was leadership focus on this issue at both the Health Plan and the Permanente Medical Groups, and that leadership in those organizations "holds direct reports accountable for results."

116. Kaiser identified that the risk score is "one of the primary drivers of overall revenue and

is a key driver for organizational performance." Kaiser knew that if it could increase the average risk scores of its patients, even by a small amount, it could receive a significant increase in revenue. As an internal Kaiser training emphasized: "If a risk score increases from, say, 1.10 to 1.11, this is considered a point. It might not sound like much of a change, but that point is worth over $28 Million dollars to a Region like Northern California and over $62 Million dollars if the overall average risk score for the whole KP program increases by a point." Kaiser calculated the value of each point every year. By 2015, Kaiser calculated that the value of each point was more than $80 million.

117. A key component of Kaiser's risk-adjustment programs involved setting risk-score targets for the average risk score for all of Kaiser's patients. The Health Plan, through the National Medicare Finance department, set the annual risk-score target for each region, specifically instructing each region what the average risk scores for its members should be. Generally, these targets would take the historical score from the region and add on points for the following year. Each region was expected to work with Kaiser's National Medicare Finance department to develop a plan, including the specific initiatives it would undertake, to meet the risk-score target. These regional initiatives were discussed regularly with Kaiser's National Medicare Finance department, who shared successful initiatives with other regions. Often, regions would present these initiatives at Kaiser's Medicare Regional Reporting Group meetings so that other regions could duplicate their efforts.

118. Kaiser set increasingly higher risk-score targets every year. As previously noted, the average risk score for Medicare beneficiaries under the CMS-HCC model is 1.0. But Kaiser set increasingly higher targets well above this 1.0 average. Kaiser's National Medicare Finance department increased these risk-score targets over time despite concerns from physicians that it created "a culture of 'meet the target at any cost.'"

119. Kaiser worked to conceal this financial motive, especially documents that could be disclosed in litigation. For example, in 2011, Karen Graham (Managing Director of the N. California Medical Group's Encounter Information Operations ("EIO") office) wrote to other members of the N. California Medical Group's management that "[i]n the past we've steered away from publicizing the dollar value of diagnoses, particularly in any printed / discoverable format." She reminded them that "[y]ou've heard Dr [David] Bliss put on his 'money grubbing' hat and comment in this fashion."

120. Kaiser's risk-adjustment program was highly successful with respect to its goal of increasing Medicare revenue and increasing risk scores. When CMS began using the CMS-HCC model in 2004, most Kaiser regions had average patient risk scores of around 0.90, with some regions slightly above and some slightly below. Kaiser's 2004 risk score, slightly below 1.0, was consistent with research showing that Medicare Advantage beneficiaries are on average healthier, have lower medical spending, and use fewer medical services than traditional Medicare beneficiaries.[9] However, by 2014, after spending substantial resources on these risk-adjustment initiatives, Kaiser's average risk score increased to 1.16, with the California and Colorado regions meeting or exceeding this score. Put differently, Kaiser's risk-score initiatives enabled it to make its patient population appear sicker, allowing Kaiser to achieve a roughly 30% increase in Medicare revenue per patient than it would have received based on its 2004 average risk score. This risk-score increase translated into billions of dollars of additional Medicare revenue to Kaiser.

B. Kaiser mined patient medical records to add lucrative risk-adjustment diagnoses via addenda to achieve risk-score targets.

121. In order to meet the ever-increasing risk-score targets set by Kaiser's National Medicare Finance Department, each region was expected to develop and implement initiatives to increase their average patient risk score. It was not sufficient for Permanente Medical Group physicians to simply have visits with their patients and identify those conditions relevant to the visits. Instead, the Defendant Kaiser Health Plans and Permanente Medical Groups created and implemented numerous initiatives aimed at raising patient risk scores.

122. Kaiser made systematic efforts in the California and Colorado regions to increase risk scores by adding lucrative risk-adjustment diagnoses *after* a patient visit, even where the condition had nothing to do with the visit. Kaiser—through the Kaiser Health Plans and the regional Permanente Medical Groups—used automated algorithms and human reviewers to mine its patients' medical files

[9] *See, e.g.*, Kaiser Family Foundation, Do People Who Sign Up for Medicare Advantage Plans Have Lower Medicare Spending? (May 2019), *available at* https://files.kff.org/attachment/Issue-Brief-Do-People-Who-Sign-Up-for-Medicare-Advantage-Plans-Have-Lower-Medicare-Spending (last visited Oct. 25, 2021); Jason Brown et al., How Does Risk Selection Respond to Risk Adjustment? Evidence from the Medicare Advantage Program, 104 *Am. Econ. Rev.* 3335 (2014); *UnitedHealthcare Ins. Co. v. Becerra*, 9 F.4th 868, 876 (D.C. Cir. 2021) (referencing studies finding "that Medicare Advantage insurers in fact have tended to attract healthier-than-average beneficiaries").

for potential additional diagnoses.

123. After identifying potential diagnoses, Kaiser then had its physicians retrospectively add these diagnoses to the patients' medical records using addenda, as if the new diagnoses were addressed in some way during the patient visits when, in fact, they were not.

124. An "addendum" is a part of a patient's medical record that is a note drafted by a physician that amends a previous note made by that same physician. In other words, an addendum is an addition to a patient's medical record made *after* the visit but linked to the record of that visit. Generally, a medical-record addendum is a means by which medical-record entries can be updated, corrected, or supplemented. An addendum can be used to clarify or correct a medical record that contains conflicting or insufficient information.

125. Under CMS rules and guidance, as well as industry practice, addenda have legitimate uses. CMS recognizes the use of an addendum where it is related to a service that was provided during the visit. *See* CMS, *Medicare Program Integrity Manual*, Chapter 3 § 3.3.2.5(A); CMS, *2008 Risk Adjustment Data Technical Assistance Participant Guide* § 6.4.2. An addendum must clearly delineate any amendment, including the date and author of the amendment, from the original content of the medical record, which must be preserved without deletion. CMS, *Medicare Program Integrity Manual*, Chapter 3 § 3.3.2.5(A).

126. Kaiser, however, did not use addenda simply to timely clarify or correct medical records. Some of the diagnoses that Kaiser added via addenda did not even exist, and many more did not require or affect patient care, treatment, or management at the patient visit as required by the ICD Guidelines. Often, these addenda were added months or even a year or more after the visit so that Kaiser could obtain risk-adjustment payments for the newly added diagnoses.

127. Broadly speaking, Kaiser pushed several types of initiatives to add diagnoses via addenda. These included "data mining" and "chart review," where Kaiser would utilize automated algorithms and/or human reviewers to identify brand-new diagnoses. Such never-before-diagnosed conditions should rarely, if ever, result in addenda because these diagnoses were, almost by definition, not relevant to the visit. Yet Kaiser routinely created addenda to medical records with these diagnoses and submitted them for payment, often without even telling the patient about these brand-new diagnoses.

128. Kaiser also employed a related data-mining program called "refresh," where Kaiser would mine patient medical files to find old diagnoses that had not been diagnosed in the current service year. Following a patient visit, if a physician failed to address any of these unrefreshed diagnoses, the physician would receive a list of these "missed-opportunity" diagnoses—i.e., opportunities for risk-adjustment payment. Because Kaiser had numerous different initiatives, physicians would often receive lengthy lists of both data-mined diagnoses and missed-opportunity diagnoses.

129. Kaiser typically brought these new mined diagnoses to the physician's attention through a query. As commonly defined in the healthcare industry, a "query" is any communication tool or process used to clarify documentation in the health record for accurate code assignment. This would encompass any communication to a physician, after the physician had a visit with a patient, relating to modifying, adding, or deleting any diagnosis in the patient's medical record for the visit. Queries can take any form; they can be written or oral.

130. There are standards, discussed in more detail in paragraphs 185-216, guiding and limiting the use of queries, including that a query cannot lead or be presumptive (i.e., cannot direct a provider to a specific diagnosis) and that a query cannot discuss the financial impact of a change to the patient's record. In general, queries are supposed to be limited to clarifying the medical record, for example to resolve conflicting information in the medical record. But Kaiser routinely violated the standards that apply to queries, and used queries not to clarify a medical record, but instead to add new diagnoses via addenda that had nothing to do with the record or the original patient visit, so that Kaiser could then seek higher payments from CMS.

131. As an illustration of how this process worked, consider hypothetical Permanente Medical Group physician Dr. Smith. Through Kaiser's refresh process, Kaiser identifies diagnoses for each of Dr. Smith's MA patients prior to the visits. If Dr. Smith were to not re-diagnose all of these diagnoses at the visits for all of her patients, Kaiser would send Dr. Smith queries following those patient visits prompting her to add the remaining "missed opportunity" diagnoses after-the-fact through addenda. Then, Kaiser would mine the medical records for Dr. Smith's patients MA patients using electronic algorithms or human reviewers to identify potential new diagnoses for conditions that had never previously been identified for Dr. Smith's MA patients. After these potential new diagnoses were

identified, Kaiser would begin sending Dr. Smith queries prompting her to also create addenda to add these new diagnoses for all of her patients. In this way, Dr. Smith would receive a continual stream of queries throughout the year prompting her to add her "missed-opportunity" and data-mining or chart-review diagnoses, the overwhelming majority of which did not matter to her visits with her patients.

132. As detailed below, each region employed similar although slightly different techniques.

1. Data mining generates new risk-adjustment diagnoses.

133. Kaiser's "data mining" programs focused on identifying brand-new diagnoses, that is, diagnoses relating to conditions that no physician had ever diagnosed the patient as having. The programs identified these diagnoses using various algorithms that mined the patient's electronic medical records for key words, lab results, medications, clinical indicators, and other items that Kaiser believed might be suggestive of potential diagnoses that would increase risk-adjustment payments.

134. As Kaiser made clear in internal training materials, "[d]ata mining is used to improve reimbursement," i.e., to increase payments from CMS.

135. In keeping with that aim, Kaiser focused only on diagnoses that would impact HCCs and increase risk scores. For example, when two Northern California auditors, Steven Simos and Ellen Lingar, discussed data mining for another medical condition that was associated with development of a cancer with a high mortality rate but that would not have resulted in increased payments to Kaiser, the response from Danielle Sheetenhelm (Clinical Review Manager), was that "our strategy is to only explore data mining suggestions for conditions that are in the CMS MA model or ACA model."[10]

136. Similarly, Kaiser focused only on those patients for whom Kaiser could receive a risk-adjustment payment. For example, Kaiser provided medical care to some traditional (fee-for-service) Medicare beneficiaries. Kaiser did not apply its data-mining algorithms to these traditional Medicare patients and instead applied them only to Medicare Advantage patients for whom Kaiser could receive additional payments from CMS.

137. Kaiser organized a large Risk Adjustment Data Mining Workgroup to collect, analyze, and disseminate information throughout Kaiser on data-mining initiatives, including effective algorithms

[10] When the Affordable Care Act ("ACA") was implemented in 2014, it provided for additional risk-adjustment payments from the Government for ACA patients.

and return on investment. This working group was comprised of representatives from the Kaiser Health Plans, including each regional health plan, as well as representatives from each regional Permanente Medical Group. Every region was represented, both from the Kaiser Health Plans and the Permanente Medical Groups. The working group was sponsored by an executive from Kaiser's National Medicare Finance department (Diane Morissette) and the Associate Executive Medical Director from the Permanente Federation (Dr. Simon Cohn). The chairs included Ken Nelson (the Health Plan's Director of Risk Adjustment Analytics) and Relator Dr. James Taylor (Director of Coding for the Colorado Medical Group). The working group grew over time to nearly 40 members across Kaiser's regions and entities.

138. Kaiser's National Medicare Finance department also organized a smaller predecessor group called the HCC Data Mining Workgroup. That workgroup had similar information sharing goals, with representatives from each of the regions.

139. The Risk Adjustment Data Mining Workgroup met approximately monthly and ensured that information regarding data mining was widely dispersed across Kaiser. Each region presented at the meetings regarding its data-mining activities and results. Topics included data-mining initiatives, tracking initiatives, algorithm-improvement ideas, and addenda to medical records. The workgroup's activities were further presented to a broader audience within Kaiser, including presentations to the Medicare Regional Reporting Group.

140. Kaiser's data-mining programs covered an extensive range of potential diagnoses. The Health Plan ran algorithms nationally for all MA patients and distributed the results to each region. In addition, individual regions developed their own algorithms and initiatives, which they regularly shared at workgroup meetings. For example, in 2014, the N. California Medical Group developed data-mining algorithms covering over 30 risk-adjusting diagnoses, which it shared with the workgroup so that these algorithms and initiatives could be duplicated in other regions.

141. Many of these diagnosis-specific algorithms coincided with regional initiatives. For example, the N. California Medical Group created an initiative in 2012 to focus on four "key conditions": protein calorie malnutrition, diabetes with neurological manifestations, aortic atherosclerosis, and chronic kidney disease. Each of these diagnoses matched up with a data-mining

algorithm run in the region. Kaiser expected each facility in the region to hit a specified prevalence rate for each condition. And Kaiser instructed the facilities that forty percent of their monetary performance allocation would depend on how well they captured these four conditions (the remaining sixty percent was based on how well they "refreshed" diagnoses, discussed in the next section). Each facility was required to develop work plans for how it would meet the diagnosis capture rate. For example, one facility stated that it would make data mining a parameter for physicians when receiving their mid-year and year-end "CMS Performance incentive."

142. Other data-mining algorithms focused on particular patients. For example, at the urging of Kaiser's National Medicare Finance department, Kaiser encouraged the regions to run algorithms to address and review any MA patients who did not have any diagnoses resulting in a risk-adjustment payment.

143. Another version of data mining, called Natural Language Processing, was developed by the Southern California region and led by Dr. Paul Minardi (the S. California Medical Group's Medical Director of Operations). Natural Language Processing involved sophisticated algorithms that purported to better read the natural language of medical records to identify potential undiagnosed diagnoses. Kaiser ultimately expanded the use of Natural Language Processing algorithms to every region across the country.

144. Generally, once the algorithm results were released, it was up to each region to determine how to turn those results into risk-adjustment payments. For the most part, this task fell to the Permanente Medical Groups, but in some cases the Health Plan communicated directly with Permanente Medical Group physicians about potential diagnoses identified via algorithm.

145. In the Colorado region, the Colorado Health Plan and the Colorado Medical Group jointly developed data-mining algorithms to support various risk-adjustment initiatives. Auditors from the Colorado Health Plan would then use the results to send a template Medicare Query directly to the physicians with the suspected diagnosis to addend the medical record.

146. Initiatives were sometimes sparked by the prospect of reduced revenue from Medicare based on existing diagnoses. For example, when CMS made changes to the CMS-HCC model related to the diagnosis of hypoxia (a below-normal level of oxygen), the Colorado Health Plan identified patients

on oxygen in an effort to generate other diagnoses that would result in risk-adjustment payment. Health plan auditors queried the patients' physicians to create addenda adding suspected diagnoses of acute and/or chronic respiratory failure and obesity hypoventilation syndrome to patient medical records. The auditors sent these queries even if the patients already had diagnoses, such as hypoxia, that would serve as a basis for the oxygen. The query—which was drafted in conjunction with Dr. Teresa Welsh (the Colorado Medical Group Director of Coding)—instructed physicians that hypoxia (and several other common diagnoses for which patients may receive oxygen) was insufficient for reimbursement and identified acute respiratory failure as an appropriate alternative diagnosis.

147. Colorado used this initiative even though Dr. Teresa Welsh acknowledged to the Kaiser Risk Adjustment Data Mining Workgroup that it was not clear that patients with hypoxia could be categorized as having acute respiratory failure.

148. In general, queries to the physicians were generated in two circumstances: (1) when data-mined diagnoses were identified through algorithms run after a patient visit had already occurred; or (2) if the data-mined diagnosis was previously released to the physician but not diagnosed at a visit. The queries themselves often violated numerous query standards, as further detailed below.

149. In some regions, in particular Northern California, a physician could not simply reject a data-mined diagnosis and end the issue. Instead, the physician was required to draft a justification for the decision—referred to internally as a "stop prompt" (i.e., a request for the organization to stop prompting the diagnosis)—which was required to be reviewed and approved by other employees in the organization. These stop prompts are discussed in greater detail later in the complaint.

150. The Kaiser regions developed various tracking mechanisms so that they could monitor the success of their data-mining initiatives. These tracking mechanisms were regularly discussed and shared across Kaiser regions and entities, including through the Risk Adjustment Data Mining Workgroups. Some of these tracking mechanisms specifically tracked how many addenda were generated and how much risk-adjustment compensation would be received. Similarly, details about data-mining programs were reported in the risk-adjustment improvement plans that were provided to the Kaiser Health Plans. In other cases, for example in Northern California, special computer programs were utilized that routinely notified physicians of their metrics relating to addressing data-mined

diagnoses, and physicians were instructed that they were expected to meet certain targets. The N. California Medical Group monitored these metrics for physicians and facilities.

2. "Refresh" and "missed-opportunities" are more data-mining programs that generate risk-adjustment diagnoses.

151. Another category of Kaiser's data-mining efforts focused on capturing diagnoses that had been made in a prior year. Kaiser referred to this program as "refresh" and to conditions that needed to be captured as "unrefreshed diagnoses." Kaiser created algorithms that mined patients' electronic medical records for any diagnoses that had been made in any setting during the past several (typically three) years. As detailed below, Kaiser meticulously monitored and tracked these diagnoses, and if a physician failed to re-diagnose these conditions at a patient visit, Kaiser would systematically pressure the physician to add the diagnoses via addenda, as it did with its other data-mining efforts.

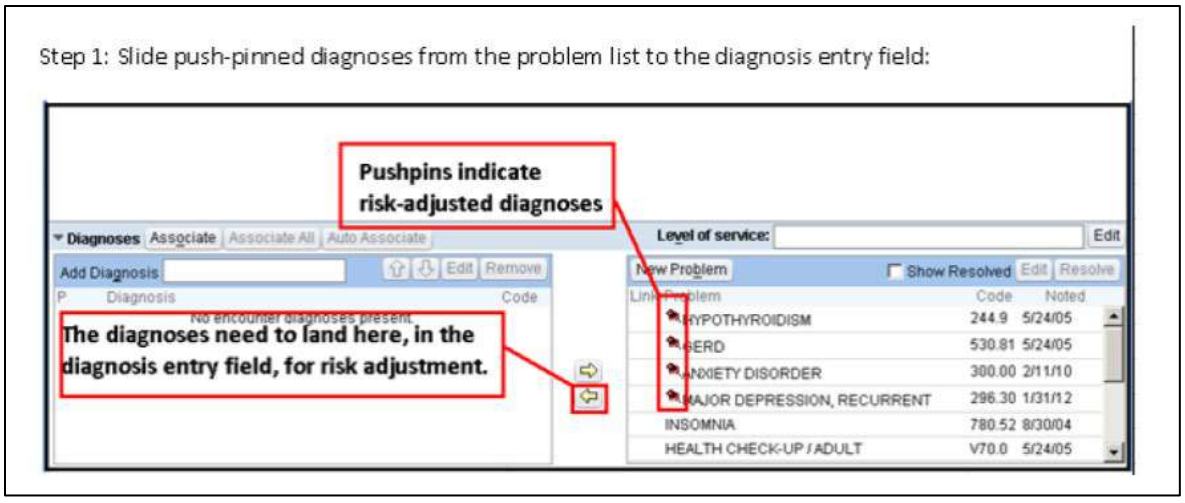
152. As with the data-mining programs, the refresh program was focused on obtaining risk-adjustment payments. The program only identified "unrefreshed diagnoses" for which Kaiser could obtain a risk-adjustment payment. Kaiser excluded any diagnosis that did not correspond to an HCC and would not result in an increased payment. Similarly, only patients for whom Kaiser could obtain a risk-adjustment payment were included. In fact, as risk-adjustment payments became available through other programs, such as the Affordable Care Act, Kaiser honed its algorithms to ensure that physicians had to refresh only the specific risk-adjusted diagnoses covered by the patient's specific program (e.g., ACA).

153. Refresh was a nationwide Kaiser program, with small adaptations in each region. At a Medicare Regional Reporting Group meeting in October 2006, Dr. Simon Cohn (Associate Executive Director of the Permanente Federation), Sue Gertz (Vice President, Medicare at the Health Plan), and Diane Morissette (National Director for Medicare Risk Adjustment, National Medicare Finance for the Health Plan) jointly presented on improving diagnosis capture for Medicare risk-adjusted payments. A key aspect of the presentation concerned unrefreshed diagnoses, which the presentation noted Kaiser tracked and was estimated to be a $400 million opportunity for Kaiser in 2006 alone. Kaiser instructed each region to reduce unrefreshed diagnoses by two-thirds in 2006 and by two-thirds again in 2007.

154. Kaiser's National Medicare Finance department identified and monitored unrefreshed

diagnoses on a regular basis and shared results with each region, some of which also ran their own algorithms to identify and monitor unrefreshed diagnoses. Each region was required to discuss their refresh program annually with Kaiser's National Medicare Finance department as part of their risk-adjustment improvement plans. Refresh was also regularly discussed amongst the regions and Kaiser entities as part of the Medicare Regional Reporting Group and the Risk Adjustment Data Mining Workgroup.

155. Much of the refresh program related to capturing diagnoses during the patient visit. Kaiser expended enormous efforts throughout its regions to ensure that a physician could easily find any refreshable diagnosis at the visit. For example, physicians would generally be given a list of refreshable diagnoses prior to each patient visit either in paper or electronic format. Further, Kaiser utilized "pushpins" in its electronic health record to flag these diagnoses. If a physician reviewed a patient's problem list during a visit, the risk-adjusted diagnoses were specifically flagged with a "pushpin." All a physician had to do was press one button to "slide" any risk-adjusted diagnoses to the medical record for the visit. In fact, this process was so easy that some within Kaiser expressed concern that physicians were adding old diagnoses that were incorrect or no longer existed. As one internal Kaiser presentation explained, "pushpins indicate risk-adjusted diagnoses" and those "diagnoses need to land here, in the diagnosis entry field, for risk adjustment":



156. To make things even easier for physicians, Kaiser also developed a tool within the electronic health record called a chronic-disease widget or chronic-disease grid. This tool automatically

populated a patient's medical record for the visit with these conditions, and physicians merely needed to add a status update for the conditions.

157. In short, Kaiser physicians were presented with numerous lists and tools that made it easy for them to identify and add refreshable diagnoses to a visit record at the time of the visit. These tools also made it all the more inappropriate for Kaiser to query physicians after a visit to add "missed opportunity" diagnoses for which there was no indication in the medical record that the diagnoses had any impact on patient, care, treatment, or management at the visit.

158. In many circumstances, Kaiser physicians did not actually consider or address all of a patient's prior diagnoses at a visit. For example, if a patient presented with an acute medical condition, the physician might spend the visit addressing that specific acute condition. Yet, Kaiser engaged in systematic efforts to have physicians add unrefreshed diagnoses via addenda that had nothing to do with the visit so that Kaiser could obtain additional risk-adjustment payments.

159. When a physician did not "refresh" (i.e., re-diagnose) at the patient visit all of the diagnoses identified by Kaiser through the refresh program, Kaiser would begin efforts to have the physician retrospectively add these diagnoses to the medical records for the visit via addenda. These "missed" refresh diagnoses had different names in different regions. For example, they were labeled "missed opportunities" in the Northern California region or "not fully refreshed" in the Colorado region. For purposes of this complaint, these diagnoses will be referred to as "missed-opportunity" diagnoses, and the allegations here concern Kaiser's systematic and improper addition of these missed-opportunity diagnoses via addenda when Kaiser knew that these diagnoses were not allowed to be coded under the ICD Guidelines.

160. Similar to data mining, once Kaiser identified a missed-opportunity diagnosis, it began sending the physician queries to add the diagnosis to a visit record. In most instances, the queries were generated by the Permanente Medical Groups. As further detailed below, these queries routinely violated national standards. Often, these queries came in the form of lists (often stretching multiple pages) labeled missed-opportunity reports or sheets, unaddressed diagnosis reports, refresh lists, and not-fully-refreshed reports. These lists compiled the unrefreshed diagnoses for a physician's patients. Many of these lists came with specific instructions as to how the physician could create an addendum to

the record of the visit, including with suggested language to be included in the addendum. As explained in more detail below, these instructions routinely ignored the ICD Guideline requirement that the diagnoses needed to have mattered to the visit, and instead provided contrary instructions to physicians.

161. If a physician did not address a condition on the list—e.g., by creating an addendum to add the diagnosis to a visit—the physician would continue to receive additional queries for the diagnosis. Depending on the facility, the physician might receive the list on a weekly to monthly basis. In some cases, these lists also included potential new diagnoses identified from data-mining initiatives. If a physician did not respond to the queries, the physician would often receive follow-ups from Permanente Medical Group employees, either in person or by email.

162. In some instances, physicians had to obtain permission in order to delete a diagnosis on a refresh list, similar to the process for data mining. For example, the Northern California region created a process whereby a physician who believed that a diagnosis identified through the refresh program was invalid had to submit a stop-prompt request in order to not assign the diagnosis. Other Kaiser employees would then review the request to determine if the stop was appropriate before it could be removed.

163. Kaiser closely tracked these missed-opportunity diagnoses and expected physicians and facilities to meet targets for refreshing diagnoses. For example, as part of its mandatory risk-adjustment improvement plan (shared with Kaiser's National Medicare Finance department), the N. California Medical Group set a goal that its physicians would "refresh" 99% of diagnoses identified by Kaiser. In fact, by 2012, the Northern California region had achieved a 99.2% "refresh" rate of all diagnoses identified through the program. The region relied so heavily on the refresh program that Karen Graham (Managing Director for EIO) described it to colleagues as the region's "bread & butter." Other regions had similar results.

164. These increasingly high targets caused physicians to improperly addend diagnoses to meet Kaiser's metric expectations. Kaiser provided recognition and awards, such as bottles of champagne, to high achievers. That included physicians who were able to "refresh" 100% of diagnoses for all patients, an achievement that would seem virtually impossible if the ICD Guidelines were being properly followed.

165. All of Kaiser's efforts, including those described in more detail below, created pressure on physicians to refresh missed-opportunity diagnoses contrary to ICD Guidelines. These efforts accelerated toward the end of each year when physicians were expected to meet their year-end targets, and when the Kaiser regions were focused on meeting their increasingly high risk-score targets for the year. Missed-opportunity diagnoses were routinely added to visits that happened much earlier in the year without regard to whether the diagnoses had any relevance to the visit or were properly coded under the ICD Guidelines. This end-of-year rush in activity was referred to by some Kaiser employees as the "dash for cash."

3. Chart review is another program to generate risk-adjustment diagnoses.

166. The Colorado region created another program, the "chart review" program, to generate more Medicare revenue. As one Colorado training slide explained, "Medicare Queries: Why Now?," and provided the answer, because "Diagnoses = Revenue."

167. Similar to data mining, the chart-review program focused on identifying brand-new diagnoses after a patient visit occurred to increase Medicare risk-adjustment payments to Kaiser. After a visit, physicians received a "Medicare Query" to add new diagnoses to the medical record for the visit, even though the diagnoses played no role in the visit. Indeed, "the goal [of the program] is to identify diagnoses that have never yet been made by a physician . . . ." Such a goal was inconsistent with the ICD Guidelines, which permit coding of only those diagnoses that require or affect patient care, treatment, or management for a visit. Instead, Kaiser submitted thousands of improper diagnoses added via addenda for tens of millions of dollars in risk-adjustment payments.

168. The Colorado Medicare Group and the Colorado Health Plan jointly ran and funded this chart review program. Key players included: Dr. Teresa Welsh (the Colorado Medical Group Director of Coding); Jeremy Walsleben (the Colorado Health Plan's Senior Manager of Risk Adjustment); and Maegen Leake (the Colorado Health Plan's Senior Risk Adjustment Operations Consultant). In addition, auditors from the Colorado Health Plan sent Medicare Queries to physicians for various HCC conditions.

169. With funding from the Colorado Health Plan, the Colorado Medical Group paid chart-review physicians to review the medical records of Colorado Health Plan beneficiaries for conditions on

"the **Review Grid** to find additional diagnoses that you will query for." (Emphasis in original.) In 2014, the "review grid" covered more than 50 risk-adjusting diagnoses.

170. The reviewers were instructed to identify only potential new diagnoses. The reviewers were further instructed that if they identified a new diagnosis that was in the same category (i.e., that corresponded to the same HCC) as another diagnosis that was already made, the reviewers should not send a query to the physician. Under the CMS-HCC model, an MA Organization can only receive a risk-adjustment payment once per HCC, so if a patient has two conditions that correspond to the same HCC, the HCC risk factor is counted only once. Accordingly, because this potential new diagnosis would not yield additional revenue to Kaiser, the chart reviewers were told not to send a query.

171. All of the conditions on the Review Grid were lined up with Medicare HCCs, even listing the HCC number. When CMS changed the CMS-HCC model, the Colorado chart-review program updated its Review Grid to remove conditions that no longer corresponded to HCCs and to add new conditions that corresponded to new HCCs.

172. As Dr. Teresa Welsh (who led the program) explained, it was necessary to pay chart-review physicians to conduct the chart review because most physicians found it too time consuming or technologically demanding.

173. The chart reviews were conducted after patient visits. Even though the chart reviewers were identifying conditions that had never been previously diagnosed, and the physicians were unaware of them during their patient visits, chart reviewers were instructed to send "Medicare Queries" to physicians every time they identified a potential new diagnosis.

174. A typical example would involve a patient whose visit was entirely unrelated to the queried condition. Following the visit, the physician would be queried to add a suspected diagnosis, such atherosclerosis of the aorta (hardening of the walls of the aorta), based on a historical radiology report from years prior. The medical record would contain no indication that the physician was aware of this historical report at the patient visit, let alone that the physician considered or addressed the condition at the patient visit. Often, the addendum would just include the diagnosis or would copy portions of the query into the medical record. The medical record would likewise contain no indication that the physician even contacted the patient about the brand-new diagnosis.

175. The chart review program violated the ICD Guidelines because it involved the systematic creation of addenda for conditions that were entirely unrelated to the visit. Because the explicit purpose of the program was to identify "new" diagnoses that had never been made by a physician, a physician queried to add a chart-review diagnosis could not have been previously aware of the condition, and certainly could not have considered, evaluated, or treated the condition at the visit. The ICD Guidelines therefore prohibited the coding of such conditions, yet Kaiser submitted thousands of such diagnoses for tens of millions of dollars in risk-adjustment payments.

176. Money was the clear driver of the program. Kaiser did not conduct these chart reviews for patients for whom they could not receive risk-adjustment payments, nor for conditions for which they could not receive such payment. Moreover, physicians were told not to spend any significant time addressing the suspected new diagnoses. Dr. Teresa Welsh wrote to clinician supervisors that physicians should not "spend more than 1 minute a query" because responding to queries was "like doing a refill request" and that she could do "two a minute." When discussing the Medicare Queries, Kaiser physicians repeatedly discussed that each added diagnosis was worth approximately $3,000 to Kaiser.

177. Physicians at the Colorado Medical Group were required to respond to queries. The Colorado Medical Group and the Colorado Health Plan tracked which physicians had open queries. When physicians had significant open queries, their clinical chiefs would be asked to address the problem with the physicians. If a physician was deleting too many queries (i.e., not adding the suspected diagnoses to the medical record), Dr. Teresa Welsh might address the issue with the physician. If that did not work, sometimes Dr. Welsh would have a meeting with them. Dr. Welsh even suggested that physicians with open queries could be placed on a performance improvement plan.

178. To further pressure physicians to respond to queries, the Colorado Medical Group and the Colorado Health Plan created a physician incentive program, to pay physicians to respond to queries. Jeremy Walsleben managed the program and determined which Colorado Medical Group physicians would be eligible for the incentive and the amount of the payment. As one of the Colorado Medical Group's chief clinicians, Dr. Jennifer Ziouras, stated in support of the incentive payment: "we are just trying to get paid for the work that we are doing, esp[ecially] when we have to go back and addend

things [because] they were not on our radar (atherosclerosis of the aorta, obesity equivalent, etc)."

179. The Colorado Medical Group and the Colorado Health Plan meticulously tracked the results of the chart-review and query program. The reviewer instructions stated that Kaiser would track both queries and addenda to identify which diagnoses were captured. In fact, Kaiser tracked all chart reviewers, all physicians, and all Kaiser facilities to determine the results of the chart reviews.

180. Through a regularly updated dashboard, the Colorado Medical Group and the Colorado Health Plan tracked every physician and facility for how many diagnoses they added via addenda and how much revenue they generated through those addenda. The Colorado Health Plan generated spreadsheets that were shared with the Colorado Medical Group tracking any open Medicare queries and which queries led to addenda.

181. The Colorado Medical Group and the Colorado Health Plan likewise tracked the overall number of queries, addenda, revenue generated, and return on investment for the program. For example, the Colorado Health Plan calculated as part of an internal financial analysis that, in 2014, the chart-review program generated 10,900 queries, leading to 9,432 addenda and $17.4 million in risk-adjustment revenue. Similarly, in 2013, the Colorado Health Plan calculated that the chart-review program resulted in 11,388 HCCs added through addenda, generating $24.9 million in risk-adjustment revenue. Calculations for other query programs involving data mining showed that they generated thousands of queries and addenda, resulting in millions of dollars in risk-adjustment revenue. These reports were widely circulated, including to Kaiser's National Medicare Finance department.

182. The Colorado Medical Group and the Colorado Health Plan even tracked all chart reviewers to identify which reviewers were generating sufficient revenue. Reviewers were placed in quadrants based on speed and effectiveness at getting diagnoses added to medical records.

183. The Colorado Health Plan provided weekly reports to Dr. Teresa Welsh to monitor the progress of the program. At times, if she thought the number of queries generated was too small, Dr. Welsh suggested placing more resources into querying physicians to ensure that the Colorado Health Plan and the Colorado Medical Group would hit the risk score targets set by the National Medicare Finance department.

C. Kaiser pressured physicians to add diagnoses via addenda.

184. After refresh, data-mining, or chart-review processes identified potential diagnoses, the next step in Kaiser's scheme was to pressure physicians to generate addenda to add these diagnoses retrospectively to the records of their past visits with their patients. As described below, Kaiser applied this pressure even when the diagnosis in question did not require or affect patient care, treatment, or management at the patient visit being amended.

1. Inappropriate queries pressured physicians to create addenda.

185. One mechanism through which Kaiser applied pressure to physicians was through inappropriate queries to physicians.

186. Kaiser's queries came in various forms. Sometimes, an auditor or other Kaiser employee would send a direct "staff message" (essentially an email within Kaiser's electronic health record) to a physician, requesting that the physician review and add a specific diagnosis from one of Kaiser's risk-adjustment initiatives to a patient visit. Other times, the queries came in the form of lists of multiple diagnoses for various patients. These lists often compiled unaddressed diagnoses from various risk-adjustment initiatives, routinely listing CMS as the payor so that it was clear to the physician why they were being asked to consider the addendum. Depending on the facility, physicians would generally receive such lists on a weekly to monthly basis. If the physician did not address the diagnoses on the list, the list would keep growing.

187. As these programs became more sophisticated, some Kaiser regions developed electronic tools so that physicians could access these lists via computer. For example, the N. California Medical Group instructed physicians to use a particular electronic report that was available on their desktop "as your default page [to] look for addendum and capture opportunities after the visit (**Missed Dxs** [diagnoses])." (Emphasis in original.)

188. Still other times, the queries came orally. For example, data-quality trainers or other similar Kaiser employees would meet with physicians in person to work on their lists of diagnoses.

189. Several regions, including both California regions, would have group coding sessions where data-quality trainers, and other similar Kaiser employees, would meet with physicians while the physicians coded their refresh lists. At these sessions, physicians would be expected to sit together,

perhaps at lunch or after work with food and beverages provided by Kaiser, and work through their lists of specified diagnoses to add to patient visits. These sessions were sometimes called "coding parties" or "refresh parties."

190. Kaiser's various query practices violated national standards relating to queries.

191. The American Health Information Management Association ("AHIMA") is an organization that sets national coding standards and provides standards for proper query language. Kaiser has incorporated the AHIMA standards into its own policy documents and training materials.

192. As far back as 2006, Kaiser issued a Program Advisory (the "Addenda Program Advisory") to all its regions that was "intended to clarify under what circumstances addenda to the medical record will be considered acceptable as support for risk adjustment data submitted to [CMS]." The designated points of contact for the Addenda Program Advisory were: Dr. Simon Cohn (Associate Executive Director for the Permanente Federation); Gina Reese (Senior Counsel for Kaiser Foundation Hospitals and Health Plans); and Janet Franklin (at the time, a Practice Leader, Coding Compliance, with the National Compliance Office).

193. There are some specific rules for queries set forth in the AHIMA standards and Kaiser's Program Advisory. *First*, the standards set by AHIMA and adopted by Kaiser make clear that queries cannot be leading; in other words, they cannot suggest a particular diagnosis. In general, queries should be written as open-ended or multiple-choice questions, so that they do not sound presumptive, directing, or prodding to the physician.

194. AHIMA's 2008 practice brief, "Managing an Effective Query Process," provides that "Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption." AHIMA's 2013 practice brief, "Guidelines for Achieving a Compliant Query Practice," which replaced the 2008 practice brief, provides that "[a] leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure."

195. Kaiser's Addenda Program Advisory specifically cited the 2001 AHIMA practice brief (which was superseded by the 2008 version) for the requirement that queries be "open-ended" and avoid

"leading" physicians to a particular diagnosis. As the Addenda Program Advisory explained, "physician queries must be carefully drafted such that undue pressure is not placed on the physician to code the diagnoses in the manner indicated on the query and/or otherwise interfere with physician decision-making." It further stated that "[q]ueries that appear to lead the physician to provide a particular response could lead to allegations of inappropriate upcoding." It also stated that queries such as "'Please enter the following diagnoses in the record' (followed by a list of diagnoses and codes[])" were not appropriate. Similarly, relying on the 2008 AHIMA practice brief, a 2011 Northern California training instructed that "[t]he query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption."

196. *Second*, queries cannot mention money; they are not allowed to include any discussion of the financial impact of altering a patient's medical record.

197. AHIMA's 2008 practice brief states that "the query should never indicate that a particular response would favorably or unfavorably affect reimbursement or quality reporting." And AHIMA's 2013 practice brief states simply that a query "should not indicate the impact on reimbursement." Kaiser's Addenda Program Advisory similarly stated that queries "should not indicate the financial impact of the response . . . ." And a 2014 training given by Nancy Andersen (then a Senior Compliance Manager with Kaiser's National Compliance Office) provided the same guidance.

198. *Third*, because a query is intended merely to clarify the medical record, queries cannot introduce new information not previously documented in the medical record.

199. AHIMA's 2008 practice brief states that "[t]he introduction of new information not previously documented in the medical record is inappropriate in a provider query." The 2008 practice brief then gives an example of an inappropriate query where a physician is given information about a diagnosis and clinical information from an emergency room record from the prior week. The practice brief states that this is inappropriate to query the physician because the diagnosis and information (from the emergency room) was not documented by the physician in the medical record of the current visit. In compliance trainings, Kaiser similarly repeatedly instructed that a query "should not introduce new information not otherwise contained in the medical record." These trainings emphasized that a query is permissible only "to the extent it provides clarification" of the medical record.

200. In practice, however, the queries Kaiser sent to physicians frequently ran afoul of the standards set by AHIMA and Kaiser's Addenda Program Advisory.

201. For example, a 2012 query sent by Priscilla Schor (an auditor in Southern California) was leading. It told the physician, Dr. Grace Jean Fu, regarding her patient: "You saw this patient on 7/3/12. Based on a chest x-ray dated 7/3/12 this patient has Atherosclerosis of Aorta. Please create an addendum to ADD the diagnosis to your 'diagnosis order entry' box." Dr. Fu created an addendum to her patient's medical record to add the diagnosis of aortic atherosclerosis after receiving the query.

202. A query sent by Data Quality Trainer Shannon Henson in Northern California in 2013 was also leading. It informed the physician, Dr. Sri Madhavi Cholleti, regarding her patient, that "[a]fter review it was found that the diagnosis, AORTIC ATHEROSCLEROSIS, is supported by Imaging Report dated 10/15/12. Please addend your visit note dated 01/04/13 to include this diagnosis. If you do not agree, please provide me with your reason so I may forward to Dr Awsare for review." Dr. Cholleti created an addendum to her patient's medical record add the diagnosis of aortic atherosclerosis after receiving the query.

203. A query sent in 2014 in Northern California by Dr. Amy Hung was similarly direct about the desired outcome. It told the physician, Dr. Luu Phuc Nguyen, regarding his patient, simply: "Could you please addendum 'thrombocytopenia' to your visit …?" Dr. Nguyen created an addendum to his patient's medical record add the diagnosis of thrombocytopenia after receiving the query.

204. A 2012 query in Southern California from Compliance Auditor Rey D. Creencia inappropriately mentioned money. It asked that the physician, Dr. Gallit Slonimsky Luftman, add a new diagnosis, aortic atherosclerosis, to her patient's last visit, explaining that "[t]he Medicare Unrefreshed Risk project requires that we report a diagnosis at least once a year to be reimbursed for treatment for the patient for the entire year." Dr. Luftman created an addendum to her patient's medical record add the diagnosis of aortic atherosclerosis after receiving the query.

205. Queries often were both leading and mentioned money. For example, a 2013 query in Northern California from Data Quality Trainer Shahida Dossa to a physician, Dr. George T. Chuang, regarding his patient, stated "[f]or reimbursement of risk adjusted diagnoses all chronic dxs [diagnoses] must be captured at face to face visit. … Please amend DOS: 9/10/13 with Major Depression in full

remission."

206. Often these queries, including many of the examples above, introduced new information and diagnoses not documented in the medical record and instead mined from elsewhere.

207. If physicians did not immediately respond to queries, they often received the query multiple times or from multiple people. For example, N. California Medical Group physician Dr. Irene Soojung O'Farrell, saw a patient in September 2012. During that visit, she chose a specific diagnosis for that patient of "failure to thrive." On November 11, 2012 (about two months after the visit), Dr. O'Farrell received a query from Data Quality Trainer Kerri Guerrero that stated: "Please review your note listed above and consider if it would be appropriate to report a label for cachexia. Thank you . . . ." Cachexia is a complex metabolic syndrome associated with physical wasting, weight loss and muscle atrophy.

208. Just one week later, Dr. O'Farrell had not responded to the query. On November 19, 2012, the Data Quality Trainer forwarded the initial query to Dr. Steven Olson (Regional Physician Director, Clinical Documentation and Coding) with the message "For your review. No response as of 11/19/12." On November 21, 2012, Dr. Olson sent Dr. O'Farrell a *second* query regarding adding cachexia for M.D.: "Hi Irene, Would you feel comfortable addending your note of 9/18/2012 and adding a dx of cachexia? We get significant additional resources to care for our members disease burden from appropriately coding that diagnosis. You had mentioned that she was losing weight-failure to thrive. She has indeed been losing weight so undoubtedly meets the criteria for cachexia. Please contact me if you would like to discuss or need help. I would ask you to addend your last visit note, and add the encounter dx [diagnosis] of cachexia if you feel that is appropriate. Also, adding it to the problem list will make it easier to code in the future. Thanks, Steve O." Two days later, Dr. O'Farrell created an addendum to add the diagnosis of cachexia.

209. Internal communications reveal that the rationale for using this type of language in queries, contrary to AHIMA guidance and Kaiser policy and training, was that if Kaiser did not "'tell' the physicians directly to capture a diagnosis (i.e., not use leading language) then the refresh rates will go down as result. Presumably because the physicians will . . . not feel like it is required to add the diagnosis."

210. As discussed above, in Colorado, Kaiser had previously data-mined and queried physicians to add hypoxia for patients receiving oxygen, specifically flagging the increased reimbursement potential. However, CMS later removed hypoxia as a condition from the CMS-HCC model. In response, the Colorado Health Plan and the Colorado Medical Group queried physicians to addend medical records for different diagnoses (acute and/or chronic respiratory failure and obesity hypoventilation syndrome) that would generate more revenue for Kaiser: "Please note that the following common diagnoses are insufficient for appropriate reimbursement for patients who need oxygen: hypoxia, sleep apnea, obesity, COPD. Please continue to use these if clinically appropriate in addition to adding one or more of the above suspected diagnoses [acute and/or chronic respiratory failure and obesity hypoventilation syndrome]."

211. These Medicare queries led to numerous false claims, with physicians simply adding the diagnoses Kaiser instructed them to add. In at least one instance, after receiving a query like the one described above from Medicare Risk Auditor Denice Hogan, Colorado Medical Group physician Dr. Patrick Martin created an addendum to add the diagnosis of obesity hypoventilation syndrome—a breathing disorder found in some *obese* individuals—to a patient who was clearly *not* obese (she was 5'9" and weighed 108 pounds).

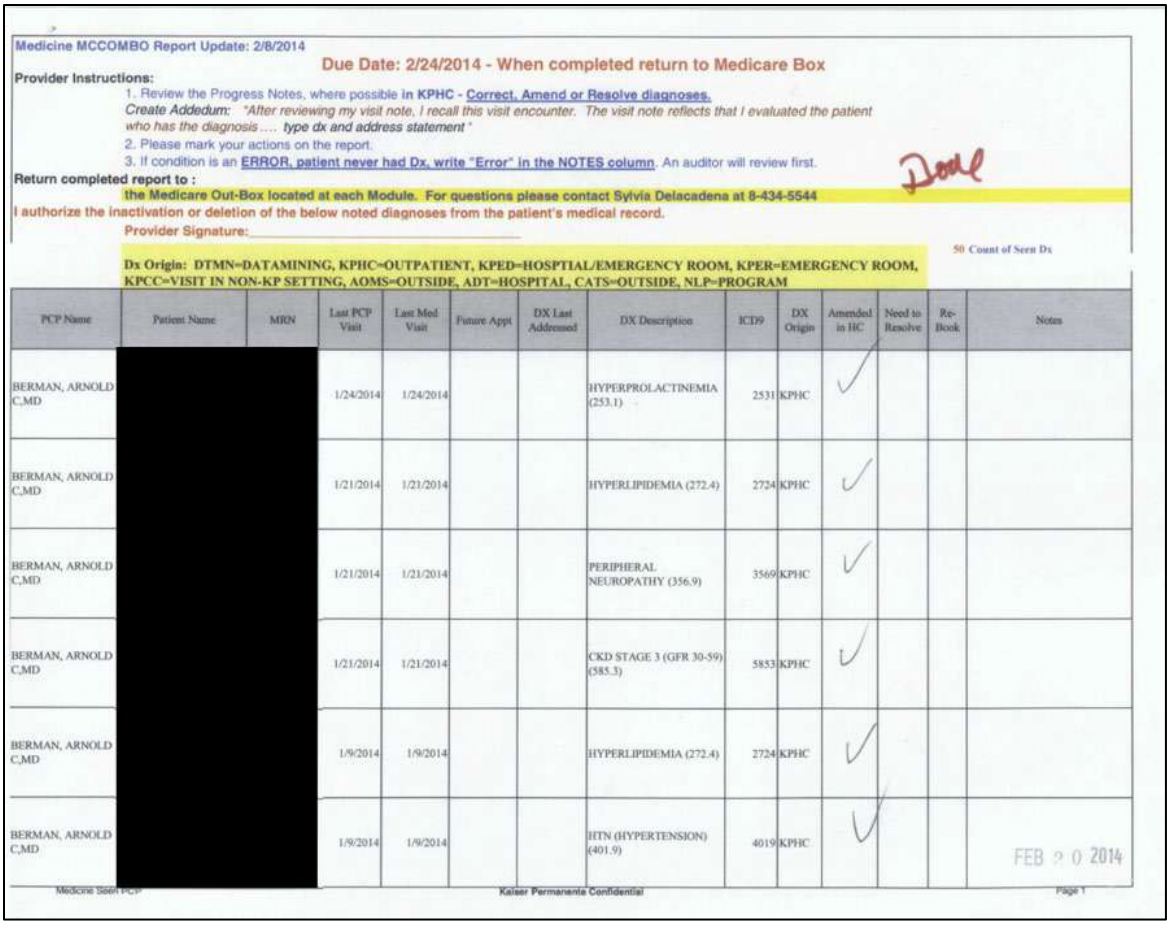
212. In October 2013, Nancy Andersen (then a Senior Compliance Manager with the National Compliance Office) specifically warned Dr. Teresa Welsh (the Colorado Medical Group Director of Coding) that the Medicare Query template that the Colorado region was using might be viewed as leading by CMS. Nancy Andersen even provided a copy of the standards and requirements that must be followed for compliant queries. Her warnings were ignored, and the Colorado Medical Group and the Colorado Health Plan continued to use the improper queries to generate thousands upon thousands of addenda.

213. Kaiser's queries to physicians also often omitted any reminder to the physician that the diagnosis in question must have been considered, evaluated, or treated at the prior patient visit in order to be included in addenda. Instead, the language in Kaiser's queries often indicated that physicians could add a condition to a prior visit record *regardless* of whether the diagnosis was based on or evaluated at that visit, so long as they could confirm *after the fact* at the time they completed the

addenda that "the patient has the listed condition."

214. For example, in queries called "GSAA Data Mining Reports," which contained lists of conditions (identified through data mining) that went to many physicians, the form instructions directed the physician to "determine whether or not the patient has the listed condition," and if so "addend the chart note and add the [diagnosis]."

215. Below is an example of the first page of a two-page 2014 "Medicine MCCOMBO Report" report that went to N. California Medical Group physician Dr. Arnold Berman. The "Provider Instructions" tell Dr. Berman to "Create Addendum" and provided the language he should use: "After reviewing my visit note, I recall this visit encounter. The visit note reflects that I evaluated the patient who has the diagnosis . . . ." The report has a "Due Date" and instructs that when the physician completes it, it should be "return[ed] to Medicare Box." This page of the report asks Dr. Berman to add six different diagnoses for three different patients. Dr. Berman added all six diagnoses:



Medicine MCCOMBO Report Update: 2/8/2014

Due Date: 2/24/2014 - When completed return to Medicare Box

Provider Instructions:

1. Review the Progress Notes, where possible in KPHC - Correct, Amend or Resolve diagnoses.
Create Addedum: "After reviewing my visit note, I recall this visit encounter. The visit note reflects that I evaluated the patient who has the diagnosis .... type dx and address statement"
2. Please mark your actions on the report.
3. If condition is an ERROR, patient never had Dx, write "Error" in the NOTES column. An auditor will review first.

Done

Return completed report to :
the Medicare Out-Box located at each Module. For questions please contact Sylvia Delacadena at 8-434-5544

I authorize the inactivation or deletion of the below noted diagnoses from the patient's medical record.

Provider Signature:_____

50 Count of Sent Dx

Dx Origin: DTMN=DATAMINING, KPHC=OUTPATIENT, KPED=HOSPTIAL/EMERGENCY ROOM, KPER=EMERGENCY ROOM, KPCC=VISIT IN NON-KP SETTING, AOMS=OUTSIDE, ADT=HOSPITAL, CATS=OUTSIDE, NLP=PROGRAM

PCP Name	Patient Name	MRN	Last PCP Visit	Last Med Visit	Future Appt	DX Last Addressed	DX Description	ICD9	DX Origin	Amended in HC	Need to Resolve	Re-Book	Notes
BERMAN, ARNOLD C,MD	[redacted]		1/24/2014	1/24/2014			HYPERPROLACTINEMIA (253.1)	2531	KPHC	✓			
BERMAN, ARNOLD C,MD			1/21/2014	1/21/2014			HYPERLIPIDEMIA (272.4)	2724	KPHC	✓			
BERMAN, ARNOLD C,MD			1/21/2014	1/21/2014			PERIPHERAL NEUROPATHY (356.9)	3569	KPHC	✓			
BERMAN, ARNOLD C,MD			1/21/2014	1/21/2014			CKD STAGE 3 (GFR 30-59) (585.3)	5853	KPHC	✓			
BERMAN, ARNOLD C,MD			1/9/2014	1/9/2014			HYPERLIPIDEMIA (272.4)	2724	KPHC	✓			
BERMAN, ARNOLD C,MD			1/9/2014	1/9/2014			HTN (HYPERTENSION) (401.9)	4019	KPHC	✓			

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Medicine Seen PCP

Kaiser Permanente Confidential

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216. For queries where physicians were being asked to addend older visits—often a year or

more after the visit—Kaiser included misleading language in many queries to assure physicians that the addenda were allowed: "Medicare allows physicians to clarify the medical record by making an addendum without any time limitations. Diagnoses that were present at the time of the visit may be clarified by entering the diagnosis in an addendum." This information was false and misleading, because it omitted the requirement, included in the ICD Guidelines and Kaiser's own policies, that only diagnoses that required or affected patient care treatment or management at the patient visit could be added to the patient's medical record.

2. Kaiser used "SmartPhrases" to make it easy for physicians to create addenda even when the condition did not require or affect patient care, treatment, or management.

217. Another mechanism Kaiser employed to ensure that physicians could easily add diagnoses via addenda was the use of "SmartPhrases." SmartPhrases are a tool within Kaiser's electronic-health-record system that, upon entry of a single phrase, automatically imported pre-formatted language into a patient's medical record.

218. Kaiser created multiple SmartPhrases that physicians were trained to use when creating addenda. The input language varied over time and across regions, but the following examples are representative.

219. Entry of ".DXOMITTED" would generate the following language in the patient record: "After review of my note for this visit encounter, I recall this encounter and am addending this note to state that this patient has diagnosis of . . . ."

220. Entry of ".FOL" would generate the following language in the patient record: "I have confirmed with the patient and/or the medical record the presence of the above diagnoses, and the diagnoses are followed or will be followed by his or her PCP or appropriate specialist."

221. Entry of ".STABLE" would generate the following language in the patient record: "Diagnoses recorded for this visit were addressed and are stable, unless otherwise indicated in this note."

222. The queries physicians received would often instruct the physician to use a specific SmartPhrase when they created the addendum.

223. For example, a 2012 Missed Opportunity Report for a physician, Dr. Stewart Wong,

instructed him for his patient to "Please consider to capture [sic] Aortic Atherosclerosis based on CXR on 08/0[sic]/11: Aortic atherosclerosis," with a "reminder" to "include .fol in your encounter."

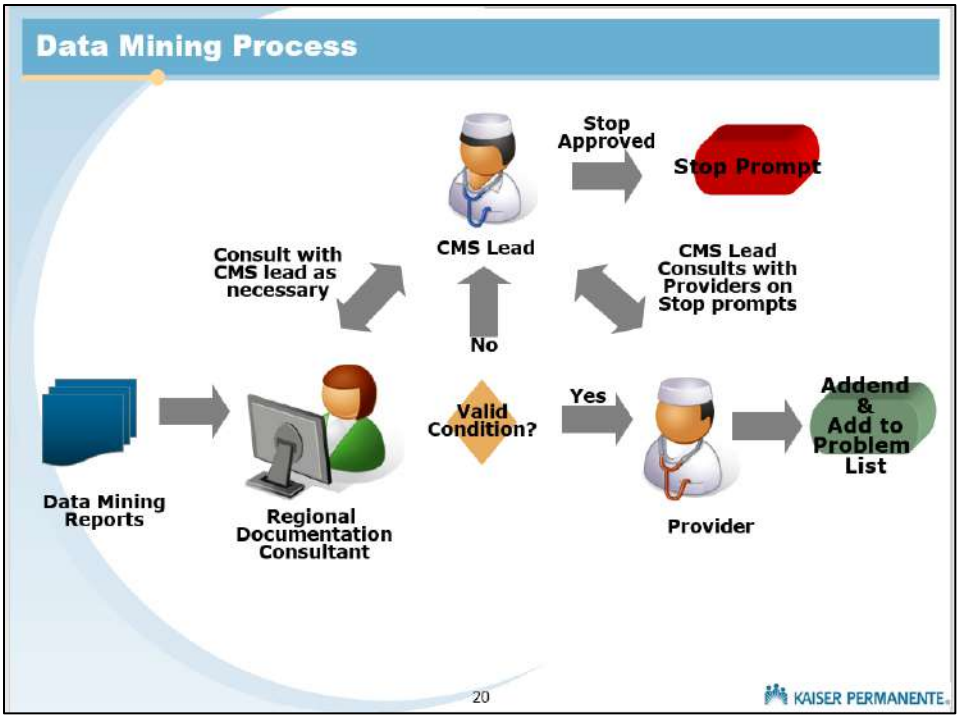
224. A 2015 query to a physician, Dr. Jan Kwong, regarding her patient, stated: "Capture AA on visit dated 6/16/15; LINK: XR which showed evidence of condition ordered on this date; If agree, addend with smartphrase .DXADDITIONAL and address dx. Add to PL as well."

225. Another 2015 query to a physician, Dr. Wendy Yang, regarding her patient, stated: "Capture SEVERE OBESITY WITH BMI OF on visit dated 4/27/15; LINK: BMI listed as 36.21 and DM2 comorobidty [sic]. If agree, addend with smartphrase .DXOMITTED and address DX."

3. Kaiser pressured physicians by requiring them to justify refusals to add diagnoses.

226. In addition to drafting queries and creating SmartPhrases in a manner that maximized positive responses, Kaiser forced physicians who declined to add diagnoses to justify their decision in burdensome ways.

227. As previously noted, in the Northern California region, the N. California Medical Group implemented the "stop prompt" process. The following diagram from an internal Kaiser training depicts how the stop prompt process generally worked:



228. After receiving a query to add a data-mining diagnosis, the easiest route a physician could take was to add the data-mining diagnosis to the patient's record (using an addendum).

229. If the physician disagreed, the physician had to initiate a "stop prompt" and justify their decision in writing, often through multiple review levels, including to a supervising physician known as the "CMS Lead."

230. Internal communications show that this process was onerous. Dr. Pearl Wu, the Documentation and Coding Lead for Redwood City, noted that a refusal by a physician to add a diagnosis went through "stringent" review, starting with collecting all of the stop prompts, having those stop prompts undergo a "second pass" by the "Trainer," "and then final review by me as Physician Lead of all stop prompts to ensure accuracy."

231. Beginning around 2012, stop prompts received *even more* review in Northern California; the Clinical Review Team within N. California Medical Group's EIO office provided a second-level review after the physician-lead review.

232. In other words, through the stop-prompt process, if a physician added a diagnosis, the process ended; if a physician refused to add a diagnosis for a patient, the physician had to justify their decision to other Kaiser employees, none of whom had actually seen the patient.

233. As Karen Graham (Managing Director for EIO) explained when one facility wanted to cease reviewing all prompts: "The concern is that if physicians know the stops are not being reviewed, they are less likely to go to the trouble to capture the dx [diagnosis]." Kaiser wanted to make it easy for physicians to add diagnoses and hard to say no.

4. Kaiser used financial incentives and other metrics to pressure Permanente Medical Group physicians to create addenda.

234. As previously discussed, consistent with the financial focus of the risk-score goals, Kaiser placed both positive and negative financial pressures on physicians (and the facilities where they worked) to add addenda to patient-visit records.

235. One form of pressure involved calling out facilities with low "refresh rates" and emphasizing that the failure to add diagnoses would cost money for Kaiser, the facilities, and the physicians themselves.

236. For example, in November 2010, when a facility in Northern California was in the "bottom third . . . of refresh performance," Mike Geranio (the Medical Office Controller) noted that the facility had not yet "received a call for a meeting nor any pressure," and then requested that Dr. Robert Klein (a N. California Medical Group Associate Executive Director) call their physician lead, Dr. Paul Rose, to say that they had "*$4 million* and 2,000 diagnos[es] at risk. Please send me your action plan every Friday or let[']s meet for 15 minutes until the end of the year." (Emphasis added.)

237. In June 2012, when a Kaiser facility in Northern California was not sufficiently "address[ing]" a specific initiative to create addenda, Joel Weiner (the Director of the Business Intelligence Team for the N. California Medical Group) spoke with their CMS Project Manager, Jeremy Lawrence, and discussed that creating the addenda was "so important, easy to do and *worth about $800K*." (Emphasis added.) Karen Graham responded, "excellent – referencing money seems to speak to some of the [CMS Project Managers]."

238. In January 2014, Dr. Teresa Welsh (the Medical Director of Coding for the Colorado Medical Group) cited "a few physicians who apparently didn't work their refresh lists to completion. . . . *Each of these diagnoses adds about $2500 to our bottom line*." (Emphasis added.) Reflective of how focused Kaiser was on getting this money, she offered to "drive around and sit with people personally if that is what it takes, usually it just takes the chief telling them to do it. In past years, I recall doctors were placed on a work improvement plan if they didn't complete this work. I will let you operations guys decide if that is what it takes."

239. In addition to calling out "underperforming" physicians and facilities, Kaiser explicitly linked physician bonuses and financial incentives to responses to data-mining diagnoses. For example, in one facility, Kaiser offered a "Bonus/Premium when addressing >90% of datamining diagnoses" as well as a "Bonus worth 30% of annual payout at 98% performance" with an "Additional premium of 2.5% for each 0.5% above 98%."

240. As noted above, as part of its mandatory risk-adjustment improvement plan (shared with Kaiser's National Medicare Finance department), the N. California Medical Group set a goal that its physicians would "refresh" 99% of diagnoses identified by Kaiser. Each physician's and facility's progress in reaching this goal was monitored and tracked throughout each year.

241. The Colorado Medical Group paid physicians a stipend in 2013 to respond to all pending queries by the end of the year. The Colorado Medical Group noted that its spending of $350,000 on paying reviewers and stipends to doctors resulted in $24 million to Kaiser over just five months.

242. The Colorado Medical Group considered the program so successful that it sought to pay thousands of dollars more in stipends to doctors in 2014. "We will post a table with the anticipated pay out by doc on the website and the average pay out so they understand the dollars being much more than last year."

243. Along these same lines, managers were required to hold documentation and "coding parties" (where physicians were expected to work on their "missed opportunity" and data-mining lists), which were described as supporting "healthy competition" and providing "performance tracking by provider and department."

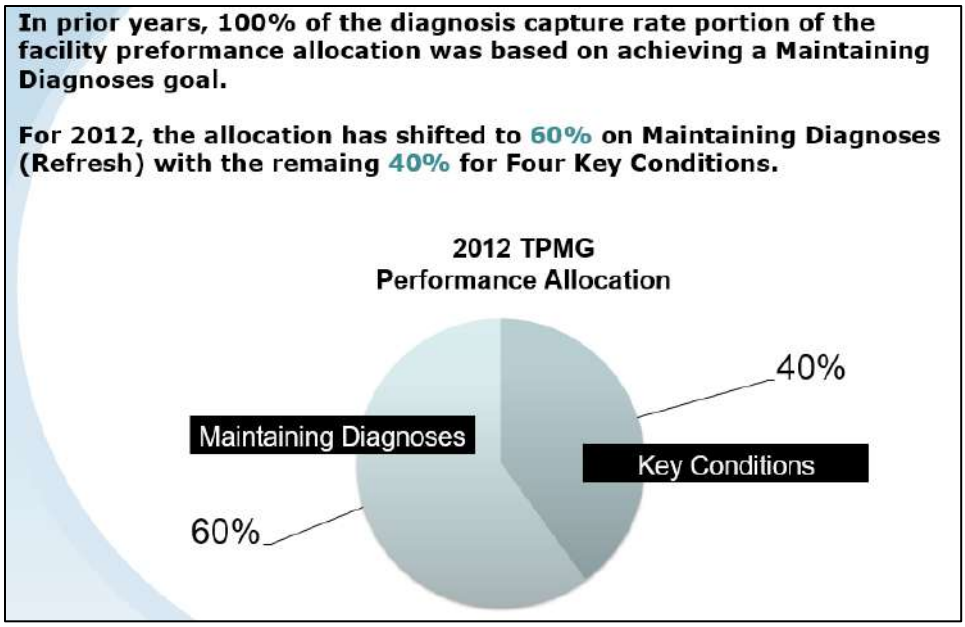
D. How Kaiser targeted the diagnosis aortic atherosclerosis to increase risk-adjustment payments: "$40M is no chump change."

244. Beginning around 2010 or 2011, one diagnosis targeted throughout all of Kaiser's regions was atherosclerosis of the aorta ("AA"), which was emphasized to have a "high rate of reimbursement." Atherosclerosis is the hardening of the artery walls, in this case of the aorta.

245. The N. California Medical Group pursued a multi-pronged strategy to code AA for "revenue capture" purposes. The process involved three basic steps: *First*, radiologists were instructed to document the presence of any calcium in the aorta in a radiology impression, regardless of significance, and describe it as AA. Kaiser tracked how well each radiologist performed and compared their performance. Radiologists were also informed that the purpose was financial. *Second*, the data-mining team would mine patient medical records by searching for the key words the radiologists had been instructed to document in the radiology reports. *Third*, based on that data mining, physicians would then be queried to diagnose AA, often by creating addenda to the medical records of prior patient visits. Physicians (and their facilities) were tracked in their performance for coding AA and received incentives and awards for coding AA.

246. The N. California Medical Group identified AA as one of four key conditions and instructed facilities that beginning in 2012, 40% of their monetary performance allocation would be

based on how well they coded these conditions, with the remaining 60% based upon their refresh performance. Facilities were told what prevalence rates they were expected to hit for AA and the other key conditions and were required to develop work plans to meet these rates. A 2012 internal training described this financial allocation:



247. The reason for this initiative was money. In response to MA plans receiving substantially more money per beneficiary than the costs for a traditional Medicare beneficiary, Congress amended the Medicare Advantage statute, and CMS altered the CMS-HCC model in an attempt to bring MA reimbursement in line with traditional Medicare. In light of these changes, Kaiser was intent on making much of this revenue back by increasing its coding of lucrative conditions such as AA. As that same 2012 internal training explained: "[G]iven the changing CMS climate regarding Medicare legislation and potential changes to the reimbursement models, it is no longer viable for us to continue to focus only on the Maintaining Diagnoses goal." Hence, the new focus on coding the four key lucrative conditions.

248. Northern California repeatedly stressed the financial benefit of coding AA. For example, one presentation by Dr. Robert Klein (a N. California Medical Group Associate Executive Director) and Dr. David Bliss (the N. California Medical Group Regional Director of Documentation and Coding) to each facility's Documentation and Coding Lead highlighted that each AA diagnosis was worth an

additional $2,800 to Kaiser, and that one medical center earned an additional $150,000 in revenue for one month by focusing on coding AA.

249. Following up on that presentation, on August 19, 2011, Dr. David Bliss sent an email to the N. California Medical Group Coding Leads. Dr. Bliss wrote that "With the Natural Language Processor, we have identified patients over the past two years with evidence of Aortic Atherosclerosis in the Radiology Report. . . . These have been pre-screened and are being sent to you to consider capturing the diagnosis of [AA]."

250. The N. California Medical Group physicians responded with concerns about diagnosing more patients with AA. At the time, every patient diagnosed with AA was entered into Kaiser's PHASE program. "PHASE," which stands for "Preventing Heart Attacks and Strokes Everyday," required physicians to perform additional monitoring of patients diagnosed with cardiovascular disease.

251. Given the large volume of patients Kaiser was directing be diagnosed with AA (and thus enrolled in PHASE), physicians were worried that this initiative would require the physicians to do more follow-up with these patients. As Karen Graham (the Managing Director for EIO) testified, "[t]here was concern about adding it [AA] to the PHASE program because it would create significant increase in workload of follow-up with the patients."

252. In response, Dr. David Bliss and Dr. Robert Klein offered a solution that addressed workload concerns without sacrificing Kaiser's bottom line: in mid-September 2011, they eliminated the requirement that patients diagnosed with AA automatically be enrolled in PHASE. This allowed Kaiser to capture the revenue associated with additional AA diagnoses (which at the time was estimated at $40 million for the Northern California Region alone) without requiring physicians to provide care, treatment, or management associated with the condition.

253. Following this change, the N. California Medical Group continued to pressure physicians to capture more AA diagnoses. As Dr. James Chang (another Associate Executive Director at the N. California Medical Group) wrote in late September 2011 to the Northern California Chiefs of Radiology, copying Dr. David Bliss and Anne Cadwell (the Managing Director of the N. California Medical Group): "We are missing a $40M opportunity. In the current reality of contracting revenue stream, this would become devastating to us." Referring to physicians who had captured fewer AA

diagnoses, Dr. Chang wrote, "What are our steps to improve? How can we tweak the environment or create habits to take us to 100%? Can we find out from the bright spots on how they do it? How do we rally the herd?" Dr. Chang concluded, "Everybody join in the discussion. $40M is no chump change."

254. Many physicians were concerned that for many patients AA was clinically irrelevant. One physician, Dr. Matthew James Sena, observed that "Aortic atherosclerosis is nearly ubiquitous in patients this age. It is not a clinically relevant diagnosis and doesn't require treatment. Isolated CXR [chest x-ray] interpretations are not grounds for clinical diagnosis in this case. . . . [I]t's clinically inconsequential in almost all cases."

255. Yet another Kaiser physician, Dr. Jill Dunton (a CMS Lead Physician), noted the disconnect between Kaiser's pressure on physicians to code the diagnosis and the clinical basis for doing so, noting that a Kaiser cardiologist said: "When people are seeing fraud cases reported in the paper, people want very much to feel that they are not putting themselves at risk. *Presenting requests to code AA when there is there may not be [sic] a clinical implication or action needed that are clearly dictated by region is causing increasing discomfort*." (Emphasis added.) Dr. Dunton made her report to: Anne Cadwell, Dr. Donald Dyson (an Associate Executive Director for the N. California Medical Group), and Dr. David Bliss.

256. Another Kaiser employee tasked with pushing the AA initiative, Lisa Woll (a N. California Medical Group Area Chief of Coding and Documentation), went so far as to say that "[n]o one believes it is a real diagnosis" and bemoaned that since "it is non-compliant to tell people to code for money, we need to really sort out a way to package this." Her complaint was forwarded to Anne Cadwell, Karen Graham, Joel Weiner (the Director of the Business Intelligence Team for the N. California Medical Group), and Dr. David Bliss.

257. Notwithstanding these and other physician complaints, Kaiser continued to press physicians to add AA.

258. In 2013, the N. California Medical Group, including through its Revenue Cycle office, instructed physicians in an internal training that AA was an "always code" condition and that physicians must "NOT put AA as [an] incidental finding or state [AA] is 'not clinically significant.'" Both instructions contradicted the ICD Guidelines. For outpatient encounters, as explained previously, the

ICD Guidelines only permit coding those conditions that require or affect patient care, treatment, or management at a patient visit. There is no such thing as a condition that is always coded. Accordingly, incidental findings or diagnoses that are not clinically significant may not be coded.

259. The results of this Northern California initiative were dramatic. In 2009 and 2010, before the initiative, Northern California physicians added AA via addenda 44 and 67 times, respectively. Once the initiative was fully implemented, Northern California physicians added AA via addenda approximately 10,500 times in 2012 and 11,500 times in each of 2013 and 2014.

260. Based on the addenda data produced by Kaiser, AA diagnoses accounted for 22% of all diagnoses added by Kaiser physicians via addenda in Northern California, Southern California, and Colorado. In some years in Northern California and Southern California, AA accounted for as much as 30-40% of all addenda diagnoses. Each AA diagnosis was generally worth roughly between $2,500 and $3,000 per patient in additional risk-adjustment payment. As a result of this high rate of reimbursement, AA accounted for an even higher percentage of the risk-adjustment revenue generated from addenda.

261. As described above, Kaiser knew, as set out in its Program Advisories, that a condition must have required or affected patient care, treatment, or management at a patient visit to be coded and submitted to CMS, and that if the physician did not *actually* consider the condition during the visit, the diagnosis could not be submitted to CMS.

262. Janet Franklin (at the time, a Compliance Manager with Kaiser's National Compliance Office) acknowledged internally that aortic atherosclerosis could "be reported only if that treating physician documents that it is more than just an incidental finding and it is relevant to the face-to-face encounter that he or she had with the patient." And in an internal policy memorandum titled "Coding Aortic Atherosclerosis," Nancy Andersen (then the Regional Director of Hospital Coding) wrote that, absent evidence of AA being treated or evaluated at the visit, AA "is considered an incidental finding and the physician should **not** be queried about it **nor should it be coded**." (Emphasis in original.)

263. Among the Physician Documentation and Coding Group, a group of physician coding leaders throughout Kaiser regions, there was complete agreement that adding AA without a physician's having addressed the condition at the patient visit was improper. According to a written summary of the meeting by Dr. Teresa Welsh (the Medical Director of Coding for the Colorado Medical Group),

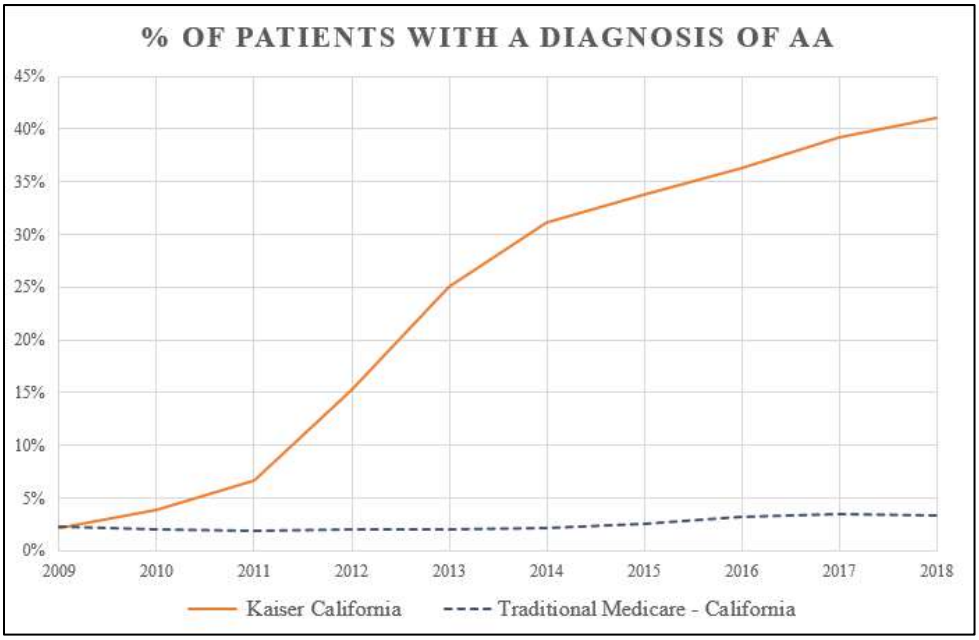
"[n]obody was in support of having the doctor add a diagnosis such as atherosclerosis of the aorta . . . in an addendum unless they had specifically addressed it within the visit note at the time of service -or- unless the doctor specifically indicates that they recall that they addressed it at the time of the visit."

264. Nevertheless, the N. California Medical Group used queries to pressure physicians to add AA diagnoses in addenda and made no mention of these requirements when sending queries to its physicians. Rather, Kaiser's queries indicated an AA diagnosis could be added to a visit record based *only* on the appearance of the condition in a radiology report—while at the same time it was pressuring radiologists to note the condition in as many reports as possible.

265. Kaiser compliance officials stated that the AA diagnoses that Kaiser was pressuring physicians to add frequently did not comply with coding requirements. Janet Franklin characterized the N. California Medical Group's practice of adding AA diagnoses as "coding for dollars" and confirmed that AA diagnosis codes should not be submitted to CMS unless AA was related to the reason that the patient was having the diagnosis test and AA's clinical significance or relevance to the patient visit was documented.

266. The AA diagnoses that Kaiser was pressuring physicians to add via addenda to medical records of prior patient visits frequently had not required or affected patient care, treatment, or management at those visits, as required by ICD guidelines.

267. The success of Kaiser's pressure campaign is reflected in the skyrocketing usage of the AA diagnosis in California. Prior to Kaiser's initiative, Kaiser physicians diagnosed around 2% of their MA patients in California with AA. This was approximately equivalent to the rate of AA diagnoses found in the traditional Medicare patient population in California. By 2018, Kaiser physicians diagnosed over 40% of their Medicare Advantage patients in California with AA, a more than 1000% increase. These additional AA diagnoses resulted in Kaiser receiving more than $500 million in increased Medicare Advantage revenue in California alone. The following chart depicts the percent of Kaiser's MA patients in California with AA compared to the traditional Medicare population:



268. As discussed further below, a targeted addenda audit conducted by the N. California Medical Group revealed that, of AA diagnoses added through addenda, only 21% were "accurate," meaning that there was a close to 80% error rate for the AA diagnosis.

E. Kaiser knew that its practices resulted in the addition of improper diagnoses to patient medical records.

269. Throughout the time period in question, Kaiser received (and ignored) numerous warnings and red flags that its practices surrounding addenda were leading to diagnoses that ran afoul of CMS rules.

1. Kaiser knew that its use of addenda to add risk-adjustment diagnoses did not comply with CMS rules for submission of diagnoses for risk-adjustment payment.

270. Kaiser knew that when it requested that physicians add conditions to the record of a prior patient visit, it needed to follow the ICD Guidelines, including the requirement that the condition must have required or affected patient care, treatment, or management at the visit.

271. For example, Kaiser's Addenda Program Advisory, which was "intended to clarify under what circumstances addenda to the medical record will be considered acceptable as support for risk adjustment data submitted to [CMS]," provides that that "the practitioner must clearly indicate that the information contained in the addendum *related to the evaluation and/or treatment rendered during the*

previous patient encounter." (Emphasis added). It further states that addenda are acceptable where the diagnosis was "actually made, considered, evaluated, and/or treated during [the] encounter," but the physician "failed to document that information in the note." Relatedly, it provides that addenda are *not* acceptable when "there is no documentation in the previous note that indicates that the diagnosis in the addendum was actually considered/treated/evaluated during the prior visit," or when "the information documented in the note does not pertain to the previous patient encounter but, instead, is new information obtained at a later date or as the result of a later visit[.]" In such cases, as Kaiser recognized in its Addenda Program Advisory, "any diagnoses documented in the addenda may not be submitted to CMS as risk adjustment data."

272. Kaiser recognized in its Addenda Program Advisory that "since these addenda will be used as support for the submission of risk adjustment data where the practitioner did not clearly document the diagnoses in the original documentation, it is essential that this use of addenda be closely monitored and audited for appropriateness" and that "[i]naccurate or false information submitted in support of claims for payment to federal health care programs may result in liability under the Federal False Claims or False Statement statutes." (Emphasis in original.)

273. Kaiser's training was consistent with its Addenda Program Advisory. For example, a 2011 Northern California training highlighted that in order to include a diagnosis in the record of a patient visit, "[t]here must be evidence that the diagnosis(es) may exist *in the documentation of the original encounter*." (Emphasis in original.) The same training instructed that an addendum may *not* be used "[w]hen the original encounter note *does not* indicate that the diagnosis was considered, treated, or evaluated." (Emphasis in original.) Similarly, a 2015 Northern California training instructed that a reason to perform an addendum was when "[y]ou have documentation to support that you considered, evaluated, and/or treated a diagnosis, but failed to capture it …."

274. In the 2015 Risk Adjustment Program Advisory, Kaiser included an Attachment that is about "Addenda to the Medical Record," and provides that an addendum may be appropriate if "the physician recalls the encounter and agrees that he or she did consider, evaluate, and/or treat the diagnosis during the encounter."

275. A 2016 training on the Fundamentals of Clinical Documentation and Reporting instructed

that an addendum could be done "[t]o clearly document that the provider considered, evaluated or treated each listed diagnosis."

2. Kaiser pushed for addenda regardless of how much time had passed since the patient visit, especially at the end of the year.

276. Despite recognizing that a physician's memory of a specific patient visit was likely to fade over time, Kaiser pushed for addenda regardless of how much time had passed since the actual patient visit. This became most apparent at year-end when Kaiser had to get diagnoses submitted in order to get paid by CMS.

277. In the Addenda Program Advisory, Kaiser recognized that "in general, practitioners are less likely to accurately recall specific details regarding patient encounters the more that has passed since the encounter." In the addendum attachment to the 2015 Risk Adjustment Program Advisory, Kaiser reiterated this concept, noting that whether an addendum was reasonable would depend in part on the "time between the applicable encounter and the drafting of the addendum," and "[a]s this time increases, the reasonableness and appropriateness of the addendum to serve as support for a diagnosis submitted as risk adjustment data decreases." The addendum attachment to the 2015 Risk Adjustment Program Advisory continues to give "under 90 days" as an example of what CMS has stated about what a "timely" addendum would be.

278. Kaiser employees shared this understanding. For example, Nancy Andersen (a Senior Compliance Manager with the National Compliance Office) testified that she could not identify "any situations" in which it would be appropriate to add a diagnosis "more than sixty days after an encounter."

279. Similarly, Janet Franklin (a Compliance Manager with the National Compliance Office) testified that only on "rare" occasions would it be appropriate to add a diagnosis "greater than 30 to 60 days after the original patient encounter."

280. In practice, however, Kaiser ignored these requirements and sought to ensure that physicians added lucrative risk-adjusting conditions to the records of their patient visits—oftentimes many months after the original visit, and regardless of whether these conditions were actually considered or addressed by the physician during the patient visits in question.

281. The extent of Kaiser's push to add diagnoses even months after the fact is borne out through addenda data produced by Kaiser.

282. These data show a significant number of addenda done a very long time after the visit. For example, from service years 2009 to 2018, Kaiser added over 150,000 diagnoses via addenda more than 90 days after a patient visit in California and Colorado, accounting for over 30% of diagnoses added via addenda. Over 12% of diagnoses added via addenda were more than 180 days after the patient visit. More than 6,000 diagnoses were added over a year after the patient visit.

283. These data also show that the time lag between patient visits and the creation of addenda was particularly pronounced at the end of each year, when Kaiser sought to meet annual financial targets. Kaiser physicians added far more diagnoses via addenda at the end of the year than at the beginning of the year, especially with respect to addenda created more than 90 days after the visit.

284. For example, for service years 2009 to 2018, Kaiser physicians added nearly three times as many diagnoses via addenda during the month of December than they did during the month of January. But the differences are even more pronounced when looking at diagnoses made through addenda more than 90 days after the visit. In January, only 13% of addenda diagnoses were more than 90 days after the visit; by December, that number jumped to over 50%. Put differently, Kaiser physicians added roughly eleven times as many diagnoses through addenda more than 90 days after the visit in December than they did in January.

285. Conversely, Kaiser's data show that, for service years 2009 to 2018, Kaiser physicians added more than five times as many diagnoses through addenda to medical visits that took place in January than they did to medical visits that took place in December. This pattern is even more pronounced for diagnoses made through addenda more than 90 days after the visit: Kaiser physicians added nearly thirteen times as many of these diagnoses through addenda to January medical visits than they did through addenda to December medical visits.

286. Similar patterns exist across each of the three Kaiser regions at issue (Northern California, Southern California, and Colorado) and across time periods. Likewise, similar patterns exist when comparing Kaiser addenda activity in the first quarter of the year versus the last quarter of the year.

287. This was not happenstance. Kaiser physicians were not especially forgetful during their January medical visits, nor did their memories suddenly improve in December. Rather, this was the result of Kaiser's end-of-year activities, sometimes referred to as the "dash for cash." Year-end pressure from Kaiser for physicians to meet metrics so that Kaiser could achieve risk score targets for the given service year caused physicians to add diagnoses to medical records for older visits from earlier in the year, routinely without regard for the ICD Guidelines and CMS requirements or whether the newly added diagnoses actually required or affected care, treatment, or management during those visits. Kaiser knew this was occurring, knew it was improper, yet still submitted these diagnoses for payment.

288. Kaiser would not have been able to submit the thousands upon thousands of risk-adjusting diagnosis codes that it added through addenda for payment by CMS if it had complied with ICD Guidelines and other CMS requirements. Instead, Kaiser systematically disregarded these requirements to boost its bottom line and used addenda to add diagnoses retrospectively to past patient visits, because, as Dr. Teresa Welsh (the Colorado Medical Group Director of Coding) explained, she could do "two a minute." As Dr. Welsh similarly discussed in January 2014—when by definition it was impossible for physicians to have visits with their patients for the 2013 service year any longer—in her view physicians "can still make addendums on 2013 dates of service for 2 more months if needed. . . . *Each of these diagnoses adds about $2500 to our bottom line*. I can drive around and sit with people personally if that is what it takes, usually it just takes the chief telling them to do it." (Emphasis added.)

3. Kaiser physicians put Kaiser on further notice of fraudulent diagnoses.

289. Physicians provided further notice that Kaiser's addenda practice was leading to fraudulent diagnoses.

290. For example, in 2011 Relator Randi Osinek (a Kaiser certified medical coder) reported to several executives, including Karen Graham (the Managing Director for EIO), that "over 50% of the physicians tell me they feel that they are being '<u>forced</u>' to add diagnoses that they did not considered, evaluated, and/or treat. Especially since they feel their bonuses are being impacted." (Emphasis in original.)

291. Pushback regarding AA diagnoses was particularly forceful. A Documentation and Coding Project Manager, Kathleen DePuydt, reported to Dr. David Bliss (the Regional Director of

Documentation and Coding for the N. California Medical Group): "One physician told me that all people over 90 have this condition but he is not necessarily treating it. He wants to know if [he] has to code this on all patients over this age? The [Family Medical Services] physicians are really pushing back with this condition and DO NOT want to code it."

292. Along the same lines, Dr. David Conant (a Chief of Medicine) noted "While we are making efforts to *capture the coding to support our bottom line*, I am hearing considerable concern about how we should be handling these patients." (Emphasis added.)

293. Similar pushback occurred when Kaiser pressured physicians to diagnose patients with cachexia.

294. As part of a 2009 training, the N. California Medical Group identified cachexia as one of a few diagnoses that would help them "Find $100 million dollars in NCal." And in 2012, cachexia was identified as one of "4 Key Conditions" for revenue purposes.

295. As part of its focus on cachexia, the N. California Medical Group created a data-mining algorithm to identify potential cachexia diagnoses. The Northern California region created an initiative around cachexia because cachexia is based on clinical judgment rather than clinical indicators, and they wanted physicians to diagnose cachexia in patients that did not meet clinical indicators for malnutrition. In March 2011, the results of the data-mining algorithm were sent to physicians with queries for them to addend their patient medical records to add cachexia diagnoses.

296. As previously noted, cachexia is not simply low body weight, yet physicians were routinely being sent queries that prompted them to add the cachexia diagnoses for patients who were merely thin.

297. After noting that physicians were protesting that naturally thin patients did not have cachexia, Dr. Inna Ravkin (an internal medicine physician in Northern California) warned Karen Graham and Dr. David Bliss in 2011 that the prompting would result in "inappropriate assignment of this diagnosis."

298. Also in 2011, Dr. Patrick Kan (a CMS Lead) reported to Dr. David Bliss and Karen Graham that "they [the treating physicians] do not see any physical signs of cachexia."

299. And in 2013, Norma Gonzalez (a Senior Consultant for CMS matters) wrote to Danielle

Sheetenhelm (Clinical Review Manager) that because she had "a couple of thousand datamining diagnoses in my area," it would be "impossible" to review them all. She further stated that the feedback from the physicians was that the queries were "garbage."

300. The cachexia initiative demonstrates the extreme distorting effect from these programs: physicians in Northern California added cachexia via addenda over *120 times* more than physicians in Southern California and Colorado, regions that did not have a cachexia initiative. Moreover, as described below, it became clear from audits that many of these diagnoses were invalid, because the patient did not even have cachexia, let alone that the physician considered or addressed the condition at the visit.

301. And in February 2015, following a meeting of the Physician Documentation and Coding Group, Dr. Teresa Welsh reported back to her colleagues at the Colorado Medical Group and the Colorado Health Plan her concerns that "most of our addendums would not be considered acceptable," because they would not meet the requirement that "diagnoses should only be added as an addendum if they were actually evaluated, treated, or considered at the time of the visit."

4. Kaiser's internal audits put Kaiser on further notice of fraudulent diagnoses.

302. CMS regulations require MA Organizations to "[a]dopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS's program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." 42 C.F.R. § 422.503(b)(4)(vi). The regulations specify that this compliance program "must, at a minimum, include [certain] core requirements," including: (1) to establish and implement "an effective system for routine monitoring and identification of compliance risks," which "should include internal monitoring and audits and, as appropriate, external audits," to evaluate the MA Organization's "compliance with CMS requirements and the overall effectiveness of the compliance program"; and (2) to establish and implement "procedures and a system for promptly responding to compliance issues as they are raised, investigating potential compliance problems as identified in the course of self-evaluations and audits, correcting such problems promptly and thoroughly to reduce the potential for recurrence, and ensuring ongoing compliance with CMS requirements." *Id.* § 422.503(b)(4)(vi)(E)-(G).

303. In the event that an MA Organization uncovers "evidence of misconduct related to payment," the regulations require the MA Organization to "conduct a timely, reasonable inquiry into that conduct" and to undertake "appropriate corrective action," including "repayment of overpayments" and "disciplinary actions" in response. *Id.* § 422.503(b)(4)(vi)(G). The regulations also provide that the MA Organization "should have procedures to voluntarily self-report potential fraud or misconduct related to the MA program to CMS or its designee." *Id.*

304. A variety of internal audits provided further notice that Kaiser's addenda and query practices were resulting in false claims to CMS.

305. Two teams within the National Compliance Office were directly involved in audit functions. The Government Audit & Reimbursement Team "[e]nsures timely, accurate and consistent responses to federal regulator inquiries and audits by providing operational support to national departments and functions." It also "[e]nsures organizational compliance with rules and requirements associated with payments and reimbursement from government entities." The National Compliance and Audit Team "[p]erforms compliance audits on high-risk areas and coordinates with governance, internal audit, and investigative functions to ensure that compliance validation is performed."

306. The Government Audit & Reimbursement Team conducted annual audits of each region, called "probe" audits. These audits were "documentation and coding review[s]" done "in order to determine the validity of each targeted hierarchical categorical condition category (HCC) under Part C." They were designed to "[e]nsure accurate risk adjustment data submission and payment integrity."

307. In the Northern California region specifically, the service year 2012 probe audit conducted by Kaiser's National Compliance Office identified a "trend" of "inappropriate use of addendums where the original documentation received by [the National Compliance Office] did not support the use of addenda."

308. The report further noted that "in each case, there was no documentation in the original note to support the use of the addenda process as required by coding and documentation guidelines and as noted" in the Program Advisory.

309. The report was submitted by Janet Franklin (at the time, a Compliance Manager with the National Compliance Office), and distributed to the Health Plan and the N. California Medical Group.

310. The service year 2013 probe audit conducted by Kaiser's National Compliance Office of the Northern California region specifically identified an "issue" with the coding of AA.

311. Janet Franklin again submitted the report, and it was distributed to the Health Plan and the N. California Medical Group.

312. As a result of this National Compliance Office audit, EIO conducted a targeted addenda audit in 2015. The scope of this audit was large: over 27,000 records where various diagnoses, including AA, had been captured by an addendum. During the audit, the reviewers were tasked with determining whether each addendum was compliant.

313. Over 17,000 of the addendum diagnoses in the audit were AA. Of the AA diagnoses, only 21% were "accurate," meaning that there was a close to 80% error rate for the AA diagnoses. And across all diagnoses, there was approximately a 75% error rate.

314. And the audit went further; it identified the reasons for the errors, including ones it described as "not eligible for remediation." For AA, nearly half of the errors, or approximately 6,700 addenda, were ones the audit determined could not be fixed. These included the following errors: "addenda doc not compliant, but AA Smart Phrase used"; "Addendum made greater than 1 month later"; "Dx not addressed"; "Dx not in encounter"; and "No link in encounter."

315. The Health Plan, including the National Compliance Office, knew the results of the 2015 EIO addendum audit. Because AA was identified as a "program-wide" issue, in 2017 the National Compliance Office ultimately created a corrective action plan for AA that covered all regions nationwide.

316. In the Southern California region specifically, the service year 2011 probe audit conducted by the National Compliance Office identified an "addendum issue" as one of the classification of errors, and described the errors as there being "no justification in [the] original note to support an addendum."

317. Janet Franklin again submitted the report, and it was distributed to the Health Plan and the S. California Medical Group.

318. In response to the National Compliance Office probe audits alleged above, the Health Plan redacted the specific diagnoses that were identified in those audits as errors. But Kaiser knew that

it made thousands upon thousands of similar improper diagnoses via addenda that it submitted for payment, but it did not redact or delete those diagnoses, and indeed continued to submit them year after year.

319. As part of the discussion that took place between the S. California Medical Group and the National Compliance Office, in July 2012, Janet Franklin wrote to Pat Lontka (the Managing Director of Business Systems of the S. California Medical Group) and others about one addendum for AA—added more than five months after the patient visit despite "no documentation in the original note to support [it]." In calling that delay into question, Janet Franklin quoted portions of Kaiser's own policies that suggested reliance on memory to such a degree is unreliable and inappropriate.

320. But Pat Lontka "strongly objected" and criticized the National Compliance Office's conclusion as "troubling." And Dr. Paul Minardi (S. California Medical Group Medical Director of Operations) bristled at the notion that "they ([National Compliance Office]) are second guessing the credibility/judgment of the treating physician." He also dismissed the criticism as seeking "perfection not progress," and complained that S. California Medical Group physicians should not be subject to the "whims of an [National Compliance Office] auditor."

321. Another example of an internal audit that put Kaiser on notice of its problematic addenda practice arises in the context of the cachexia program. As part of the audit, the Clinical Review Team (within EIO) found that over 90% of the time a physician added the cachexia diagnosis based on a Kaiser query, the documentation is "either lacking or contradict[s] the definition of Cachexia." In other words, when the physicians were creating addenda based on the query, those addenda were not accurate.

322. Despite this knowledge, the N. California Medical Group did not modify its cachexia data-mining algorithm or stop-prompt program for several years.

323. The Health Plan, including Kaiser's National Medicare Finance department and the National Compliance Office, knew about the N. California Medical Group's cachexia data-mining algorithm and stop-prompt analysis.

324. In the Colorado region specifically, the National Compliance Office had concerns about the leading queries being used by the Colorado Medical Group beginning in 2013.

325. In 2013, Dr. Teresa Welsh (the Colorado Medical Group Director of Coding) presented

Colorado's chart review and query program to other Kaiser regions at a semi-annual meeting of the Medicare Regional Reporting Group.

326. After seeing the presentation, Nancy Andersen (then a Senior Compliance Manager with the National Compliance Office) told Dr. Teresa Welsh, "I do have a couple of concerns regarding the query language used and how it may be viewed by CMS and the OIG [the HHS Office of Inspector General]." She continued that the language "'this patient has a suspected diagnosis' introduces a diagnosis or suspected diagnosis not previously mentioned by the provider and from a compliance perspective may be interpreted as 'leading.'" She further attached information on how to craft a compliant query, with suggestions how to alter the query.

327. The Colorado Medical Group did not change its query language at that time. In the service year 2013 probe audit conducted by the National Compliance Office, the findings noted that "[t]he audit process surfaced questions about the use of queries. The questions will be further analyzed outside of this report."

328. Kaiser ultimately determined that it had to redact all diagnoses associated with the Colorado region's chart review and leading query program, deleting over 10,000 addenda diagnoses that it had previously submitted to CMS for payment.

329. One example of such a diagnosis is with Patient #11. Dr. Janisse Rears (a Colorado Medical Group physician) saw Patient #11 on October 17, 2013, for a physical examination.

a. The visit note identifies a number of active diagnoses, including hypercholesterolemia, hypertension, diabetes, arthritis of the right knee, and severe obesity, as well as number of other diagnoses listed on the problem list.

b. The visit note makes no mention of emphysema.

c. On October 23, 2013, Dr. Rears received a query from Dr. Jennifer Hronkin, as part of the Colorado chart review program described in paragraphs 166-83. As explained earlier, the chart review program involved physician reviewers going through patient files after a visit to "identify diagnoses that have never yet been made by a physician."

d. The query states in relevant part: "Suspected diagnosis= 'Emphysema'

Supporting data= CT thorax 10/24/08 shows 'There is minimal emphysema.'

If you agree that this data indicates a diagnosis that should be documented, please:

1. Double click above to open the chart as an addendum.

2. Add the diagnosis to the diagnosis entry field.

3. Slide all chronic diagnoses over to the problem list.

4. Add supporting data or other documentation into the progress note. . . ."

e. On the same day she received the query, Dr. Rears created an addendum, copying language from the query: "emphysema Supporting data= CT thorax 10/24/08 shows 'There is minimal emphysema.'"

f. The CT scan referenced in the query was five years old. There was no indication in the visit note that Dr. Rears was aware of, let alone considered, this CT scan or the requested diagnosis of emphysema.

g. There in nothing in the medical record that indicates that Dr. Rears communicated the diagnosis of emphysema to Patient #11 after creating the addendum.

h. The Colorado Health Plan submitted an ICD diagnosis code for emphysema for Patient #11 for service year 2013 and received a risk-adjustment payment of $2,813.76 for payment year 2014 based upon this submission.

i. The Colorado Health Plan was not entitled to this risk-adjustment payment because emphysema did not require or affect patient care, treatment, or management during the visit. The diagnosis of emphysema was merely added to Patient #11's medical record after Dr. Rears was prompted by a query to add the diagnosis based on five-year-old CT scan.

330. After receiving the risk-adjustment payment, the Colorado Health Plan redacted (i.e., deleted) the diagnosis on April 29, 2015, as part of its redaction of diagnoses associated with the Colorado region's unlawful chart-review and leading-query program. These redactions reflected that Kaiser was aware that its improper query and addenda issues were material to CMS and that it was not lawfully allowed to submit these improper diagnoses to CMS for payment. Based on these redactions, CMS collected back the payments for these diagnoses through reconciliation. However, when Kaiser

redacted this information, it failed to furnish the Government—either CMS, HHS-OIG, or the Department of Justice—with any information regarding its fraudulent diagnosis submissions, including its improper use of addenda and queries.

331. Patient #11 is similar in all relevant respects to thousands upon thousands of other patients, including the specific additional ten patient examples in the allegations below. Yet Kaiser did not take steps to remediate the hundreds of thousands of improper diagnoses that Kaiser submitted for payment for these similar patients in Colorado, Northern California, or Southern California. The small number of diagnoses that Kaiser redacted were a miniscule fraction of the improper addenda diagnoses that Kaiser submitted to CMS and for which Kaiser received payment from CMS. Had Kaiser fully disclosed that its unlawful addenda practices had resulted in other fraudulent diagnoses, CMS would have taken appropriate actions to ensure that Kaiser did not receive or retain risk-adjustment payments to which it was not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions.

VIII. KAISER RECEIVED MONEY FROM MEDICARE BASED ON THE PRESENTATION OF FALSE CLAIMS.

332. For service years 2009 to 2018, the Defendant Kaiser Health Plans submitted and received payment from CMS for nearly 500,000 diagnoses that were added to patient medical records using addenda. Approximately 100,000 of these diagnoses were for AA. The Defendant Kaiser Health Plans received in the range of $1 billion from CMS as a result of these addenda.

333. For service years 2009 to 2018, over 12,500 physicians employed by the Defendant Permanente Medical Groups created addenda to patient medical records to add diagnoses for which the Defendant Kaiser Health Plans received payment from CMS. There are over 1,600 physicians that added more than 100 diagnoses via addenda during this time period. And over two dozen physicians each added over 500 diagnoses via addenda during this time period.

334. Kaiser's consistent pressure on physicians to add conditions to patient-visit records led to numerous diagnoses that were not based on the original visit and did not require or affect patient care, treatment, or management.

335. During the period at issue, Kaiser knowingly submitted false and/or fraudulent diagnosis

codes for tens of thousands of Medicare Advantage beneficiaries using the risk-adjustment data reporting systems provided by CMS. These false claims inflated CMS's reimbursements to the Kaiser Health Plans by hundreds of millions of dollars.

336. The specific examples, described below, are of Kaiser patients that had diagnoses added to their medical records by Defendant Permanente Medical Group physicians, often many months after the visit. As is clear from the medical record from the visit, those diagnoses did not require or affect patient care, treatment, or management for the visit, yet the Defendant Kaiser Health Plans submitted them to CMS, and received and retained a risk-adjustment payment from CMS as a result. In these and thousands of other instances, Kaiser's misconduct had a direct and foreseeable impact on CMS. Specifically, Kaiser's misconduct not only enabled it to obtain and retain higher risk-adjustment payments from CMS, it also adversely affected the integrity and accuracy of CMS's risk adjustment payment system.

A. **Patient #1**

337. The Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #1.

a. Dr. Sangita Shah (a N. California Medical Group physician) saw Patient #1 on March 28, 2012, for rib pain during coughing. Dr. Shah ordered a chest x-ray at the visit. There was no mention of AA in the medical record for the visit.

b. On March 28, 2012 (the same day of the visit), Dr. Shah sent Patient #1 a message after reviewing the radiologist's report of the chest x-ray: "Your xrays of the rib and lung area all looked normal. The bones are normal and show no evidence of 'lytic' or destructive lesions. I believe the pain is a neuralgia as we discussed today." Patient #1 responded thanking Dr. Shah for the assuring note.

c. Although the radiology report notes the presence of AA as an incidental finding, Dr. Sangita Shah did not mention or communicate anything about AA to Patient #1 in her message.

d. On June 21, 2012 (almost three months after the visit), Dr. Shah received a data-mining query from Data Quality Trainer Ellie Kamkar that stated: "Hello Please

review imaging impression notes on 03/28/2012 and consider diagnosis of ATHEROSCLEROSIS AORTA. If agreed, please add the diagnosis of AORTIC ATHEROSCLEROSIS & amend the visit note for the DOS 03/28/12 Thank you."

e. Two weeks after receiving the query, Dr. Shah created an addendum to add the diagnosis of AA.

f. The addendum is nothing more than a listing of the diagnosis.

g. There is nothing in the medical record that indicates that Dr. Shah communicated to Patient #1 the diagnosis of AA after creating the addendum.

h. The Health Plan submitted an ICD diagnosis code for AA for Patient #1 for service 2012 and received a risk-adjustment payment of $2,780.16 for payment year 2013 based on that submission.

i. The Health Plan was not entitled to this risk-adjustment payment for AA for Patient #1 because AA did not require or affect patient care, treatment, or management during the visit. The diagnosis of AA was merely added to Patient #1's medical record—three months after Patient #1's visit—after Dr. Shah was prompted by a Kaiser data-mining query to add the diagnosis.

B. Patient #2

338. The Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #2.

a. Dr. Silvester Rocque Lim (a S. California Medical Group physician) saw Patient #2 on May 30, 2012, for a blood pressure check and to review lab results. Dr. Lim's sole diagnosis for Patient #2 in the brief visit note was hypertension (high blood pressure). The note also included a discussion that the recent labs showed that Patient #2's creatine had improved with increased water intake.

b. No radiology exam was ordered at the visit.

c. On November 29, 2012 (approximately six months after the visit), Dr. Lim received a query from William Wang, of the "Coding Flying Squad," that stated:

"Hi Dr. Lim, I was working on your list of uncoded patients, and this patient was seen earlier this year. He has several uncoded diagnoses the region thinks should be picked up:

ATHEROSCLEROSIS AORTA (seen on CT 12/21/05)

EMPHYSEMA (seen on CT 12/21/05)-hasn't been clinically diagnosed yet though.

PROSTATE CANCER . . . ."

d. The CT scan referred to in the query for AA and emphysema was seven years old. There was no indication in the visit note that Dr. Lim was aware of, let alone considered, this CT scan or the requested diagnoses. There was no mention of AA or emphysema, which the query noted had never been clinically diagnosed. The medical record from the original visit further stated that Patient #2 had a *history of* prostate cancer (identified with a different ICD history code) and did not have active prostate cancer.

e. The same day he received the query, Dr. Lim created an addendum to add the diagnoses of AA, emphysema, and prostate cancer.

f. There is nothing in the record that indicates that Dr. Lim communicated to Patient #2 that he had AA or emphysema, or that his prior prostate cancer had returned.

g. The Health Plan submitted an ICD diagnosis code for AA, emphysema, and active prostate cancer for Patient #2 for service year 2012 and received a risk-adjustment payment of $7,282.68 for payment year 2013 based upon these submissions.

h. The Health Plan was not entitled to this risk-adjustment payment for Patient #2 because these conditions did not require or affect patient care, treatment, or management during the visit. The diagnoses were merely added to Patient #2's medical record—six months after Patient #2's visit—after Dr. Lim was prompted by a data-mining query to add the diagnoses.

C. Patient #3

339. The Health Plan submitted a false claim and received money from CMS based on

diagnoses added in addenda for Patient #3.

a. Dr. Chitra Chandran (a N. California Medical Group physician) saw Patient #3 on January 17, 2013, for shortness of breath and diagnosed Patient #3 with exacerbation of chronic obstructive pulmonary disease ("COPD"). Dr. Chandran prescribed prednisone (a steroid) and doxycycline (an antibiotic). Dr. Chandran ordered a chest x-ray to rule out pneumonia. When the results of the x-ray came back, Dr. Chandran told Patient #3 that the "x-ray did not show pneumonia," and that "he should take the antibiotics and prednisone like we discussed." There is no indication in the original visit note that Dr. Chandran considered, evaluated, or treated any other condition at this visit.

b. There is no mention of AA in the visit note.

c. On September 16, 2013 (eight months later), Dr. Chandran received a query from Data Quality Trainer Shahida Dossa, which stated: "Dear Dr. Chandran, On 1/17/13 you stated: A/P: ACUTE EXACERBATION OF COPD (primary encounter diagnosis) Note: will get CXR to r/o PNA, . . . XR CHEST, PA AND LATERAL.. Subsequently the imaging you ordered showed Positive Aortic Atherosclerosis. Therefore we would like you to amend the note for DOS: 1/17/13, and capture AA. A smart phrase you may want to use is DOT AORTICATHEROSCLEROSIS. Pls add AA to Problem List."

d. The SmartPhrase ".AORTICATHEROSCLEROSIS" was created by the N. California Medical Group. Entry of this SmartPhrase would generate the following language in the patient record: "Aortic Atherosclerosis noted on review of the radiology exam associate with chart review and this visit. Will follow longitudinally as an independent risk factor for CVD and CVA, with management per standard risk factor controls over time by PCP or appropriate specialist."

e. One day after receiving the query, Dr. Chandran created an addendum to add the diagnosis of AA using the SmartPhrase as instructed.

f. The addendum states: "After review of my note for this visit encounter, I recall

this encounter and am addending this note to state that this patient has diagnosis of: ATHEROSCLEROSIS AORTA. Note: Aortic Atherosclerosis noted on review of the radiology exam associated with this visit. Will follow longitudinally as an independent risk factor for CVD and CVA, with management per standard risk factor controls over time."

g. There is nothing in the medical record that indicates that Dr. Chandran communicated to Patient #3 the diagnosis of AA after creating the addendum.

h. Dr. Chandran then later created two additional addenda, eight months and nine months after the visit, to add twelve more diagnoses to Patient #3's medical record. There is no indication in the original note or addenda that any of these 12 additional conditions required or affected patient care, treatment or management at the visit. This is confirmed by Dr. Chandran's addenda note which states: "I have confirmed with the patient and/or the medical record the presence of the above diagnoses, and the diagnoses are followed or will be followed by his or her PCP or appropriate specialist."

i. One of these diagnoses added via addendum was for severe obesity equivalent. The medical record states that Patient #3's BMI was 31 at the visit, which contradicts a diagnosis of severe obesity equivalent, which requires a BMI of at least 35.

j. The Health Plan submitted an ICD diagnosis code for AA, morbid (severe) obesity, diabetes with other specified manifestations, and colostomy status for Patient #3 for service year 2013 and received a risk-adjustment payment of $13,925.28 for payment year 2014 based upon these submissions.

k. The Health Plan was not entitled to this risk-adjustment payment for Patient #3 because the four diagnoses did not require or affect patient care, treatment, or management during the visit. The diagnosis of AA was merely added to Patient #3's medical record—eight months after Patient #3's visit—after Dr. Chandran was prompted by a leading query to add the diagnosis based on an incidental

finding noted in a radiology report. The remaining diagnoses likewise did not require or affect patient care, treatment, or management during the visit. And the condition of severe obesity equivalent did not exist at the time of the visit, as indicated by the medical record.

D. Patient #4

340. The Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #4.

a. Dr. Natalia Volkova (a N. California Medical Group physician) saw Patient #4 on July 17, 2013, for an ear problem. Dr. Volkova diagnosed Patient #4 with cellulitis on the ear lobe (bacterial skin infection).

b. The visit note makes no mention of any prior cardiac history or any past myocardial infarction ("MI").

c. On July 2, 2014 (almost one year later), Dr. Volkova received a query from Clinical Documentation Consultant Danilo Camacho that stated: "Dear Dr. NATALIA B VOLKOVA MD, This message is sent on behalf of the Regional Clinical Review Team. [Patient #4] has been prescreened for possible Hx of MI. Please review the following clinical information: Pt was diagnosed with 'Old MI' in several office visits. The last one was on 10/27/08. Cardio office visit 11/10/08 stated 'prior h/o MI and subsequent 2 vessel CABG in 92'. Please consider evaluating and documenting Hx of MI at the next Visit if appropriate Please consider to add [sic] it to problem list as a reminder. This makes the diagnosis explicit to other clinicians and ensures quality of care. Thank you for considering this diagnosis and please respond with the action taken."

d. The same day of the query, Dr. Volkova created an addendum to add the diagnosis of history of myocardial infarction.

e. The entire addendum states: "HX OF MI. Status: Stable/Unchanged."

f. The Health Plan submitted an ICD diagnosis code for history of myocardial infarction for Patient #4 for service year 2013 and received a risk-adjustment

payment of $328.79 for payment year 2014 based on this submission.

g. The Health Plan was not entitled to this risk-adjustment payment for Patient #4 because history of myocardial infarction did not require or affect patient care, treatment, or management during the visit. The diagnosis of history of myocardial infarction was merely added to Patient #4's medical record—one year after Patient #4's visit—after Dr. Volkova was prompted by a query regarding the diagnosis based on a different visit that took place five years prior. The added diagnosis code was completely unrelated to the visit that actually occurred for a skin infection on the ear lobe.

E. Patient #5

341. The Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #5.

a. Dr. Jennifer Win-Yun Lam (a S. California Medical Group physician) saw Patient #5 on January 21, 2014, because of a right eye problem. Dr. Lam diagnosed Patient #5 with a stye on her right eyelids and prescribed an antibiotic.

b. The visit note makes no mention of any skin issues and states "skin is warm."

c. On May 15, 2014 (about four months later), Dr. Lam received a query from Compliance Auditor Belinda Covington that stated:

"Subject: Action Required: Coding Clarification Request

Dear Provider, The following diagnoses are on the 2014 Seen Not Coded Diagnosis List. WHAT SHOULD I DO WITH THESE DIAGNOSES? Please review your progress note. If appropriate, you may complete an addendum in Health Connect to add the diagnosis and reason for the addendum. - Or - If the diagnosis is Not Active, please indicate if the diagnosis is Resolved or is Incorrect on the Problem list in KP Health Connect as per instructions on the In-basket Addendum Process handout.

Diagnosis: 287.2 - Purpura Nos

Dx Source: CLIN

Dx. Date: 11/08/2013"

d. On September 13, 2014 (approximately eight months after the visit), Dr. Lam responded: "Addendum done."

e. On the same day, Dr. Lam created an addendum that states: "Upon further review, pt has 287.2 SENILE PURPURA -stable."

f. The Health Plan submitted an ICD diagnosis code for purpura, not otherwise specified for Patient #5 for service year 2014 and received a risk-adjustment of $679.08 for payment year 2015 based upon this submission.

g. The Health Plan was not entitled to this risk-adjustment payment for Patient #5 because purpura (skin bruising) did not require or affect patient care, treatment, or management during the visit. The diagnosis was merely added to Patient #5's medical record—eight months after Patient #5's visit—after Dr. Lam was prompted by a query regarding a historical diagnosis. The added diagnosis code was unrelated to the visit that actually occurred for a stye on the right eyelid.

F. Patient #6

342. The Colorado Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #6.

a. Dr. Timothy Holcomb (a Colorado Medical Group physician) saw Patient #6 on May 1, 2014, for a hospital follow up. There was no mention of depression in the visit note.

b. On or around October 14, 2014 (five months after the visit), Dr. Holcomb received a "missed opportunity" query in the form of a report titled "Risk Adjustment Refresh – Patients seen by PCP and not all Chronic Diagnoses Addressed." Patient #6 was among dozens of patients on Dr. Holcomb's report, which listed "Major Depression, Recurrent" as the diagnosis for Patient #6.

c. Two days after receiving the query, Dr. Holcomb created an addendum to add the diagnosis of major depression, recurrent.

d. The addendum states "Major depression – stable at this time."

e. The Colorado Health Plan submitted an ICD diagnosis code for major depression, recurrent for Patient #6 for service year 2014 and received a risk-adjustment payment of $3,018.96 for payment year 2015 based upon this submission.

f. The Colorado Health Plan was not entitled to this risk-adjustment payment for Patient #6 because major depression did not require or affect patient care, treatment, or management during the visit. The diagnosis of major depression was merely added to Patient #6's medical record—five months after Patient #6's visit—after Dr. Holcomb was prompted by a "missed opportunity" query to add the diagnosis.

G. Patient #7

343. The Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #7.

a. Dr. Amitabh Joglekar (a N. California Medical Group physician) saw Patient #7 on August 4, 2014, for a cough. Dr. Joglekar diagnosed Patient #7 with gastroesophageal reflux disease at the visit.

b. There was no mention of AA in the medical record from the original visit, and no radiology exam ordered at the visit.

c. On or around December 18, 2014 (four months after the visit), Dr. Joglekar received a data-mining query that stated: "Please review PA & LATERAL CHEST imaging impression notes on 12/10/2014 and consider diagnosis of ATHEROSCLEROSIS AORTA, if appropriate." Notably, the radiology exam referred to in the query was ordered *after* Patient #7's visit with Dr. Joglekar by a *different* physician, Dr. Ted Young.

d. Nevertheless, approximately four days after receiving the query, Dr. Joglekar created an addendum to add the diagnosis of AA and did so based on the radiology exam that occurred four months after the patient visit, and that was ordered by a different physician, Dr. Young.

e. The addendum states: "Reason new information. After review of my note for this

visit, I recall this encounter and am addending this note to state that this patient has a diagnosis of Aortic atherosclerosis - seen on 12/10/14 CXR. Goal Met, continue with current plan. He is on ARB, beta blocker. Did not tolerant statins. BP controlled."

f. There is nothing in the medical record that indicates that Dr. Joglekar communicated the diagnosis of AA to Patient #7 after creating the addendum.

g. The Health Plan submitted an ICD diagnosis code for AA for Patient #7 for service year 2014 and received a risk-adjustment payment of $2,920.20 for payment year 2015 based upon this submission.

h. The Health Plan was not entitled to this risk-adjustment payment for Patient #7 because AA did not require or affect patient care, treatment, or management during the visit as the purported basis for the diagnosis did not even exist at the time. The diagnosis of AA was merely added to Patient #7's medical record—four months after Patient #7's visit—after Dr. Joglekar was prompted by a query to add the diagnosis based on an incidental finding noted in a radiology report for an x-ray that was ordered by different physician after the visit.

H. Patient #8

344. The Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #8.

a. Dr. John Pakula (a N. California Medical Group physician) saw Patient #8 on August 11, 2014, for edema. There was no mention of AA in the visit note and no radiology exam ordered at the visit.

b. On or around October 11, 2014 (two months after the visit), Dr. Pakula received a data-mining query that stated: "Please review NONCONTRAST CARDIAC CT imaging impression notes on 10/01/2014 and consider diagnosis of ATHEROSCLEROSIS AORTA, if appropriate." Notably, the CT exam referred to in the query was ordered *after* the visit by a *different* physician, Dr. Terry Anderson.

c. Nevertheless, approximately one month after receiving the query, and three months after the visit, Dr. Pakula created an addendum to add the diagnosis of AA and did so based on the radiology exam that occurred two months *after* the patient visit, and that was ordered by a different physician, Dr. Anderson.

d. The addendum states: "After reviewing my visit note, I recall this visit encounter. The visit note an[sic]/or labs reflect that I evaluated the patient who has the diagnosis of: ATHEROSCLEROSIS OF AORTA. Note: Aortic Atherosclerosis noted on review of the radiology exam (CT for calcium score, 10/1/14 by cardiologist Dr. Anderson) subsequent to this visit. Pt on BB, statin, and ACE-i. Will follow longitudinally as an independent risk factor for CVD and CVA, with management per standard risk factor controls over time."

e. There is nothing in the medical record that indicates that Dr. Pakula communicated the diagnosis of AA to Patient #8 after creating the addendum.

f. The Health Plan submitted an ICD diagnosis code for AA for Patient #8 for service year 2014 and received a risk-adjustment payment of $2,785.80 for payment year 2015 based upon this submission.

g. The Health Plan was not entitled to this risk-adjustment payment for Patient #8 because AA did not require or affect patient care, treatment, or management during the visit as the purported basis for the diagnosis did not even exist at the time. The diagnosis of AA was merely added to Patient #8's medical record—three months after Patient #8's visit—after Dr. Pakula was prompted by a query to add the diagnosis based on an incidental finding noted in a radiology report for an CT scan that was ordered by different physician after the visit.

I. Patient #9

345. The Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #9.

a. Dr. Christina Le (a N. California Medical Group physician) saw Patient #9 on August 22, 2014, for a hospital follow-up.

b. The visit note makes no mention of hypogammaglobulinemia.

c. On February 3, 2015 (almost six months later), Dr. Le received a query from Clinical Documentation Consultant Dani Castillo that stated: "Dear Doctor CHRISTINA ANH LOAN LE MD: This message is sent on behalf of the Regional Code Review Team and Dr. Alphana Shekhar (Documentation and Coding Lead). [Patient #9] has been prescreened for possible Hypogammaglobulinemia, either primary or secondary. . . . Action requested for Data Mining effort: If appropriate, please consider dx of Hypogammaglobulinemia. Please consider to add [sic] diagnosis to the problem list as you deem appropriate. This helps make the diagnosis explicitly apparent to other physicians and ensures quality of care. Thank you for considering this diagnosis, and please respond with the action taken."

d. The same day of the query, Dr. Le created an addendum to add the diagnosis of hypogammaglobinemia and responded to the query: "Addended. Thanks, cle."

e. The addendum states: "After review of my note for this visit encounter, I recall this encounter and am addending this note to state that this patient has diagnosis of: HYPOGAMMAGLOBULIN. Note: fu per heme/ofnc."

f. The Health Plan submitted an ICD diagnosis code for hypogammaglobinemia for Patient #9 for service year 2014 and received a risk-adjustment payment of $9,917.64 for payment year 2015 based upon this submission.

g. The Health Plan was not entitled to this risk-adjustment payment for Patient #9 because hypogammaglobinemia did not require or affect patient care, treatment, or management during the visit. The diagnosis of hypogammaglobulinemia was merely added to Patient #9's medical record—six months after Patient #9's visit—after Dr. Le was prompted by a query to add the diagnosis.

J. Patient #10

346. The Health Plan submitted a false claim and received money from CMS based on a diagnosis added in an addendum for Patient #10.

a. Dr. Shih-Chin Thomas Wang (a N. California Medical Group physician) saw Patient #10 on October 23, 2014, for the flu.

b. The visit note makes no mention of cachexia or of Patient #10's nutritional status.

c. On November 6, 2014 (about two weeks later), Dr. Wang received a query from Clinical Documentation Consultant Albina Dvorkis that stated that Patient #10 "has been prescreened for possible Cachexia. Patient has met criteria: BMI <18.5 plus diagnosed with following comorbidities: HIV/AIDS, Active CA, COPD, rheumatoid Arthritis, Heart Failure, End Stage Liver Disease, End Stage Renal Disease, Chronic Kidney Disease, Tuberculosis, Alzheimer and Dementia. Please review the following clinical information: 73 yo female w/Bipolar, CKD st3. Wt loss 7.41% last 5 mon and 17.31% last 3 years. Last BMI -18.44. Please consider to evaluate for Cachexia next visit and add to diagnosis list if appropriate based on your clinical judgment. Please remember to update the problem list I would appreciate if you will respond with the action taken. Thank you."

d. Approximately two weeks later, Dr. Wang created an addendum to add the diagnosis of cachexia.

e. The addendum states "Cachexia. Note: patient has no general debility. But lost some lbs of weight. Will continue to follow."

f. By stating "no general debility," the addendum contradicts a diagnosis of cachexia. The medical record further indicates that the patient is "well appearing" and that the weight loss is associated with the flu.

g. The Health Plan submitted an ICD diagnosis code for cachexia for Patient #10 for service year 2014 and received a risk-adjustment of $6,363.48 for payment year 2015 based upon this submission.

h. The Health Plan was not entitled to this risk-adjustment payment for Patient #10 because cachexia did not exist and did not require or affect patient care, treatment, or management during the visit. In fact, the addendum that was created to add that diagnosis to the medical record contradicts the representation that the patient

had cachexia. The diagnosis of cachexia was merely added to Patient #10's medical record—one month after Patient #10's visit—after Dr. Wang was prompted by a query regarding the diagnosis.

IX. CAUSES OF ACTION

FIRST CLAIM FOR RELIEF
False Claims Act: Presenting or Causing to be Presented False Claims
31 U.S.C. § 3729(a)(1)(A) (formerly 31 U.S.C. § 3729(a)(1))

347. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 346 above as though they are fully set forth herein.

348. Defendants violated 31 U.S.C. § 3729(a)(1)(A) by knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval to CMS, resulting in their receiving inflated Medicare payments from CMS to which they were not entitled.

349. Specifically, Defendants presented or caused to be presented false claims for risk-adjustment payments in the form of improper diagnosis codes for Defendants' Medicare patients, in violation of CMS regulations and policies, which Defendants agreed to and were obligated to comply with.

350. If CMS had known that Defendants had presented or caused to be presented false claims based on these improper codes, CMS would have refused to make risk-adjustment payments based on the improper coding and/or taken other appropriate actions to ensure that Defendants did not receive or retain risk-adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions, and CMS has now done so via this suit that it has authorized.

351. By reason of the false claims that Defendants knowingly presented or caused to be presented, the United States has been damaged in a substantial amount to be determined at trial, and is entitled to recover treble damages plus a civil monetary penalty for each false claim.

SECOND CLAIM FOR RELIEF
False Claims Act: Making or Using False Records or Statements
31 U.S.C. § 3729(a)(1)(B) (formerly 31 U.S.C. § 3729(a)(2))

352. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 351 above as though they are fully set forth herein.

353. Defendants violated 31 U.S.C. § 3729(a)(1)(B) by knowingly making, using, and causing to be made or used, false records or statements material to false or fraudulent claims resulting in their receiving inflated Medicare payments from CMS to which they were not entitled.

354. If CMS had known that Defendants had made, used, and caused to be made or used, false records or statements material to false claims based on these improper codes, CMS would have refused to make risk-adjustment payments based on the improper coding and/or taken other appropriate actions to ensure that Defendants did not receive or retain risk-adjustment payments to which they were not entitled, including by recouping payments through administrative processes, payment adjustments, or obtaining repayments in enforcement actions, and CMS has now done so via this suit that it has authorized.

355. By reason of the false records and statements that Defendants knowingly made, used, and caused to made or used, the United States has incurred damages and therefore is entitled to treble damages under the FCA, plus a civil penalty for each violation of the Act.

THIRD CLAIM FOR RELIEF
Conspiracy to Violate the False Claims Act
31 U.S.C. § 3729(a)(1)(C) (formerly 31 U.S.C. § 3729(a)(3))

356. The United States repeats and realleges the allegations contained in ¶¶ 1 to 355 above as though they are fully set forth herein.

357. Defendants Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Health Plan of Colorado knowingly conspired with the Permanente Medical Group, Inc., the Southern California Permanente Medical Group, and the Colorado Permanente Medical Group, P.C. to violate 31 U.S.C. §§ 3729(a)(1)(A) and (B) to submit and cause the submission of false claims and to make, use, and cause to make or use, false records and statements material to false or fraudulent claims to the United States and use false records and statements material to false or fraudulent claims.

358. By reason of Defendants' conspiracy, the United States has incurred damages and therefore is entitled to treble damages under the FCA, plus a civil penalty for each violation of the Act.

FOURTH CLAIM FOR RELIEF
Payment by Mistake

359. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 358 above as

though they are fully set forth herein.

360. As a consequence of Defendants' misconduct and the acts set forth above, Defendants received monies from the United States as a result of a mistaken understanding. Specifically, the United States reimbursed the Health Plan and the Colorado Health Plan, which in turn reimbursed the N. California Medical Group, the S. California Medical Group, and the Colorado Medical Group, under the mistaken understanding of the United States that such claims were based on valid risk-adjustment diagnosis submissions. Had the United States known the truth, it would not have paid such claims and/or taken other appropriate actions to ensure that Defendants did not receive or retain risk-adjustment payments to which they were not entitled. Payment was therefore by mistake.

361. As a result of such mistaken payments, the United States has sustained damages for which Defendants are liable in an amount to be determined at trial.

FIFTH CLAIM FOR RELIEF
Unjust Enrichment

362. The United States repeats and re-alleges the allegations contained in ¶¶ 1 to 361 above as though they are fully set forth herein.

363. As a consequence of Defendants' conduct and the acts set forth above, Defendants were unjustly enriched at the expense of the United States. In equity and good conscience such money belongs to the United States.

364. The United States is entitled to recover such money based on Defendants' unjust enrichment in an amount to be determined at trial.

X. PRAYER FOR RELIEF

WHEREFORE, the United States requests that judgment be entered in its favor and against Defendants as follows:

On Claims I, II, and III (False Claims Act), against all Defendants jointly and severally, for: (i) the amount of the United States' damages, trebled as required by law; (ii) the maximum civil penalties allowed by law, (iii) the costs of this action, plus interest as provided by law, and (iv) any other relief that this Court deems appropriate.

As to Claim IV (Payment by Mistake), for: (i) an amount equal to the money paid by the United

States through the Medicare Advantage program as a result of Defendants' false submissions, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate.

As to Claim V (Unjust Enrichment), for: (i) an amount equal to how much Defendants were unjustly enriched, plus interest; (ii) the costs of this action, plus interest, as provided by law; and (iii) any other relief that this Court deems appropriate.

XI. DEMAND FOR JURY TRIAL

The United States of America hereby demands a trial by jury.

DATED: October 25, 2021

Respectfully submitted,

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA *ex rel.* RONDA OSINEK, Plaintiff, v. KAISER PERMANENTE, KAISER FOUNDATION HEALTH PLAN, INC., and THE PERMANENTE MEDICAL GROUP, INC. Defendants.	**Case No. 3:13-cv-03891-EMC** **FIRST AMENDED COMPLAINT FOR MONEY DAMAGES AND CIVIL PENALTIES FOR VIOLATIONS OF THE FALSE CLAIMS ACT** **DEMAND FOR JURY TRIAL**

NATURE OF THE ACTION

1. This is a civil action brought by Relator Ronda Osinek on her own behalf and on behalf of the United States of America against Kaiser Permanente, Kaiser Foundation Health Plan, Inc., and The Permanente Medical Group, Inc. (collectively, "Kaiser") under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, to recover damages, civil penalties, and other relief owed to the United States and Relator.

2. Kaiser is a private provider of Medicare Advantage insurance under Medicare Part C. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage plans than any other organization in California. Kaiser defrauded the United States through a sophisticated scheme to upcode diagnoses to ensure Medicare payments for reimbursable, high-value conditions. Kaiser effectuated its scheme through data mining and pressuring physicians and staff to retroactively change patient medical records.

3. Kaiser's upcoding scheme is a direct violation of the Federal requirements for Medicare beneficiary reimbursement, leads to the submission of false and fraudulent claims to the United States, and results in Kaiser receiving excess Medicare payments.

PARTIES

4. Plaintiff is the United States of America by and through Relator, Ronda Osinek. Relator was a resident of the State of California when this action was initiated; she is now a resident of the State of Oregon. Plaintiff brings this action on behalf of the United States Department of Health and Human Services and its component, the Centers for Medicare & Medicaid Services.

5. Relator Ronda Osinek was employed by Kaiser as a Data Quality Trainer from June 2006 through mid-2014. Internal, non-public information known to Relator serves as the basis for this action. Relator has direct knowledge of methods used by Defendants to submit false or fraudulent data to CMS for reimbursement.

6. Defendant Kaiser Permanente is headquartered in Oakland, California and comprises Kaiser Foundation Health Plan, Inc. and the Permanente Medical Groups (including The Permanente Medical Group, Inc.), along with Kaiser Foundation Hospitals and its subsidiaries.

7. Defendant Kaiser Foundation Health Plan, Inc. is a California corporation with its principal place in Oakland, California. Kaiser Foundation Health Plan, Inc. is a healthcare organization and provides health care plans to members of the public. At all times relevant, Kaiser Foundation Health Plan, Inc. conducted business in California.

8. Defendant The Permanente Medical Group, Inc. is a California corporation and has its principal place of business in Oakland, California. The Permanente Medical Group, Inc. is the largest medical group in the United States, providing and arranging professional medical services for over 4.5 million patients in Northern California. At all times relevant, The Permanente Medical Group, Inc. conducted business in California.

JURISDICTION AND VENUE

9. This Court has subject matter jurisdiction under 28 U.S.C. §1345. This Court has subject matter jurisdiction over the claims alleged in this Complaint under 28 U.S.C. §§ 1331 (Federal question), 1345 (United States as plaintiff), and 31 U.S.C. § 3732(a) (False Claims Act).

10. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because Defendants can be found, reside, and transact business in the Northern District of California and because an act proscribed by 31 U.S.C. § 3729 occurred within this District.

11. This Complaint is not based on the facts underlying any pending action, within the meaning of the False Claims Act's first to file rule, 31 U.S.C. § 3730(b)(5).

12. This action is not precluded by any provisions of the False Claims Act's jurisdiction bar. 31 U.S.C. § 3730(e) *et seq*.

a. This Complaint is not based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the United States is already a party. 31 U.S.C. §3730(e)(3).

b. There has been no "public disclosure" of the matters alleged herein and this action is not "based upon" any such disclosure, within the meaning of 31 U.S.C. §3730(e)(4)(A). Notwithstanding the foregoing, Relator is an "original source" of this information as defined by 31 U.S.C. §3730(e)(4)(B) of the False Claims Act, and as such, she is expressly excepted from its public disclosure bar.

13. Venue is proper in the San Francisco or Oakland Divisions of the Northern District of California under 31 U.S.C. § 3732(a), 28 U.S.C. § 1391(b), and Civil Local Rule 3-2(d) because Defendants can be found in and transact business within this District.

THE FEDERAL FALSE CLAIMS ACT

14. The False Claims Act was originally enacted in 1863 and was substantially amended in 1986. Congress enacted the 1986 amendments to enhance and modernize the government's tools for recovering losses sustained by frauds against it after finding that federal program fraud was pervasive. The amendments were intended to create incentives for individuals with knowledge of government frauds to disclose the information without fear of reprisals or government inaction, and to encourage the private bar to commit resources to prosecuting fraud on the government's behalf.

15. The False Claims Act provides that any person who presents, or causes to be presented, false or fraudulent claims for payment or approval to the United States Government, or knowingly makes, uses, or causes to be made or used false records and statements to induce the government to pay or approve false and fraudulent claims, is liable for a civil penalty ranging from $5,500 up to $11,000 for each such claim, plus three times the amount of the damages sustained by the federal government. No proof of specific intent to defraud is required under the Act.

16. The Act also allows any person having information about false or fraudulent claims to bring an action for himself or herself and the government, and to share in any recovery. Based on these provisions, Relator seeks through this action to recover all available damages, civil penalties, and other relief for state and federal violations alleged. Although the precise amount of the loss from Kaiser's misconduct alleged in this action cannot presently be determined, it is estimated that the damages and civil penalties amount to millions of dollars.

BACKGROUND

17. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program. Medicare is a federally-funded health insurance program for people who are over the age of 65, under age 65 with certain disabilities, and for people of all ages with End-Stage Renal Disease. As of 2012, Medicare provided insurance to approximately 50.7 million people.

18. The Centers for Medicare & Medication Services ("CMS") is the division of the Department of Health and Human Services that is responsible for the reimbursement, administration, and supervision of the Medicare program. Medicare includes the following categories of benefits: hospital insurance for inpatient hospital care (Part A), medical insurance for doctors' services and outpatient care (Part B), and prescription drug coverage to offset the cost of medications (Part D). Medicare beneficiaries may opt out of the traditional program and receive benefits through Medicare Part C, also known as "Medicare Advantage." Medicare Advantage plans are federally funded privately-run insurance plans. For a monthly fee established by Medicare that is determined per enrollee, Medicare Advantage organizations, such as Kaiser, provide the services available through Medicare Parts A and B (inpatient and outpatient services).

19. The per-enrollee monthly fee is derived by a formula that is primarily based on two main factors. The first factor, the base rate, is the standard cost of providing Medicare Parts A and B benefits to an average beneficiary. The second factor is a risk score that takes into consideration the enrollee's actual health risks based on disease conditions and his or her demographics, such as age and gender. The risk score is calculated using a complex statistical model called the CMS-HCC Risk Adjustment Model. The result is that enrollees with more severe health risks derive a higher monthly payment because Medicare expects that they will require more expensive care. In other words, the higher the risk score, the more money Medicare pays the Medicare Advantage organization (such as Kaiser) each month.

20. CMS requires Medicare enrollees' disease conditions to be diagnosed and memorialized by a physician as a result of a face-to-face encounter according to the *International Classification of Disease, Ninth Revision, Clinical Modification* ("ICD-9"), which is the official system of assigning codes to diagnoses associated with health care in the United States. The ICD-9 codes are mapped to disease groups known as hierarchical condition categories or HCCs. The HCC categories are, in turn, used under the risk adjustment model to reflect the enrollee's health risks, and thus directly correlate to the amount of payments the Government is to pay the Medicare Advantage organization each month.

FEDERAL REQUIREMENTS FOR MEDICARE ADVANTAGE PAYMENTS

21. Medicare Advantage plans such as Kaiser are legally obligated to accurately and properly submit data to CMS to receive payment for Medicare beneficiaries. The Medicare Advantage plan must have documentation from provider encounters (rather than prescriptions or test results) supporting associated ICD-9 diagnoses. Any causal link between a disease and a resulting complication must be established and supported during the doctor-patient visit. According to the ICD-9 Official Guidelines:

> The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.
>
> The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

22. All relevant documentation is entered into a medical record at the time of service. CMS recognizes, however, there may be times that a provider will need to amend, correct, or enter documentation related to an encounter. CMS expects supplemental documentation to be occasional, and that delayed or amended entries will be entered within a reasonable time frame. *See* Medicare Program Integrity Manual, Pub. 100-08, ¶3.3.2.5 (Rev. 442, Implementation Jan. 8, 2013). CMS will consider delayed or amended explanations for diagnoses so long as the explanations are for clarification and not for substantiating retroactive diagnoses. According to the leading organization that trains and certifies individuals on physician-based medical coding, the American Association of Professional Coders or AAPC, Medicare understands a reasonable time frame to be 24 to 48 hours because it is not reasonable for a provider to recall a visit two weeks (or more) after it occurred. Similarly, according to AAPC, addenda to medical records should not be a normal practice, but an exception to CMS' general rule in which a provider fully documents a visit at the time of the encounter or shortly thereafter.

23. CMS also requires that all documentation in a medical record be specific to a given patient's situation at the time of the documented visit, which means medical records documentation

language should not be the same (i.e., cloned or boilerplate) from patient to patient or provider to provider.

KAISER VIOLATED THE FALSE CLAIMS ACT

24. Prior to 2004, Medicare Advantage organizations such as Kaiser were paid by CMS only based on an enrollee's demographic information. For instance, prior to 2004, Kaiser was paid the same for all 77-year-old women in a community regardless of their actual disease conditions. When Congress passed the Medicare Modernization Act of 2003, CMS phased in the CMS-HCC Risk Adjustment Model between 2004 and 2007. Beginning in 2007, Medicare Advantage plans received payments based entirely on the CMS-HCC Risk Adjustment Model, which, as described above, considers an enrollee's actual health risk.

25. In response to the phase-in of the Risk Adjustment Model, Kaiser established the Encounter Information Operations department. The department is managed by The Permanente Medical Group, Inc., in Oakland, California, and tasked with overseeing Medicare coding and ensuring document standards are met. The Encounter Information Operations department includes Data Quality Trainers, Data Quality Auditors, CMS project managers, and CMS lead physician(s) who are assigned to, and work out of, each of Kaiser's Northern California facilities. Relator, a trained and certified medical coder, was recruited and hired by The Permanente Medical Group as the Data Quality Trainer and Audit Manager for the San Rafael Kaiser facility in 2006. Relator trained physicians on coding guidelines. If the facility's auditor found discrepancies between coding and documentation in progress or visit notes, Relator was sent to meet with the physicians to remediate the discrepancies and re-train them on proper coding practices.

26. In or about 2007, there was a shift in the interactions with doctors and the management of the Encounter Information Operations department at Kaiser. Kaiser's Encounter Information Operations department began using a system to capture "missed opportunities," which are brought to the attention of physicians to ensure that all possible Medicare billing opportunities are captured, a process some Kaiser physicians refer to as "diagnosis chasing." By moving away from its focus on data quality and auditing physician coding to what Kaiser terms "refreshing" and "data mining," Kaiser was able to increase its billings for high value hierarchical condition categories or HCCs.

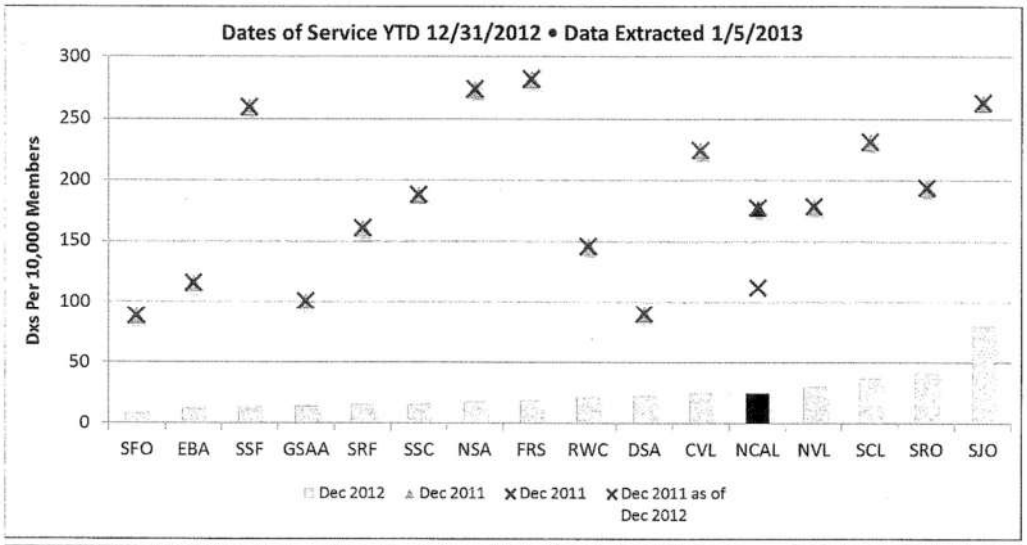
27. Kaiser focuses its data mining on high value disease conditions for which Kaiser can maximize its reimbursement from Medicare and increase its revenue. Put another way, Kaiser identified the higher value HCCs and then determined the diagnoses its doctors would need to make to support the HCCs Kaiser wanted to submit for Medicare reimbursement. As of 2012, the Encounter Information Operations department used a variety of algorithms to identify the following disease conditions for data mining, which leads to upcoding (changes made over time in the diagnosis codes that make their enrollees appear less healthy than they actually are):

a. Chronic kidney disease
b. Diabetes mellitus with diabetic chronic kidney disease
c. Diabetes mellitus with diabetic nephropathy
d. Congestive heart failure
e. Depression
f. Amputations
g. Ostomy
h. Tracheostomies
i. Stable angina
j. Peripheral vascular disease
k. Diabetic peripheral vascular disease
l. Diabetes with diabetic dyslipidemia
m. Diabetes with diabetic erectile dysfunction
n. Chronic respiratory failure
o. Cachexia/Protein Calorie Malnutrition
p. Severe obesity
q. Dementia
r. Seizure
s. Chronic pancreatitis

28. The consequence of Kaiser's focus on refreshing and data mining for missed opportunities is that physicians take into consideration HCCs and the Medicare payment system when

coding and recording patient encounters. For example, Kaiser told its physicians to diagnose chronic kidney disease instead of the lower value nephritis or nephropathy. From 2010 to 2012, Kaiser shifted diagnoses from the lower risk nephropathy to the higher health risk (and higher-paying) chronic kidney disease. The charts below demonstrate Kaiser's success in bringing up its chronic kidney disease diagnoses while shifting away from the lower-paying nephropathy. HCC 132 (nephropathy) dropped by 200 diagnoses per 10,000 members from 2010 to 2012. HCC 131 (chronic kidney disease), which has a higher risk and is reimbursable at a higher rate than HCC 132, increased by more than 400 diagnoses per 10,000 members during the same time period.

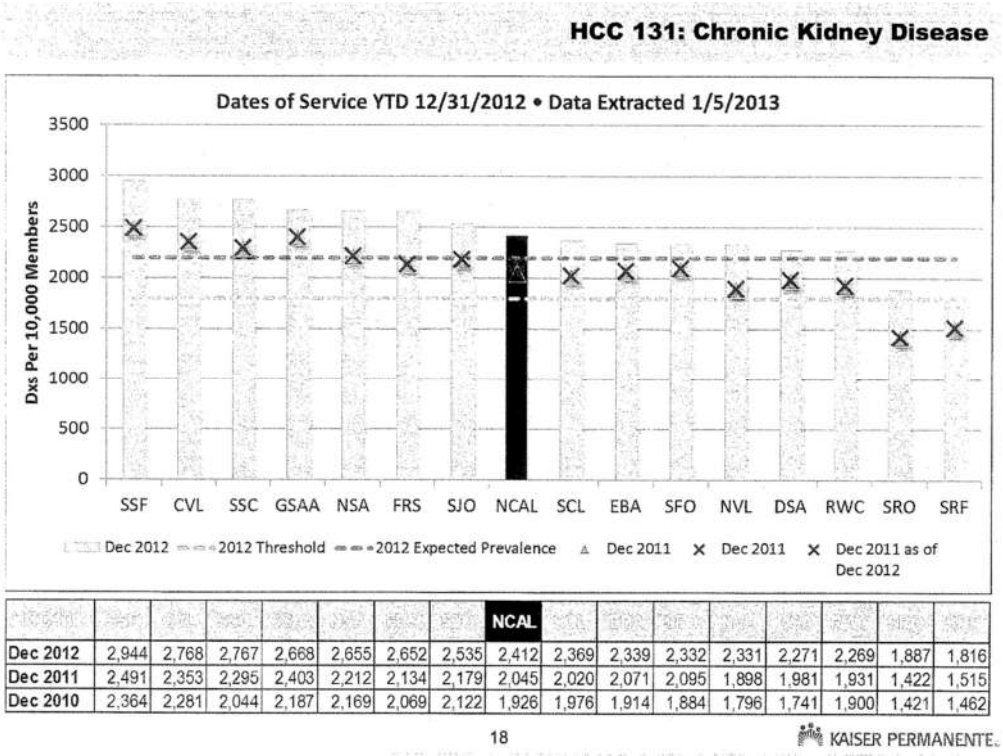
HCC 132: Nephropathy



												NCAL				
Dec 2012	9	12	13	14	15	16	17	18	21	23	25	25	30	37	41	80
Dec 2011	88	115	259	101	161	188	274	282	146	90	225	177	178	232	194	263
Dec 2010	253	215	246	245	171	320	259	268	136	204	217	225	184	253	198	282

19

KAISER PERMANENTE



29. Likewise, when CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser tells its physicians to change coding practices to reflect new reimbursable codes. CMS is "concerned about the high rate of coding of other HCCs by M[edicare] A[dvantage] organizations, [Fee for Service or] FFS providers, given that the coefficients are calibrated on FFS data." Therefore, CMS "made changes to . . . HCCs to address M[edicare] A[dvantage] coding intensity." For example, "[s]ince the clinically-revised model allowed [CMS] to better estimate marginal costs for a wider range of renal disease (specifically, the current HCC131 renal failure is split among a range of acute and chronic kidney conditions), we removed the lower-severity kidney disease HCCs, including Chronic Kidney Disease (CKD) stage 3, CKD stages 1-2, or unspecified; unspecified renal failure; and nephritis." In other words, to address upcoding, CMS notified Medicare Advantage providers that starting in 2014, the HCCs for chronic kidney disease stages 1 through 3 would be eliminated, meaning that Kaiser would no longer receive reimbursement for patients submitted with HCC 131. In response to CMS's notification that HCC 131 will be eliminated, Kaiser promptly sent materials to its staff to begin prompting physicians to code diagnoses for acute kidney injury instead of

chronic kidney disease stage 1, 2, or 3, which will be included in the 2014 HCC list and reimbursable by Medicare.

30. To support the HCCs submitted to Medicare, Kaiser needs its physicians to amend patient files. Under CMS guidelines, physicians must verify that they considered a diagnosis or treated a diagnosis during the physician encounter, which means a physician must address what was contemporaneously considered if he or she addends a diagnosis. Kaiser's Medicare enrollee medical records include addenda with supporting statements or documentation that were not addressed at the time of an encounter. Kaiser should be training physicians to follow Medicare best practices and guidelines to contemporaneously document and code disease conditions during or immediately after face-to-face visits. Instead, Kaiser has its physicians systematically addend patient records retroactively—often many months after visits—with cloned or boilerplate language to make the patient record appear to comply with CMS instructions.

31. After an encounter, Kaiser tells physicians to go back to see what a member's previous test results showed to make diagnoses, which is not an appropriate data source for coding a diagnosis under CMS guidelines nor does it comply with CMS best practices for contemporaneous documentation and coding. In the specific example below, a patient was seen for a knee and sleep problem. Two months after the visit, the physician addended the progress note to say the patient has diabetes with chronic kidney disease (DM2 W DIABETIC CKD STAGE 1) based on laboratory tests, with no indication that the diabetes or chronic kidney disease was addressed at the visit:

Reason For Visit History

User	Date & Time
Sitchler, Christi A	**7/6/2012 2:26 PM**

Reason For Visit
KNEE PROBLEM
Comment : RT x 2 days
SLEEP PROBLEM

User	Date & Time
Sitchler, Christi A	**7/6/2012 2:25 PM**

Reason For Visit
KNEE PROBLEM
Comment : RT x 2 days

User	Date & Time
Sitchler, Christi A	**7/6/2012 2:25 PM**

Reason For Visit
KNEE PROBLEM

Diagnoses

SPRAIN TIBIOFIBULA, SUPERIOR - Primary	844.3
MAJOR DEPRESSION, RECURRENT	296.30
DYSSOMNIA	780.56
DM 2 W DIABETIC CKD STAGE 1 (GFR >= 90)	250.40, 585.1

After Visit Summary

After Visit Summary

Progress Notes

Lewis, Anna Klaertje (M.D.) 9/19/2012 7:50 PM Signed
After review of my note for this visit encounter, I recall this encounter and am addending this note to state that this patient has diagnosis of:

DM 2 W DIABETIC CKD STAGE 1 (GFR >= 90)
Note: GLOMERULAR FILTRATION RATE - AFRICAN AMERICAN >60 07/06/2012
GLOMERULAR FILTRATION RATE - AFRICAN AMERICAN >60 04/03/2012
GLOMERULAR FILTRATION RATE - AFRICAN AMERICAN >60 06/21/2011
GLOMERULAR FILTRATION RATE, NONAFRICAN AMERICAN >60 07/06/2012
GLOMERULAR FILTRATION RATE, NONAFRICAN AMERICAN >60 04/03/2012
GLOMERULAR FILTRATION RATE - NONAFRICAN AMERICAN >60 06/21/2011
GLOMERULAR FILTRATION RATE - NONAFRICAN AMERICAN >60 11/04/2010
GLOMERULAR FILTRATION RATE - NONAFRICAN AMERICAN >60 03/18/2010
CREATININE 0.78 07/06/2012
ALBUMIN/CREATININE RATIO, UR 54.5 07/06/2012
GFR is stable, but patient has microalbuminuria. Will follow. Control DM, HTN

32. In addition, Kaiser tells it doctors to change diagnoses to upcode to higher value and more complicated forms of diseases. For example, Kaiser prompted physicians to addend diabetes diagnoses to include hyperlipidemia as a complication where tests or records reflected hyperlipidemia regardless of whether the hyperlipidemia was actually *due to* diabetes. Likewise, changed diagnoses to add complications are addended long after patient encounters. Dr. Pont, in the example below, addended her progress note seven months after the initial patient visit to change a diagnosis from diabetes without complications (ICD-9 250.00) to diabetes with mixed hyperlipidemia (250.80, 272.2), which maps to a higher reimbursement HCC:

Visit and Patient Information

Encounter Date
2/3/12

Reason For Visit History

User	Date & Time
Griffin, Kristine G (M.A.)	2/3/2012 10:51 AM

Reason For Visit
PHYSICAL EXAMINATION

Diagnoses

ACTINIC KERATOSIS - Primary	702.0
PHASE POPULATION MANAGEMENT PROGRAM.	V49.89
DM, WO RETINOPATHY	250.00
DM 2	250.00
HYPERLIPIDEMIA	272.4
HTN	401.9
GOUT	274.9
SCREENING FOR CA, COLON	V76.51
ELEVATED PROSTATE SPECIFIC ANTIGEN MEASUREMENT	790.93
HYPERPARATHYROIDISM, PRIMARY	252.01
DM 2 W DIABETIC HYPERLIPIDEMIA, MIXED	250.80, 272.2

After Visit Summary

After Visit Summary

Progress Notes

Pont, Joan Turner (M.D.) 9/20/2012 6:57 PM Signed
Addendum to previous chart entry on 2-3-12
After reviewing the notes from the aforementioned visit, I recall the visit. The previous note reflects that I evaluated the patient who has the diagnosis of dm2 with mixed hyperlipidemia as evidence by tg 210 on 11-8-05, ldl 134 on 6-5-01.

Pont, Joan Turner (M.D.) 2/3/2012 11:30 AM Signed
Clinical Progress Note:
Patient presents with a chief complaint of PHYSICAL EXAMINATION

HPI: completed cataract surgery and whiter and brighter vision! Left still needs to be done

I have reviewed
medical history with no changes 2/3/2012, social history with no changes 2/3/2012 and family history with no changes 2/3/2012

33. Kaiser also addended and submitted diagnostic codes for complex conditions without proper support (i.e., not a true causal connection). In 2009, providers were told to capture diagnoses of Peripheral Vascular Disease ("PVD") and Diabetic Peripheral Vascular Disease ("DPVD") using Carotid Artery Stenosis as evidence.

a. Dr. Lori Selleck saw a patient on April 10, 2009 at 4:31 PM. There is no mention of PVD, however, four months later, on December 30, 2009, there is an addendum stating, "PVD = carotid a stenosis." Not only is the code assigned long after the patient encounter, but there is no evidence or documentation showing that the condition was present during the physician encounter. Furthermore, PVD and Carotid Artery Stenosis have no causal link:

Visit and Patient Information

Encounter Date
4/10/09

Reason For Visit History

User	Date & Time
Steenburgh, Tyrone N (M.A.)	**4/10/2009 4:31 PM**

Reason For Visit
PHYSICAL EXAMINATION

Diagnoses

HEALTH CHECK UP, ADULT - Primary	V70.0
HYPERTENSION	401.9
GIANT CELL ARTERITIS	446.5
HYPERLIPIDEMIA	272.4
CAROTID ARTERY STENOSIS, ASYMPTOMATIC	433.10
PERIPHERAL VASCULAR DISEASE	443.9

After Visit Summary
After Visit Summary

Progress Notes
Selleck, Lori Z. (M.D.) 12/30/2009 12:28 PM Addendum
PVD = carotid a stenosis

b. Dr. David Conant met with a patient on June 28, 2011. Almost one year later, on May 28, 2012, at 8:44 AM he addended his progress note to replace nephropathy with chronic kidney disease, just as Kaiser encouraged to ensure the higher value HCC would be captured when Medicare paid for this enrollee:

Visit and Patient Information

Encounter Date
6/28/11

Reason For Visit History

User	Date & Time
Jones, Marlene J. (M.A.)	**6/28/2011 8:58 AM**

Reason For Visit
HEALTH MAINTENANCE

Diagnoses

HEALTH CHECK UP, ADULT - Primary	V70.0
DM 2 W LOW HDL AND HIGH TRIGLYCERIDE DUE TO DM (DIABETIC DYSLIPIDEMIA)	250.80, 272.4
HYPERLIPIDEMIA	272.4
HTN	401.9
DM 2 W DIABETIC CHRONIC KIDNEY DISEASE, STAGE 1	250.40, 585.1

After Visit Summary
After Visit Summary

Progress Notes
Conant, David Loring (M.D.) 5/17/2012 8:44 AM Addendum
Diagnosis of DM2 with diabetic nephropathy microalbuminuria was replaced with DM2 with diabetic chronic kidney disease stage 1 because the latter is more appropriate for his condition.

Conant, David Loring (M.D.) 6/28/2011 9:26 AM Signed
Chief Complaint
Member presents with Patient presents with:
HEALTH MAINTENANCE

HPI: Accompanied by mother and sister. Generally doing well. Attending day program, using stationary bike 45 minutes on most days.

At today's visit I reviewed the patient's problem list, past medical and surgical history, social history and relevant family history.

34. Kaiser also provides boilerplate phrases to help its physicians justify addenda. Kaiser's boilerplate addendum phrases can be automatically inserted through a combination of key strokes and physicians are expected to use these phrases rather than their own language and discretion based on what they recall from visits. The language Kaiser physicians use is intended to give CMS the impression that the doctor thought about the addenda and wants to comply with Medicare instructions for amendments and corrections. Encounter Information Operations staff send emails to physicians recommending the use of macros such as ".DXUPDATE" for addendum phrases, leading the physicians to state exactly what Kaiser needs records to say to amend records for coding. For example, when a physician enters ".DXUPDATE," the following phrases will populate the medical record: "After review of my note for this encounter, I recall this visit and am addending this note to state that this patient has a more specific diagnosis of: @diag@."

a. Dr. Rukiye Yoltar met with a patient on September 5, 2012. At 5:53 PM on October 9, 2012, a month later she writes: "After review of my note for this encounter, I recall this visit and am addending this note to state that this patient has a more specific diagnosis of: DM 2 W DIABETIC MIXED HYPERLIPIDEMIA (primary encounter diagnosis)."

b. Dr. Charles E. Metzger met with a patient on January 19, 2012 at 11:13 AM. Nearly nine months later on October 9, 2012, at 6:34 PM he used nearly identical language as Dr. Yoltar on the same day: "After review of my note for this encounter, I recall this visit and am addending this note to state that this patient has a more specific diagnosis of: DM2 W DIABETIC MIXED HYPERLIPIDEMIA."

c. Another example of boilerplate language was sent through email for use with upcoding to diabetes with diabetic chronic kidney disease:

FROM EMAIL SENT BY KAREN GRAHAM TO DOC CODING LEADS

Karen Graham/CA/KAIPERM
11/08/2011 11:34 PM

To Doc Coding Leads-KPNC
cc
Subject EBA-SmartPhrase for Addendum to capture DM w/DCKD

As a follow up to the Doc & Coding Leads conf call, East Bay provided the following Smartphrase which Dr. David Law created to use in an Addendum for DM w/DCKD:

"After reviewing my visit note, I recall this encounter. The visit note reflects that I evaluated the patient, who has the diagnosis of diabetic CKD, stage 1. Plan is to optimize control of blood pressure and diabetes, and recheck urine protein"

35. Although physicians should be using their own discretion for diagnosing, if doctors disagree with the prompt to review and addend records, they must explain their refusal to the regional Encounter Information Operations auditors. To ensure there are almost no "missed opportunities" to capture data mined and refreshed diagnoses, Kaiser pressures its physicians to addend diagnoses and capture the high value HCCs, with the assistance of staff, including Relator. For example, to ensure capturing of HCCs, Kaiser instituted an escalation process for physicians who do not agree with the data mining prompts. Physicians will have to meet one-on-one with Data Quality Trainers if they refuse to make diagnoses changes that are presented by data mining. The physicians must explain why they disagree, resulting in The Permanente Medical Group's management engaging with these physicians directly until there is resolution. Physicians often give in and use the diagnoses that management asks for rather than using their own, original judgment in coding diagnoses. The following slide from the Encounter Information Operations department describes the escalation process, including meeting with management such as Lead Physician Jill Dunton.

36. In addition to the escalation process the physicians face if they refuse to comply with the prompts to refresh or retroactively change diagnoses, physicians have personal report cards based on how they perform in certain areas, which are tied to their compensation. After the Encounter Information Operations shifted to emphasizing the importance of HCC and their matching diagnostic codes, the physician report cards included how they respond to refreshing and data mining prompts. In other words, bonuses for doctors now become, at least in part, tied to diagnosis chasing.

37. Kaiser also pressures providers into approving retroactive diagnoses, which increase revenue, but does not ensure quality of care. Kaiser has mandatory meetings called "coding parties," where physicians are gathered in a single room with computers and asked to review past progress notes for addenda related to revised medical diagnoses. Coding parties occur on at least a yearly basis. There are new diagnoses to focus on every year and physicians are expected to addend 30 to 40 progress notes over a 3-hour period. Addenda made in September and October of 2012, demonstrate there were "coding parties" where, for example, the following physicians amended medical records for diagnoses of diabetes with mixed hyperlipidemia, as described above:

a. On September 19, 2012:

- Dr. Irina Sophie Cons Defischer addended at 6:15 PM;

- Dr. Patrick Flynn Roland addended at 6:38 PM; and
- Dr. Anna Klaertje Lewis addended at 7:11, 7:22, 7:25, and 7:50 PM.

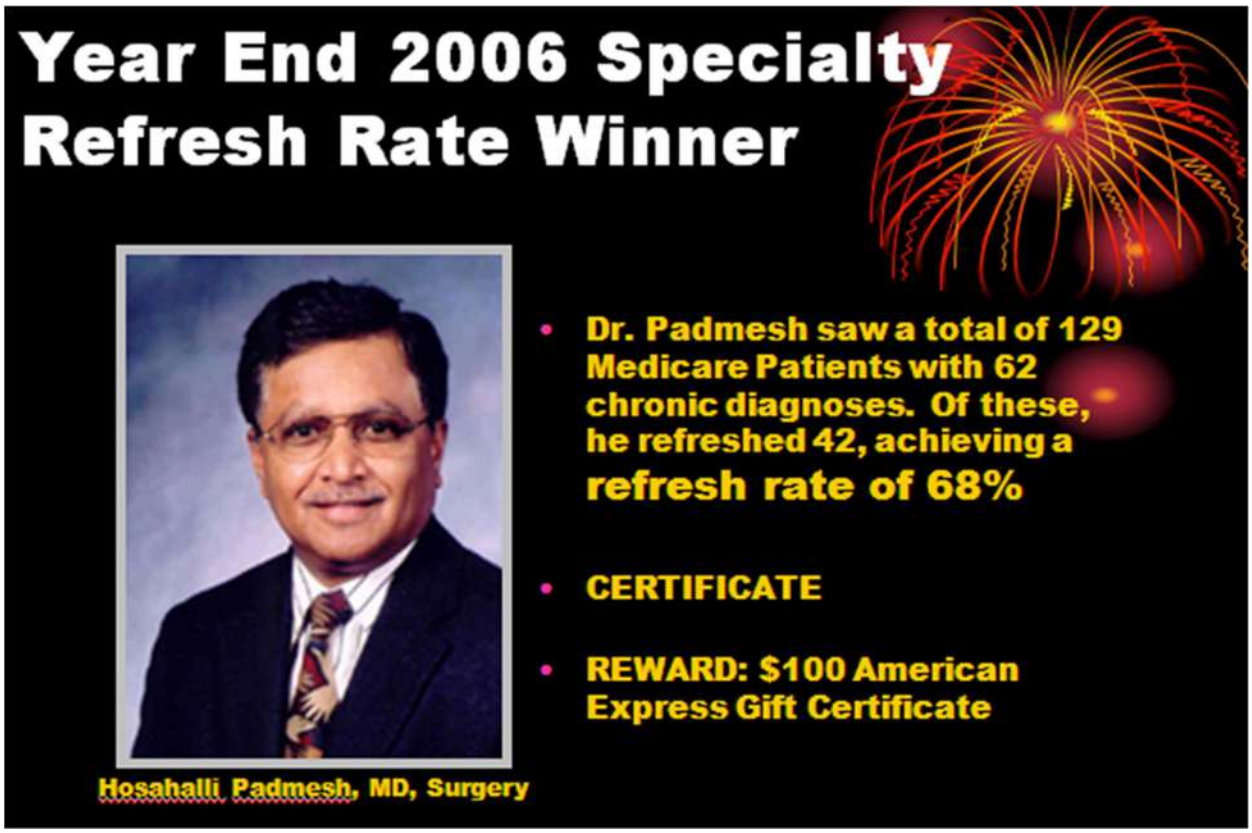
b. On September 20, 2012:

- Dr. Raymund Mafnus Damian addended at 6:14 PM;
- Dr. Carolyn Mar addended at 6:37 PM;
- Dr. Jill Dunton addended at 6:40 PM and 7:10 PM;
- Dr. John David Culbertson addended at 6:42 PM;
- Dr. Roberto Gonzalez addended at 6:46 PM;
- Dr. Ryan Scott Lum addended at 6:47 PM;
- Dr. Joan Turner Pont addended at 6:47 and 6:57 PM;
- Dr. John David Culbertson addended at 6:56 PM;
- Dr. Alan Kneital addended at 6:56, 6:59, 7:01, 7:06, and 7:10 PM; and
- Dr. Lori Selleck addended at 7:04 PM.

c. On October 9, 2012:

- Dr. Rukiye Yoltar addended at 5:53 and 6:20 PM;
- Dr. Daniel Gerard White addended at 6:16 PM; and
- Dr. Charles Metzger addended at 6:33 and 6:34 PM.

38. Kaiser also pressures physicians to diagnose Medicare patients through incentive programs, such as this doctor's $100 reward:



39. Kaiser tracks and rewards physicians based on the percentage of chronic conditions they are able to capture and refresh. Additionally, Kaiser positioned the Southern California Region against Northern California in competition for the highest risk scores and physician approval rates. The following demonstrates the competition from the Physician Leads Meeting in March 2008:

HCC Hierarchy	Norhern Cal		Southern Cal		Potential Increase
	Higher HCCs	Low HCCs	High HCCs	Low HCCs	
Diabetes HCC 15-19	56%	44%	73%	27%	$53M
Cancer HCC 7-10	16%	84%	20%	80%	$17M
Renal Failure HCC 131-132	83%	17%	99%	1%	$10M
Depression	569 / 10k		852 / 10k		$20M
Protein Calorie Malnutrition	37 / 10k		157 / 10k		$33M
Totals					$133M

"Highest Specificity" Documentation (It's more than 'See & Capture' now)

ISSUE:

In five HCCs categories, SCal appears to document more conditions in higher diagnostic categories of the same hierarchy, which could result in:

- enhanced patient care tracking
- improved disease monitoring
- appropriate reimbursement for illness burden
- significant financial impact, estimated at an estimated $80M variance for capture within the 5 categories

Regional Focus Audit Verification:

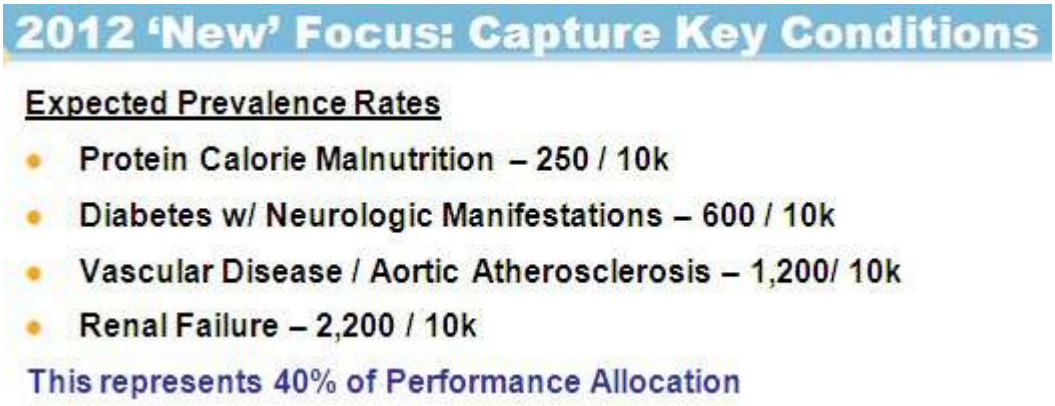
- 7% of Cancer HCC7 indicated metastatic disease was implicitly or explicitly documented but not captured
- 25% of Diabetes complications – not captured

40. The competitive pressure is not only exerted between regions, but within the region. An email from Aaron Smith regarding the San Rafael Kaiser facility on May 17, 2013, describes the ranking of facilities on documentation and coding "missed opportunities" for April 2013. Mr. Smith states:

> Refresh: We are at 70.9%, 6th in the Region (down from 5th last month), above where we were in 2012 (69%), above the tracking goal of 64%, as well as the Region average of 67.3 percent.
>
> With the change in payment structure for 2013 (60% for Data Mining, 40% for Refresh), I believe passing the April benchmark brings our performance payment for the year to $143,114.

> We currently have just under 1600 outstanding missed opportunities out to PCP's. Granted many of those are data mining prompts, which are not in our refresh denominator, but are in the addressed data mining denominator (which is actually worth more locally than standard refresh). So we certainly could and should be doing better than our 70.9% rate if that number could be significantly reduced through one-on-one sit-down with those PCP's who have a large number of dx that we have not hard [sic] back on."
>
> Seeing Pts: We are at 78.1%, 3rd in the Region, above where we were at this point in 2012 (76.7%) and the Region average (75.6%).
>
> The caller and PCP/MA's are currently calling those members who were unable to reach when they were originally on a call list and were due for an appointment in the first half of the year. With such an elevated Seeing Patients percentage, it's a bit disappointing that hasn't translated to a higher overall refresh percentage and data mining addressed rate which are two [of] the benchmarks that **we are financially incentivized on** [emphasis added].
>
> …
>
> Data Mining: We are below the Region average in terms of coding (88.8% vs. 91.9%) and have gone through a lower percentage of overall prompts than the NCAL [Kaiser Northern California] average to date (43.5% vs. 48.2%). This places us 13th in NCAL, which is staggeringly low considering where we are at with Patients Seen and Refresh. The percentage of prompts required to either be stopped or coded for by the end of the year is 90 percent. Doing that will lead to receiving the remaining 60% of the annual allocation not tied in with refresh.
>
> Part of the gap between the 43.5 and 48.2 numbers could be made up by that overwhelming number of PCP missed opportunities mentioned above, which includes a large number of data mining prompts that even if we can't addend for or stop could at least be put on the Problems List to alert the clinician the next time they see the member. That will be of utmost importance as this is a category that the denominator can continue to grow through October 31, which is the deadline for Region in releasing prompts that need to be addressed or stopped by December 31, 2013.

41. Kaiser ties funding allocations to a facility's refresh and data mining rates such that a facility will lose an allocation if goals are not met. For example, in 2012, Kaiser's goal for refreshing chronic diagnoses was 99%, which was 60% of a facility's total allocation. The 2012 goal for addressing data mining conditions was 90%, which was 40% of the total allocation. In other words, if the providers do not address at least 90% of the data mined conditions, 40% of the allocation was unavailable the next year.



42. In 2013, Kaiser's goal for refreshing chronic diagnoses is 99%, which is 40% of a facility's total allocation. The 2013 goal for addressing data mining conditions is still 90%, but it is now 60% of the total allocation. Data mining is a key factor for Kaiser's facility allocations. The Data Quality Trainers, such as Relator, are managed by the regional office in Oakland, so the pressure is primarily on the physicians to make sure they address all the refreshing and data mining for own their facilities.

43. The focus since 2007 on data mining and high value HCCs has ensured increased billings from Kaiser to Medicare. For example in 2009 alone, high value HCCs resulted in $51 million dollars in CMS payments to Kaiser's Northern California region:

Data-Mining Condition	Volume	Reimbursement
HF	62	$ 52,500.00
CKD	3434	$ 7,237,327.00
DEP	4927	$ 9,470,285.00
DM w/ PN	7499	$ 7,762,590.00
Protein Calorie Malnutrition	435	$ 1,048,829.00
AMP, OST-STOMA, Trach	142	$ 440,911.00
DM w/ PVD	188	$ 392,679.00
DM w/ CKD	1785	$ 6,018,734.00
MDD	1318	$ 3,101,175.00
CAD	6983	$ 4,639,435.00
PVD	439	$ 755,458.00
DM w/ DYS	2965	$ 6,133,814.00
DM w/ ED	1791	$ 3,705,113.00
Totals	**31968**	**$51M**

44. Kaiser failed to, and continues to fail to, comply with CMS guidelines and instructions. With the addition of more data mining prompts each year, despite CMS' efforts to rein in payments to Medicare Advantage organizations, Kaiser's reimbursement continues to grow, violating the False Claims Act.

COUNT I

False Claims Act Violations – Presentation of False Claims

(31 U.S.C. § 3729(a)(1)(A))

45. Relator re-alleges and incorporates all paragraphs alleged herein.

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

47. By reason of these payments, the United States has been damaged, and continues to be damaged, by a substantial amount.

COUNT II

False Claims Act Violations – False Records or Statements

(31 U.S.C. § 3729(a)(1)(B))

48. Relator re-alleges and incorporates all paragraphs alleged herein.

49. By virtue of the acts described above, Defendants knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims paid or approved by the United States Government in violation of 31 U.S.C. § 3729(a)(1)(B).

50. By reason of these payments, the United States has been damaged, and continues to be damaged, by a substantial amount.

PRAYER FOR RELIEF

WHEREFORE, Relator Ronda Osinek requests that judgment be entered against Defendants, ordering that:

51. Defendants pay not less than $5,500 and not more than $11,000 for each violation of 31 U.S.C. § 3729(a) plus three times the amount of damages the United States has sustained because of Defendants' actions;

52. Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d);

53. Relator be awarded all costs of this action, including attorneys' fees and costs pursuant to 31 U.S.C. § 3730(d); and

54. The United States and Relator recover such other relief as the Court deems just and proper.

JURY TRIAL

Pursuant to Federal Rule of Civil Procedure 38, Plaintiff demands a trial by jury.

Dated: October 7, 2021

Respectfully Submitted

By: */s/ Amy M. Zeman*

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK, Plaintiff, v. KAISER PERMANENTE, Defendant.	Case No. 3:13-cv-03891-EMC **UNITED STATES' NOTICE OF ELECTION TO INTERVENE IN PART AND TO DECLINE TO INTERVENE IN PART; ORDER TO UNSEAL** **FILED UNDER SEAL**

(captions continued on next page)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR, and PRIME HEALTHCARE SERVICES, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **UNITED STATES' NOTICE OF ELECTION TO INTERVENE IN PART AND TO DECLINE TO INTERVENE IN PART; ORDER TO UNSEAL** **FILED UNDER SEAL**
UNITED STATES OF AMERICA ex rel. MARCIA STEIN AND RODOLFO BONE, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **UNITED STATES' NOTICE OF ELECTION TO INTERVENE IN PART AND TO DECLINE TO INTERVENE IN PART; ORDER TO UNSEAL** **FILED UNDER SEAL**
UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:18-cv-01347-EMC **UNITED STATES' NOTICE OF ELECTION TO INTERVENE IN PART AND TO DECLINE TO INTERVENE IN PART; ORDER TO UNSEAL** **FILED UNDER SEAL**

(captions continued on next page)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiff, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **UNITED STATES' NOTICE OF ELECTION TO INTERVENE IN PART AND TO DECLINE TO INTERVENE IN PART; ORDER TO UNSEAL** **FILED UNDER SEAL**
UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:21-cv-03894-EMC **UNITED STATES' NOTICE OF ELECTION TO INTERVENE IN PART AND TO DECLINE TO INTERVENE IN PART; ORDER TO UNSEAL** **FILED UNDER SEAL**

1. Pursuant to the False Claims Act, 31 U.S.C. § 3730(b)(2) and (4), the United States notifies the Court that it hereby intervenes in part and declines to intervene in part in the above-captioned consolidated *qui tam* actions. Specifically, the United States intervenes on the allegations that defendants Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group, Inc.; and Colorado Permanente Medical Group, P.C.; submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda under Medicare Part C from the years 2009 until present. The United States declines to intervene on all other allegations. The United States will file and serve its consolidated complaint within 90 days (i.e., by October 25, 2021), as provided for in Federal Rule of Civil Procedure 4(m).

2. The United States requests that the following be unsealed:

a. the Complaint filed on August 22, 2013, by the relator in *United States ex rel. Osinek v. Kaiser Permanente*, No. 3:13-cv-03891-EMC (N.D. Cal.);

b. the Complaint filed on September 4, 2015, by the relators in *United States ex rel. Arefi v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-01558-EMC (N.D. Cal.);

c. the Complaint filed on May 16, 2016, by the relators in *United States ex rel. Stein v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-05337-EMC (N.D. Cal.);

d. the First Amended Complaint filed on November 3, 2016, by the relators in *United States ex rel. Stein v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-05337-EMC (N.D. Cal.);

e. the Complaint filed on March 1, 2018, by the relators in *United States ex rel. Bryant v. Kaiser Permanente*, No. 3:18-cv-01347-EMC (N.D. Cal.);

f. the Complaint filed on February 10, 2020, by the relator in *United States ex rel. Bicocca v. Permanente Medical Group, Inc.*, No. 3:21-cv-03124-EMC (N.D. Cal.);

g. the First Amended Complaint filed on October 9, 2020, by the relator in *United States ex rel. Bicocca v. Permanente Medical Group, Inc.*, No. 3:21-cv-03124-

EMC (N.D. Cal.);

h. the Complaint filed on October 22, 2014, by the relator in *United States ex rel. Taylor v. Kaiser Permanente*, No. 3:21-cv-03894-EMC (N.D. Cal.);

i. the First Amended Complaint filed on November 3, 2014, by the relator in *United States ex rel. Taylor v. Kaiser Permanente*, No. 3:21-cv-03894-EMC (N.D. Cal.);

j. the United States' Motion to Consolidate Cases filed on June 11, 2021;

k. the Order Granting the United States' Motion to Consolidate Cases filed on June 25, 2021;

l. this Notice of Election to Intervene in Part and to Decline to Intervene in Part, and accompanying order; and

m. all future filings in this action.

All other contents of the Court's files in these matters (including, but not limited to, any applications filed by the United States for an extension of the investigative period under 31 U.S.C. § 3130(b)(3) or for any other reason) should remain under seal (and not placed on the public docket) and not be served upon the defendants.

3. Although the United States declines to intervene in a portion of these consolidated actions, we respectfully refer the Court to 31 U.S.C. § 3730(b)(1), which allows a relator to maintain the declined portion of an action in the name of the United States; providing, however, that the "action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting." The United States Court of Appeals for the Ninth Circuit has held that, notwithstanding this language, the United States only has the right to a hearing when it objects to a settlement or dismissal of the action. *United States ex rel. Green v. Northrop Corp.*, 59 F.3d 953, 959 (9th Cir. 1995); *United States ex rel. Killingsworth v. Northrop Corp.*, 25 F.3d 715, 723–25 (9th Cir. 1994). Therefore, the United States requests that, should either a relator or a defendant propose that the portion of these actions in which the United States has not intervened be dismissed, settled, or otherwise discontinued, this Court provide the United States with notice and an opportunity to be heard before ruling or granting its approval.

4. Furthermore, pursuant to 31 U.S.C. § 3730(c)(3), the United States requests that all

pleadings filed in this action, even as to the non-intervened portion of these actions, be served upon the United States. The United States also requests that all orders issued by the Court be sent to the government's counsel. The United States reserves its right to order any deposition transcripts and to intervene in the portion of these actions in which it is declining to intervene today, for good cause, at a later date. The United States reserves the right to seek the dismissal of any relator's action or claim on any appropriate grounds, including under 31 U.S.C. §§ 3730(b)(5) and (e)(4).

5. The United States requests that the initial case management conference be set at least one month after October 25, 2021, so that the parties may have adequate time to confer after the United States' complaint is filed and served, and prior to the conference.

DATED: July 27, 2021

Respectfully submitted,

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Attorneys for the United States of America

ORDER

The Court, having considered the United States' Notice of Election to Intervene in Part and to Decline to Intervene in Part, hereby orders that:

1. All current contents of the Court's files in these consolidated actions shall remain under seal (and not placed on the public docket) and not be served upon Defendants, except for:

a. the Complaint filed on August 22, 2013, by the relator in *United States ex rel. Osinek v. Kaiser Permanente*, No. 3:13-cv-03891-EMC (N.D. Cal.);

b. the Complaint filed on September 4, 2015, by the relators in *United States ex rel. Arefi v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-01558-EMC (N.D. Cal.);

c. the Complaint filed on May 16, 2016, by the relators in *United States ex rel. Stein v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-05337-EMC (N.D. Cal.);

d. the First Amended Complaint filed on November 3, 2016, by the relators in *United States ex rel. Stein v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-05337-EMC (N.D. Cal.);

e. the Complaint filed on March 1, 2018, by the relators in *United States ex rel. Bryant v. Kaiser Permanente*, No. 3:18-cv-01347-EMC (N.D. Cal.);

f. the Complaint filed on February 10, 2020, by the relator in *United States ex rel. Bicocca v. Permanente Medical Group, Inc.*, No. 3:21-cv-03124-EMC (N.D. Cal.);

g. the First Amended Complaint filed on October 9, 2020, by the relator in *United States ex rel. Bicocca v. Permanente Medical Group, Inc.*, No. 3:21-cv-03124-EMC (N.D. Cal.);

h. the Complaint filed on October 22, 2014, by the relator in *United States ex rel. Taylor v. Kaiser Permanente*, No. 3:21-cv-03894-EMC (N.D. Cal.);

i. the First Amended Complaint filed on November 3, 2014, by the relator in *United States ex rel. Taylor v. Kaiser Permanente*, No. 3:21-cv-03894-EMC (N.D. Cal.);

j. the United States' Motion to Consolidate Cases filed on June 11, 2021;

k. the Order Granting the United States' Motion to Consolidate Cases filed on June 25, 2021;

l. the United States' Notice of Election to Intervene in Part and to Decline to Intervene in Part filed on July 27, 2021; and

m. this Order.

2. The seal is lifted as to all matters occurring in these consolidated actions after the date of this Order.

3. The United States shall promptly serve Defendants with a copy of this Order and the United States' Notice of Election to Intervene in Part and to Decline to Intervene in Part, and shall serve defendants Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group, Inc.; and Colorado Permanente Medical Group, P.C., as well as any other newly named defendants, with the United States' complaint by October 25, 2021, in accordance with Federal Rule of Civil Procedure 4(m).

4. Counsel for the United States shall file a notice of appearance in this action, if they have not already done so, for the purpose of receiving ECF notifications of all pleadings and motions filed in this action, as provided for in 31 U.S.C. § 3730(c)(3). The United States may order any deposition transcripts and is entitled to intervene in the portion of these actions in which it is declining to intervene today, for good cause, at any time.

5. Should either a relator or a defendant propose that the portion of these actions in which the United States has not intervened be dismissed, settled, or otherwise discontinued, the Court will provide the United States with notice and an opportunity to be heard before ruling or granting its approval, in accordance with 31 U.S.C. § 3730(b)(1).

6. The initial case management conference in these consolidated actions shall be held on **October 26, 2021 at 1:30PM** conducted by Zoom Webinar. The parties shall file a joint case management statement no later than seven days before the conference.

IT IS SO ORDERED

DATED: July 28, 2021

HON. EDWARD M. CHEN
United States District Judge

CERTIFICATE OF SERVICE

The undersigned hereby certifies that he is an employee of the Office of the United States Attorney for the Northern District of California and is a person of such age and discretion to be competent to serve papers. The undersigned further certifies that he is causing a copy of:

UNITED STATES' NOTICE OF ELECTION TO INTERVENE IN PART AND TO DECLINE TO INTERVENE IN PART; [PROPOSED] ORDER TO UNSEAL

FILED UNDER SEAL

to be served this date upon the parties as follows:

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_____ BY FEDERAL EXPRESS

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__√__ BY EMAIL: I caused each such document to be sent by email to the person or offices of each address above.

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I declare under penalty of perjury, under the laws of the United States, that the foregoing is true and correct.

DATED: July 27, 2021

/s/ Benjamin J. Wolinsky
BENJAMIN J. WOLINSKY
Assistant United States Attorney

TAB 23

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

UNITED STATES OF AMERICA ex rel. RONDA OSINEK, Plaintiff, v. KAISER PERMANENTE, Defendant.	Case No. 3:13-cv-03891-EMC **UNITED STATES' UNOPPOSED EX PARTE MOTION TO CONSOLIDATE CASES; [~~PROPOSED~~] ORDER** **FILED UNDER SEAL**

(captions continued on next page)

UNITED STATES OF AMERICA ex rel. NASER AREFI, AJITH KUMAR, and PRIME HEALTHCARE SERVICES, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-01558-EMC **UNITED STATES' UNOPPOSED EX PARTE MOTION TO CONSOLIDATE CASES; [~~PROPOSED~~] ORDER** **FILED UNDER SEAL**
UNITED STATES OF AMERICA ex rel. MARCIA STEIN AND RODOLFO BONE, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	Case No. 3:16-cv-05337-EMC **UNITED STATES' UNOPPOSED EX PARTE MOTION TO CONSOLIDATE CASES; [~~PROPOSED~~] ORDER** **FILED UNDER SEAL**
UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:18-cv-01347-EMC **UNITED STATES' UNOPPOSED EX PARTE MOTION TO CONSOLIDATE CASES; [~~PROPOSED~~] ORDER** **FILED UNDER SEAL**

(captions continued on next page)

UNITED STATES OF AMERICA and STATE OF CALIFORNIA ex rel. MICHAEL BICOCCA, Plaintiff, v. PERMANENTE MEDICAL GROUP, INC., et al., Defendants.	Case No. 3:21-cv-03124-EMC **UNITED STATES' UNOPPOSED EX PARTE MOTION TO CONSOLIDATE CASES; ~~[PROPOSED]~~ ORDER** **FILED UNDER SEAL**
UNITED STATES OF AMERICA ex rel. JAMES M. TAYLOR, Plaintiff, v. KAISER PERMANENTE, INC., et al., Defendants.	Case No. 3:21-cv-03894-EMC **UNITED STATES' UNOPPOSED EX PARTE MOTION TO CONSOLIDATE CASES; ~~[PROPOSED]~~ ORDER** **FILED UNDER SEAL**

INTRODUCTION

Pursuant to Federal Rule of Civil Procedure 42(a), the United States respectfully requests that the Court consolidate the following six qui tam actions, which are all designated as related:

1. *United States ex rel. Osinek v. Kaiser Permanente*, No. 3:13-cv-03891-EMC (N.D. Cal.) (UNDER SEAL);
2. *United States ex rel. Arefi v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-01558-EMC (N.D. Cal.) (UNDER SEAL);
3. *United States ex rel. Stein v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-05337-EMC (N.D. Cal.) (UNDER SEAL);
4. *United States ex rel. Bryant v. Kaiser Permanente*, No. 3:18-cv-1347-EMC (N.D. Cal.) (UNDER SEAL);
5. *United States ex rel. Bicocca v. Permanente Medical Group, Inc.*, No. 3:21-cv-03124-EMC (N.D. Cal.) (UNDER SEAL); and
6. *United States ex rel. Taylor v. Kaiser Permanente*, No. 3:21-cv-03894-EMC (N.D. Cal.) (UNDER SEAL).

The United States respectfully submits that consolidation is warranted because these six qui tam actions are brought against common defendants — related Kaiser Permanente ("Kaiser") entities — and involve common questions of fact and law, and because consolidation will significantly promote judicial economy.

This motion is being filed under seal because the six qui tam actions are currently sealed pursuant to the False Claims Act ("FCA"), 31 U.S.C. § 3729–33. Due to the sealed nature of all six cases and because Defendants have not yet been served in these cases, this notice is not being served on Defendants. The United States has conferred with Relators in all six cases, and none of the Relators opposes this motion.

DISCUSSION

Federal Rule of Civil Procedure 42(a) provides that "[i]f actions before the court involve a common question of law or fact, the court may . . . consolidate the actions[.]"

"[A] district court has broad discretion under [Rule 42(a)] to consolidate cases pending in the

same district." *Investors Research Co. v. U.S. Dist. Ct.*, 877 F.2d 777, 777 (9th Cir. 1989). In determining whether or not to consolidate cases, the court should "weigh the interest of judicial convenience against the potential for delay, confusion and prejudice." *Zhu v. UCBH Holdings, Inc.*, 682 F. Supp. 2d 1049, 1052 (N.D. Cal. 2010). "[T]ypically, consolidation is favored." *Tse v. Apple, Inc.*, No. C 12-0265, 2013 WL 451639, at *3 (N.D. Cal. Feb. 5, 2013).

The six qui tam actions each raise claims under the FCA to recover damages to the government due to allegedly fraudulent conduct of Kaiser Permanente, a health care consortium headquartered in Oakland, California. The six actions each allege that Kaiser submitted claims to the Medicare Advantage Program, also known as Medicare Part C, for risk-adjustment payments for diagnoses that its patients did not actually have and/or that were not actually addressed by the treating physician during a patient encounter as required by Medicare billing rules. The United States is the real party in interest in all six actions, the defendants are the same or related Kaiser entities in all six actions, and the six actions involve common questions of fact and law. Because of their commonality, the six actions likely will involve the same or similar discovery and motions practice and, if the actions proceed to trial, the same or similar witnesses, evidence, and exhibits. In light of the commonality between the six actions, consolidating the actions will conserve judicial resources and promote the efficient conduct and determination of the actions.

CONCLUSION

The United States respectfully requests that the Court consolidate the *Osinek*, *Arefi*, *Stein*, *Bryant*, *Bicocca*, and *Taylor* actions. A proposed order is attached.

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DATED: June 11, 2021

Respectfully submitted,

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s/Shiwon Choe
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Attorneys for the United States

[~~PROPOSED~~] ORDER

The Court, having considered the United States of America's Unopposed Ex Parte Motion to Consolidate Cases, hereby orders that the following actions shall be consolidated for all purposes:

1. *United States ex rel. Osinek v. Kaiser Permanente*, No. 3:13-cv-03891-EMC (N.D. Cal.) (UNDER SEAL);
2. *United States ex rel. Arefi v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-01558-EMC (N.D. Cal.) (UNDER SEAL);
3. *United States ex rel. Stein v. Kaiser Foundation Health Plan, Inc.*, No. 3:16-cv-05337-EMC (N.D. Cal.) (UNDER SEAL);
4. *United States ex rel. Bryant v. Kaiser Permanente*, No. 3:18-cv-1347-EMC (N.D. Cal.) (UNDER SEAL);
5. *United States ex rel. Bicocca v. Permanente Medical Group, Inc.*, No. 3:21-cv-03124-EMC (N.D. Cal.) (UNDER SEAL); and
6. *United States ex rel. Taylor v. Kaiser Permanente*, No. 3:21-cv-03894-EMC (N.D. Cal.) (UNDER SEAL).

The Parties shall file all future pleadings and other filings in the consolidated actions on the docket in Case No. 3:13-cv-03891-EMC (N.D. Cal.).

IT IS SO ORDERED.

DATED: June 25, 2021

HON. EDWARD M. CHEN
United States District Judge

TAB 24

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FILED
Oct 09, 2020
CLERK, U.S. DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA

SEALED

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
Sacramento Division

UNITED STATES OF AMERICA AND THE STATE OF CALIFORNIA, *ex rel.*

MICHAEL BICOCCA
2530 Highland Hills Drive
El Dorado Hills, CA 95762

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC.
1950 Franklin Street, 18th Floor,
Oakland, CA 94612

SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, INC.
393 Walnut Drive,
Pasadena, CA 91107

THE PERMANENTE FEDERATION, LLC.
One Kaiser Plaza,
27th Floor,
Oakland, CA 94612

Case No. 2:20-cv-296

FILED UNDER SEAL

FIRST AMENDED COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, 31 U.S.C. §§ 3729, *et seq.*; AND THE CALIFORNIA FALSE CLAIMS ACT, CAL. GOV'T CODE §§ 12650, *et seq.*

JURY TRIAL DEMANDED

KAISER FOUNDATION HEALTH PLAN, INC.
One Kaiser Plaza Suite 15L,
Oakland, CA 94612

Defendants.

FIRST AMENDED COMPLAINT

I. Introduction

1. *Qui tam* relator Michael Bicocca ("Relator"), through his attorneys, individually, and on behalf of the United States of America and the State of California, files this First Amended Complaint against the above-named Defendants to recover damages, penalties, and attorneys' fees for violations of the federal False Claims Act ("FCA"), 31 U.S.C. §§ 3729 *et seq.*, and the California False Claims Act ("CFCA"), Cal. Gov't Code § 12651 *et seq*.

2. Defendants require Permanente physicians to record that their Medicare and California Public Employees' Retirement System ("CalPERS") patients have chronic conditions, and that the physician discussed and adequately considered the patients' chronic condition during the physicians' treatment. This diagnosis and management recordation is required of all Permanente physicians regardless of whether the physician has the appropriate training, skills, or expertise to identify much less address the specific chronic conditions.

3. Additionally, Defendants training instructs Permanente physicians to indicate diagnosis and management of their patients' chronic conditions whether the physician actually diagnosed, confirmed, or managed the condition.

4. As will be described below, the Kaiser defendants then use these diagnoses and statements to inflate the risk adjustment scores submitted to Medicare and CalPERS to receive inflated capitation payments from the United States and the State of California.

5. Because the risk adjustment data Defendants submit or cause to be submitted to Medicare and CalPERS for continued capitation rates intentionally and falsely states that the patients' chronic conditions were properly diagnosed and were effectively managed, Defendants receive additional, undeserved capitation amounts.

II. Jurisdiction and Venue

6. This Court has subject matter jurisdiction over this action under the FCA because it is an action arising under the laws of the United States, specifically 31 U.S.C. § 3730(b).

7. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because Defendants transact business in this judicial district.

8. Venue is proper in this Court under 28 U.S.C. § 1391(c) and 1395(a) because illegal acts occurred within this judicial district, Defendants are resident of this district, and because Defendants transact business within this judicial district.

9. This Court has personal jurisdiction over Defendants because the Defendants are in the State of California.

III. Parties

10. Relator Bicocca is an anesthesiologist with more than 20 years of experience. Bicocca holds a Bachelor of Science degree from California Polytechnic State University in San Luis Obispo and earned his MD from Northeastern Ohio Universities Colleges of Medicine and Pharmacy.[1] Bicocca completed his residency at the University of California, Davis, and did a fellowship at Massachusetts General Hospital in Boston.

11. Bicocca served as Chief of Pain Management for Kaiser Hospitals in Modesto, Stockton, and South Sacramento, California, before he voluntarily stepped down to return to

[1] Northeastern Ohio Universities Colleges of Medicine and Pharmacy is now known as Northeast Ohio Medical University (NEOMED).

medical practice full-time. Bicocca subsequently worked as a pain management physician at Kaiser's South Sacramento facility until he retired in December 2019.

12. Bicocca's practice focused primarily on pain management. Pain management includes, but is not limited to, management of chronic pain, including facet joint injections.

13. The Permanente Federation, LLC, (Permanente Federation) is a network of corporations that employs thousands of physicians. These corporations are not legally affiliated with each other. However, the Permanente groups' upper level management frequently comingle between firms. For example, Rich Isaacs, CEO and Executive Director of Permanente Medical Group, is also the President and CEO of Mid-Atlantic Permanente, while also working as Co-Chief Executive Officer of the Permanente Federation.

14. Through the Permanente Federation, the heads of the other Permanente branches coordinate on larger business decisions and plans, while sharing best practices.

15. Permanente Federation contracts with Kaiser to provide physicians to Kaiser hospitals and the Kaiser insurance group. Permanente Federation provides services exclusively to Kaiser.

16. One of the corporations within the Permanente Federation network is Permanente Medical Group ("Permanente"), which has twenty one (21) locations in California, including: Antioch, Fremont, Fresno, Modesto, Oakland, Redwood City, Richmond, Roseville, Sacramento, San Francisco, San Jose, San Leandro, San Rafael, Santa Clara, Santa Rosa, South Sacramento, South San Francisco, Stockton, Vacaville, Vallejo, and Walnut Creek.

17. Permanente serves as both the Northern California regional group and as the flagship group of the Permanente Federation. Permanente is based in Northern California and is the largest Permanente Medical physicians' group, with more than 25,000 employees.

18. About one third of Permanente's patients are Medicare recipients who are covered by Kaiser under Medicare Part C plans.

19. Southern California Permanente Medical Group, Inc. is the Permanente group within the Permanente Federation responsible for administering medical care to Southern California residents.

20. Kaiser Foundation Health Plan, Inc. is a nonprofit organization and a Medicare Advantage plan called Kaiser Permanente Senior Advantage. The Kaiser Permanente Senior Advantage offers several plans throughout its Regions. Kaiser Foundation Health Plan maintains Regions in Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washing, and Washington, D.C.

IV. Medicare Overview

21. In 1965, Congress enacted Title XVIII of the Social Security Act under 42 U.S.C. § 1395, *et seq.* ("The Medicare Program" or "Medicare") authorizing the federal government to pay for the cost of certain medical services for persons aged 65 and older.

22. The United States, through the Department of Health and Human Services ("HHS"), administers the Medicare program.

V. Medicare Advantage Organizations under Medicare

23. Medicare Part C, or Medicare Advantage, is a program in which CMS works closely with private companies, called Medicare Advantage Organizations (MAOs), to offer semi-private, semi-public plans that cover Medicare Part A and B services. Part C plans will sometimes also cover prescription drug benefits under Medicare Part D. *See U.S., ex rel. Osheroff v. HealthSpring, Inc.*, 938 F. Supp. 2d 724, 726 (M.D. Tenn. 2013).

24. "The Centers for Medicare & Medicaid Services ('CMS') compensates MAOs at a capitated rate for the delivery of benefits. To participate in the Medicare Advantage program,

MAOs must submit bids to CMS every year in which they offer to provide services for a specified amount per member, per month. Each participating MAO must then enter into a contract with CMS, the terms of which require the MAO to comply with certain laws, including. . . . the [False Claims Act]. To receive payment for services provided under the Medicare Advantage program, MAOs must submit monthly payment requests to CMS along with monthly reports certifying that all information submitted to CMS in this report is accurate, complete, and truthful." *United States ex rel. Derrick v. Roche Diagnostics Corp.*, 318 F. Supp. 3d 1106, 1110 (N.D. Ill. 2018) (internal citations and quotations omitted).

25. "[B]y statute CMS must pay Medicare Advantage insurers in a manner that ensures 'actuarial equivalence' with payments to traditional Medicare providers." *UnitedHealthcare Ins. Co. v. Azar*, No. CV 16-157 (RMC), 2020 WL 417867, at *1 (D.D.C. Jan. 27, 2020) (citing 42 U.S.C. § 1395w-23(a)(1)(C)(i)).

26. "Traditional Medicare uses a fee-for-service payment model, whereby the more services physicians perform, the more money they earn. . . . Capitation means an amount is paid per person. Under Medicare Advantage's capitation system, private health insurance organizations provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage. These organizations pocket for themselves or pay out to their enrollees' providers the difference between their capitation revenue and their enrollees' medical expenses, creating an incentive for the organizations to rein in costs." *United States ex rel. Anita Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018) (internal citations and quotations omitted).

27. "CMS calculates the payment for each enrollee based on various risk adjustment data, such as an enrollee's demographic profile and the enrollee's health status, as reflected in the medical diagnosis codes associated with healthcare the enrollee receives. These diagnosis

codes (also known as encounter data) are reported by Medicare Advantage organizations to CMS. Because Medicare Advantage organizations have a financial incentive to exaggerate an enrollee's health risks by reporting diagnosis codes that may not be supported by the enrollee's medical records, Medicare regulations require a Medicare Advantage organization, as an express condition of receiving payment, to certify (based on best knowledge, information, and belief) that the risk adjustment data it submits ... are accurate, complete, and truthful." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1166 (9th Cir. 2016) (citing 42 C.F.R. § 422.504(*l*), (*l*)(2))). (internal quotations omitted).

28. Simply put, Medicare Advantage is supposed to compensate these organizations for expected healthcare costs, paying "less for healthier enrollees and more for less healthy enrollees." *WellPoint, Inc.*, 904 F.3d at 672.

29. Capitation rates are based largely on an individual's "risk adjustment data," which reflect several factors that can affect healthcare costs. *Id.* Chief among these data are individuals' medical diagnoses. *Id.*

30. The method by which CMS calculates the capitated rate to Medicare Advantage organizations is described in greater detail below. *See Infra* at Section VII.

31. Defendants' patients covered by public insurance programs are predominantly participants in the Kaiser Permanente Senior Advantage Enhanced Plan (HMO), which is a Medicare Part C plan that provides Medicare Part D benefits as well.

32. Kaiser therefore receives a capitation rate from CMS for each Part C patient it covers. This rate is meant to cover the cost of care for the patient.

VI. California Public Employees' Retirement System

33. CalPERS is a retirement system created by statute, for the purpose of administering retirement, disability and death benefits for California state employees. Cal. Gov't Code § 20001 *et seq.*

34. "CalPERS is a unit of the Government Operations Agency. In addition to administering the retirement system for employees of California and other public entities, CalPERS operates health insurance plans, including the PERS Choice health plan. . . ." *Orthopedic Specialists of S. California v. Pub. Employees' Ret. Sys.*, 228 Cal. App. 4th 644, 646 (2014) (quotations omitted).

35. As a retiree, when a member first becomes eligible for Medicare, they must request a change from a CalPERS Basic Health Plan to a CalPERS Medicare Health Plan. When a CalPERS member retires and enrolls in Medicare Part A and Part B, CalPERS will work with the CMS to obtain the retiree's Medicare information and automatically transfer the retiree from a CalPERS Basic (non-Medicare) health plan to a CalPERS Medicare health plan.

36. The CalPERS Medicare Health Plan requires Medicare to assume the role as the primary payer for health care costs, thus CalPERS members who receive health services result in expenditures to Medicare.

37. At least 10% of the entire Permanente patient population is on the CalPERS program.

VII. Risk Adjustment Factors for Capitation Rate Calculations

38. "CMS calculates the payment for each enrollee [in a MAO] based on various risk adjustment data, such as an enrollee's demographic profile and the enrollee's health status, as reflected in the medical diagnosis codes associated with healthcare the enrollee receives. These diagnosis codes (also known as encounter data) are reported by Medicare Advantage

organizations to CMS." *United Healthcare Ins. Co.*, 848 F.3d at 1166 (citing 42 C.F.R. § 422.504(l), (l)(2))).(internal quotations omitted).

39. Capitation rates are based largely on an individual's "risk adjustment data," which reflect several factors that can affect healthcare costs. Chief among these data are individuals' medical diagnoses. *WellPoint, Inc.*, 904 F.3d at 672.

40. "Risk adjustment using diagnoses provides more accurate payments for MA organizations, with higher payments for enrollees at risk for being sicker, and lower payments for enrollees predicted to be healthier." CMS, Pub. No. 100-16, Medicare Managed Care Manual, ch. 8, § 50 (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c08.pdf.

41. "The [Balanced Budget Act of 1997] and later legislation required CMS to adjust per-beneficiary capitation payments with a risk adjustment methodology using diagnoses to measure relative risk due to health status instead of just demographic characteristics such as age, sex, and Medicaid eligibility." *Id.*

42. "Effective January 1, 2005, CMS implemented the ESRD CMS-HCC models based on diagnoses from inpatient, outpatient, and physician settings, and distinguishing dialysis, transplant, and functioning graft statuses." *Id.*

43. "The CMS-HCC models function by categorizing International Classification of Diseases codes into disease groups called Hierarchical Condition Categories (HCCs). Each HCC includes diagnosis codes that are related clinically and have similar cost implications. The CMS-HCC models are prospective in the sense that they use diagnosis information from a base year to predict costs for the next year. Models of this type are largely driven by the costs associated with chronic diseases, and they capture the systematic risk (costs) associated with Medicare populations." *Id.*

44. CMS uses "CMS-HCC risk adjustment models . . . to calculate risk scores, which predict individual beneficiaries' health care expenditures, relative to the average beneficiary. Risk scores are used to adjust payments and bids based on the health status (diagnostic data) and demographic characteristics (such as age and gender) of an enrollee." CMS, Pub. No. 100-16, Medicare Managed Care Manual, ch. 7, § 70 (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf.

45. "Beneficiary risk scores are used to adjust each plan's base payment rate for member health status, the first step in determining the per-person per month payment to MA organizations." CMS, Pub. No. 100-16, Medicare Managed Care Manual, ch. 8, § 50 (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c08.pdf.

46. "CMS uses demographic and diagnostic information from original Medicare and from all MA organizations a beneficiary may have joined (taken from diagnostic data submitted by the organizations) to determine the appropriate risk score for each beneficiary. The risk score is computed for each beneficiary for a given year and applied prospectively. *The risk score generally follows the beneficiary for one calendar year*." *Id.* (emphasis added).

47. Medicare Advantage organizations obtain diagnosis codes from healthcare providers after these providers have had medical visits with plan enrollees. *See* CMS, Pub. No. 100-16, Medicare Managed Care Manual, ch. 7, § 40 (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf. In turn, Medicare Advantage organizations report the diagnosis codes that they receive to the CMS for use in the risk adjustment model that is the key to calculation of capitation rates. *Id*.

48. All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. The diagnosis must be coded according to

International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting. *Id.*

49. For the diagnosis to be considered in the capitation calculation, the MAO must, "submit all required diagnosis codes for each beneficiary and submit unique diagnoses at least once during the risk adjustment data-reporting period. Submitters must filter diagnosis data to eliminate the submission of duplicate diagnosis clusters. . . If upon conducting an internal review of submitted diagnosis codes, the plan sponsor determines that any diagnosis codes that have been submitted do not meet risk adjustment submission requirements, the plan sponsor is responsible for deleting the submitted diagnosis codes as soon as possible." *Id.*

50. Similarly, the plan must "receive and reconcile CMS Risk Adjustment Reports in a timely manner. Plan sponsors must track their submission and deletion of diagnosis codes on an ongoing basis." *Id.*

51. "Once CMS calculates the final risk scores for a payment year, plan sponsors may request a recalculation of payment upon discovering the submission of inaccurate diagnosis codes that CMS used to calculate a final risk score for a previous payment year and that had an impact on the final payment. Plan sponsors must inform CMS immediately upon such a finding." *Id.*

52. "CMS requires Medicare Advantage plans to collect hospital inpatient, hospital outpatient, and physician risk adjustment data and submit the data to CMS at least quarterly for calculation of the risk score for use in the payment calculation and payment reconciliation… Once plans have collected the data and verified the data came from an acceptable data source, the plans submit the data using the Risk Adjustment Processing System (RAPS) format and provide the five required data elements in the cluster." *Id.* At Section 120. The five required data elements include: the Health Insurance Claim Number (the beneficiary identification number),

the diagnosis code, the "service from date", the "service to date" (may be the same as the "service from date for outpatient and physician services), and the provider type (must be a hospital inpatient facility, hospital outpatient facility, or physician). *See* i*d.*

53. CMS requires that diagnostic data for the purposes of risk management reporting come from and appropriate source – specifically a hospital inpatient facility, hospital outpatient facility, or a physician. *Id.* At Section 120.1.1. "Diagnostic radiologists typically do not document confirmed diagnoses. The diagnosis confirmation comes from referring physicians or physician extenders and is, therefore, not assigned in the medical record documentation from diagnostic radiology services alone." *Id.*

54. "The collection of physician data relevant for risk adjustment is *associated with the physician's specialty*." *Id.* (emphasis added). "Qualified physician data for risk adjustment requires a face-to-face visit with the exception of pathology services (professional component only). Only those physician specialties and other clinical specialists identified [by CMS] are acceptable for risk adjustment." *Id.* (*See* Table 19. Acceptable Physician Specialty Types Payment Year 2011 (dates of service 2010 at p. 46 for list of physician specialties and other clinical specialists deemed appropriate to identify data for risk adjustment purposes.).

VIII. Chronic Condition Management (CCM)

55. In 2015, Medicare changed its rules to focus on preventative care, especially regarding patients who suffer from chronic health conditions.

56. The latest change or rules related to chronic care management can be found in the Federal Register, from a proposed, and accepted rules change in November 2016. *Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management (CCM) Services* 81 FR 80243.

57. The proposed rule changes provide further information regarding the rationale for these changes. "Beginning in CY 2015, [CMS] implemented separate payment for CCM services under CPT code 99490 (Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month) . . . ." 81 FR 80243.

58. The purpose of this change was "to improve payment for, and encourage long-term investment in, care management services." 81 FR 80243 (*citing* 79 FR 67715).

59. The changes in the rules reflected the regulators' desire to make sure physicians and facilities had "the resources required to furnish complex chronic care management services to beneficiaries with multiple (that is, two or more) chronic conditions were not adequately reflected in the existing E/M codes." 81 FR 80243.

60. In addition to making sure physicians had the time, resources, and compensation to fully manage their patients' chronic conditions, the regulators were also concerned with making sure physicians were sufficiently *capable of furnishing such services*.

61. "In finalizing separate payment for CPT code 99490, [CMS] considered whether [CMS] should develop standards to ensure that physicians and other practitioners billing the service would have the capability to fully furnish the service." 81 FR 80243 (*citing* 79 FR 67721).

62. "[CMS] established requirements to furnish a preceding qualifying visit, obtain advance written beneficiary consent, use certified electronic health record (EHR) technology to furnish certain elements of the service, share the care plan and clinical summaries electronically, document specified activities, and other items. . . ." 81 FR 80243.

63. A common complaint listed among stakeholders was that the chronic care management CPT code was usually exceeded without additional benefit, disincentivizing care

longer of 20 minutes, which led to the revision/creation of CPT code 99487, meant specifically for "complex" cases, where there would be higher reimbursement for 60 minutes of time spent with patients. *See* 81 FR 80244.

64. There are two categories chronic conditions that Medicare focuses on: complex and non-complex.

65. The criteria for billing for monitoring and management of "non-complex" chronic conditions (CPT Code 99490) are:

a. a doctor/physician assistant/nurse practitioner must spend at least 20 minutes with the patient per month,

b. the patient must have multiple chronic conditions expected to last at least 12 months,

c. the chronic condition must place the patient at significant risk of death, decompensation, or functional decline, and

d. a comprehensive care plan must be established, implemented and monitored by the care giver.

66. If the criteria for non-complex patients' chronic care management plans are met, providers would receive a reimbursement of approximately $43.00 per patient per month on a fee-for-service plan (FFS).

67. The criteria for billing for monitoring "complex" chronic conditions (CPT Code 99487) are the following:

a. patients must have multiple chronic conditions expected to last at least 12 months (or until death),

b. the chronic conditions place the patient at significant risk of death or functional decline,

c. the medical providers establish a comprehensive care plan,

d. there must be moderate or high complexity in medical decision making, and

e. a doctor/physician assistant/nurse practitioner must spend at least 60 minutes with the patient per month.

68. Physicians should be providing an in-depth analysis of patient conditions to determine if the conditions are being controlled; a physician can't simply ask if the patient is on medication or if they have experienced mood swings but needs to provide a more thorough service to bill for the complex chronic care management.

69. If the criteria for complex patients' chronic care management plans are met, providers would receive a reimbursement of approximately $94.00 per patient per month on a Fee-for-service (FFS) plan.

70. Several conditions qualify as chronic conditions. These include:

a. Alzheimer's Disease and Related Dementia

b. Arthritis (Osteoarthritis and Rheumatoid)

c. Asthma

d. Atrial Fibrillation

e. Autism Spectrum Disorders

f. Cancer (Breast, Colorectal, Lung, and Prostate)

g. Chronic Kidney Disease

h. Chronic Obstructive Pulmonary Disease

i. Depression

j. Diabetes

k. Heart Failure

l. Hepatitis (Chronic Viral B & C)

m. HIV/AIDS

n. Hyperlipidemia (High cholesterol)

o. Hypertension (High blood pressure)

p. Ischemic Heart Disease

q. Osteoporosis

r. Schizophrenia and Other Psychotic Disorders

s. Stroke

71. MAOs offered under Medicare Part C cover all Part A and Part B services. Since CCM is a current Part B benefit, all Medicare Advantage plans have CCM as a covered benefit for their enrolled members. *See* National Council on Aging, *Chronic Care Management Information Resource* 11 (March 2018), https://www.ncoa.org/wp-content/uploads/CCM-Information-Resource_FINAL_031218.pdf.

72. The CCM program developed by CMS and billed by providers under CPT Codes 99490 and 99487 apply only to Medicare Part B Fee for Service plans, not to Medicare Part C plans. However, because Part C plans must encompass all the services provided under Parts A and B, a discussion of CCM in the Fee for Service context is necessary to provide the baseline of CCM services that must be provided by Part C plans. Additionally, the fact that CCM services are reimbursed as additional services demonstrates that the provision of CCM services is material to CMS payment decisions.

73. The regulations governing chronic condition management and the costs of such care are factored into the capitation rates given to Defendants by CMS both because CCM is a service offered under Part B, and because existence of additional chronic conditions increases the Part C plan's risk adjustment score leading to increased capitation rates.

74. In sum, CCM is meant to be an in-depth review and plan for managing difficult, often complex, conditions that usually require the skills of a specialist, or that of an experienced general physician and to appropriately compensate providers for the extra time and effort required to manage these chronic conditions.

75. "CCM was designed for *primary care practitioners* who comprehensively manage all of a patient's care. For example, it includes a comprehensive care plan addressing all health issues and ensuring receipt of preventive services. However, any practitioner who meets the CCM requirements can bill CCM . . . ." CMS, *Frequently Asked Questions about Physician Billing for Chronic Care Management Services* 6 (January 1, 2019), https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/Payment_for_CCM_Services_FAQ.pdf (emphasis added).

76. Relator Bicocca, before Permanente's scheme began, would rarely engage in CCM as a part of his Paint Management specialty.

77. Relator's knowledge of medical practice in general suggests that most specialists also spend little time on CCM unless that chronic condition is directly applicable to that specialist's practice.

78. Relator's knowledge of medical practice in general suggests that, aside from specialists engaging in CCM related to their practices, most CCM comes into play with experienced generalists who have elderly patients with multiple chronic conditions.

IX. The False Claims Act and California False Claims Act

79. The FCA, 31 U.S.C. §§ 3729–3733 was enacted in 1863 by Congress and provides that any person who knowingly submitted false claims to the government was liable for damages plus a penalty for each claim. The FCA has been amended several times.

80. The FCA imposes liability on any person or entity who knowingly presents or causes to be presented a false or fraudulent claim for payment or approval. 31 U.S.C. § 3729(a)(1)(A). Additionally, those who make, use or cause to be made a false statement or record material to the claim are also liable under the FCA. 31 U.S.C. § 3729(a)(1)(B).

81. The terms "knowing" and "knowingly" are defined by the statute as a "person" having actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, or acting in reckless disregard of the truth or falsity of the information. 31 U.S.C. § 3729(a)(3)(B)(4).

82. The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property. 31 U.S.C. § 3729(a)(3)(B)(4).

83. "A claim under the False Claims Act requires a showing of (1) a false statement or fraudulent course of conduct, (2) made with the scienter, (3) that was material, causing (4) the government to pay out money or forfeit moneys due." *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 899 (9th Cir. 2017), *cert. denied sub nom. Gilead Scis., Inc. v. U.S. ex rel. Campie*, 139 S. Ct. 783, 202 L. Ed. 2d 566 (2019).

84. Any person who violates the FCA is liable for damages in the amount of three (3) times the amount of loss the government sustained and penalties which range between $10,957 and $21,916 per claim. 31 U.S.C. § 3729(a); 28 C.F.R. § 85.3.

85. The California False Claims Act also imposes liability on any person or entity who knowingly presents or causes to be presented a false or fraudulent claim for payment or approval to the State of California. Cal. Gov't Code § 12651 *et seq*.

86. "[Fraud against] [t]he Medicare Advantage capitation payment system is subject to the False Claims Act." *WellPoint, Inc.*, 904 F.3d at 673.

X. Factual Overview

87. The Kaiser defendants, who contracts with CMS, to insure Medicare beneficiaries through the Medicare Advantage program, and the State of California to provide insurance to CalPERS beneficiaries improperly increases its capitation rate through identifying and adding as many diagnosis as possible to increase the risk adjustment data submitted to CMS which in turn increases the capitation rate Kaiser receives for provide care to Medicare beneficiaries.

88. The Permanente defendants work hand in glove with the Kaiser defendants to perpetuate this overbilling by training all Permanente physicians to indicate that Medicare and CalPERS patients have chronic conditions and record that the chronic conditions were discussed with the patient so that it appears that the diagnosis, re-affirmation of the diagnosis, and chronic condition management was appropriately provided by the physician. Permanente reinforces this training by tracking compliance metrics and offering "retraining" to physicians whose certification numbers fall too low.

89. Bicocca raised concerns to the trainers and Permanente management that what he and his fellow physicians were being instructed to do was not truthful and amounted to fraud. In response, Bicocca and his team were given sufficient leeway to alter the language in the charts to be truthful to the services Bicocca felt were performed, but this exception was not communicated to other Permanente physicians resulting in the vast majority of Permanente physicians blindly indicating the existence of chronic conditions and management of the same.

a. Permanente trains its physicians to indicate that Medicare and CalPERS patients have chronic conditions and chart that the conditions were confirmed and discussed.

90. In or around 2015, Permanente changed how it directed its physicians to "manage" chronic conditions through a series of trainings on billing, note writing, and coding.

91. Permanente claimed that this change was to increase patient care. However, that statemen was quickly belied by the fact that the change in how physicians were required to manage chronic conditions was only required for Medicare and CalPERS patients, not all patients.

92. The trainings and policy changes directed by Permanente management were meant specifically to affect only Medicare and other public benefits patients, creating a two-tiered system of chronic care management, where private health insurance patients are given the usual chronic care management, if any, and where physicians are required to check off all chronic conditions that could conceivably apply to a Medicare of CalPERS patient and place a certifying statement in the patient's record that the condition was discussed and managed, without adequate *management* of those chronic conditions as required by federal regulations and CMS. Again, this mandate was only required for patients with public benefits, not all patients seen by Permanente physicians.

93. Over time, Defendants' method of directing physicians to perform this fraud grew more subtle as Bicocca continually objected to the trainings.

94. In or around 2015, along with rolling out new training on chronic conditions, Permanente started providing physicians with MDP reports. These reports were printed in hard copy for each Medicare or CalPERS patient the doctor had scheduled that day and the report listed the patient's chronic conditions that Permanente wanted the doctor to check off in the EMR. An electronic version of the MDP Report existed in the EMR and was called an App1.

95. In addition to the printed MDP reports, the EMR had "pushpins" that listed the patient's chronic conditions separate from their other problems and conditions. These pushpins were set apart to draw attention to the chronic conditions so that the doctor would check the box next to these chronic conditions in the EMR.

96. Finally, in 2015, Permanente added a new column to the doctors' schedules in the EMR – an MDP column. This column indicated who in the doctor's daily schedule was a Medicare or CalPERS beneficiary who had outstanding chronic conditions to be check off.

97. If a doctor saw a patient with an MDP report, but did not check off on all of the chronic conditions listed on the MDP report and in the EMR, the doctor would get a follow up email, automatically generated by the system, asking the doctor if they had confirmed and addressed those diagnoses and forgot to chart that in the EMR. The email then told the doctor that they still had time to check off the chronic conditions and add a chart note explaining the delay.

98. In addition to clicking the boxes in the EMR for the patient's chronic conditions, the physicians were also instructed to include language in the patient's chart for the visit that indicated that the condition's diagnosis was confirmed, considered in the doctor's care, that the condition was discussed, and that the condition is stable.

99. Senior leadership at Permanente, including Jason Guardino, the Assistant Physician in Charge (APIC) and Chief of Gastroenterology Department, provide the language for the certifying statements.

100. Senior leadership at Permanente, through emails and training initiatives, directed physicians to insert the following in their charts:

> I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient. At the time of the visit, the medical record indicates, and/or the patient states, that there are no changes in these conditions unless otherwise noted. As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist.

101. This statement suggests that some, but not all of the steps of management of a patient's chronic conditions are satisfied: (1) the physician confirms that the patient has

qualifying chronic conditions, and (2) the physician considers these chronic conditions when making medical decisions about that patient.

102. The statement also notes that, if there are no additional notes, then there were no changes in the patient's chronic conditions, while also noting that the patient was advised to speak to their specialist physicians regarding those specialist conditions if necessary.

103. This is problematic, however, as the regulations show that management of a patient's condition typically means *acting as that specialist*, not simply referring the issue away.

104. For example, below is an email from Permanente confirming the language of the certification, dated August 11, 2015. The email includes a statement by Serene Tran, a trainer for Permanente.

Serene N Tran "I have confirmed the presence of the above clini... 08/11/2015 01:24:31 PM

From: Serene N Tran/CA/KAIPERM
To: Jeremy Lawrence/CA/KAIPERM@KAIPERM
Cc: Jason M Guardino/CA/KAIPERM@Kaiperm, Keshia Y Redmond/CA/KAIPERM@Kaiperm, Michael J Bicocca/CA/KAIPERM@Kaiperm
Date: 08/11/2015 01:24 PM
Subject: Re: .refresh - clarification needed

"I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient. At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these

conditions unless otherwise noted. As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist. "

Above is the revised version of the .FOL which is included in our .REFRESH smartphrase.

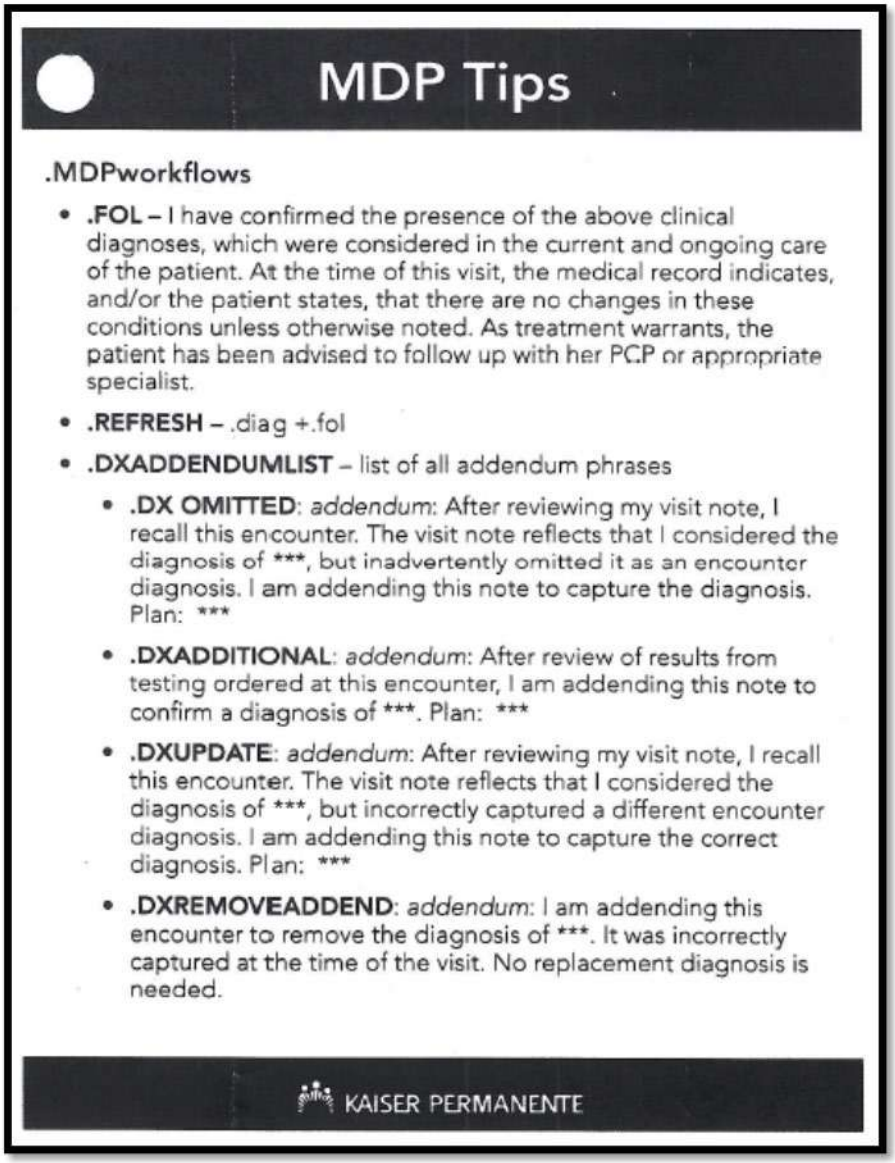
What I take from this is that as long as you review the chart (problem list, medication list, and/or labs) when you see the patient, you can confirm that the patient has the diagnosis and the decision you make will be influenced (explicitly or implicitly) by the patient's medical history.
Also, the revised version included the phrase "as treatment warrants" to imply that if there is no change of treatment needed, you do not need to advise the patient to follow up with pcp or specialist.

I hope this helps.

Serene

NOTICE TO RECIPIENT: If you are not the intended recipient of this e-mail, you are prohibited from sharing, copying, or otherwise using or disclosing its contents. If you have received this e-mail in error, please notify the sender immediately by reply e-mail and permanently delete this e-mail and any attachments without reading, forwarding or saving them. Thank you.

105. This statement is widely distributed to physicians at Permanente. Insertion of the statement in appointment notes is made easy using something called a "dot phrase," which only requires typing a quick shortcut to have the entire statement appear on the patient's records. The statement, as can be seen below, can be efficiently input by just typing the dot phrase ".FOL" into the electronic database.



MDP Tips

.MDPworkflows

- **.FOL** – I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient. At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these conditions unless otherwise noted. As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist.
- **.REFRESH** – .diag +.fol
- **.DXADDENDUMLIST** – list of all addendum phrases
  - **.DX OMITTED**: *addendum*: After reviewing my visit note, I recall this encounter. The visit note reflects that I considered the diagnosis of ***, but inadvertently omitted it as an encounter diagnosis. I am addending this note to capture the diagnosis. Plan: ***
  - **.DXADDITIONAL**: *addendum*: After review of results from testing ordered at this encounter, I am addending this note to confirm a diagnosis of ***. Plan: ***
  - **.DXUPDATE**: *addendum*: After reviewing my visit note, I recall this encounter. The visit note reflects that I considered the diagnosis of ***, but incorrectly captured a different encounter diagnosis. I am addending this note to capture the correct diagnosis. Plan: ***
  - **.DXREMOVEADDEND**: *addendum*: I am addending this encounter to remove the diagnosis of ***. It was incorrectly captured at the time of the visit. No replacement diagnosis is needed.

KAISER PERMANENTE

106. Interestingly, the above list contains more than the original statement. Also included are addenda phrases meant to modify the list of diagnoses confirmed after the fact. While it is reasonable that physicians may accidentally over or under include diagnoses after an

appointment, Bicocca states that one purpose of these additional dot phrases was to allow for physicians not meeting their criteria to increase their "success rate."[2] These codes do not just add language to remedy an existing diagnosis where the provider failed to enter a timely .FOL statement indicating that the chronic condition was adequately managed, these additional codes also encourage providers to add additional diagnoses to the chronic condition list that were not previously present in the patient chart.

107. Permanente requires physicians, in addition to adding the .FOL statement, to go through the a list of chronic conditions with every public benefits patient, check up on the status of those diagnoses, and confirm them, regardless of whether physicians have the time or qualifications to do so. It is difficult for physicians to do this, and Bicocca believes that many of the Permanente physicians are not doing this for each of the chronic conditions their patients have.

108. Two sources exist for the diagnoses that physicians are required to add onto Medicare and CalPERS patient records through this process.

109. The first source are diagnoses that these patients had already, confirmed in previous years by other physicians. While, as a matter of first impression, this does not seem to be a violation of regulations, since the patients have already had the diagnoses confirmed by others, having physicians re-confirm these diagnoses without spending sufficient time on it and without having any expertise on these diagnoses is still a violation of Medicare's regulations on confirming diagnoses for the purpose of risk adjustment.

110. The second source of diagnoses that physicians were required to pretend to address were diagnosis items were generated, through data mining, by a computer search of patient records looking for key words that had been entered but never followed up on or

[2] As will be seen in a later section, Permanente tracked physicians' compliance with the new trainings and established quotas of diagnoses called the "success rate."

confirmed as a true diagnosis. These diagnoses, about 10% of the total diagnoses to be added, were added on to patient records without any previous confirmation by qualified physicians, meaning they could have been inaccurate.

111. The data-mined diagnoses would show up under patient names on the "MDP sheets" that physicians received every day in which patients who needed diagnoses coded had appointments. Physicians were required to review these records to add more coding when necessary.

112. Bicocca provides the following by way of example:

a. Aortic atherosclerosis might be in the report of a chest X-ray from a visit unrelated to the visit with Bicocca. Bicocca would be required to enter the Aortic atherosclerosis diagnosis during his appointment. This is because CMS specifically does not allow diagnoses for the purposes of risk adjustment data to be added based on radiological testing alone, it must be confirmed and added by a physician.

b. "Asthma" might have appeared in an emergency room note, but not entered on the patient's problem list. Bicocca would then be required to determine if that patient did indeed have this condition (something a specialist like Bicocca did not have the qualifications to do, since it falls outside of his specialty). Bicocca was supposed to enter the diagnosis on their problem list and code for it.

c. If a patient comes to see Bicocca for a facet injection, but also has diabetes, high blood pressure, a history of cancer, depression, or high cholesterol, then the foregoing policy would obligate Bicocca and other physicians to confirm all of the above conditions are still present, certify that the patient's conditions

are stable, and recommend the patient follow-up as necessary with their primary care physician or specialist. Bicocca, a pain management physician, is not trained and does not have the expertise or ability to manage the patient's cancer or depression. Nor are some of the above conditions relevant to Bicocca's medical decision making regarding the patient's pain management issues. However, he would still be obligated to record, using a .FOL statement, that he confirmed the diagnosis of these conditions and discussed the management of the conditions with the patient.

113. Permanente physicians may not have the expertise to diagnose, confirm, or address the chronic conditions Permanente is pressuring them to address. This is problematic for patient care and also because CMS guidance states, "the collection of physician data relevant for risk adjustment is *associated with the physician's specialty*." CMS, Pub. No. 100-16, Medicare Managed Care Manual, ch. 7, § 120.1.1 (2014), https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c07.pdf

114. Bicocca and other physicians do not typically have appointments which last long enough to discuss each of these conditions in full detail and to, in good faith, write the Permanente-supplied certification in the chart.

115. Below is a quick overview of Bicocca's typical appointments, which begin at 7:30 AM every weekday.

a. As of Fall 2018, forty-five-minute consultations for new patients, with limited discussion of non-pain-related conditions insofar as they would impact any pain management procedures.

b. Before Fall 2018, initial consults were only thirty minutes, giving physicians less time for comprehensive chronic condition care.

c. Thirty-minute procedure appointments, including facet injections. There is little discussion of any non-pain-related conditions unless any would affect the immediate procedure. During this appointment, Dr. Bicocca is performing a medical procedure.

d. Thirty-minutes follow-up discussion appointments on the effectiveness of the procedure and whether any anything else is needed, including a limited discussion of other conditions for their effect on the recovery.

116. None of the appointments provide Bicocca and other physicians in his practice the time or opportunity to evaluate, diagnose, or manage any chronic conditions a patient may have. Dr. Bicocca has reason to believe that other specialty physicians at Permanente conduct their appointments in a similar manner and would also not have the time in any given appointment necessary to discuss, evaluate, or manage a patient's chronic conditions.

117. Based on Relator's experience, patients typically spend 17 to 20 minutes with their pain management physicians during a procedure appointment, 25 minutes in a return appointment, 25 minutes during initial consultations, and 40 minutes during initial consultations that occurred after Fall 2018, with five minutes of documentation time, none of which is enough time to describe, discuss, and cover the nearly two dozen chronic conditions listed above. Relator estimates that his own practice has longer appointments than the norm for specialists, which he believes are typically around 20 minutes each.

118. Worse, even if they were given the time they needed, in theory, Bicocca and other specialist physicians do not have the expertise to fully advise their patients on the various ailments that are listed above.

119. Each of these conditions in themselves require years of study and training in order to conduct a proper consultation or follow up appointment.

120. For example, a pain management specialist does not have the neurological and psychological training or credentials to conduct a full review of a patient's Alzheimer's or schizophrenia. A pain management specialist could not effectively review or manage a patient with heart failure, atrial fibrillation, ischemic heart disease, hyperlipidemia, and hypertension the way that a cardiologist could. Typically, only a primary care physician or pulmonologist could diagnose or manage asthma or chronic obstructive pulmonary.

121. In fact, the only condition initially Bicocca felt even nominally comfortable discussing with patients is diabetes, even though he is not an endocrinologist. Dr. Bicocca would discuss a patient's diabetes but only to the extent that such a condition would affect the patient's pain management procedure, not a full evaluation with moderate or high complexity in medical decision-making as is required by the chronic condition management.

122. Upon reading Medicare's requirements, Bicocca realized that he was not qualified to even discuss diabetes by CMS's standards, and that he only felt comfortable with the topic under the false training provided by Defendants.

123. In fact, very few specialists could cover more than just a few of the chronic conditions listed above, and none of the other pain management physicians in Bicocca's office could do so.

124. Bicocca and his fellow physicians are instructed to certify something they have neither the expertise nor time to certify that every patient who comes into the South Sacramento Medical Center is given a comprehensive assessment of all their chronic conditions, all to Permanente's benefit.

125. The result of this essential impossibility for being able to check off chronic conditions at every appointment with Medicare and public benefits patients at Permanente is that every physician is either misled into or forced into falsely confirming diagnoses, and creating a

record in the patient note that the diagnosis was confirmed and discussed. These false statements are all for the purposes of increased reimbursement to Defendants as evidenced by the fact that they are only required for Medicare and CalPERS patients.

126. In addition, the training in fraudulent documentation Relator and his fellow physicians received is also occurring at Southern California Permanente and could exist at other Permanente groups, suggesting a common source from the Permanente Federation.

b. Defendants track physicians to ensure compliance with its fraud scheme.

127. Defendants have created an internal regulatory system and data-collection apparatus with the sole purpose of tracking whether its physicians are complying with the foregoing requirements.

128. This includes gathering data on the success rate of each physician, the percentage of diagnoses the physician had been assigned that were actually confirmed through checking the MDP box and using the dot phrases.

129. When Bicocca voiced his concerns to the training instructors regarding potential fraud, the trainer's response was that including the statement was not mandatory and should not be included where the physician is not "comfortable" doing so.

130. However, the trainers and even Permanente management would immediately follow up with the expectation that Bicocca be "comfortable" with 90% of diagnoses and therefore include the statement for at least 90% of the diagnoses he was assigned.

131. The assurance that checking off all chronic conditions and using the. FOL phrase was not mandatory was almost never provided to the physicians during the training, leading most physician to believe that including the statements provided was mandatory.

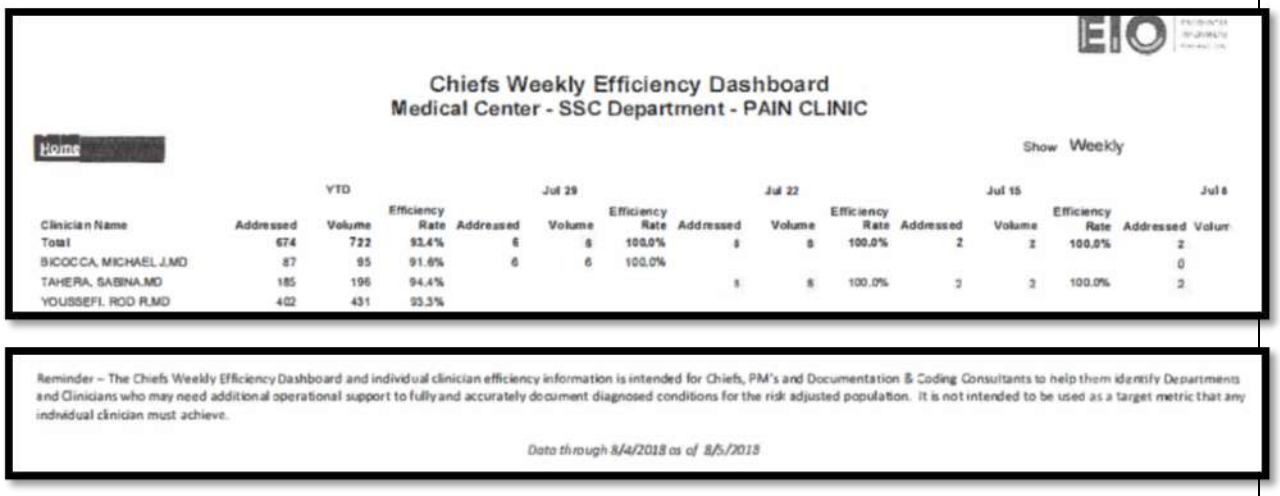
132. Bicocca, and every physician working with Bicocca, understood that this 90% benchmark is not only a suggestion, but a requirement to be more likely to obtain bonuses,

promotions, and other benefits, and a metric by which entire offices, departments, and careers, are judged.

133. Crucially, a dataset that Bicocca obtained from Permanente listing doctors and their success rates shows that most physicians have scores that meet the 90% requirement, suggesting that Permanente's instructions led to physicians including this language with nearly every single Medicare and CalPERS patient.

134. Defendants do this by turning chronic condition management into a performance metric in all but name for all physicians: while never explicitly stated, Bicocca and his coworkers understood that a good "success rate" – i.e. providing to Defendants as many diagnoses as possible and certifying chronic care management – was a means to increased salary, bonuses, and potentially other benefits, such as promotion.

135. A weekly email send to Bicocca and others with success rate information contains a disclaimer that reads "Reminder -The Chiefs Weekly Efficiency Dashboard and individual clinician efficiency information is intended for Chiefs, PM's and Documentation & Coding Consultants to help them id Departments and Clinicians who may need additional operational support to fully and accurately document diagnosed conditions for the risk adjusted population. It is not intended to be used as a target metric that any individual clinician must achieve."



Chiefs Weekly Efficiency Dashboard
Medical Center - SSC Department - PAIN CLINIC

Home

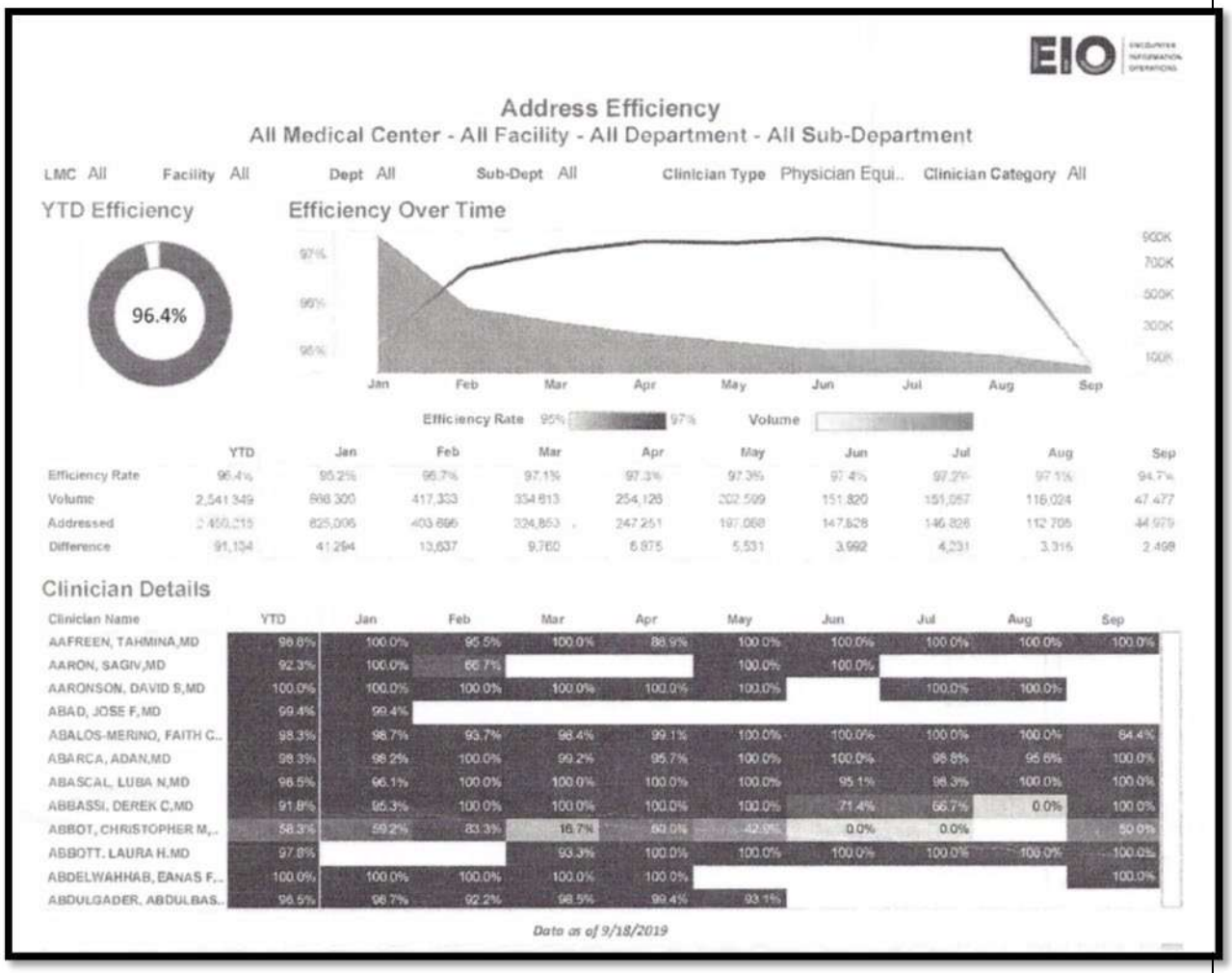
Show Weekly

	YTD			Jul 29			Jul 22			Jul 15			Jul 8	
Clinician Name	Addressed	Volume	Efficiency Rate	Addressed	Volume	Efficiency Rate	Addressed	Volume	Efficiency Rate	Addressed	Volume	Efficiency Rate	Addressed	Volum
Total	674	722	93.4%	6	6	100.0%	8	8	100.0%	2	2	100.0%	2	
BICOCCA, MICHAEL J,MD	87	95	91.6%	6	6	100.0%							0	
TAHERA, SABINA,MD	185	196	94.4%				8	8	100.0%	2	2	100.0%	2	
YOUSSEFI, ROD R,MD	402	431	93.3%											

Reminder – The Chiefs Weekly Efficiency Dashboard and individual clinician efficiency information is intended for Chiefs, PM's and Documentation & Coding Consultants to help them identify Departments and Clinicians who may need additional operational support to fully and accurately document diagnosed conditions for the risk adjusted population. It is not intended to be used as a target metric that any individual clinician must achieve.

Data through 8/4/2018 as of 8/5/2018

136. However, individual clinicians are being rated along this metric. An implicit understanding exists between clinicians and their managers that these metrics are one of several that impact performance scores, and therefore impact bonuses and other opportunities.



137. Documents such as the above are sent out weekly, with updated numbers to encourage further compliance among physicians. The dataset contains 1,000 physicians that have a 100% success rate. A 100% success rate would be difficult to achieve were it not for Defendants' intentional oversimplification of what was necessary to diagnose, confirm, and manage the chronic conditions.

138. Defendants made clear that the "success rate" was as much a part of a physician's record as any official performance metric. Bicocca himself once got an email from a compliance

officer at Permanente stating that his success rate was too low and suggested additional training. Bicocca declined additional training, as he was near retirement and did not fear any potential repercussions. He did not face immediate consequences but believes that he would likely have suffered long-term consequences had he stayed at Permanente.

139. This pressure to comply with Defendants' chronic condition certification and management system is nearly all-encompassing, as one third of Permanente patients are Medicare patients, and one in ten of Permanente's patients are CalPERS patients.

c. Defendants dot phrases are false statements in support of false claims for increased capitated rates.

140. Defendants require use of the dot phrases to make it appear as if the Permanente physicians have done more than simply tick off a check box with it comes to diagnosing and managing chronic conditions.

141. The language coded in the dot phrases are placed into the patient's EMR and indicate that the physician performed much more work that Bicocca alleges most physicians do when it comes to a patient's chronic conditions.

142. Additionally, as evidenced by Bicocca's email communications with management, the dot phrases do not accurately reflect the work the physicians are doing or the work that management expects them to do. As such, these statements are false.

143. These false dot phrase statements support an appearance of properly diagnosing, confirming the diagnosis, and discussing the chronic conditions in support of continued, increased capitation rates.

144. Relator also recalls discussions of these dot phrases and their purposes being related to financial incentives during trainings on the chronic condition management requirements. The trainers that Bicocca recalls arriving in 2015 told physicians that inputting these diagnoses codes are vital to their paychecks, i.e. Permanente could not hire, provide raises

and promotions, and could not buy any new equipment. Bicocca was also instructed that each of the chronic conditions for Medicare and CalPERS patients had to be checked off (essentially confirming the continued existence of the diagnosis) every year for Defendants to be paid for that patient.

145. What these 2015 and onward trainings conveyed was that filling these diagnoses out, and checking that they had been reviewed in subsequent visits, is the how Permanente gets paid, and that certain patients have more funds as a part of their public insurance plans, and that the .FOL statement leads to higher reimbursement.

d. Bicocca Raises Concerns About Permanente's Unlawful Practices

146. Over the course of multiple mass emails and several regular trainings, Bicocca and other physicians received instruction to include every problem that qualifies as chronic for a patient in that patient's chart after the appointment.

147. In or around 2015, Guardino gave the first mandatory educational meeting at South Sacramento Medical Center. His original statement, mirrored by the PowerPoint presentation he showed the audience, was something to the effect of "for this new billing process, you must check and discuss every chronic condition, and then you're done."

148. The implication here is that any mention of a condition by the physician or patient, even inquiring if the patient has the condition, warranted certification that the chronic conditions were present and being managed.

149. In or around 2015, another trainer stated that if a patient states in response to a question that he or she is taking medication for a certain condition, this would satisfy that the condition was present and being managed. This is in direct contradiction to the foregoing guidelines and Bicocca's opinion of what it requires for a medical professional to diagnose, confirm the diagnosis, or manage a condition.

150. Relator immediately reached out to the training staff after the session was complete to note that the training materials could not possibly be accurate, as they imply that Permanente is asking physicians to diagnose and "manage" conditions that they have no time nor expertise to diagnose or manage.

151. Over time, the training staff responded, only to Bicocca, that he was only to manage chronic conditions he was "comfortable with," such as diabetes. This seemed to be a softening of their position, until they stated that he was required to be "comfortable with" 95% of the conditions listed above. The clarification in Permanente's requirement for physicians was only given to Bicocca after he pushed back, it was not distributed to all physicians who previously received training to check off the condition and use the .FOL statement if the patient so much as mentioned they were on medication for a chronic condition.

152. Worse, Defendants, through training staff and regular check in meetings, implied that physicians would be disciplined or otherwise adversely acted upon if they did not meet this threshold. Examples of this were a reduction of bonus.

153. After the first training, in which physicians were told by the training staff from Permanente that they needed to check nearly every box showing stability in the patient's chronic condition, Permanente sent non-physician trainers to every department to ensure that this directive was being followed.

154. At one point, the trainers specifically told Bicocca that a patient who was taking an antidepressant qualified to be marked as "stable" under the chronic condition of depression. Relator told the trainers that taking an antidepressant is in no way proof that a patient is stable in that area, and that he could not determine such a thing, since he is not a psychiatrist or a primary care physician.

155. Every week, the administrative chiefs of every department received emails detailing which doctors were not checking at least 90% of the listed chronic conditions with every patient.

156. In meetings between department chiefs, the group would discuss which departments were most successful in meeting this criterion.

157. At one point in time, the highest achieving department in South Sacramento was Orthopedic Surgery, where most of the physicians would not have the clinical expertise to diagnose, confirm, or manage these conditions to the extent required by CMS.

158. As the Chief of Pain Management at the time, other physicians under Bicocca's supervision brought concerns to Bicocca about the practice.

159. On August 11, 2015, shortly after another meeting in which Bicocca was given suspect training on what was required or chronic conditions, Bicocca called Manager of Financial Services Jeremy Lawrence to express his concerns about the chronic condition language mandate Defendants were requiring.

160. Lawrence immediately forwarded these concerns to Serene Tran, Guardino, and Keshia Redmond, stating: "Dr. Bicocca indicated that he was told during the meeting today that .FOL had changed to indicate more of a 'yes, I confirm these conditions are still listed in Healthconnect' type of statement. *He is concerned about fraud* since it's unlikely that he (or most other specialists) won't actually ask about or address conditions outside of what they are treating the patient for." (emphasis added).

Jeremy Lawrence Hello Serene & Keshia - I just received a call fro... 08/11/2015 01:09:12 PM

From: Jeremy Lawrence/CA/KAIPERM
To: Serene N Tran/CA/KAIPERM@Kaiperm, Keshia Y Redmond/CA/KAIPERM@KAIPERM
Cc: Michael J Bicocca/CA/KAIPERM@Kaiperm, Jason M Guardino/CA/KAIPERM@KAIPERM
Date: 08/11/2015 01:09 PM
Subject: .refresh - clarification needed

Hello Serene & Keshia -

I just received a call from Dr. Bicocca in Pain Management seeking clarification on the use of .REFRESH, specifically around the language provided by .FOL.

.FOL seems to be a bit too specific in his opinion by implying that the physician actually confirmed the presence of the condition by way of conversation with the patient or by review of the medical record. Dr. Bicocca indicated that he was told during the meeting today that .FOL had changed to indicate more of a "yes, I confirm these conditions are still listed in Healthconnect" type of statement.

He is concerned about fraud since it's unlikely that he (or most other specialists) won't actually ask about or address conditions outside of what they are treating the patient for. Can you please offer clarification on this? thank you

Jeremy Lawrence, MBA
Manager, Medical Office Financial Services
TPMG Controller's Office, South Sacramento Medical Center
Mobile - (916) 956-9815 / Work - (916) 525-3028 tie 8-415 / Fax - (916) 525-3091 tie 8-415

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161. Guardino responded on the same day, stating that simply asking if the patient has a condition is enough to mark the condition as having been managed.

{In Archive} Re: .refresh - clarification needed

Jason M Guardino to: Jeremy Lawrence 08/11/2015 01:16 PM

Cc: Keshia Y Redmond, Michael J Bicocca, Serene N Tran

Each physician should ask about these... It's simply 'you have athlerosclerosis correct Mr. Smith'.
If they don't know, and it's on a CT, then its fine... (in this example).

Also... a key point. Lets say a person has hx of breast cancer and has nothing to do with a pain block in the leg whatsoever.
The fact that you thought about it has nothing to do with this pain block, is a way of acknowledging it as well.
In other words, you thought about how it has no bearing on this procedure.
Just as if you would think about something having a bearing on doing the procedure.
i.e. both pertinent positives and negatives.

Hope that makes sense.

Also, FOL is a regional phrase passed by many lawyers and others in region.

Thanks.

162. Tran's answer repeated that simply asking about and reviewing the diagnosis would be enough, if one's medical judgment was "implicitly" influenced by the diagnosis.

Serene N Tran "I have confirmed the presence of the above clini... 08/11/2015 01:24:31 PM

From: Serene N Tran/CA/KAIPERM
To: Jeremy Lawrence/CA/KAIPERM@KAIPERM
Cc: Jason M Guardino/CA/KAIPERM@Kaiperm, Keshia Y Redmond/CA/KAIPERM@Kaiperm, Michael J Bicocca/CA/KAIPERM@Kaiperm
Date: 08/11/2015 01:24 PM
Subject: Re: .refresh - clarification needed

"I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient. At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these

conditions unless otherwise noted. As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist. "

Above is the revised version of the .FOL which is included in our .REFRESH smartphrase.

What I take from this is that as long as you review the chart (problem list, medication list, and/or labs) when you see the patient, you can confirm that the patient has the diagnosis and the decision you make will be influenced (explicitly or implicitly) by the patient's medical history.
Also, the revised version included the phrase "as treatment warrants" to imply that if there is no change of treatment needed, you do not need to advise the patient to follow up with pcp or specialist.

I hope this helps.

Serene

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163. Bicocca responded to these emails on August 13, 2015, by pointing out the lack of consistency between Guardino and Tran, along with the lack of consistency between what was discussed via email, and what had been discussed earlier during trainings, when the requirements were implied to be even looser.

164. Bicocca then asked "[w]hy are we promoting the use of a phrase we know is making our medical documentation incorrect. I think that is fraud."

From: Michael J Bicocca/CA/KAIPERM
To: Serene N Tran/CA/KAIPERM@Kaiperm
Cc: Jeremy Lawrence/CA/KAIPERM@KAIPERM, Jason M Guardino/CA/KAIPERM@KAIPERM, Keshia Y Redmond/CA/KAIPERM@KAIPERM
Date: 08/13/2015 05:49 PM
Subject: Re: .refresh - clarification needed

I hate to be a thorn but it does not help. All my MDs feel the same as I do about this.

I can see that reading the problem list is considering the diagnosis, but the rest of the statement is not true based on the work flow we discussed the other day.

At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these conditions unless otherwise noted.

That statement says I either reviewed the chart or discussed with the patient to determine that these conditions have "no changes". I am not doing that when "I consider breast cancer" before doing an injection. Nor am I doing that when I review their medications or read the problem list. I'll hypothesize that no one besides a PCP is doing that.

As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist

For this to be true I would have to tell every patient to follow up with their PCP or specialist at every appointment I use this phrase. Jason are you saying that to patients?

Jason do you really ask every patient if they have every problem on the problem list?

I just can't imagine that MDs are doing all the things that would be required to make this a true statement. Let's be realistic. I doubt the attorneys said this was OK if the MDs aren't doing it. Why are we promoting the use of a phrase we know is making our medical documentation incorrect. I think that is fraud.

Serene, asking the patient if they have every problem on the problem list, telling them to follow up if needed and confirming that these conditions are stable, is not what you said we needed to do. I was real clear in asking and what all of my MDs heard is that all we were doing is confirming that these diagnoses are on the problem list. The work flow Jason is suggesting is drastically different.

Mike

165. Guardino, pushed back with his own email, reproduced below, and the practices have continued. Guardino's email glosses over the actual requirements by CMS, and instead dissects the certification that Permanente pressures physicians into using.

{In Archive} Re: .refresh - clarification needed
Jason M Guardino to: Michael J Bicocca, Steve Olson 08/14/2015 08:01 AM
Cc: Serene N Tran, Jeremy Lawrence, Keshia Y Redmond

History: This message has been replied to and forwarded.

Jeremy/Keshia.... Can you both meet with Mike and his group.
It seems he does not understand the issue(s).

Mike,
I'm going to encourage you to read this email a few times to help clarify. I think you don't understand the issues.

Step 1.
Any doctor should always review the Active Problem List (APL), meds, allergies, just like vital signs. I think you agree. I hope you agree.

Step 2.
MDP form is the gold standard.
If a patient has 20 problems on the APL.... while you should review them all because it is good medicine... if the MDP form only has 3 of those 20... those are the three you code. NOT ALL 20!

Step 3.
Lets say pt has DM and hx of Breast cancer (and these appear on the MDP form) and 5 other diagnosis are NOT on the MDP form (while you should reviews these other 5 for the practice of good medicine, they do not need to be coded).
So you move ONLY DM and Hx of Breast cancer (the ones on the MDP form) over from right to left and at end of your note type .Refresh.

[Let me interject here that if you are completely uncomfortable coding a diagnosis because you are simply in no way familiar with it (lets say it is 1 of the 5 dx on the MDP form). Then you code the four you feel comfortable and then route your note to the PCP and say, I coded 4 of the 5 diagnosis, but I don't feel comfortable with XYZ dx - then PCP can do when they see patient - this would hopefully be rare instance].

Now.
Let's dissect the phrase knowing that it applies only to the ones you coded and moved over that corresponded to the MDP form. In this case DM and Hx of Breast Cancer.

I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient.

So you are telling me that when a patient presents for pain block and has a history of breast cancer you don't think for one second..... "hmmmm maybe this is metastatic breast cancer? But not likely because they are 5 years out and saw onc recently", for example. You are not thinking... "maybe this is DM radiculopathy?" What if a patient has a history of BKA.... has nothing to do with RUE pain for example. Weather you thought about these as pertinent positives or negatives, I hope you thought about them and asked the patient about them. And yes.. I do ask. Before I do a colonoscopy you bet your colo I look at the APL, allergies, meds, etc and think about what reactions they might have to conscious sedation or polypectomy, etc. In fact I ask almost every patient "do you take any medications called plavix or coumadin"... even though it is not on their list at all!!

At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these conditions unless otherwise noted.

Again... I don't know what to tell you if you are not asking about DM or Hx of breast cancer if you are doing a block for pain.... I ask people about 'I know you had breast surgery... any surgery on your belly' before I do a cscope.

The medical record indicates... if you saw a note from onc during your chart review (hopefully you are doing some limited chart review) that says patient is five years out of breast cancer and clear.... the medical record indicates. You don't need to ask it if you don't want to.

As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist.

As treatment warrants.... means if it is clinically indicated. If DM is totally in control then treatment is not warranted. If it is not in control..... you don't say 'DM radiculopopathy may cause you more pain some day and you need to get your DM in control'. Why not?
If that was your relative you wouldn't want a pain doc (or any other doc) telling them they should stop smoking for example?

I'm confused. Your email sounds like some doctors are robots without thinking and then do their jobs in isolation... that is poor quality.
At the end of the day... coding ensures high quality of care - it ensures problems are being dealt with.... and that things don't fall through the cracks. Yes, it takes a few extra minutes. But I think most doctors need to start treating the whole patient... not only a nerve that causes some pain. It's far from fraud Mike, if done right with thoughtful purpose. As a chief I hope you are not poisoning the well of your docs with this and instead looking at this through a different lens of making sure the entire patient is being treated.

Thanks.
jason

Jason M. Guardino, DO, MS Ed., FACP
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166. The last set of emails from Bicocca include Regional Physician Director of Clinical Documentation and Coding Dr. Steve Olson, who these concerns were escalated up to afterwards.

167. Dr. Olson oversaw training physicians on the chronic condition and .FOL language for Permanente.

168. Olson responded by stating, again not engaging with the substance of Bicocca's worries: "if someone is on an anti depressant, and has a prior diagnosis of depression, it may not

be out of scope to ask if the patient is still taking the medication for depression that is listed on the medication list. If the patient says yes, and relates that s/he is being followed by PCP, etc, then would feel comfortable using the .FOL statement."

169. Once again, Olson's response was markedly different and more stringent than what Bicocca was told during trainings, but still essentially recommended that physicians mark diagnoses and their management simply by asking patients about their conditions.

170. Importantly, in explaining this, Olson did confirm that the point of these trainings was the capture of diagnoses for risk adjustment.

> Risk adjusted payment mechanisms require us to comprehensively and accurately code all the chronic conditions that exist in our patient population every calendar year. To be able to submit a diagnosis for recognition and reimbursement, it must be compliantly coded in a qualifying encounter performed by a qualifying clinician.

171. In one of the few instances in which Relator Bicocca was able to speak directly with Dr. Olson. Olson told Bicocca something to the effect of "of course Mike, if you don't know anything about hypoparathyroidism then don't code it." However, Olson then told Bicocca that he was expected to "know" about 90% of the listed conditions.

172. Relator Bicocca again attempted to raise up the issue and clarify the legality of the certification he has been told to insert into his medical notes in September 2017.

173. On September 18, 2017, Relator wrote to Jason Gritti, the doctor who was then responsible for trainings at South Sacramento, as well as Galina Flury and Keshia Redmond, to confirm what the coder who visited his office said was correct: "She said as long as we 'address' the problems and she was clear that all that needs is to confirm they were on a medication for that problem and tell them to follow up with the treating MD if needed. We could then include the visit diagnoses and a statement saying, 'these diagnoses were addressed today and the patient

was told to follow up with their treating provider if needed'." This was the same instruction Bicocca spent weeks clarifying with Dr. Olson in 2015.

174. Gritti responded on the same day, stating "If you specifically address each item e.g. Migraine: continue topomax [sic] and follow up with the pcp as needed, then that is quite alright as well. You would just have to ensure you address each and every separate coded item."

175. Gritti is essentially telling Relator Bicocca that, if he asks the patient about the condition, whether the patient is taking medication, and telling them to follow up with another physician on that condition, that he could diagnose or confirm the diagnosis of a condition and use the .FOL phrase to indicate that the condition was being managed.

XI. Conclusion

176. "Under Medicare Advantage's capitation system, private health insurance organizations provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage. These organizations pocket for themselves or pay out to their enrollees' providers the difference between their capitation revenue and their enrollees' medical expenses, creating an incentive for the organizations to rein in costs. Unfortunately, human nature being what it is, Medicare Advantage organizations also have some incentive to improperly inflate their enrollees' capitation rates, if these organizations fall prey to greed." *WellPoint, Inc.*, 904 F.3d at 667 (internal citations omitted).

177. A common form of fraud, one that is occurring here, is falsely claiming to provide coverage and services to a beneficiary population that is not as sick as claimed.

178. By explicit setting up separate requirements for physicians treating Medicare beneficiaries and patients with other public benefits plans differently than private pay or employer-based insurance, Defendants demonstrate knowledge that checking off additional

chronic conditions and using the .FOL language is material to the Government's decision to pay increased capitation for public benefits beneficiaries.

179. Defendants are aware of the issues with this method of billing due to Bicocca raising the concerns of multiple physicians related to this issue.

180. Defendants' misrepresentations are material to the government's decision to continue paying Defendants its capitation rate under the assumption patients are sicker than they really are.

181. As a result, the government and the state have been damaged in a yet to be quantified amount.

COUNT I
Defendant Knowingly Presents, or Causes to be Presented
False Claims
31 U.S.C. § 3729(a)(1)(A)

182. Relator reasserts and incorporates by reference all paragraphs set forth above as if restated herein.

183. 31 U.S.C. § 3729(a)(1)(A) subjects to liability any person or entity that "knowingly presents, uses, or causes to be presented, a false or fraudulent claim for payment or approval."

184. Defendants knowingly presented or caused to be presented to the United States, false or fraudulent claims, and knowingly failed to disclose material facts, in order to obtain payment or approval under the federally funded Medicare program in violation of 31 U.S.C. § 3729(a)(1)(A).

185. Defendants knowingly submitted claims and received payment from the United States of America through CMS for inflated capitation rates that were based on false reporting of risk adjustment data by Defendants.

186. The United States of America has been damaged by all the misrepresentations and failures to comply with requisite laws and regulations in an as of yet undetermined amount.

COUNT II
Defendant Knowingly Made, Used, or Caused to be Made or Used, False Records or Statements Material to False Claims 31 U.S.C. § 3729(a)(1)(B)

187. Relator reasserts and incorporates by reference all paragraphs set forth above as if restated herein.

188. The False Claims Act imposes liability on any person 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)(B).

189. As a result of Defendants' actions, the Government paid funds from the Medicare Advantage program for capitation rates covering services not actually rendered.

190. As a result of Defendants' actions, the Government paid funds from the Medicare programs for services that were not or could not be performed.

191. Defendants knowingly made or used false records material to false claims when they, among other things, created records that indicated physicians rendered appropriate case management services, when in fact, appropriate case management services were not rendered to patients.

192. The United States of America has been damaged by all the misrepresentations and failures to comply with requisite laws and regulations in an as of yet undetermined amount.

COUNT III
California False Claims Act Violations Pursuant to Cal. Gov't Code § 12651(a)(1) Knowingly Submitting False Claims for Payment

193. Relator reasserts and incorporates by reference all paragraphs set forth above as restated herein.

194. Defendants, individually and through the acts of their agents, servants, officers, and employees, knowingly presented, or caused to be presented, to an officer or employee of the California government, false or fraudulent claims for payment or approval under the CalPERS program in violation of Cal. Gov't. Code § 12651 (a)(1).

195. Defendants knowingly presented, or caused to be presented, to an officer or employee of the California government, false or fraudulent claims for payment or approval under the CalPERS program in violation of Cal. Gov't. Code § 12651 (a)(1).

196. Cal. Gov't. Code § 12651 (a)(1) imposes liability on a person or entity that knowingly presented, or caused to be presented, to an officer or employee of the California government, false or fraudulent claims for payment or approval.

197. The government of California, unaware of the falsity of the claims made by Defendants and in reliance on the accuracy thereof, paid Defendants for such false or fraudulent claims.

198. Defendants violate Cal. Gov't. Code § 12651 (a)(1) when they submit claims for inflated capitation rates that were based on false reporting of risk adjustment data by Defendants.

199. The claims submitted by Defendants are material to the state of California's decision on whether, and how much, to pay Defendants for services provided to CalPERS beneficiaries.

200. By reasons of the acts and conduct of Defendants in violation of Cal. Gov't. Code § 12651 (a)(1), the government of California has suffered actual damages, including the amounts paid in response to all such false or fraudulent claims for payment.

201. The state of California is entitled to recover civil money penalties, and other monetary relief as deemed appropriate.

COUNT IV
California False Claims Act Violations
Pursuant to Cal. Gov't Code § 12651 (a)(2)
Knowingly Making False Records Material to a False Claim

202. Relator reasserts and incorporates by reference all paragraphs set forth above as restated herein.

203. Defendants, individually and by their own acts, or through the acts of their agents, servants, officers, and employees, knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim in violation of Cal. Gov't Code § 12651 (a)(2).

204. Defendants knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim in violation of Cal. Gov't Code § 12651 (a)(2).

205. Defendants violate Cal. Gov't Code § 12651 (a)(2) when they knowingly made or used false records material to false claims when they, among other things, created records that indicated physicians rendered appropriate case management services, when in fact, appropriate case management services were not rendered to patients.

206. At all relevant times, Defendants were aware of, and displayed a conscience and reckless disregard for, the applicable CalPERS rules and regulations regarding the submission of claims for payment.

207. The false statements created and submitted by Defendants is material to the state's decision on whether, and how much, to pay Defendants for services provided to CalPERS beneficiaries.

208. By reasons of the acts and conduct of Defendants in violation of Cal. Gov't Code § 12651 (a)(2), the State of California has suffered actual damages, including the amounts paid in response to all such false or fraudulently supported claims for payment.

209. The state of California is entitled to recover civil money penalties, and other monetary relief as deemed appropriate.

PRAYER FOR RELIEF

WHEREFORE, Relator Michael Bicocca, acting on behalf of and in the name of the United States of America and the State of California, and on his own behalf, pray that judgment be entered against Defendants for violation of the False Claims Act as follows:

(a) In favor of the United States and State of California against the Defendants for treble damages to the federal and State government from the submission of false claims, and the maximum civil penalties for each violation of the False Claims Acts and California False Claims Act;

(b) In favor of the Relator for the maximum amount pursuant to 31 U.S.C. § 3730(d) to include reasonable expenses, attorney fees, and costs incurred by the Relator;

(c) For all costs of the False Claims Act and California False Claims Act civil action; and

(d) In favor of the Relator, the United States, and California for further relief as this court deems just and equitable.

DEMAND FOR A JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure and pursuant to the local rules of this Court, Relator demands a jury trial as to all issues so triable.

October 2, 2020

Respectfully submitted,

s/ J. Bernard Alexander

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No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
VOLUME 7 of 9

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EASTERN DISTRICT OF CALIFORNIA
BY _____ DEPUTY CLERK

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
Sacramento Division

UNITED STATES OF AMERICA AND THE STATE OF CALIFORNIA, *ex rel.* [UNDER SEAL] *Plaintiff*, v. [UNDER SEAL] *Defendants*.	**Case No.** 2:20-CV-296 TLN EFB **FILED UNDER SEAL** **COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, 31 U.S.C. §§ 3729, *et seq.*; AND THE CALIFORNIA FALSE CLAIMS ACT, CAL. GOV'T CODE §§ 12650, *et seq.*** **JURY TRIAL DEMANDED**

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF CALIFORNIA
Sacramento Division

UNITED STATES OF AMERICA AND THE STATE OF CALIFORNIA, *ex rel.* MICHAEL BICOCCA 2530 Highland Hills Drive El Dorado Hills, CA 95762 *Plaintiff*, v. PERMANENTE MEDICAL GROUP, INC. 1950 Franklin Street, 18th Floor, Oakland, CA 94612 SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, INC. 393 Walnut Drive, Pasadena, CA 91107 THE PERMANENTE FEDERATION, LLC. 1 Kaiser Plaza, 27th Floor, Oakland, CA 94612 *Defendants*.	**Case No. _____** **FILED UNDER SEAL** **COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, 31 U.S.C. §§ 3729, *et seq.*; AND THE CALIFORNIA FALSE CLAIMS ACT, CAL. GOV'T CODE §§ 12650, *et seq.*** **JURY TRIAL DEMANDED**

COMPLAINT

I. Introduction

1. *Qui tam* relator Michael Bicocca ("Relator") by his attorneys, individually and on behalf of the United States of America and the State of California, files this Complaint against the above-named Defendants to recover damages, penalties, and attorneys' fees for violations of the federal False Claims Act ("FCA"), 31 U.S.C. §§ 3729 *et seq.*, and the California False Claims Act ("CFCA"), Cal. Gov't Code § 12651 *et seq.*

2. Defendants intentionally instruct physicians to certify that they have managed their patients' chronic conditions, even though they have not managed the chronic condition, and in many instances are not equipped to manage a patient's chronic conditions. Defendants then bill these false certifications in claims to Medicare and the California Public Employees' Retirement System ("CalPERS") to receive undeserved capitation payments from the United States and the State of California.

3. Because the data Defendants submit to Medicare and CalPERS for continued capitation rates intentionally and falsely states that the patients' chronic conditions were effectively managed, Defendants receive additional, undeserved capitation amounts.

4. CMS regulations state that Chronic Condition Management (CCM), i.e. the treatment of reoccurring, constant, and damaging conditions overtime, must be specialized and detail-oriented in order to be reimbursable.

5. Rather than promoting these regulations to its physicians, Defendants tell their physicians to insert a certification in their doctors' notes meant to show compliance with CMS regulations stating that the patient's chronic conditions were listed, considered in medical-decision-making, and referred to a specialist, if applicable. This certification, on a broad level, indicates compliance with CMS regulations related to CCM.

6. However, Defendants do not require, and effectively discourage physicians from complying with CMS regulations *or its own certification*. Instead, various trainings attended by Defendants' physicians, including Relator Bicocca, repeatedly instructed physicians that all that needed to be done to justify adding this certification to the patient's appointment record was to verify that the patient had chronic conditions, and to make sure that these chronic conditions are "stable."

7. Even though CCM regulations promoted by CMS are meant to promote specialized and detail-oriented management of patients' chronic conditions, neither the certification nor the trainings promoted by Defendants reflect this.

8. Worse, Defendants *require* all physicians to satisfy this requirement during every appointment. It is effectively impossible for most physicians to comply with the requirements for CCM because they have neither the time nor the expertise to manage every chronic condition for every patient they see. For example, Bicocca's specialty is pain management, meaning he does not have the qualifications to manage a patient's depression.

9. Use of this certification results in coding to the CCM CPT codes, either normal or complex, despite the requirements for those codes not being met. Despite Defendants' receiving capitated payments from CMS under Medicare Part C with the cost of CCM built-in, Defendants do not engage in Chronic Condition Management such that they should be receiving capitated rates from CMS at the level they are.[1]

10. The result of this is profit at the expense of the United States of America and the State of California.

[1] While most patients seen by Permanente with public benefits are Medicare Part C beneficiaries, some patients in this scheme may be under other programs or plans, resulting in Defendants receiving FFS payments from CMS for fraudulent use of the CCM CPT code.

II. Jurisdiction and Venue

11. This Court has subject matter jurisdiction over this action under the FCA because it is an action arising under the laws of the United States, specifically 31 U.S.C. § 3730(b).

12. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because Defendants transact business in this judicial district.

13. Venue is proper in this Court under 28 U.S.C. § 1391(c) and 1395(a) because illegal acts occurred within this judicial district, Defendants are resident of this district, and because Defendants transact business within this judicial district.

14. This Court has personal jurisdiction over Defendants because the Defendants are in the State of California.

III. Parties

15. Relator Bicocca is an anesthesiologist with more than 20 years of experience. Bicocca holds a Bachelor of Science degree from California Polytechnic State University in San Luis Obispo and earned his MD from Northeastern Ohio Universities Colleges of Medicine and Pharmacy.[2] Bicocca completed his residency at the University of California, Davis, and did a fellowship at Massachusetts General Hospital in Boston.

16. Bicocca served as Chief of Pain Management for Kaiser Hospitals in Modesto, Stockton, and South Sacramento, California, before he voluntarily stepped down to return to medical practice full-time. Bicocca subsequently worked as a pain management physician at Kaiser's South Sacramento facility until he retired in December 2019.

17. Bicocca's practice focuses primarily in pain management. Pain management includes, but is not limited to, management of chronic pain, including facet joint injections.

[2] Northeastern Ohio Universities Colleges of Medicine and Pharmacy is now known as Northeast Ohio Medical University (NEOMED).

18. The Permanente Federation, LLC, (Permanente Federation) is a network of corporations that employs thousands of physicians. These corporations are not legally affiliated with each other. However, the Permanente groups' upper level management frequently comingle between firms. For example, Rich Isaacs, CEO and Executive Director of Permanente Medical Group, is also the President and CEO of Mid-Atlantic Permanente, while also working as Co-Chief Executive Officer of the Permanente Federation.

19. Through the Permanente Federation, the heads of the other Permanente branches coordinate on larger business decisions and plans, while sharing best practices.

20. Permanente Federation contracts with Kaiser to provide physicians to Kaiser hospitals and the Kaiser insurance group. Permanente Federation provides services exclusively to Kaiser.

21. One of the corporations within the Permanente Federation network is Permanente Medical Group ("Permanente"), which has twenty one (21) locations in California, including: Antioch, Fremont, Fresno, Modesto, Oakland, Redwood City, Richmond, Roseville, Sacramento, San Francisco, San Jose, San Leandro, San Rafael, Santa Clara, Santa Rosa, South Sacramento, South San Francisco, Stockton, Vacaville, Vallejo, and Walnut Creek.

22. Permanente serves as both the Northern California regional group and as the flagship group of the Permanente Federation. Permanente is based in Northern California and is the largest Permanente Medical physicians' group, with more than 25,000 employees.

23. About one third of Permanente's patients are Medicare recipients. Around 90% of those patients have Medicare Part C plans.

24. Southern California Permanente Medical Group, Inc. is the Permanente group within the Permanente Federation responsible for administering medical care to Southern California residents.

IV. Medicare Overview

25. In 1965, Congress enacted Title XVIII of the Social Security Act under 42 U.S.C. § 1395, *et seq.* ("The Medicare Program" or "Medicare") authorizing the federal government to pay for the cost of certain medical services for persons aged 65 and older.

26. The United States, through the Department of Health and Human Services ("HHS"), administers the Medicare program.

27. Medicare reimbursement to providers of medical services is accomplished through private insurance carriers ("carriers"), as provided by 42 U.S.C. § 1395u. The carrier, on behalf of the Medicare Program, reviews and approves claims submitted for reimbursements by Medicare.

28. At all relevant times hereto, Defendant signed or caused to be executed provider agreements with Medicare that permitted Defendant to submit claims and accept payment for services provided by Defendant.

29. As a condition of participation in the Medicare program, providers agree to be familiar with, and abide by, the program's reimbursement policies. When the Defendant physicians submitted their Medicare Enrollment Applications, they certified to the following requirements:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. 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 supplier's compliance with all applicable conditions of participation in Medicare.
>
> I agree that any existing or future overpayment made to the supplier by the Medicare program may be recouped by Medicare through the withholding of future payments.

> I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
>
> *See* CMS Form 855-B, Medicare Enrollment Application.

30. Accordingly, Defendant has a duty to be knowledgeable of the statutes, regulations, and guidelines regarding coverage for Medicare services.

31. Medicare generally does not cover, and providers agree not to submit claims for, services provided that are not necessary, not appropriately administered, or not properly documented.

32. In short, for Defendant to be properly reimbursed by the Medicare program, CMS requires that the treating physician order the applicable medically necessary services, and appropriately document the justification and administration of those services.

33. Before accepting Medicare assignments, Defendant, and all providers who submit claims for services provided to Medicare beneficiaries, must certify that they will operate in accordance with HHS requirements.

34. In addition, requests for Medicare reimbursement are submitted on Health Insurance Claim Form CMS-1500. The CMS-1500 form includes a box for the "SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)"

35. Among the statements on the reverse of the CMS-1500 form is the following:

> **SIGNATURE OF PHYSCIAN OR SUPLLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)**
>
> In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate, and complete; 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide

> sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complied with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment …
>
> NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

36. When filing the electronic equivalent of the CMS-1500, a provider also certifies that:

> The services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

37. When submitting a claim using the CMS-1500 form, the provider/supplier also certifies that (i) the information on the form is "true, accurate and complete"; (ii) payment of the claim will be from federal funds; and (iii) "any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal . . . laws."

38. Completed CMS-1500 forms are submitted electronically to a Medicare contractor that then reviews the claims for blatant errors, such as missing fields and/or information, and HIPPA violations. If a claim is accepted, the requesting company receives electronic notification.

39. Although the Medicare contractor is checking for errors, the certifying physician or supplier is ultimately responsible for the accuracy of the information upon which the claim is based.

V. Medicare Advantage Organizations under Medicare

40. Medicare Part C, or Medicare Advantage, is a program in which CMS works more closely with private companies, called Medicare Advantage Organizations (MAOs), to offer semi-private, semi-public plans that cover Medicare Part A and B services. Part C plans will sometimes also cover prescription drug benefits under Medicare Part D. *See U.S., ex rel. Osheroff v. HealthSpring, Inc.*, 938 F. Supp. 2d 724, 726 (M.D. Tenn. 2013).

41. "The Centers for Medicare & Medicaid Services ("CMS") compensates MAOs at a capitated rate for the delivery of benefits. To participate in the Medicare Advantage program, MAOs must submit bids to CMS every year in which they offer to provide services for a specified amount per member, per month. Each participating MAO must then enter into a contract with CMS, the terms of which require the MAO to comply with certain laws, including. . . . the [False Claims Act]. To receive payment for services provided under the Medicare Advantage program, MAOs must submit monthly payment requests to CMS along with monthly reports certifying that all information submitted to CMS in this report is accurate, complete, and truthful." *United States ex rel. Derrick v. Roche Diagnostics Corp.*, 318 F. Supp. 3d 1106, 1110 (N.D. Ill. 2018) (internal citations and quotations omitted).

42. "By law, CMS must pay Medicare Advantage insurers in a manner that ensures 'actuarial equivalence' between payments for healthcare under Medicare and Medicare Advantage plans[.]" *UnitedHealthcare Ins. Co. v. Azar,* 330 F. Supp. 3d 173, 178 (D. D.C. 2018), *appeal filed* 11/14/18, U.S. Court of Appeals for the D.C. Circuit, Case No. 18-5326 (citing 42 U.S.C. § 1395w-23(a)(1)(C)(i)).

43. "Traditional Medicare uses a fee-for-service payment model, whereby the more services physicians perform, the more money they earn . . . . Capitation means an amount is paid per person. Under Medicare Advantage's capitation system, private health insurance

organizations provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage. These organizations pocket for themselves or pay out to their enrollees' providers the difference between their capitation revenue and their enrollees' medical expenses, creating an incentive for the organizations to rein in costs." *United States ex rel. Anita Silingo v. WellPoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018) (internal citations and quotations omitted).

44. Simply put, Medicare Advantage is supposed to compensate these organizations for expected healthcare costs, paying "less for healthier enrollees and more for less healthy enrollees." *United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1166 (9th Cir. 2016) (*citing* 42 C.F.R. § 422.504(*l*), (*l*)(2))).

45. Defendants are members of the Medicare Advantage Program and are therefore MAOs.

46. Bicocca's patients covered by public insurance programs are mainly participants in the Kaiser Permanente Senior Advantage Enhanced Plan (HMO), which is a Medicare Part C plan that provides Medicare Part D benefits as well.

47. Permanente therefore receives a regular capitation rate from CMS for each Part C patient it sees. This rate is meant to cover the cost of caring for the patient.

VI. California Public Employees' Retirement System

48. CalPERS is a retirement system created by statute, for the purpose of administering retirement, disability and death benefits for California state employees. Cal. Gov't Code § 20001 *et seq.*

49. "CalPERS is a unit of the Government Operations Agency responsible for administering the retirement systems for the State of California and contracting agencies—local public agencies that have elected to have all or part of their employees become members of this

system and that have contracted with CalPERS for that purpose." *Marzec v. California Pub. Employees Ret. Sys.*, 236 Cal. App. 4th 889, 896 (2015) (internal quotations omitted).

50. "CalPERS is a unit of the Government Operations Agency. In addition to administering the retirement system for employees of California and other public entities, CalPERS operates health insurance plans, including the PERS Choice health plan. . . ." *Orthopedic Specialists of S. California v. Pub. Employees' Ret. Sys.*, 228 Cal. App. 4th 644, 646 (2014) (quotations omitted).

51. CalPERS is the United States' largest public pension fund and provides benefits to approximately 1.9 million members. CalPERS members include public employees, retirees, and their families. CalPERS provides benefits to its members including health insurance, long-term insurance, death benefits, mortgage programs, and the distribution of pension and retirement-related financial benefits.

52. When members, their spouses, or their dependents become Medicare eligible due to age or disability, the members are encouraged to notify CalPERS so that they can be enrolled in the CalPERS Medicare health plan.

53. As a retiree, when a member first becomes eligible for Medicare, they must request a change from a CalPERS Basic Health Plan to a CalPERS Medicare Health Plan. When a CalPERS member retires and enrolls in Medicare Part A and Part B, CalPERS will work with the CMS to obtain the retiree's Medicare information and automatically transfer the retiree from a CalPERS Basic (non-Medicare) health plan to a CalPERS Medicare health plan.

54. The CalPERS Medicare Health Plan requires Medicare to assume the role as the primary payer for health care costs, thus CalPERS members who receive health services result in expenditures to Medicare.

VII. Chronic Condition Management (CCM)

55. In 2015, Medicare changed its rules to focus on preventative care, especially regarding patients who suffer from chronic health conditions.

56. The latest change or rules related to chronic care management can be found in the Federal Register, from a proposed, and accepted rules change in November 2016. *Reducing Administrative Burden and Improving Payment Accuracy for Chronic Care Management (CCM) Services* 81 FR 80243.

57. The proposed rule changes provide further information regarding the rationale for these changes. "Beginning in CY 2015, we implemented separate payment for CCM services under CPT code 99490 (Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health professional, per calendar month) . . . ." 81 FR 80243.

58. The purpose of this change was "to improve payment for, and encourage long-term investment in, care management services." 81 FR 80243 (*citing* 79 FR 67715).

59. The changes in the rules reflected the regulators' desire to make sure physicians and facilities had "the resources required to furnish complex chronic care management services to beneficiaries with multiple (that is, two or more) chronic conditions were not adequately reflected in the existing E/M codes." 81 FR 80243.

60. One concern of the regulators was compensating and incentivizing physicians to spend an adequate amount of time on patients with chronic conditions. "Medical practice and patient complexity required physicians, other practitioners and their clinical staff to spend increasing amounts of time and effort managing the care of comorbid beneficiaries outside of face-to-face E/M visits, for example, complex and multidisciplinary care modalities that involve regular physician development and/or revision of care plans; subsequent report of patient status;

review of laboratory and other studies; communication with other health care professionals not employed in the same practice who are involved in the patient's care; integration of new information into the care plan; and/or adjustments of medical therapy." 81 FR 80243.

61. In addition to making sure physicians had the time, resources, and compensation to fully manage their patients' chronic conditions, the regulators were also concerned with making sure physicians were sufficiently *capable of furnishing such services*.

62. "In finalizing separate payment for CPT code 99490, we considered whether we should develop standards to ensure that physicians and other practitioners billing the service would have the capability to fully furnish the service." 81 FR 80243 (*citing* 79 FR 67721).

63. "We established requirements to furnish a preceding qualifying visit, obtain advance written beneficiary consent, use certified electronic health record (EHR) technology to furnish certain elements of the service, share the care plan and clinical summaries electronically, document specified activities, and other items. . . ." 81 FR 80243.

64. A common complaint listed among stakeholders was that the chronic care management CPT code was usually exceeded without additional benefit, disincentivizing care longer of 20 minutes, which led to the revision/creation of CPT code 99487, meant specifically for "complex" cases, where there would be higher reimbursement for 60 minutes of time spent with patients. *See* 81 FR 80244.

65. The below CPT codes, therefore, are meant to incentivize spending more time on patients with chronic conditions and so that the physician can conduct an in-depth review of the patient's chronic condition as opposed to simply a quick check-up.

66. CMS therefore reimburses health providers a certain amount per patient for a condition in a month/year basis – not on a per visit basis for treatment of chronic conditions.

67. There are two categories chronic conditions that Medicare focuses on: complex and non-complex.

68. The criteria for billing for monitoring and management of "non-complex" chronic conditions (CPT Code 99490) are:

a. a doctor/physician assistant/nurse practitioner must spend at least 20 minutes with the patient per month,

b. the patient must have multiple chronic conditions expected to last at least 12 months,

c. the chronic condition must place the patient at significant risk of death, decompensation, or functional decline, and

d. a comprehensive care plan must be established, implemented and monitored by the care giver.

69. If the criteria for non-complex patients' chronic care management plans are met, Permanente would receive a reimbursement of approximately $43.00 per patient per month on a fee-for-service plan (FFS).

70. The criteria for billing for monitoring "complex" chronic conditions (CPT Code 99487) are the following:

a. patients must have multiple chronic conditions expected to last at least 12 months (or until death),

b. the chronic conditions place the patient at significant risk of death or functional decline,

c. the medical providers establish a comprehensive care plan,

d. there must be moderate or high complexity in medical decision making, and

e. a doctor/physician assistant/nurse practitioner must spend at least 60 minutes with the patient per month.

71. Physicians should be providing an in-depth analysis of patient conditions to determine if the conditions are being controlled; a physician can't simply ask if the patient is on medication or if they have experienced mood swings but needs to provide a more thorough service to bill for the complex chronic care management.

72. If the criteria for complex patients' chronic care management plans are met, Permanente would receive a reimbursement of approximately $94.00 per patient per month on a Fee-for-service (FFS) plan.

73. Several conditions qualify as chronic conditions. These include:

a. Alzheimer's Disease and Related Dementia

b. Arthritis (Osteoarthritis and Rheumatoid)

c. Asthma

d. Atrial Fibrillation

e. Autism Spectrum Disorders

f. Cancer (Breast, Colorectal, Lung, and Prostate)

g. Chronic Kidney Disease

h. Chronic Obstructive Pulmonary Disease

i. Depression

j. Diabetes

k. Heart Failure

l. Hepatitis (Chronic Viral B & C)

m. HIV/AIDS

n. Hyperlipidemia (High cholesterol)

o. Hypertension (High blood pressure)

p. Ischemic Heart Disease

q. Osteoporosis

r. Schizophrenia and Other Psychotic Disorders

s. Stroke

74. While most of Bicocca's patients are not served under an FFS plan, the regulations governing chronic condition management and the costs of such care are factored into the capitation rates given to Defendants by CMS.

75. Permanente's scheme affects Medicare more than CalPERS. At least 10% of the entire Permanente patient population is on the CalPERS program.

76. In sum, CCM is meant to be an in-depth review and plan for managing difficult, often complex, conditions that usually require the skills of a specialist, or that of an experienced general physician.

77. Relator Bicocca, before Permanente's scheme began, would rarely engage in CCM as a part of his Paint Management specialty.

78. Relator's knowledge of medical practice in general suggests that most specialists also spend little time on CCM unless that chronic condition is directly applicable to that specialist's practice.

79. Relator's knowledge of medical practice in general suggests that, aside from specialists engaging in CCM related to their practices, most CCM comes into play with experienced generalists who have elderly patients with multiple chronic conditions.

VIII. The False Claims Act and California False Claims Act

80. The FCA, 31 U.S.C. §§ 3729–3733 was enacted in 1863 by Congress and provides that any person who knowingly submitted false claims to the government was liable for damages plus a penalty for each claim. The FCA has been amended several times.

81. The FCA imposes liability on any person or entity who knowingly presents or causes to be presented a false or fraudulent claim for payment or approval. 31 U.S.C. § 3729(a)(1)(A). Additionally, those who make, use or cause to be made a false statement or record material to the claim are also liable under the FCA. 31 U.S.C. § 3729(a)(1)(B).

82. The terms "knowing" and "knowingly" are defined by the statute as a person having actual knowledge of the information, acting in deliberate ignorance of the truth or falsity of the information, or acting in reckless disregard of the truth or falsity of the information. 31 U.S.C. § 3729(a)(3)(B)(4).

83. The term "material" means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property. 31 U.S.C. § 3729(a)(3)(B)(4).

84. "A claim under the False Claims Act requires a showing of (1) a false statement or fraudulent course of conduct, (2) made with the scienter, (3) that was material, causing (4) the government to pay out money or forfeit moneys due." *United States ex rel. Campie v. Gilead Scis., Inc.*, 862 F.3d 890, 899 (9th Cir. 2017), *cert. denied sub nom. Gilead Scis., Inc. v. U.S. ex rel. Campie*, 139 S. Ct. 783, 202 L. Ed. 2d 566 (2019).

85. Any person who violates the FCA is liable for damages in the amount of three (3) times the amount of loss the government sustained and penalties which range between $10,957 and $21,916 per claim. 31 U.S.C. § 3729(a); 28 C.F.R. § 85.3.

86. The California False Claims Act also imposes liability on any person or entity who knowingly presents or causes to be presented a false or fraudulent claim for payment or approval to the State of California. Cal. Gov't Code § 12651 *et seq.*

87. "[Fraud against] [t]he Medicare Advantage capitation payment system is subject to the False Claims Act." *United States ex rel. Anita Silingo v. WellPoint, Inc.*, 904 F.3d 667, 673 (2018).

IX. Factual Overview

88. Permanente instructs physicians to certify that they meet the conditions of CPT codes 99487 or 99490 for every Medicare or other public benefits appointment they have but instructed the physician to do so in a manner that could never satisfy CMS requirements. These certifications by physicians were then coded under the above CPT codes and billed to Medicare and CalPERS for the purpose of receiving a higher capitation rate from the United States, and in order to make a larger profit off the capitation rate Permanente receives.

89. Rather than fulfilling the requirements of the CPT codes as set out by CMS, physicians at Permanente were instructed to simply discuss the chronic conditions, insert the foregoing certification, and consider the conditions assessed as is required by CMS.

90. Relator raised concerns that for most providers it would be effectively impossible to sufficiently meet CCM requirements to management and Permanente staff who conducted training on CCM, but never received a meaningful response, one that adequately provided Relator the tools to truthfully make the certification Defendants required. Defendants have not changed their policies and trainings.

a. **Permanente bills for chronic care management even though many of its physicians do not engage in chronic care management.**

91. In or around 2015, Permanente changed how it directed its physicians to manage chronic conditions through a series of trainings on billing, note writing, and coding.

92. The trainings and policy changes directed by Permanente management were meant specifically to affect only Medicare and other public benefits patients, creating a two-tiered system of CCM, where private health insurance patients are given the usual CCM treatment, if any, and where physicians are required to give public benefits patients CCM coverage.

93. The trainings contained inaccurate information. In fact, before reviewing the foregoing rules himself, Bicocca was falsely trained to believe that CCM CPT codes were satisfied with one visit per year with the patient with a lump sum payment representing one year of coverage

94. Permanente directs its physicians to check off all chronic conditions that could conceivably apply to a patient and place a certifying statement in the patient's record, without adequate *management* of those chronic conditions as required by federal regulations and CMS. Again, this mandate was only required for patients with public benefits, not all patients seen by Permanente physicians.

95. For example, Defendants' trainings never mentioned the requirement that CCM required the creation of a comprehensive care plan for the chronic conditions.

96. Over time, Defendants' method of directing physicians to perform this fraud grew more subtle as Bicocca continually objected to the trainings.

97. Senior leadership at Permanente, including Jason Guardino, the Assistant Physician in Charge (APIC) and Chief of Gastroenterology Department, provide the language for the certifying statements.

98. Senior leadership at Permanente, through emails and training initiatives, directed physicians to write the following in their charts:

> I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient. At the time of the visit, the medical record indicates, and/or the patient states, that there are no changes in these conditions unless otherwise noted. As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist.

99. This statement suggests that some, but not all of the steps of management of a patient's chronic conditions are satisfied: (1) the physician confirms that the patient has qualifying chronic conditions, and (2) the physician considers these chronic conditions when making medical decisions about that patient.

100. The statement also notes that, if there are no additional notes, then there were no changes in the patient's chronic conditions, while also noting that the patient was advised to speak to their specialist physicians regarding those specialist conditions if necessary.

101. This is problematic, however, as the regulations show that management of a patient's condition typically means *acting as that specialist*, not simply referring the issue away.

102. For example, below is an email from Permanente confirming the language of the certification, dated August 11, 2015. The email includes a statement by Serene Tran, a trainer, citing an improper interpretation of what is needed to satisfy the CCM requirements.

Serene N Tran "I have confirmed the presence of the above clini... 08/11/2015 01:24:31 PM

From: Serene N Tran/CA/KAIPERM
To: Jeremy Lawrence/CA/KAIPERM@KAIPERM
Cc: Jason M Guardino/CA/KAIPERM@Kaiperm, Keshia Y Redmond/CA/KAIPERM@Kaiperm, Michael J Bicocca/CA/KAIPERM@Kaiperm
Date: 08/11/2015 01:24 PM
Subject: Re: .refresh - clarification needed

"I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient. At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these

conditions unless otherwise noted. As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist. "

Above is the revised version of the .FOL which is included in our .REFRESH smartphrase.

What I take from this is that as long as you review the chart (problem list, medication list, and/or labs) when you see the patient, you can confirm that the patient has the diagnosis and the decision you make will be influenced (explicitly or implicitly) by the patient's medical history.
Also, the revised version included the phrase "as treatment warrants" to imply that if there is no change of treatment needed, you do not need to advise the patient to follow up with pcp or specialist.

I hope this helps.

Serene

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103. Permanente requires physicians, in order to use the certification, to go through the entire list of chronic conditions, regardless of whether physicians have the time or qualifications to do so. It is difficult for physicians to accomplish without lying.

104. For example, if a patient comes to see Dr. Bicocca for a facet injection, but also has diabetes, high blood pressure, a history of cancer, depression, or high cholesterol, then the foregoing policy would obligate Dr. Bicocca and other physicians to check all of the above conditions, certify that the patient's conditions are stable, and recommend the patient follow-up as necessary with their primary care physician or specialist. Dr. Bicocca, a pain management physician, is not trained and does not have the expertise or ability to manage the patient's cancer or depression for example. Nor are some of the above conditions relevant to Dr. Bicocca's medical decision making regarding the patient's pain management issues.

105. Despite billing for managing chronic conditions as defined by the above CPT codes, Permanente physicians do not meet the time requirements set forth by CMS to bill for managing those conditions. In addition, Permanente physicians may not have the expertise to address the chronic conditions Permanente is pressuring them to address.

106. Bicocca and other physicians do not typically have appointments which last long enough to discuss each of these conditions in full detail and to, in good faith, write the Permanente-supplied certification in the chart.

107. Below is a quick overview of Relator Bicocca's typical appointments, which begin at 7:30 AM every weekday.

a. As of Fall 2018, forty-five-minute consultations for new patients, with limited discussion of non-pain-related conditions insofar as they would impact any pain management procedures.

b. Before Fall 2018, initial consults were only thirty minutes, giving physicians less time for comprehensive chronic condition care.

c. Thirty-minute procedure appointments, including facet injections. There is little discussion of any non-pain-related conditions unless any would affect the immediate procedure. During this appointment, Dr. Bicocca is performing a medical procedure.

d. Thirty-minutes follow-up discussion appointments on the effectiveness of the procedure and whether any anything else is needed, including a limited discussion of other conditions for their effect on the recovery.

108. None of the appointments provide Bicocca and other physicians in his practice the time or opportunity to evaluate or manage any chronic conditions a patient may have. Dr. Bicocca has reason to believe that other specialty physicians at Permanente conduct their appointments in a similar manner and would also not have the time in any given appointment necessary to discuss, evaluate, or manage a patient's chronic conditions.

109. Based on Relator's experience, patients typically spend 17 to 20 minutes with their pain management physicians during a procedure appointment, 25 minutes in a return

appointment, 25 minutes during initial consultations, and 40 minutes during initial consultations that occurred after Fall 2018, with five minutes of documentation time, none of which is enough time to describe, discuss, and cover the nearly two dozen chronic conditions listed above. Relator estimates that his own practice has longer appointments than the norm for specialists, which he believes are typically around 20 minutes each.

110. Further, the "complex" CCM code requires that at least one hour of staff time per month must be directed towards a patient by the physician for the "complex" requirements to be met. This requirement cannot not be consistently met at Permanente and is never mentioned by Permanente trainings.

111. Worse, even if they were given the time they needed, in theory, Bicocca and other specialist physicians do not have the expertise to fully advise their patients on the various ailments that are listed above.

112. Each of these conditions in themselves require years of study and training in order to conduct a proper consultation or follow up appointment.

113. For example, a pain management specialist does not have the neurological and psychological training or credentials to conduct a full review of a patient's Alzheimer's or schizophrenia. A pain management specialist could not effectively review or manage a patient with heart failure, atrial fibrillation, ischemic heart disease, hyperlipidemia, and hypertension the way that a cardiologist could. Typically, only a primary care physician or pulmonologist could manage asthma or chronic obstructive pulmonary disease in the manner described by the CPT codes.

114. In fact, the only condition initially Bicocca felt even nominally comfortable discussing with patients is diabetes, even though he is not an endocrinologist. However, Dr. Bicocca would discuss a patient's diabetes but only to the extent that such a condition would

affect the patient's pain management procedure, not a full evaluation with moderate or high complexity in medical decision-making as is required by the complex chronic condition management code.

115. Upon reading Medicare's requirements, Bicocca realized that he was not qualified to even discuss diabetes by CMS's standards, and that he only felt comfortable with the topic under the false training provided by Defendants.

116. In fact, very few specialists could cover more than just a few of the chronic conditions listed above, and none of the other pain management physicians in Bicocca's office could do so.

117. Reviewing the relevant regulations shows the absurdity of the requirements as laid out by Permanente. For example, a comprehensive care plan needs to be established for CCM, but no physician would be qualified to establish one except for the specific chronic conditions they specialize in. Very few physicians would be able to set up a comprehensive care plan for every patient for 90% of the conditions as Defendants require.

118. Bicocca and his fellow physicians are instructed to certify something they have neither the expertise nor time to certify that every patient who comes into the South Sacramento Medical Center is given a comprehensive assessment of all their chronic conditions, all to Permanente's benefit.

119. The result of this essential impossibility for adding on a CCM treatment to every appointment with Medicare and public benefits patients at Permanente is that every physician is either misled into or forced into falsely certifying compliance with CCM requirements for the purposes of increased reimbursement to Defendants.

120. This billing tactic affects all Medicare and CalPERS patients who receive treatment at any Permanente facility.

121. In addition, the training in fraudulent documentation Relator and his fellow physicians received is also occurring at Southern California Permanente and could exist at other Permanente groups, suggesting a common source from the Permanente Federation.

122. Physicians at Permanente achieved a 96% "success rate" for certifying CCM from January through September 2019.

b. Bicocca Raises Concerns About Permanente's Unlawful Practices

123. Over the course of multiple mass emails and several regular trainings, Bicocca and other physicians received an instruction to include every problem that qualifies as chronic for a patient in that patient's chart after the appointment.

124. In or around 2015, Guardino gave the first mandatory educational meeting at South Sacramento Medical Center. His original statement, mirrored by the PowerPoint presentation he showed the audience, was something to the effect of "for this new billing process, you must check and discuss every chronic condition, and then you're done."

125. The implication here is that any mention of a condition by the physician or patient, even inquiring if the patient has the condition, warranted certification that the chronic conditions were managed by CMS guidelines.

126. In or around 2015, another trainer stated that if a patient states in response to a question that he or she is taking medication for a certain condition, this would satisfy the CCM requirements. This is in direct contradiction to the foregoing guidelines.

127. Relator immediately reached out to the training staff after the session was complete to note that the training materials could not possibly be accurate, as they imply that Permanente is asking physicians to manage conditions that they have no time nor expertise to manage.

128. Over time, the training staff responded, only to Bicocca, that he was only to manage chronic conditions he was "comfortable with," such as diabetes. This seemed to be a softening of their position, until they stated that he was required to be "comfortable with" 95% of the conditions listed above. The clarification in Permanente's requirement for physicians was only given to Bicocca after he pushed back, it was not distributed to all physicians who previously received training to certify CCM if the patient so much as mentioned they were on medication for a chronic condition.

129. Worse, Defendants, through training staff and regular check in meetings, implied that physicians would be disciplined or otherwise adversely acted upon if they did not meet this threshold. Examples of this were a reduction of bonus.

130. After the first training, in which physicians were told by the training staff from Permanente that they needed to check nearly every box showing stability in the patient's chronic condition, Permanente sent non-physician trainers to every department to ensure that this directive was being followed.

131. At one point, the trainers specifically told Bicocca that a patient who was taking an antidepressant qualified to be marked as "stable" under the chronic condition of depression. Relator told the trainers that taking an antidepressant is in no way proof that a patient is stable in that area, and that he could not determine such a thing, since he is not a psychiatrist or a primary care physician.

132. Every week, the administrative chiefs of every department received emails detailing which doctors were not checking at least 90% of the listed chronic conditions with every patient.

133. In meetings between department chiefs, the group would discuss which departments were most successful in meeting this criterion.

134. At one point in time, the highest achieving department in South Sacramento was Orthopedic Surgery, where most of the physicians would not have the clinical expertise to manage these conditions to the extent required by CMS.

135. As the Chief of Pain Management at the time, other physicians under Bicocca's supervision brought concerns to Bicocca about the practice.

136. On August 11, 2015, shortly after another meeting in which Bicocca was given the suspect training, Bicocca called Manager of Financial Services Jeremy Lawrence to express his concerns about the CCM mandate Defendants were requiring.

137. Lawrence immediately forwarded these concerns to Serene Tran, Guardino, and Keshia Redmond, stating: "Dr. Bicocca indicated that he was told during the meeting today that .FOL had changed to indicate more of a 'yes, I confirm these conditions are still listed in Healthconnect' type of statement. *He is concerned about fraud* since it's unlikely that he (or most other specialists) won't actually ask about or address conditions outside of what they are treating the patient for." (emphasis added).

Jeremy Lawrence Hello Serene & Keshia - I just received a call fro... 08/11/2015 01:09:12 PM

From: Jeremy Lawrence/CA/KAIPERM
To: Serene N Tran/CA/KAIPERM@Kaiperm, Keshia Y Redmond/CA/KAIPERM@KAIPERM
Cc: Michael J Bicocca/CA/KAIPERM@Kaiperm, Jason M Guardino/CA/KAIPERM@KAIPERM
Date: 08/11/2015 01:09 PM
Subject: .refresh - clarification needed

Hello Serene & Keshia -

I just received a call from Dr. Bicocca in Pain Management seeking clarification on the use of .REFRESH, specifically around the language provided by .FOL.

.FOL seems to be a bit too specific in his opinion by implying that the physician actually confirmed the presence of the condition by way of conversation with the patient or by review of the medical record. Dr. Bicocca indicated that he was told during the meeting today that .FOL had changed to indicate more of a "yes, I confirm these conditions are still listed in Healthconnect" type of statement.

He is concerned about fraud since it's unlikely that he (or most other specialists) won't actually ask about or address conditions outside of what they are treating the patient for. Can you please offer clarification on this? thank you

Jeremy Lawrence, MBA
Manager, Medical Office Financial Services
TPMG Controller's Office, South Sacramento Medical Center
Mobile - (916) 956-9815 / Work - (916) 525-3028 tie 8-415 / Fax - (916) 525-3091 tie 8-415

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138. Guardino responded on the same day, stating that simply asking if the patient has a condition is enough to mark the condition as having been managed.

{In Archive} Re: .refresh - clarification needed
Jason M Guardino to: Jeremy Lawrence 08/11/2015 01:16 PM
Cc: Keshia Y Redmond, Michael J Bicocca, Serene N Tran

Each physician should ask about these... It's simply 'you have athlerosclerosis correct Mr. Smith'.
If they don't know, and it's on a CT, then its fine... (in this example).

Also... a key point. Lets say a person has hx of breast cancer and has nothing to do with a pain block in the leg whatsoever.
The fact that you thought about it has nothing to do with this pain block, is a way of acknowledging it as well.
In other words, you thought about how it has no bearing on this procedure.
Just as if you would think about something having a bearing on doing the procedure.
i.e. both pertinent positives and negatives.

Hope that makes sense.

Also, FOL is a regional phrase passed by many lawyers and others in region.

Thanks.

139. Tran's answer repeated that simply asking about and reviewing the diagnosis would be enough, if one's medical judgment was "implicitly" influenced by the diagnosis.

Serene N Tran "I have confirmed the presence of the above clini... 08/11/2015 01:24:31 PM

From: Serene N Tran/CA/KAIPERM
To: Jeremy Lawrence/CA/KAIPERM@KAIPERM
Cc: Jason M Guardino/CA/KAIPERM@Kaiperm, Keshia Y Redmond/CA/KAIPERM@Kaiperm, Michael J Bicocca/CA/KAIPERM@Kaiperm
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"I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient. At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these

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conditions unless otherwise noted. As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist. "

Above is the revised version of the .FOL which is included in our .REFRESH smartphrase.

What I take from this is that as long as you review the chart (problem list, medication list, and/or labs) when you see the patient, you can confirm that the patient has the diagnosis and the decision you make will be influenced (explicitly or implicitly) by the patient's medical history.
Also, the revised version included the phrase "as treatment warrants" to imply that if there is no change of treatment needed, you do not need to advise the patient to follow up with pcp or specialist.

I hope this helps.

Serene

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140. Bicocca responded to these emails on August 13, 2015, by pointing out the lack of consistency between Guardino and Tran, along with the lack of consistency between what was discussed via email, and what had been discussed earlier during trainings, when the requirements were implied to be even looser.

141. Bicocca then asked "[w]hy are we promoting the use of a phrase we know is making our medical documentation incorrect. I think that is fraud."

From: Michael J Biocca/CA/KAIPERM
To: Serene N Tran/CA/KAIPERM@Kaiperm
Cc: Jeremy Lawrence/CA/KAIPERM@KAIPERM, Jason M Guardino/CA/KAIPERM@KAIPERM, Keshia Y Redmond/CA/KAIPERM@KAIPERM
Date: 08/13/2015 05:49 PM
Subject: Re: .refresh - clarification needed

I hate to be a thorn but it does not help. All my MDs feel the same as I do about this.

I can see that reading the problem list is considering the diagnosis, but the rest of the statement is not true based on the work flow we discussed the other day.

At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these conditions unless otherwise noted.

That statement says I either reviewed the chart or discussed with the patient to determine that these conditions have "no changes". I am not doing that when "I consider breast cancer" before doing an injection. Nor am I doing that when I review their medications or read the problem list. I'll hypothesize that no one besides a PCP is doing that.

As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist

For this to be true I would have to tell every patient to follow up with their PCP or specialist at every appointment I use this phrase. Jason are you saying that to patients?

Jason do you really ask every patient if they have every problem on the problem list?

I just can't imagine that MDs are doing all the things that would be required to make this a true statement Let's be realistic. I doubt the attorneys said this was OK if the MDs aren't doing it. Why are we promoting the use of a phrase we know is making our medical documentation incorrect. I think that is fraud.

Serene, asking the patient if they have every problem on the problem list, telling them to follow up if needed and confirming that these conditions are stable, is not what you said we needed to do. I was real clear in asking and what all of my MDs heard is that all we were doing is confirming that these diagnoses are on the problem list. The work flow Jason is suggesting is drastically different.

Mike

142. Guardino, pushed back with his own email, reproduced below, and the practices have continued. Guardino's email glosses over the actual requirements by CMS as written down in the CPT codes, and instead dissects the certification that Permanente pressures physicians into using.

(In Archive) Re: .refresh - clarification needed
Jason M Guardino to: Michael J Bicocca, Steve Olson 08/14/2015 08:01 AM
Cc: Serene N Tran, Jeremy Lawrence, Keshia Y Redmond

History: This message has been replied to and forwarded.

Jeremy/Keshia.... Can you both meet with Mike and his group.
It seems he does not understand the issue(s).

Mike,
I'm going to encourage you to read this email a few times to help clarify. I think you don't understand the issues.

Step 1.
Any doctor should always review the Active Problem List (APL), meds, allergies, just like vital signs. I think you agree. I hope you agree.

Step 2.
MDP form is the gold standard.
If a patient has 20 problems on the APL.... while you should review them all because it is good medicine... if the MDP form only has 3 of those 20... those are the three you code. NOT ALL 20!

Step 3.
Lets say pt has DM and hx of Breast cancer (and these appear on the MDP form) and 5 other diagnosis are NOT on the MDP form (while you should reviews these other 5 for the practice of good medicine, they do not need to be coded).
So you move ONLY DM and Hx of Breast cancer (the ones on the MDP form) over from right to left and at end of your note type .Refresh.

[Let me interject here that if you are completely uncomfortable coding a diagnosis because you are simply in no way familiar with it (lets say it is 1 of the 5 dx on the MDP form) Then you code the four you feel comfortable and then route your note to the PCP and say, I coded 4 of the 5 diagnosis, but I don't feel comfortable with XYZ dx - then PCP can do when they see patient - this would hopefully be rare instance].

Now.
Let's dissect the phrase knowing that it applies only to the ones you coded and moved over that corresponded to the MDP form. In this case DM and Hx of Breast Cancer.

I have confirmed the presence of the above clinical diagnoses, which were considered in the current and ongoing care of the patient.

So you are telling me that when a patient presents for pain block and has a history of breast cancer you don't think for one second ..... "hmmmm maybe this is metastatic breast cancer? But not likely because they are 5 years out and saw onc recently", for example. You are not thinking... "maybe this is DM radiculopathy?" What if a patient has a history of BKA... has nothing to do with RUE pain for example. Weather you thought about these as pertinent positives or negatives, I hope you thought about them and asked the patient about them. And yes.. I do ask. Before I do a colonoscopy you bet your colo I look at the APL, allergies, meds, etc and think about what reactions they might have to conscious sedation or polypectomy, etc. In fact I ask almost every patient "do you take any medications called plavix or coumadin"... even though it is not on their list at all!!

At the time of this visit, the medical record indicates, and/or the patient states, that there are no changes in these conditions unless otherwise noted.

Again... I don't know what to tell you if you are not asking about DM or Hx of breast cancer if you are doing a block for pain.... I ask people about 'I know you had breast surgery... any surgery on your belly' before I do a cscope.

The medical record indicates... if you saw a note from onc during your chart review (hopefully you are doing some limited chart review) that says patient is five years out of breast cancer and clear.... the medical record indicates. You don't need to ask it if you don't want to.

As treatment warrants, the patient has been advised to follow up with her PCP or appropriate specialist.

As treatment warrants.... means if it is clinically indicated. If DM is totally in control then treatment is not warranted. If it is not in control..... you don't say 'DM radiculopopathy may cause you more pain some day and you need to get your DM in control'. Why not?
If that was your relative you wouldn't want a pain doc (or any other doc) telling them they should stop smoking for example?

I'm confused. Your email sounds like some doctors are robots without thinking and then do their jobs in isolation... that is poor quality.
At the end of the day... coding ensures high quality of care - it ensures problems are being dealt with.... and that things don't fall through the cracks. Yes, it takes a few extra minutes. But I think most doctors need to start treating the whole patient... not only a nerve that causes some pain. It's far from freud Mike. if done right with thoughtful purpose. As a chief I hope you are not poisoning the well of your docs with this and instead looking at this through a different lens of making sure the entire patient is being treated.

Thanks.
jason

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143. The last set of emails from Bicocca include Regional Physician Director of Clinical Documentation and Coding Dr. Steve Olson, who these concerns were escalated up to afterwards.

144. Dr. Olson oversaw training physicians on the CCM certification for Permanente.

145. Olson responded by stating, again not engaging with the substance of Bicocca's worries: "if someone is on an anti depressant, and has a prior diagnosis of depression, it may not be out of scope to ask if the patient is still taking the medication for depression that is listed on

the medication list. If the patient says yes, and relates that s/he is being followed by PCP, etc, then would feel comfortable using the .FOL statement."

146. Once again, Olson's response was markedly different and more stringent than what Bicocca was told during trainings, but still essentially recommended that physicians mark diagnoses and their management simply by asking patients about their conditions.

147. In one of the few instances in which Relator Bicocca was able to speak directly with Dr. Olson. Olson told Bicocca something to the effect of "of course Mike, if you don't know anything about hypoparathyroidism then don't code it." However, Olson then told Bicocca that he was expected to "know" about 90% of the listed conditions.

148. Relator Bicocca again attempted to raise up the issue and clarify the legality of the certification he has been told to insert into his medical notes in September 2017.

149. On September 18, 2017, Relator wrote to Jason Gritti, the doctor who was then responsible for trainings at South Sacramento, as well as Galina Flury and Keshia Redmond, to confirm what the coder who visited his office said was correct: "She said as long as we 'address' the problems and she was clear that all that needs is to confirm they were on a medication for that problem and tell them to follow up with the treating MD if needed. We could then include the visit diagnoses and a statement saying, 'these diagnoses were addressed today and the patient was told to follow up with their treating provider if needed'." This was the same instruction Bicocca spent weeks clarifying with Dr. Olson in 2015.

150. Gritti responded on the same day, stating "If you specifically address each item e.g. Migraine: continue topomax [sic] and follow up with the pcp as needed, then that is quite alright as well. You would just have to ensure you address each and every separate coded item."

151. Gritti is essentially telling Relator Bicocca that, if he asks the patient about the condition, whether the patient is taking medication, and telling them to follow up with another

physician on that condition, that he could write the certificate and that Permanente would code to either of the foregoing CPT codes.

152. This is false based on the plain meaning of the CPT code requirements, including the requirements for a comprehensive plan, for a certain minimum amount of time spent, and moderate to high complexity medical decision-making.

X. Conclusion

153. "Under Medicare Advantage's capitation system, private health insurance organizations provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program—regardless of actual healthcare usage. These organizations pocket for themselves or pay out to their enrollees' providers the difference between their capitation revenue and their enrollees' medical expenses, creating an incentive for the organizations to rein in costs. Unfortunately, human nature being what it is, Medicare Advantage organizations also have some incentive to improperly inflate their enrollees' capitation rates, if these organizations fall prey to greed." *United States ex rel. Anita Silingo v. WellPoint, Inc.*, 904 F.3d 667 (2018) (internal citations omitted).

154. A common form of fraud, one that is occurring here, is falsely claiming to give patients a level of service that they are not providing, and simply pocketing more of the capitation rate than one should.

155. By explicit setting up separate requirements for physicians treating Medicare beneficiaries and patients with other public benefits plans differently than private pay or employer-based insurance, Defendants demonstrate knowledge that the certification regarding CCM is material to the Government's decision to pay increased reimbursement for public benefits beneficiaries.

156. On a mass scale, with every physician ordered to certify CCM work without performing it, Permanente is able to collect capitation rates from CMS for comparatively little work.

157. In this manner, Defendants submit false claims to the government when they bill for chronic care management even though not all elements of this billing code are satisfied.

158. Defendants were aware of the issues with this method of billing due to Bicocca raising the concerns of multiple physicians related to this issue.

159. Defendants submit false claims to the government when they bill visit codes that show false documentation.

160. Defendants' misrepresentations are material to the government's decision to continue paying Defendants its capitation rate under the assumption patients are getting the care they need.

161. As a result, the government and the state have been damaged in a yet to be quantified amount.

COUNT I
Defendant Knowingly Presents, or Causes to be Presented False Claims
31 U.S.C. § 3729(a)(1)(A)

162. Relator reasserts and incorporates by reference all paragraphs set forth above as if restated herein.

163. 31 U.S.C. § 3729(a)(1)(A) subjects to liability any person or entity that "knowingly presents, uses, or causes to be presented, a false or fraudulent claim for payment or approval."

164. Relator has first-hand knowledge of services that could not have been provided but for which Defendants billed.

165. Defendants knowingly presented or caused to be presented to the United States, false or fraudulent claims, and knowingly failed to disclose material facts, in order to obtain payment or approval under the federally funded Medicare program in violation of 31 U.S.C. § 3729(a)(1)(A).

166. For each of the services described, Defendants knowingly submitted claims and received payment from the United States of America through CMS for services that were not provided to Medicare beneficiaries.

167. The United States of America has been damaged by all the misrepresentations and failures to comply with requisite laws and regulations in an as of yet undetermined amount.

COUNT II
Defendant Knowingly Made, Used, or Caused to be Made or Used, False Records or Statements Material to False Claims
31 U.S.C. § 3729(a)(1)(B)

168. Relator reasserts and incorporates by reference all paragraphs set forth above as if restated herein.

169. The False Claims Act imposes liability on any person 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)(B).

170. As a result of Defendants' actions, the Government paid funds from the Medicare Advantage program for capitation rates covering services not actually rendered.

171. As a result of Defendants' actions, the Government paid funds from the Medicare programs for services that were not or could not be performed.

172. Defendants knowingly made or used false records material to false claims when they, among other things, created records that indicated physicians rendered appropriate case management services, when in fact, appropriate case management services were not rendered to patients.

173. The United States of America has been damaged by all the misrepresentations and failures to comply with requisite laws and regulations in an as of yet undetermined amount.

COUNT III
California False Claims Act Violations
Pursuant to Cal. Gov't Code § 12651(a)(1)
Knowingly Submitting False Claims for Payment

174. Relator reasserts and incorporates by reference all paragraphs set forth above as restated herein.

175. Defendants, individually and through the acts of their agents, servants, officers, and employees, knowingly presented, or caused to be presented, to an officer or employee of the California government, false or fraudulent claims for payment or approval under the CalPERS program in violation of Cal. Gov't. Code § 12651 (a)(1).

176. Defendants knowingly presented, or caused to be presented, to an officer or employee of the California government, false or fraudulent claims for payment or approval under the CalPERS program in violation of Cal. Gov't. Code § 12651 (a)(1).

177. Cal. Gov't. Code § 12651 (a)(1) imposes liability on a person or entity that knowingly presented, or caused to be presented, to an officer or employee of the California government, false or fraudulent claims for payment or approval.

178. The government of California, unaware of the falsity of the claims made by Defendants and in reliance on the accuracy thereof, paid Defendants for such false or fraudulent claims.

179. Defendants violate Cal. Gov't. Code § 12651 (a)(1) when they bill for services rendered for chronic care management when those services were not provided.

180. The claims submitted by Defendants are material to the state of California's decision on whether, and how much, to pay Defendants for services provided to CalPERS beneficiaries.

181. By reasons of the acts and conduct of Defendants in violation of Cal. Gov't. Code § 12651 (a)(1), the government of California has suffered actual damages, including the amounts paid in response to all such false or fraudulent claims for payment.

182. The state of California is entitled to recover civil money penalties, and other monetary relief as deemed appropriate.

COUNT IV
California False Claims Act Violations
Pursuant to Cal. Gov't Code § 12651 (a)(2)
Knowingly Making False Records Material to a False Claim

183. Relator reasserts and incorporates by reference all paragraphs set forth above as restated herein.

184. Defendants, individually and by their own acts, or through the acts of their agents, servants, officers, and employees, knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim in violation of Cal. Gov't Code § 12651 (a)(2).

185. Defendants knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim in violation of Cal. Gov't Code § 12651 (a)(2).

186. Defendants violate Cal. Gov't Code § 12651 (a)(2) when they knowingly made or used false records material to false claims when they, among other things, created records that indicated physicians rendered appropriate case management services, when in fact, appropriate case management services were not rendered to patients.

187. At all relevant times, Defendants were aware of, and displayed a conscience and reckless disregard for, the applicable CalPERS rules and regulations regarding the submission of claims for payment.

188. The false statements created and submitted by Defendants is material to the state's decision on whether, and how much, to pay Defendants for services provided to CalPERS beneficiaries.

189. By reasons of the acts and conduct of Defendants in violation of Cal. Gov't Code § 12651 (a)(2), the State of California has suffered actual damages, including the amounts paid in response to all such false or fraudulently supported claims for payment.

190. The state of California is entitled to recover civil money penalties, and other monetary relief as deemed appropriate.

PRAYER FOR RELIEF

WHEREFORE, Relator Michael Bicocca, acting on behalf of and in the name of the United States of America and the State of California, and on his own behalf, pray that judgment be entered against Defendants for violation of the False Claims Act as follows:

(a) In favor of the United States and State of California against the Defendants for treble damages to the federal government from the submission of false claims, and the maximum civil penalties for each violation of the False Claims Acts and California False Claims Act;

(b) In favor of the Relator for the maximum amount pursuant to 31 U.S.C. § 3730(d) to include reasonable expenses, attorney fees, and costs incurred by the Relator;

(c) For all costs of the False Claims Act and California False Claims Act civil action; and

(d) In favor of the Relator, the United States, and California for further relief as this court deems just and equitable.

DEMAND FOR A JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure and pursuant to the local rules of this Court, Relator demands a jury trial as to all issues so triable.

February 5, 2020

Respectfully submitted,

s/ Gail A. Glick

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TAB 26

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

[SUPPRESSED],

Plaintiffs-Relators,

v.

[SUPPRESSED],

Defendants.

CV 18 1347 JSC

Case No. _____

DEMAND FOR JURY TRIAL

FILED IN CAMERA AND UNDER SEAL (Pursuant to 31 U.S.C. § 3730)
DO NOT PLACE ON PACER
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COMPLAINT

UNDERSEAL

FILED
MAR 01 2018
SUSAN Y. SOONG
CLERK, U.S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA and STATE OF CALIFORNIA, *ex rel.* GLORYANNE BRYANT and VICTORIA M. HERNANDEZ, Plaintiffs-Relators, v. KAISER PERMANENTE, KAISER FOUNDATION HEALTH PLAN, INC., THE PERMANENTE FEDERATION, LLC, KAISER FOUNDATION HOSPITALS, THE PERMANENTE MEDICAL GROUP, SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, COLORADO PERMANENTE MEDICAL GROUP P.C., SOUTHEAST PERMANENTE MEDICAL GROUP, HAWAII PERMANENTE MEDICAL GROUP, MID-ATLANTIC PERMANENTE MEDICAL GROUP, PC, NORTHWEST PERMANENTE PHYSICIANS & SURGEONS, P.C., and WASHINGTON PERMANENTE MEDICAL GROUP, Defendants.	Case No. _____ DEMAND FOR JURY TRIAL COMPLAINT FOR VIOLATIONS OF FEDERAL FALSE CLAIMS ACT AND CALIFORNIA FALSE CLAIMS ACT **[UNDER SEAL** PER 31 U.S.C. § 3730(b)(2)]

COMES NOW, Plaintiffs and *Qui Tam* Relators Gloryanne Bryant ("Ms. Bryant") and Victoria M. Hernandez ("Ms. Hernandez," and together with Ms. Bryant, "Relators"), individually and on behalf of the United States of America and the State of California, to recover treble damages and civil penalties under the federal False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, and the California False Claims Act, California Government Code § 12651, et seq., for monies unlawfully obtained and/or retained from the federal Medicare Program and the California Medi-Cal Program by Defendant Kaiser Permanente and various of its direct and indirect subsidiaries and affiliates (together, "Kaiser" or the "Kaiser Defendants"), and allege as follows:

INTRODUCTION

The Kaiser Defendants are now and have been, in some cases since at least 2009, engaged in a widespread scheme to knowingly submit, or cause to be submitted, false claims for payment to the United States by submitting false "risk adjustment" information to the Centers for Medicare & Medicaid Services ("CMS") in order to improperly increase the amounts CMS pays them. Likewise, the Kaiser Defendants have knowingly retained overpayments received from CMS as a result of their false risk adjustment submissions.

1. Millions of elderly and disabled individuals throughout the United States receive their Medicare benefits through the Medicare Advantage Program (also referred to as "Medicare Part C"). A central, distinguishing feature of the Medicare Advantage Program is the provision of Medicare benefits by private healthcare insurance organizations. Medicare beneficiaries enroll in managed healthcare insurance plans called Medicare Advantage Plans ("MA Plans") that are owned and operated by these private organizations, called Medicare Advantage Organizations ("MA Organizations"). This case involves, in large part, conduct by Kaiser — which operates one of the nation's largest MA Organizations — to improperly obtain or avoid returning payments under the Medicare Advantage Program that it was not entitled to receive.

2. The Government pays each MA Organization a fixed monthly payment for each Medicare beneficiary enrolled in its plans. The Government adjusts these payments for various risk factors that affect expected healthcare expenditures, including the health status of each enrollee. The adjustments are intended to ensure that MA Organizations are paid more for those enrollees expected to incur higher healthcare costs and less for healthier enrollees expected to incur lower costs.

3. To obtain payments based on adjustments for health status, MA Organizations submit diagnosis codes to the Government for the beneficiaries in their MA Plans. These diagnosis codes are from the beneficiaries' medical encounters (*e.g.*, office and hospital

visits). Using these diagnosis codes, the Government calculates a risk score for each beneficiary. The beneficiary's risk score is then used to calculate monthly payments to the MA Organization for that beneficiary for the following year. In general, the more numerous the conditions diagnosed, and the more severe the conditions, the higher the risk score for a beneficiary and, thus, the greater the risk-adjusted payments made to the MA Organization for that beneficiary.

4. This payment model creates powerful incentives for MA Organizations to over-report diagnosis codes in order to exaggerate the expected healthcare costs for their enrollees. In order to combat these incentives and protect the Government from making erroneous payments to MA Organizations, the Government requires that submitted diagnoses be supported and validated by the beneficiaries' medical records. It is a well-established requirement that all diagnosis codes submitted to the Medicare Program for risk adjustment payments must be unambiguously supported by clinical documentation included in the beneficiaries' medical records. Kaiser knew that these medical records are the "source of truth" for the purpose of receiving and retaining risk adjustment payments, and for each individual member's medical history and clinical profile.

5. In addition, each MA Organization must expressly certify in "Risk Adjustment Attestations" submitted to CMS that the diagnosis codes it has provided are accurate and truthful. 42 C.F.R. § 422.504(1)(2). Each MA Organization must also "[a]dopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with [the Government's] program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse." 42 C.F.R. § 422.503(b)(4)(vi).

6. In excess of one million elderly and disabled Medicare beneficiaries are currently enrolled in MA Plans that are owned and operated by Kaiser throughout the United States, and that number is growing. In 2011, approximately one million Medicare beneficiaries in

the United States were enrolled in Kaiser's MA Plans. In 2015, Kaiser's MA Plans had grown to 1.3 million beneficiaries, and in 2016 to 1.4 million.

7. The United States also contributes to premiums paid by individuals to private health insurance companies, including Kaiser, under the Affordable Care Act (sometimes referred to as the "ACA"). The Affordable Care Act authorizes the Department of Health and Human Services (HHS) to utilize criteria and methods similar to those utilized under the Medicare Advantage program to implement risk adjustment, and requires similar attestations/certifications from health insurance companies as to the accuracy and documentation of their risk adjustment data. The HHS risk adjustment methodology developed by and on behalf of the Centers for Medicare & Medicaid Services ("CMS") is based on the premise that premiums should reflect the differences in plan benefits, quality, and efficiency, and not the health status of the enrolled population. Accordingly, as under the Medicare Advantage program, the ACA risk adjustment model creates powerful incentives for private health insurance companies like Kaiser to over-report diagnosis codes in order to exaggerate the expected healthcare costs for their enrollees; the more codes that are reported, the higher premiums the companies are permitted to charge, and the higher contributions will be made to such premiums by the United States.

8. The United States pays billions of taxpayer dollars each year to Kaiser for the Medicare beneficiaries enrolled in its MA Plans and ACA Plans. Risk adjustment payments account for a substantial amount of these dollars. The diagnoses submitted by Kaiser drive a large percentage of the payments it receives from the Medicare Program. It is not surprising then that Kaiser is not a passive conduit of diagnoses from healthcare providers to the Medicare Program. Rather, for many years, Kaiser has conducted programs and engaged in other activities to increase the amount of risk adjustment payments from Medicare. This includes programs and other efforts to directly influence and capture both the number of diagnoses and the severity of the medical conditions reported by providers and coded by Kaiser staff.

9. In addition to payments received from the United States pursuant to the Medicare Advantage and the ACA, Kaiser also receives government dollars through the Medi-Cal

program, which is the Medicaid program in California. California administers and partially funds the Medi-Cal program; the United States also contributes funds to Medi-Cal pursuant to the federal Medicaid program. Under Medi-Cal, eligible beneficiaries can enroll with managed care organizations like Kaiser for a capitated rate paid by Medi-Cal that provides at least those services provided to standard Medi-Cal beneficiaries. Kaiser hospitals and medical groups also provide and are paid by Medi-Cal for the provision of health care to Medi-Cal beneficiaries on a fee-for-service basis. Like Medicare Advantage and the ACA, payment and reimbursement under Medi-Cal depends, in part, on documentation and accurate coding. As relevant to the claims in this Complaint, managed care organizations like Kaiser and providers like Kaiser's hospitals and medical groups document and code the medical diagnoses and procedures received by each member/patient as a basis for payment/reimbursement, with the more serious diagnoses and procedures eligible for greater amounts. Kaiser systematically games this system as well, routinely and intentionally miscoding and over-coding the severity of diagnoses and procedures, and retaining overpayments from Medi-Cal arising therefrom.

10. Ms. Bryant, until her retirement on October 3, 2017, was National Director for Kaiser's national coding quality group, and, prior to that, was Managing Director of Kaiser's Health Information Management program ("HIM") for the Kaiser Foundation Health Plan in Kaiser's Northern California ("NCAL") region. Ms. Hernandez was employed by the Kaiser Defendants in various positions from June 1995 through October 2015, and as a Kaiser contract employee through May 2016, in functions that included Regional Director of auditing and coding services for The Permanente Medical Group in Kaiser's NCAL region.

11. In these positions, Relators discovered that the Kaiser Defendants were and are engaged in fraudulent schemes pursuant to which they routinely and systematically overcharge the following government programs in the following ways:

a. Medicare Advantage

(i) Defendants "upcode" risk adjustment claims by manipulating the documentation and submitting claims and codes to the Medicare Advantage program for diagnoses that the member does not have or for which the member was not treated in the relevant year, or by claiming that a member was treated for a more serious condition than the member actually has, or by documenting and submitting a diagnosis that was labeled significant when it was not, or by training, educating, and programming its personnel and systems to support these fraudulent activities; and

(ii) Defendants refuse to implement and ignore processes to correct (and refuse to reimburse Medicare for) previously submitted risk adjustment claims when the Defendants discover, or in the exercise of reasonable care should discover, that those previously submitted claims were false, and subvert and ignore Kaiser's internal compliance function and pressure it to cooperate; and

(iii) Defendants manipulate and falsify risk-adjustment data in a deliberate scheme to over-charge the Medicare Advantage program.

b. Affordable Care Act

(i) Similarly, Defendants overdocument and upcode risk adjustment claims relevant to individuals covered by the ACA in the same manner and pursuant to the same schemes as relevant to the Medicare Advantage program, and similarly refuse to correct or reimburse Medicare for overpayments caused by this conduct, in a deliberate scheme to over-charge the Medicare program;

c. Medi-Cal

(i) Defendants overdocument and upcode fee-for-service coded data submitted for Medi-Cal payment/reimbursement and data pertinent to determining the capitated rate for Kaiser's managed care organizations under Medi-Cal by similarly manipulating and falsifying diagnosis and procedure documentation and coding submitted to Medi-Cal; and similarly refuse to correct or reimburse Medi-Cal for these overpayments, in a deliberate scheme to over-charge Medicaid and the Medi-Cal program.

d. Through this fraudulent scheme, the Kaiser Defendants have defrauded the United States and the State of California of hundreds of millions—and likely billions—of dollars for more than nine years.

12. Defendants' conduct alleged herein violates the federal False Claims Act and, as pertinent to claims relating to over-charging the Medi-Cal program, the California False Claims Act. The federal False Claims Act (the "FCA") was originally enacted during the Civil War. Congress substantially amended the Act in 1986—and, again, in 2009 and 2010—to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. The Act was amended after Congress found that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the amendments would create incentives for individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf.

13. The FCA prohibits, inter alia: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government; and (d) conspiring to violate any of these three sections of the FCA. 31 U.S.C. §§3729(a)(1)(A)-(C), and (G). Any person who violates the FCA is liable for a civil penalty of up to $21,916 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. §3729(a)(1).

14. For purposes of the FCA, a person "knows" a claim is false if that person: "(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate ignorance of the

truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. §3729(b)(1). The FCA does not require proof that the defendants specifically intended to commit fraud. Id. Unless otherwise indicated, whenever the words "know," "learn," discover" or similar words indicating knowledge are used in this Complaint, they mean knowledge as defined in the FCA.

15. Each claim for risk adjustment payments that defendants have submitted or caused to be submitted to CMS, where the patient was not treated by a qualified provider for that condition in the year in question, and/or the treatment and condition are not properly documented in the medical record is a false and/or fraudulent claim within the meaning of the FCA, so long as defendant knew that the claim was false when it was submitted, or the defendant later discovered its falsity and refused to correct the claim.

16. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. The FCA requires that the Complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

17. Similarly, each claim for payment to the Medi-Cal program by Kaiser based upon documentation and codes that were manipulated or false, and which caused the Medi-Cal program to overpay the Defendants, is a false and/or fraudulent claim within the meaning of the California False Claims Act, which operates in a manner similar to the federal FCA, including providing for the recovery of treble damages and statutory penalties.

18. Based on the foregoing laws, Relators Gloryanne Bryant and Victoria M. Hernandez seek, through this action, to recover damages and civil penalties arising from the false or fraudulent records, statements and/or claims that the Defendants made or caused to be made in

connection with false and/or fraudulent claims for Medicare Advantage risk adjustment payments, Affordable Care Act insurance premiums, and Medi-Cal capitated and fee-for-service payments.

JURISDICTION

19. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

20. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides in, transacts business in, or has committed the alleged acts in the Northern District of California.

VENUE AND INTRADISTRICT ASSIGNMENT

21. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to the claims occurred in San Francisco County and Alameda County, and within the Division and Courthouse in which this action has been commenced.

PARTIES

I. PLAINTIFFS

22. Plaintiff-Relator Gloryanne Bryant is an individual who, currently and during all times relevant to this action, resides in this judicial district. After her distinguished career in senior coding compliance positions with other California-based health care companies, Kaiser hired Ms. Bryant in May 2009 into a senior leadership position as Managing Director HIM for the Kaiser Foundation Health Plan, Northern California Revenue Cycle. Ms. Bryant remained at Kaiser until her recent retirement, effective as of October 3, 2017. In September 2013, Ms. Bryant was promoted to National Director Coding Quality, Education, Systems and Support for Kaiser's National Revenue Cycle Program Office, a position which she held until her retirement. Ms. Bryant is a nationally recognized expert and educator in coding, clinical documentation

improvement, and physician querying, and speaks and teaches regularly to state, regional, and national audiences. She holds professional designations of RHIA, RHIT, CCS, CDIP, and CCDS, and is an AHIMA-Approved ICD-10-CM/PCS Trainer.

23. Plaintiff-Relator Victoria M. Hernandez is an individual who, currently and during all times relevant to this action, resides in this judicial district. Ms. Hernandez is a coding professional with over 23 years of experience in the healthcare field. She was employed by the Kaiser Defendants in various coding leadership positions from January 2000 through October 2015, including: (i) Regional Director of Auditing & Coding Services for TPMG from October 2014 through October 2015; (ii) Regional Director of Hospital Coding Audit & Education for Kaiser Foundation Health Plan from April 2012 through October 2014; and (iii) Regional Coding Review Manager for Kaiser Foundation Health Plan's Revenue Cycle HIM from February 2010 through April 2012. She holds professional designations of RHIA, CDIP, CCS, CCS-P and is an AHIMA-Approved ICD-10-CM/PCS Trainer.

24. The United States and the State of California, on whose behalf Relator brings this suit, are the real parties in interest. The United States has ongoing contracts with Defendants through CMS, in accordance with Defendants' participation in the Medicare and Medicaid programs. The State of California has ongoing contracts with Defendants through the Medi-Cal program, in accordance with Defendants' participation in the Medicaid program.

II. THE DEFENDANTS

25. Kaiser Permanente is a healthcare consortium that operates one of the nation's largest health plans, serving over 11 million members. Kaiser employs doctors and other medical professionals and provides medical services through its Permanente Medical Groups, a for-profit set of regional affiliates that includes The Permanente Medical Group ("TPMG") in Northern California, Southern California Permanente Medical Group ("SCPMG") in Southern California, and five other regional areas including Hawaii, the Pacific Northwest, Colorado, Georgia and the Mid-Atlantic States. Kaiser owns and operates acute care hospitals in four

regions (Northern California, Southern California, Northwest and Hawaii), and provides care in other settings through its non-profit Kaiser Foundation Hospitals ("KFH").

26. Kaiser's private health insurance plan covers the majority of its patient population. Kaiser also operates, however, various MA Plans through its subsidiary Kaiser Foundation Health Plan, Inc., including its Medicare Advantage HMO plans called "Senior Advantage," serving approximately 1.4 million members in approximately seven states and one district in 2016. Kaiser's Medicare Advantage Program serves approximately 10% of Kaiser's overall patient population (10.7 million total as of 2016), but generates approximately 30% of Kaiser's overall profits. Kaiser's Medicare Fee-for-Service program, which includes charges to the Medi-Cal program, serves approximately 1-3% of its patient population.

27. Kaiser reported overall operating revenue of $64.6 billion in 2016, compared to $60.7 billion in 2015. Kaiser reported net income of $3.1 billion in 2016, compared to $1.9 billion in 2015.

Kaiser Permanente Total Health Plan Membership, by Region (as of early 2017)

Northern California:	4,134,194
Southern California:	4,390,653
Colorado:	671,500
Georgia:	306,806
Hawaii:	250,221
Mid-Atlantic States (Va., Md., D.C.):	702,516
Northwest (Ore./Wash.):	575,688
Washington:	677,050

Source: https://share.kaiserpermanente.org/article/fast-facts-about-kaiser-permanente/

28. Pursuant to inter-company agreements, the Kaiser Foundation Health Plan, Inc. shares moneys received from federal and state governments with Kaiser's various Permanente Medical Groups and Kaiser Foundation Hospitals. Accordingly, all of the named Kaiser Defendants possess financial interests in maximizing the amounts claimed to and paid by the governments, and each Kaiser Defendant has participated in various aspects of the fraudulent practices, as described further herein.

29. Defendant Kaiser Foundation Health Plan, Inc. is a California corporation with its principal place of business in Oakland, California within this judicial district.

30. Defendant The Permanente Federation LLC is a Delaware corporation with its principal place of business in Oakland, California within this judicial district.

31. Defendant Kaiser Foundation Hospitals is a California corporation with its principal place of business in Oakland, California within this judicial district.

32. Defendant The Permanente Medical Group, Inc. ("TPMG") is a California corporation with its principal place of business in Oakland, California within this judicial district. TPMG operates all Kaiser medical group operations in the Northern California region ("NCAL region").

33. Defendant Southern California Permanente Medical Group, Inc. ("Southern California PMG" or "SCPMG") is a California corporation with its principal place of business in Pasadena, California. SCPMG operates all Kaiser medical group operations in the Southern California region ("SCAL region").

34. Defendant Colorado Permanente Medical Group, P.C. ("Colorado PMG") is a Colorado corporation with its principal place of business in Denver, Colorado. The Colorado PMG operates all Kaiser medical group operations in the Colorado region.

35. Defendant The Southeast Permanente Medical Group, Inc. ("Southeast PMG") is a Georgia corporation with its principal place of business in Atlanta, Georgia. The Southeast PMG operates all Kaiser medical group operations in the Southeast region.

36. Defendant Hawaii Permanente Medical Group, Inc. ("Hawaii PMG") is a Hawaii corporation with its principal place of business in Honolulu, Hawaii. The Hawaii PMG operates all Kaiser medical group operations in the Hawaii region.

37. Defendant Mid-Atlantic Permanente Medical Group, PC ("Mid-Atlantic PMG") is a Maryland corporation with its principal place of business in Rockville, Maryland. The Mid-Atlantic PMG operates all Kaiser medical group operations in the Mid-Atlantic region, including Georgia.

38. Defendant Northwest Permanente, P.C. ("Northwest PMG") is an Oregon corporation with its principal place of business in Portland, Oregon. The Northwest PMG operates all Kaiser medical group operations in the Northwest region, including Oregon.

39. Defendant Washington Permanente Medical Group, Inc. ("Washington PMG") is a Washington corporation with its principal place of business in Seattle, Washington. The Washington PMG operates all Kaiser medical group operations in the Washington region.

40. TPMG, Southern California PMG, Colorado PMG, Southeast PMG, Hawaii PMG, Mid-Atlantic PMG, Northwest PMG, and Washington PMG are referred to collectively herein as "The Permanente Medical Groups" or "PMGs". Unless stated otherwise, references to Kaiser actions or conduct taking place in a particular Kaiser region refers to the actions or conduct of the specific Permanente Medical Group that operates in that region.

THE LAW

A. Medicare Advantage (Medicare Part C)

41. Under Medicare Part C, the Medicare Program pays each MA Organization a predetermined monthly amount for each Medicare beneficiary in the plan. This monthly payment is known as a "per-member, per-month" payment (or "PMPM"). This capitated payment for each plan varies depending on various factors, including amounts set forth in the plan's bid submitted to CMS. Since 2000, Congress has also required that the payments be risk adjusted for each beneficiary based on demographic factors (*e.g.*, gender, age) and health status. By risk adjusting

for health status, Congress required that more be paid for beneficiaries with higher risk scores than be paid for beneficiaries with lower risk scores. CMS currently employs a health-based risk adjustment model — known as the Hierarchical Conditions Category ("HCC") model — that takes into account diagnoses from inpatient hospital stays, emergency and outpatient surgery encounters, and physician office visits.

42. The HCC model is prospective, meaning that it relies on diagnoses for certain medical conditions assigned to beneficiaries by their physicians in a one calendar year timeframe (referred to by CMS as the "data collection" year but also generally known as the "date of service" or "DOS" year) to set the payment for each beneficiary for the following year (often referred to as the "payment year" or "PY"). The medical conditions included in the model are grouped into HCCs, which are categories of clinically-related medical diagnoses. *See* 42 C.F.R. § 422.2. The diagnoses grouped into HCCs include major, severe/acute, and/or chronic illnesses. Related groups of diagnoses are ranked on the basis of disease severity and the cost associated with their treatment. Between 2004 and 2013, the CMS-HCC model included 70 HCCs. Starting in 2014, the CMS-HCC model included 79 HCCs.

43. The Government assigns a relative numerical value/weight to each HCC group that correlates to the predicted incremental costs of care associated with treating the medical conditions in each category. It determines the relative values based on the amounts that it paid to fee-for-service providers to treat these major, severe, and chronic medical conditions under Parts A and B of the Medicare Program. Higher relative values/weights are assigned to HCCs that include diagnoses with greater disease severity and greater costs associated with their treatment.

44. As previously stated, the HCC risk adjustment model is prospective and a beneficiary's risk score for a particular payment year is determined by his or her medical conditions during the previous year (*i.e.*, the date of service year). These medical conditions must be documented by a qualified healthcare provider (*e.g.*, a doctor, physician's assistant, etc. as defined by the CMS MA program) in the beneficiary's medical record during the previous year.

45. Each beneficiary's risk score is calculated anew for each payment year. For example, a beneficiary's risk score for payment year 2012 is determined by the diagnoses that his

or her qualified healthcare providers documented in his or her medical records during face-to-face medical encounters during date of service year 2011.

46. MA Organizations obtain diagnosis data from the healthcare providers that treat the beneficiaries in their plans. Healthcare providers can transmit diagnosis codes to MA Organizations with claims for payment for services rendered, in encounter records reporting the services rendered, or by alternative means.

47. MA Organizations submit risk adjustment data, including diagnoses, to CMS using CMS' Risk Adjustment Processing System ("RAPS"). Each RAPS submission must include the following information: the Medicare beneficiary's identification number (called a "HIC number" or "HICN"); the date(s) of the medical encounter; the type of provider (physician or hospital); and the diagnosis code(s) reported by the provider for the encounter. Medical encounters include physician office visits, hospital outpatient visits, and hospital inpatient stays.

48. MA Organizations are entitled to risk adjustment payments based on the diagnosis codes that they submit to CMS only if the codes are from face-to-face medical encounters between the Medicare beneficiary and provider, the encounter occurred during the relevant date of service year, the provider was of a type and specialty acceptable for risk adjustment purposes, and at the time of the encounter, the provider documented the medical conditions identified by the diagnosis codes in the medical record based on acceptable documentation. In addition, codes should be based on documented conditions that require or affect patient care treatment or management. *See* 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Participant Guide ("2008 RA Participation Guide") at § 6.4.1.

49. Risk adjustment claims are true, and the resulting risk adjustment payments are valid, only to the extent that the diagnosis codes submitted by the MA Organizations are valid. The diagnoses must be coded according to the *International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting* ("ICD-9- CM" & "ICD-10-CM") and documented with sufficient clinical specificity. All diagnosis codes submitted by MA Organizations must be supported by medical record documentation. If the medical record is ambiguous, it cannot be relied on for diagnosis information for risk adjustment payments. *See*

2008 RA Participation Guide at § 7.2.4.1 (stating that risk adjustment claims and payments cannot be based on questionable diagnoses).

50. MAOs have a statutory obligation to report and return any overpayment received from the Government, 42 U.S.C. § 1320a-7k(d). Further, federal regulations are clear that MAOs like Kaiser are required to report and return both overpayments that they have identified and overpayments that they "should have determined through the exercise of reasonable diligence" were made by CMS. 42 C.F.R. 422.326(c). The law is clear that any overpayment retained after the statutory deadline of 60 days is an "obligation" for purposes of 31 U.S.C. § 3729. 42 U.S.C. § 1320a-7k(d)(4)(B) (defining overpayments); 42 C.F.R. 422.326(e).

B. *Affordable Care Act ("ACA")*

51. The Affordable Care Act sets up a program of risk adjustment in individual and group markets to lessen or eliminate the influence of risk selection on the premiums that plans charge. In the risk adjustment model utilized under the ACA, which is named the HHS-Hierarchical Condition Categories ("HHS-HCC") risk adjustment model, HHS utilizes criteria and methods similar to those utilized under the Medicare Advantage program, and adapts Medicare Advantage HCCs for use in the HHS-HCC model. The chief goal in the design of the HHS-HCC model is to assure that premiums reflect differences in benefits and plan efficiency. The HHS-HCC model uses current year diagnoses and demographics to predict the current year's spending, as distinguished from the Medicare Advantage program, which uses the risk adjustment model to predict next year's spending. But in the end, the effect of risk adjustment on ACA premiums is similar to the impact of risk adjustment on capitated payments made under the Medicare Advantage program. Insurers like Kaiser receive more ACA premiums the more documented and coded conditions are submitted for their insureds.

52. Pursuant to the ACA, the United States contributes, through tax credits, to premiums paid by low-income individuals to private health insurance companies, including Kaiser, based upon a sliding scale calibrated to the poverty line. Accordingly, when premiums are artificially high due to documentation and coding fraud, both enrollees and the United States are harmed by the overcharges.

C. *Medi-Cal*

53. Medi-Cal's capitated and fee-for-service rates, like payments made under Medicare Advantage and the ACA, depend, in part, on documentation and accurate coding by managed care organizations like Kaiser and providers like Kaiser's hospitals and medical groups. These organizations and providers document and code the medical diagnoses and procedures received by each member/patient as a basis for payment/reimbursement, with the more serious diagnoses and procedures eligible for greater amounts. Miscoding and over-coding of the severity of diagnoses and procedures thus causes the Medi-Cal program to overpay.

THE FACTS

I. KAISER AND ITS RELATED COMPANIES OVERDOCUMENT AND OVERCODE/UPCODE "HIGH-VALUE" HIERARCHICAL CONDITION CODES ("HCCS")

54. Ms. Bryant and Ms. Hernandez have witnessed Kaiser and its related companies engage in systematic fraud on the Medicare Advantage program, and other government programs including the ACA and Medi-Cal, for many years through teaching and implementing "HCC maximization techniques" to physicians and coding staff, resulting in systematic over-documenting, over-coding and upcoding of certain high value HCCs, as detailed below. The HCCs directly impact risk adjustment scores, meaning that the Government overpays Kaiser for its patient population which is not as sick as Kaiser reports.

55. Kaiser submitted a Risk Adjustment Attestation to the Medicare Program each year after the final risk adjustment submission deadline and knew that it was required to submit a truthful Risk Adjustment Attestation. Despite its obligations under Medicare law, Kaiser's documentation, coding and Risk Adjustment Attestations have been false.

A. *Aortic Atherosclerosis ("AA")*

(i) *Clinical significance, documentation and coding convention*

56. AA is sometimes referred to as "hardening of the arteries." It describes a thickening and loss of elasticity in the arterial wall. This condition is often an incidental finding in radiology and imaging reports and neither treated nor managed after being identified. It often has no impact on patient care or outcomes. Unless AA is related to signs, symptoms or conditions/diagnoses that necessitated the performance of the radiology and imaging test, treatment and management is actually directed toward the AA, or a follow-up office visit is ordered for treatment, it should not be reported/coded to Medicare.

57. For example, the American Hospital Association's ("AHA") Coding Clinic, the official clearing house for ICD-9-CM and ICD-10-CM/PCS coding guidance, publishes the following guidance for outpatient encounters, including emergency room visits: "It is inappropriate to report an incidental finding found on a radiology report when the finding is unrelated to the sign, symptom, or condition that necessitated the performance of the test for a patient being seen in the emergency department (ED). The ED physician would need to clarify that the finding was clinically significant and related to the visit in order for it be coded." *See* Exhibit 1.

58. Official Coding and Reporting Guidelines applicable to inpatient encounters further confirm the standard:

> encounters for diagnostic tests that have been interpreted by a provider.

When it is coded, AA is currently assigned ICD-10-CM code 170.0 (Atherosclerosis of Aorta). Under ICD-9-CM, AA was assigned ICD-9-CM code 440.0 (Atherosclerosis of Aorta). The AA diagnosis is assigned to HCC 108; in 2016, Kaiser received approximately $2,260 for each HCC 108 code.

(ii) *Kaiser's scheme*

59. Labeled an "area of significant missed opportunity" by Kaiser's Medicare Finance Group and Kaiser's Permanente Medical Groups, Kaiser implemented an HCC initiative in 2011 to review and capture AA diagnoses in all clinic, emergency, outpatient surgery, and inpatient encounters, even when incidental to the encounter. In Kaiser's NCAL region, Kaiser

subsidiary TPMG trained its physicians to choose a diagnosis from Kaiser's proprietary, electronic diagnosis "pick list" to capture AA, even when it was merely an incidental finding.

60. Kaiser's TPMG senior clinician leaders took the position that AA is a "chronic, systemic condition" that is a permanent risk factor once diagnosed, and thus is properly codeable regardless of its actual significance or treatment. This interpretation, if accurate, would result in the AA diagnosis meeting the Official Coding and Reporting Guideline for the coding of a systemic condition without coding staff questioning it. Kaiser's NCAL TPMG region directed Regional Health Information Management ("Regional HIM") coding leaders to instruct and train to "always code" AA on the basis that it was supposedly a systemic condition and should always be coded. This direction and instruction ignored coding conventions and guidance, and internal feedback from Kaiser NCAL's Regional HIM, including Ms. Bryant and Ms. Hernandez who questioned whether this condition was truly systemic. This improper TPMG direction was eventually migrated to Kaiser's other regions as a "best practice."

61. Kaiser's NCAL Regional HIM, led by Ms. Bryant, remained uncomfortable with the TPMG instruction on AA. Ms. Bryant had numerous conversations with individuals within TPMG and others within Kaiser regarding her and her colleagues' concerns, and submitted a written inquiry to AHA Coding Clinic as to whether the diagnosis of AA is properly considered a chronic, systemic condition (similar to hypertension and diabetes mellitus) that is codeable on a routine basis even in the absence of treatment, management, and/or monitoring. The guidance received from AHA Coding Clinic subsequently rejected NCAL TPMG's clinical determination. But TPMG management exerted intimidation, pressure and other undermining techniques to silence Ms. Bryant and her Regional HIM staff.

62. To provide "documentation" that would constitute evidence of the clinical significance of AA and meet the Official Coding and Reporting Guidelines, Kaiser's NCAL TPMG region developed a "SMARTPHRASE" to automatically populate the medical record when AA was observed and/or diagnosed in radiology and imaging reports that would routinely, automatically, and falsely state that the diagnosis was significant, not incidental, and would

require clinical follow-up. This process was implemented so that the hospital coding staff would assign the ICD-9-CM code for AA, and the HCC for AA would be captured.

63. Ms. Bryant continued to bring her concerns to Kaiser's National Compliance Ethics & Integrity Office ("National Compliance Office" or "NCO") and finally, in August 2015, Kaiser NCO announced that a Kaiser Permanente ("KP") clinical review overruled NCAL TPMG's clinical determination that AA is a chronic, systemic condition that should always be coded. But three years had passed and hundreds of thousands of inaccurate, false codes entered before that belated direction was issued. There was no discussion of or action plan developed to address the inaccuracies of the past with the AA diagnosis and HCC capture.

64. Kaiser coded data reports from 2010-2016 shows that the increased AA diagnosis-capture scheme worked – AA diagnoses and coding increased four- and five-fold across all Kaiser regions over that period and spread to all patient populations and payers.

(iii) *Chronology and evidence*

65. In late 2011, members of Kaiser's National Compliance Office and NCAL Revenue Cycle teams for The Kaiser Foundation Health Plan and Hospitals ("NCAL KFHP") focused attention on the accurate coding of AA as a result of internal inquiries and requests for guidance. After an exchange of emails, members of these teams, including Ms. Bryant and Ms. Hernandez, drafted and published a memo to all Regional HIM Directors and hospital Coding Staff in March 2012 outlining the correct coding convention for AA. *See* Exhibit 2. The memo correctly stated that AA should not be coded except under certain limited conditions (see above).

66. TPMG Director Anne Cadwell, NCAL Revenue Cycle VP David Nyburg, and TPMG Physician Liaison Dr. David Bliss reacted unfavorably to this memo immediately. In calls with Ms. Bryant, they took the position that AA "is always significant and a risk factor so thus they will teach the MDs to document that so it will be coded." *See* Exhibit 3. Ms. Bryant noted that she was "troubled" by this approach in an email to Janet Franklin, Kaiser's Senior Compliance Practice Leader in its National Compliance Office. *Id.* Ms. Hernandez and other

HIM coding leaders shared Ms. Bryant's concern. No definitive guidance was provided nor action taken by Kaiser's National Compliance Office.

67. In 2012, TPMG trained its doctors to document AA as if it were always significant, and KFH hospital coding staff to always code AA, as directed by Dr. Bliss and other TPMG Directors (*e.g.*, Anne Cadwell, Karen Graham, and Erica Eastham). In a December 3, 2012 email, TPMG's Ms. Cadwell wrote to Ms. Bryant and Ms. Hernandez that she was concerned that Kaiser Hospital coding staff was not getting the communication about AA: "We need to get everyone on the same page that AA is **not** an incidental finding from a clinical perspective." *See* Exhibit 4 (emphasis in original). Ms. Bryant and Ms. Hernandez felt that they were being strongly pressured to violate coding guidelines and to participate in manipulating documentation and codes.

68. During a December 12, 2012 WebEx/call with TPMG, TPMG Director Ms. Cadwell told NCAL HIM Leadership that the NCAL region would develop and implement a "SMARTPHRASE" for its doctors to add to patients' electronic files (*e.g.*, in their EPIC electronic health records, called "KP Health Connect") whenever AA was found on a radiology report in order to indicate its significance. It was requested that NCAL HIM leadership approve this documentation so that AA would be "always coded." *See* Exhibit 5 (WebEx meeting invitation).

69. The "SMARTPHRASE" developed by TPMG in Kaiser's NCAL region stated as follows: "Aortic Atherosclerosis noted on review of the radiology exam associated with chart review and this visit. Will follow longitudinally as an independent risk factor for CVD and CVA, with management per standard risk factor controls over time by PCP or appropriate specialist." *See* Exhibit 6 at REL0000061. This phrasing was developed in an attempt to satisfy the numerous concerns raised by NCAL HIM Leadership (*i.e.*, Ms. Bryant and Ms. Hernandez) that documentation of AA was required, including language of clinical significance, to pass audit and/or coding compliance testing. But it was clinically false and misleading. AA can be clinically insignificant and incidental and should not always be coded, but Kaiser was training its physicians to always document the clinical significance of the findings so as to cause coders to always code it without question. In December 2012, NCAL HIM was still waiting for Kaiser's National Compliance Office to provide definitive guidance. In the meantime, Ms. Bryant and Ms.

Hernandez made repeated but futile attempts to help TPMG leadership understand the compliant and appropriate documentation for the coding of AA.

70. By January 2013, Dr. Bliss, TPMG Director Ms. Cadwell and other senior management had fully overridden the coding memo issued in March 2012 by NCAL HIM Leadership. Summarizing Kaiser NCAL's new directive for coding AA in the hospital setting, Ms. Bryant emailed Kaiser's National Compliance personnel, including Ms. Franklin, as follows (copying Ms. Hernandez) to alert NCO as to the new direction in the NCAL region: "TPMG takes the position that once AA is present it never goes away and is then a lifelong risk factor .... We (NCAL) do believe that AA meets the criteria to be reportable and does impact care and decision making. To go further with this discussion I believe needs individual with greater clinical knowledge like physicians and would invite TPMG *i.e.* Dr David Bliss) [sic] to discuss this further." *See* Exhibit 7. Kaiser's National Compliance Office did nothing to stop this new direction.

71. In fact, Ms. Bryant was required to be "supportive," "collaborative," and a "partner" with TPMG's direction for capturing the AA HCC by putting together an educational power point presentation with Dr. Bliss titled "Documentation and Coding Aortic Atherosclerosis Clarification," which they presented during a January 2013 WebEx conference call for NCAL Regional hospital coding staff and Clinical Documentation Integrity Staff (CDI). *See* Exhibit 8. The presentation identified AA as an "Area of significant missed opportunity."[1] *Id.* at REL0000069. The presentation adopted TPMG's and Dr. Bliss' position that AA is a "systemic disease" that should always be diagnosed, documented, and coded when identified in a radiology report, and should be added to Kaiser's "Always Code" List (which is a Kaiser National Compliance Office document).

[1] Two years earlier, in a September 2011 power point presentation entitled "Documentation and Coding Leads Meeting," TPMG used the same phrase for capturing AA – "Area of significant missed opportunity" – establishing that capturing the diagnosis had been a long-term focus in the Kaiser NCAL region. *See* Exhibit 9 at REL0000107.

72. Similar presentations were made throughout 2013, 2014 and 2015 to various Kaiser regional leadership audiences. TPMG's AA directive and smartphrase were migrated to Kaiser's other regions and adopted by Kaiser's other Permanente Medical Groups. For example, at Kaiser's Regional Reporting Group ("RRG") meetings, Kaiser regional leaders overseeing its Medicare Advantage programs presented on opportunities and techniques to capture high-yield HCCs, including AA, emulating NCAL TPMG. *See* Exhibit 10 at REL0000137. Similarly, Kaiser NCAL's Revenue Cycle Clinical Documentation Integrity/Improvement ("CDI") included vascular disease (including AA) as an HCC target, and an opportunity to query physicians based on radiology and imaging findings. *See* Exhibit 11 at REL0000179-80.

73. On behalf of NCAL HIM Regional Leadership, Ms. Bryant remained deeply concerned and continued to pursue direction and guidance from Janet Franklin of Kaiser's National Compliance Office, but received none. Moreover, Ms. Bryant and NCAL HIM Regional Leadership, including Ms. Hernandez, continued to question the new direction taken by TPMG leadership regarding AA diagnosis and coding. Due to her continued concern, Ms. Bryant went so far as to submit a question to AHA Coding Clinic, the recognized authority on ICD-9 and ICD-10 coding, on the issue in December 2012. *See* Exhibit 12.

74. Kaiser drafted queries to Coding Clinic at least two other times regarding the proper coding of AA (*see* Exhibit 13): In May 2013, Kaiser queried Coding Clinic regarding the status of AA as "a chronic systemic condition." *Id.* at REL0000189. In its May 16, 2013 response, Coding Clinic stated that if the impact of AA were unclear, the physician should be queried. *Id.* Over a year later, in approximately November 2014, Kaiser NCO's Janet D. Franklin, with the assistance of Ms. Bryant, drafted a detailed follow-up question to AHA Coding Clinic: Would AA "be considered a systemic condition that can be coded even in the absence of active intervention in the same way that other systemic diagnoses noted in Coding Clinic (*e.g.* COPD, CHF, Diabetes, Parkinson's Disease, hypertension) may be coded without additional documentation of evaluation, treatment, consideration, etc."? *Id.* at REL0000186-87. Ms. Franklin noted in the attached exhibit that her draft was subject to review by Dr. Simon Cohn, Kaiser's physician lead for The Medical Group Federation and RRG, and other Kaiser staff. Ms.

Bryant was later told by Nancy Anderson of Kaiser's NCO group that the question was never submitted to AHA Coding Clinic based upon a decision by Kaiser leadership, yet another Kaiser decision that caused Ms. Bryant and Ms. Hernandez significant concern.

75. In the meantime, while the Permanente Medical Groups in Kaiser's other regions were following TPMG's practice to always document and code AA, Kaiser's National Compliance Office was taking its time deciding whether that direction was proper. On July 23, 2014, TPMG approached Ms. Bryant and Ms. Hernandez to meet to discuss viewpoints regarding AA capture for Kaiser's National Compliance office. *See* Exhibit 14 (calling the long-delayed meeting "a high priority and time critical").

76. On July 31, 2014, a presentation was given to Kaiser's Coding Governance Group (CGG), which represents all Kaiser Regions, on the topic of AA capture for coding, taking the position that AA should be added to Kaiser's "Always Code List" as a chronic, systemic condition. *See* Exhibit 15 at REL0000220.

77. In 2015, Dr. Simon Cohn, the physician lead for Kaiser's Medical Group Foundation and RRG, requested that Ms. Bryant meet with him face-to-face, but did not provide the topic of the discussion in advance. During the meeting in Dr. Cohn's office, Dr. Cohn asked Ms. Bryant to summarize the events surrounding AA HCC capture at Kaiser, including the TPMG guidance and direction of Dr. Bliss and others, which she did. Dr. Cohn told Ms. Bryant that this issue was being further reviewed by the medical groups. Ms. Bryant told Dr. Cohn that it was not her place to question the clinical and medical interpretations of Dr. Bliss, so she accepted his direction but felt compelled to go to NCO for further and final advice. In the meantime, the improper coding of AA continued throughout Kaiser.

78. *Finally*, on August 4, 2015, Kaiser's National Compliance Office and Medical Group Federation completed its "clinical review" of TPMG's AA directive, requiring that it be changed back to the way that Ms. Bryant, Ms. Hernandez and their colleagues in NCAL HIM stated it in 2011 and early 2012: "After having gone through clinical review, AA is not considered a systemic condition and will not appear on the final list of examples of systemic conditions. The clinician must do more than just list this condition. There must be documentation to show how it

impacted the current encounter. It will be up to the region to decide if they want to query the provider about this condition when it is only listed. Without a query and additional documentation from the provider to show how it impacted the encounter, it cannot be coded." *See* Exhibit 16 at REL0000224. This information from NCO was shared with Kaiser Coding Leaders as well so that they would be informed and comply with the directive.

(iv) Impact of Kaiser's HCC AA "missed opportunity" directive

79. Kaiser's internal data establishes that its efforts to mine for AA succeeded in capturing and submitting an enormous increase of AA codes to Medicare and other payers, beginning with fewer than 600,000 AA codes captured and submitted in 2010 and culminating in over three million submitted in 2015. AA Dx ("Diagnosis") Frequency Report 2010-2016 (Source: Kaiser internal data aggregated by Ms. Bryant) *see* Exhibit 17 at REL0000226. Medicare claims for HCC 108 (Vascular Disease), the classification that includes AA diagnoses, were among the highest in number and revenue for Kaiser during 2014-2016. *See* Exhibit 18 at REL0000254. (Over 350,000 HCC 108 cases in 2014 submitted for almost $800 million in revenue).

80. In early 2016, Ms. Bryant discovered in the course of ICD-10-CM/PCS national coding quality monitoring and coding validation that Kaiser was still coding AA based upon it being a systemic condition, notwithstanding the August 2015 conclusion of Kaiser NCO rejecting AA as a "chronic, systemic condition." Ms. Bryant, who was at that time working in Kaiser's National Revenue Cycle group, shared this finding with Ms. Hernandez, who was also working for this group at the time. Both Ms. Bryant and Ms. Hernandez were disturbed and troubled. Ms. Bryant brought the AA findings to the attention of Janet D. Franklin and Nancy Anderson of Kaiser NCO. Ms. Bryant requested that the appropriate coding guidance be posted in the National Coding Bulletin Board for all Kaiser Regions to see. She also provided the appropriate coding advice on AA to regional HIM leaders during leadership forum meetings and requested that each region disseminate the guidance to all appropriate staff and stakeholders, including Kaiser's medical groups.

81. In 2016, after Kaiser had started to pull back the directive, there were still almost two million AA codes submitted across payers. Exhibit 17. In just the first four months of 2016, Kaiser reported to Medicare Advantage over 300,000 cases of vascular disease (HCC 108), which includes the AA diagnosis codes, accounting for almost $700 million. Exhibit 18. Many Kaiser members now have the diagnosis of AA assigned to their clinical profiles incorrectly, potentially impacting patients' future insurance coverage and profile.

82. Ms. Bryant's and Ms. Hernandez believe and therefore allege that Kaiser has never gone back to validate the accuracy of AA documentation and coding for years prior to 2016, and has never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding AA. Moreover, they believe and therefore allege that there has been no specific AA validation of documentation and coding or discussion regarding rebilling or resubmission of corrected claims or data. Indeed, shortly before her retirement from Kaiser in October 2017, Ms. Bryant was asked by NCO's Nancy Andersen to join a coding workgroup to look at AA, as the Kaiser Medical Groups wanted to revisit the issue, *yet again*, of whether the condition is "systemic." Thus, Kaiser continues its efforts to avoid "missed opportunities" with this false documentation and coding.

B. *Mechanical Ventilation Dependence Status ("Vent Dependence")*

(i) *Clinical significance, documentation and coding convention*

83. The HCC for "dependence on respirator status" is HCC 82 (linked with ICD-9-CM code V46.11 (Dependence on respirator, status) and ICD-10-CM code Z99.11 (Dependence on respiratory ventilator status)). Dependence on respirator (or ventilator) status is a "status code" that is used when a patient requires long-term, continued ventilator support to breathe beyond the acute care phase. The status code is/was reported for both for Medicare Advantage HCCs and HHS HCCs (*e.g.*, Medicaid under the Affordable Care Act). In 2016, Kaiser received approximately $11,497 for each HCC 82.

84. On February 7, 2014, Coding Clinic stated in a specific response to Kaiser's inquiry – an inquiry initiated by Ms. Bryant with Ms. Hernandez's input – that "this code should

be reported when the patient requires continued ventilator support for an unexpected period of time and not for the short-term acute phase of a condition." Coding Clinic further stated that "there is no time frame set on what constitutes ventilator dependency." *See* Exhibit 19.

85. In short, the HCC for vent dependence status should never be coded if a patient is weaned from a ventilator during or at the end of an acute short-term stay in the hospital (of whatever length) and discharged home or to a post-acute-care facility without vent support. That does not constitute "vent dependence status." Rather, a patient is vent dependent only if the patient relies on the ventilation to live on a long-term basis *and not for the short-term acute phase of a condition.*

(ii) *Kaiser's scheme*

86. Kaiser's directives on vent dependence documentation and coding differ region by region, but are all invalid, with regions establishing a "time frame"-based criteria for documenting vent dependence status after which the specific code assignment is permitted. For example, TPMG, the medical group in Kaiser's NCAL region, defines the time period as 30 days or more on a ventilator before the status condition should be documented and then be coded irrespective of discharge status or disposition. Kaiser's Southern California PMG only requires 21 days as its time-frame criteria for documenting and coding this status.

87. These directives contravene AHA Coding Clinic's caution that there is no "set time frame" and that vent dependence should not be reported for the short-term acute phase of a condition. Kaiser, especially its Permanente Medical Groups, consciously ignores Coding Clinic's response, instead criticizing and rejecting Ms. Bryant's professional coding decision to seek input from Coding Clinic in the first place, which led to Ms. Bryant being excluded from further coding discussions on this topic and others. By elevating set time periods over actual long-term dependence, Kaiser manipulates the system to over-code for vent dependence status. Any patient that is on a ventilator for a set period of time is assigned the status code by Kaiser, even if the patient's reliance is neither long-term nor continuous but instead arises from the acute phase of a condition or following a procedure.

88. Moreover, Kaiser is ignoring its own improper directives by coding for vent dependence status even when patients are on vents for just a few days, then discharged without the vent. Kaiser data shows high volumes of patients being coded for vent dependence status even after being discharged from the acute care hospital without a ventilator, and even for lengths of stay as short as one or two days across four hospital regions.

(iii) *Chronology and evidence*

(A) **October/November 2013**

89. Ms. Hernandez and Ms. Bryant were first made aware of Kaiser's vent dependence status documentation and coding practices in the context of newborns that are placed on ventilators temporarily in the hospital before being discharged home. This came about due to the patient population impacting the Affordable Care Act, and questions were raised internally by Regional NCAL HIM leadership (Ms. Bryant, Ms. Hernandez and Dawna Toews) about whether V46.11 (vent dependence status) was appropriate in this circumstance. Ms. Bryant, Ms. Hernandez and Ms. Toews were extremely concerned with the direction that TPMG wanted to take with the V46.11 status code. The three of them discussed the situation and agreed that the status code should be infrequently assigned and coded; given the high number of such codes at Kaiser, it thus appeared that TPMG was focusing on capturing this status code inappropriately.

90. In a series of meetings and emails, chronicled contemporaneously by Ms. Hernandez (*see* Exhibit 20), Ms. Hernandez and Ms. Bryant investigated Kaiser's existing coding practices, researched the proper coding convention, reached out to external clinical and coding experts and, on November 21, 2013, submitted an email query to AHA's Nelly Leon-Chisen, Director and Editor of Coding Clinic, and Sue Bowman, American Health Information Management Association ("AHIMA") Senior Director of Coding Policy and Compliance. ("AHIMA," like AHA's Coding Clinic, is a neutral organization that can be queried for guidance by coding professionals.)

91. On November 22, 2013, AHIMA's Ms. Bowman responded by email as follows: "V46.11 is intended for 'dependence' on a ventilator – meaning long-term dependence

(such as patients with spinal cord injuries or progressive neuromuscular diseases such as multiple sclerosis) – not for short-term use of a ventilator during an acute illness, following surgery, etc. So it seems unlikely that a newborn would be declared ventilator-dependent". *Id.* at REL0000262.

92. On November 25, 2013, Kaiser's NCAL HIM's Regional Coding Review Managers met onsite. All agreed that the vent dependence status code would not be appropriate for newborn initial clinic visits, follow-up clinic visits, or hospital short-term acute care visits, nor if the newborn was weaned and discharged home without ventilation. They concluded and insisted that Kaiser's hospital coding staff should follow and be compliant with official coding guidelines.

(B) **December 2013**

93. During a follow-up phone conference on December 3, 2013 attended by Ms. Hernandez and members of TPMG's Encounter Information Operations group ("EIO," a TPMG group that specifically focuses on the Medicare Advantage program and was led at the time by Director Anne Cadwell), the above coding guidance conclusion was rejected over Ms. Hernandez's objection and notwithstanding the references provided, including that Ms. Bryant had submitted an inquiry to AHA Coding Clinic. TPMG stated that it would move forward with capturing vent dependence status if a newborn was placed on ventilation for at least 12 continuous hours, even if the baby was successfully weaned and discharged.

94. The December 3 directive was followed by a call to Ms. Hernandez on December 4, 2013 from TPMG Director Ms. Cadwell and Dr. Bliss, who focused not on Kaiser's invalid coding of vent dependence or references provided, but on why Coding Clinic was queried by Ms. Bryant in the first place. Ms. Hernandez was required to provide Ms. Bryant's cell phone number so that the TPMG EIO Directors could immediately contact Ms. Bryant once they learned that she was the one who submitted the Coding Clinic query. Dr. Bliss and Ms. Cadwell called Ms. Bryant to rebuke and chastise her for submitting a query to Coding Clinic without notifying TPMG. Both Ms. Hernandez and Ms. Bryant were in Dr. Bliss' "line of fire," and were very distressed. *See* Exhibit 21.

95. Ms. Hernandez and Ms. Bryant were told not to inquire outside Kaiser anymore on such issues without input and approval from Kaiser's Coding Governance Group (CGG). They were warned that outside inquiry would create risk for Kaiser. Once again, pressure and criticism were directed at Ms. Bryant and Ms. Hernandez for not agreeing to TPMG's approach to capturing this diagnosis.

96. On December 8, 2013, Ms. Hernandez was further instructed by TPMG Clinical Documentation Improvement ("CDI") Physician Director Dr. Shirley Cachola, to "use 'respirator dependence' for patients with tracheal intubation until the specifics are clarified by the coding clinic .... Not sure this meets compliance since it is not defined but this is how med. group wishes to proceed for now." Exhibit 22 at REL0000273. Ms. Bryant and Ms. Hernandez believed this instruction to be clear error and unethical, a sentiment echoed by their colleague in the Regional HIM group, Dawna Toews, who questioned how the company could proceed "when it is clearly out of compliance.... I am not inclined to continue working for a company that blatantly ignores guidelines I have promised to follow, and that put me in jeopardy of losing my professional licensing." *Id.* at REL0000269.

97. Ms. Bryant was directed by TPMG to quickly follow-up on the pending response from Coding Clinic on the newborn-specific issue of vent dependence coding. On December 6, 2013, Coding Clinic's Senior Coding Consultant Anita Rapier wrote via email to Ms. Bryant that "code V46.11 (respirator dependence status) is used to describe patients who have been dependent on mechanical ventilation over a period of time. It is not used for newborns who are placed on a vent for a short period." Exhibit 20 at REL0000267.

98. Ms. Bryant sent a follow-up email to Anita Rapier as follows: "Thus if a newborn was placed on a vent for 12 or even 20 hours and then at discharge is NO longer on the vent, we would not assign the V46.11 status code to that discharge/stay." AHA Coding Clinic's Senior Coding Consultant Ms. Rapier responded immediately: "Yes, that is my interpretation." *Id.* at REL0000266. Thus, Coding Clinic corroborated AHIMA's response and Ms. Bryant's and Ms. Hernandez's original conclusion. Coding Clinic's more formal February 7, 2014 response letter to Ms. Bryant, quoted above, confirmed its guidance. *See* Exhibit 19.

99. Contemporaneously, Ms. Bryant and Ms. Hernandez continued to have deep concern and investigated Kaiser's coding practices for vent dependence status both inside and outside of the newborn care context, including for patients in the Medicare Advantage program. They quickly confirmed that they were similar. TPMG in Kaiser's NCAL region required its CDI Physician Director Dr. Cachola, CDI Managers, Susan Ingerbretsen and Donna McIvor (under Dr. Bliss' leadership) to create an acceptable timeline for the capture of vent status code. In Diagnostic Guidelines published in November 2013, TPMG CDI established a "greater than 30 day" rule for vent dependence status: that is, if a patient is receiving respiratory support through a tube for more than 30 days, then vent dependence status code is to be assigned, even if the patient is successfully weaned and discharged without a ventilator. Exhibit 23 (TPMG Neonatal Intensive Care Unit Diagnostic Guidelines), at REL0001005.

100. Similarly, in Kaiser's SCAL region, SCPMG's regional CDI program established a 21-day duration of care to constitute vent dependence. Exhibit 24 (HIX Neonatology Documentation and Coding 2014), at REL0001040.

101. The RRG meetings that Ms. Bryant attended often included the capture of specific HCCs, and ventilation status was included on numerous occasions. In this way, Kaiser's improper practice for coding the ventilation status code was migrated throughout the Kaiser regions and adopted by all of Kaiser's Permanente Medical Groups, notwithstanding the coding guidance from Coding Clinic and AHIMA.

(iv) *Impact of Kaiser's vent dependence practices*

102. Kaiser data compiled by Ms. Bryant through her national coding quality monitoring work establishes that the Vent Dependence status code is being captured frequently by Kaiser. Medicare Advantage and HHS-HCC payer data specifically indicated a high volume of these codes, particularly in Kaiser's NCAL and SCAL regions. *See* Exhibit 25 and Exhibit 18.

103. The coding data includes a high volume of cases in which patients are successfully weaned from ventilation and routinely discharged home or to self-care, including after just a day or two in the hospital. *See id.*; Exhibit 26 (showing NCAL vent dependence

cases). In a December 2013 validation audit, Ms. Hernandez and her NCAL audit team concluded that 100% of a sample of TPMG vent dependence cases were invalid. See Exhibit 27.

104. Data from all Kaiser Regions confirms that the vent dependence coding volume has skyrocketed across Kaiser. *See* Exhibit 28 (Kaiser data gathered by Ms. Bryant). *See also* Exhibit 18 (includes vent dependence (HCC 82) data submitted by Kaiser to the Medicare Advantage program from January, 2014 through April, 2016).

105. Kaiser cannot articulate or produce any clinical research, standards or evidence-based medical justification for coding vent dependence status once a patient has been ventilated and removed after a set number of days; for coding vent dependence status even when ventilation is used for far fewer days than the purported thresholds; or for setting different policies for determining ventilation dependence status within the various Kaiser regions.

106. Ms. Bryant and Ms. Hernandez further believe and therefore allege that Kaiser's proprietary, diagnoses electronic "pick list" is being utilized by Kaiser to easily and falsely capture this inaccurate status code in all clinical settings. Moreover, they believe and therefore allege that Kaiser has never gone back to validate the coding to identify incorrect codes, and has never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding vent dependence status. To their knowledge, there has been no validation or discussion for rebilling or resubmission of corrected claims or data.

C. *Sepsis (and related conditions)*

(i) *Clinical significance and coding convention*

107. Sepsis (and Septicemia, SIRS, etc.) (HCC 2) refers to a systemic inflammatory response due to an infection. It is coded under ICD-9-CM codes 038.0–038.9 (Sepsis/Septicemia) and 995.91-95 (SIRS with/without organ dysfunction), and under ICD-10-CM codes A41.0–A41.19 (Sepsis/Septicemia) and R65.10-.11 (SIRS of non-infectious origin with/without acute organ dysfunction) and R65.20-21 (SIRS with/without septic shock). It is a serious condition that can be fatal if not promptly identified and treated. Severe sepsis is sepsis

with associated acute organ dysfunction. In 2016, Kaiser received approximately $4,047 for each HCC 2.

108. "Lactic Acidosis" is a buildup of lactic acid levels in the blood stream that is often but not always caused by organ failure and can be a sign of impending sepsis. It is coded under ICD-9-CM code 276.2 (Acidosis) and ICD-10-CM code E87.2 (Acidosis). Coding Clinic has issued guidelines that state that coding professionals cannot use lactic acidosis alone as the basis for severe sepsis without physician documentation of the specific type of organ failure (*i.e.*, respiratory failure, renal failure, etc.).

109. Given the seriousness of severe sepsis, it should be extremely uncommon for a patient with this condition to be released from the hospital within three or fewer days of being diagnosed. The Medicare Severity Diagnosis Related Group (MS-DRG) length of stay for Fiscal Year 2017 for the three sepsis MS-DRGs are: DRG 870, with geometric length of stay of 12.6 days, MS-DRG 871, with geometric length of stay of 4.9 days and MS-DRG 872, with geometric length of stay of 3.8 days.

(ii) *Kaiser's scheme*

110. Motivated initially by *bona fide* quality concerns (there appeared to be under-reporting of sepsis in Kaiser's NCAL KFH region, impacting patient outcomes and mortality scores), Kaiser initiated programs to educate physicians and coding staff to better capture sepsis diagnoses in documentation and coding. Efforts to identify "early sepsis" were undertaken by Kaiser's Quality group and other clinical areas.

111. Kaiser's *revenue* goals, however, quickly subsumed the quality effort, leading to a significant trend of *over*-diagnosing, documenting, and coding sepsis in the hospital inpatient setting, at least in Kaiser's NCAL KFH region under the influence of TPMG. The focus, again, was on HCC capture. The over-coding came in two forms. First, TPMG physicians and leadership, NCAL KFH CDI staff, and NCAL KFH coding staff, under the direction and guidance of TPMG's Dr. David Bliss, diagnosed, documented, and coded severe sepsis and organ dysfunction whenever lactic acidosis was present. As noted above, lactic acidosis can be an

indicator for severe sepsis, but should not be diagnosed or coded absent specific organ dysfunction/failure. Dr. Bliss had many MA-HCC focus areas for capturing additional revenue, which included the severe sepsis HCC and the Medicare Advantage HCC for organ failure.

112. Second, sepsis was frequently diagnosed, documented, and coded even when patients were discharged within a few days of being diagnosed, including many that were discharged home. This is a red flag for accuracy that was never adequately explained or followed-up on.

113. Kaiser's NCAL region continued these documentation and over-coding practices for lactic acidosis as organ dysfunction and the inappropriate capture of sepsis and severe sepsis for a period of time even after Ms. Bryant raised her concerns. Kaiser never reviewed, corrected the false sepsis, severe sepsis, and organ dysfunction codes, nor was there any repayment of money received under false pretenses as far as Ms. Bryant and Ms. Hernandez are aware.

(iii) *Chronology and evidence*

114. In approximately mid-2010, Kaiser's NCAL Regional Quality group (led by Dr. Alan Whippy) grew concerned with lower-than-expected reporting of inpatient sepsis cases within the regional medical centers, and the higher-than-expected hospital mortality rate among patients without a diagnosis of sepsis. Dr. Whippy and her Director, Barbara Crawford, RN, reached out to Ms. Bryant to determine if there were coding issues in this inpatient diagnostic population group.

115. Beginning with the Vallejo Medical Center in August 2010, Kaiser's NCAL Regional HIM group, led by Ms. Bryant, conducted hospital inpatient audits to determine if sepsis was being under-reported through validation of documentation and coding. *See* Exhibit 29.

116. By March 2011, Kaiser NCAL KFH and TPMG had developed and begun conducting presentations to educate physicians and hospital coding staff on proper documentation, optimal coding and reporting of sepsis. Ms. Bryant participated in developing these programs and collaborated on a Kaiser National level to present to coding staff across Kaiser. These

presentations correctly presented the issues and the coding guidelines and conventions. *See* Exhibit 30.

117. Lactic acidosis issue. At around the same time in 2011, however, Kaiser TPMG's Dr. Bliss, with the support of TPMG's Encounter Information Operations (EIO) under the direction and leadership of Anne Cadwell and Karen Graham, began instructing physicians that lactic acidosis is more than an indicator of severe sepsis, but is the *equivalent* of severe sepsis such that the presence of lactic acidosis should always lead to a severe sepsis diagnosis and should be coded by the hospital coding staff.

118. In addition, TPMG provided guidance to NCAL CDI to capture lactic acidosis and organ dysfunction. NCAL Regional HIM, led by Ms. Bryant, informed NCAL CDI that they were not comfortable with this guidance. Ms. Bryant again took the lead and wrote AHA Coding Clinic on January 24, 2011. *See* Exhibit 31.

119. On January 30, 2012, Coding Clinic responded to Ms. Bryant: "It would not be appropriate to assign code 995.62, Severe Sepsis for a patient diagnosed with sepsis and 'Lactic Acidosis'. The providers documentation must indicate the specific type of organ dysfunction (*i.e.*, kidney, heart, liver, etc.) in order to assign code 995.92." Coding Clinic's response is dated April 15, 2011, but Ms. Bryant did not receive it until January 30, 2012, as reflected in the attached emails. *See* Exhibit 32; Exhibit 33, Coding Clinic's response supported the opinion of Ms. Bryant and Ms. Hernandez.

120. Ms. Bryant immediately notified Janet Franklin of Kaiser's National Compliance Office by email of Coding Clinic's decision, noting that she was "concerned with past practices and capturing HCCs and MCCs." *See* Exhibit 32. The next day, on January 31, 2012, Ms. Bryant forwarded Coding Clinic's guidance to Dr. Bliss, Ms. Anne Cadwell and other senior personnel at TPMG so they would take the appropriate action to implement the guidance. *See* Exhibit 34. On February 13, 2012, Ms. Bryant and her team drafted and circulated a memo to all Kaiser NCAL HIM Directors and Coding Staff quoting and implementing the correct Coding Clinic guidance. *See* Exhibit 35.

121. Notwithstanding Coding Clinic's straightforward, unambiguous guidance, and Kaiser's own policy adopting it, Dr. Bliss and TPMG under the direction of Ms. Cadwell and Ms. Graham did not immediately act on it. There was confusion with hospital coding staff due to TPMG's and Dr. Bliss' continuing interpretation, ongoing physician education, and the existing physician documentation equating lactic acidosis with organ failure for severe sepsis. Ms. Bryant and Ms. Hernandez were alarmed to see medical records and coding audits indicating that Kaiser's physicians were diagnosing and documenting sepsis, severe sepsis, and lactic acidosis as organ dysfunction at a high frequency, which resulted in the improper coding of sepsis. The guidance was slowly accepted and instituted for NCAL hospital coding, but not until many more codes (ICD-9-CM) were improperly submitted.

122. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser never corrected the improperly-submitted sepsis and lactic acidosis codes, or otherwise notified payers, including the MA program, of what it had done.

123. Short-stay sepsis issue. Over time, Ms. Bryant and Ms. Hernandez also became concerned with a disturbing trend in the NCAL region for hospital inpatient records: Sepsis was being regularly diagnosed, documented, and coded even when patients were discharged from the hospital within a few days of the diagnosis being made. They believed that most if not all such short-length-of-stay cases were likely misdiagnosed, misdocumented, and miscoded because sepsis is too serious of a condition to lead to such a quick recovery and discharge. They also observed that sepsis had been diagnosed, documented, and coded in outpatient settings on several occasions, where patients were merely being "observed" by Kaiser Hospital medical staff. They believed that sepsis could not be properly diagnosed, documented or coded at all under these circumstances.

124. Ms. Bryant and those assisting her with the audit and review of the issue concluded that one contributing cause of the over-diagnosing (and over-coding) in these short-stay situations was the query form used by Kaiser's NCAL CDI department (under TPMG EIO's leadership and guidance). The query tip form was leading in that it improperly suggested that the physician select "sepsis" based on 2 out of 6 clinical criteria being met (*i.e.*, temperature >100.1,

heart rate >20, etc.) when the proper diagnosis was likely a separate infectious process or some other less serious condition. *See* Exhibit 36 (CDI Query "Tip Sheet") at REL0000412. *See also* Exhibit 37 (emails from April 2013 discussing one short-stay case).

125. This concern was shared by Ms. Bryant and Ms. Hernandez with the NCAL Revenue Cycle Director of Risk Management, Sue Muscarella, RN. Ms. Muscarella reviewed the material and audit findings provided to her by Ms. Bryant and Ms. Hernandez (see Exhibit 38), and agreed that there was cause for concern, especially in the 1-2 day lengths of stay and observation, and that there should be a discussion with Dr. Whippy and Dr. Bliss. Ms. Bryant and Ms. Hernandez recall such a meeting being planned but do not believe that it ever occurred; they never received any information from Ms. Muscarella or otherwise that action had been taken to address the issue.

126. By the end of 2013, Ms. Bryant had left Kaiser's NCAL region to take a position with Kaiser National Revenue Cycle located in a different building in the downtown Oakland area as National Director of Coding Quality, Education, Systems and Support. She was not privy to TPMG's follow-up regarding the short-stay sepsis issue after that date, although in her national role she continued to see data indicating that the issue had not changed and had never been corrected. Ms. Hernandez, in her NCAL Regional HIM role, continued to see the issue come up in audits conducted by her and her staff of Regional Coding Review Managers throughout 2013.

(iv) ***Impact of Kaiser's Sepsis Over-Coding***

127. Sepsis diagnosis/HCC has been identified as a top-two most frequently reported ICD-9-CM/ICD-10-CM code in the hospital setting in four Kaiser hospital regions from 2011-2016 (Hawaii, Northwest, Northern California and Southern California Regions). Accordingly, the revenue impact of over-coding of this condition was substantial, especially for Medicare Advantage, HHS/HCC, Medicare Part A and other payers. *See* Exhibit 18 (includes sepsis (HCC 2) data submitted by Kaiser to the Medicare Advantage program from January, 2014 through April, 2016).

128. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser has never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding sepsis, severe sepsis and organ dysfunction. Moreover, they believe and therefore allege that there has been no documentation and coding validation or discussion regarding rebilling or resubmission of corrected claims or data.

D. ***Morbid obesity.***

129. AHA Coding Clinic guidance states that ICD-9 Code V85.4, Body Mass Index ("BMI") 40 and over for adults generally corresponds to extremely obese. This is well recognized as a health risk and can impact Medicare reimbursement.

130. In early 2013, Dr. Bliss, Senior Medicare Coding Leader (CDI Physician Liaison) for Kaiser's NCAL TPMG region was focusing on the capture of HCC 22 for morbid obesity. Contradicting Coding Clinic, Dr. Bliss and other TPMG leadership instructed physicians to diagnose morbid obesity when BMI is between 35 and 39.9 and "another condition" is also present. He instructed the physicians to utilize the Kaiser Health Connect (EHR) diagnosis "pick list" to select morbid obesity or severe obesity in such circumstances, leading to over-coding of the morbid obesity diagnosis. Other diagnosis categories at issue include ICD-9-CM codes 278.01 (Morbid Obesity), V84.35-.39 (BMI 35.0-39.9, Adult) and ICD-10-CM codes E66.01 (Morbid Obesity) and Z68.35-.39 (BMI 35.0-39.9, Adult). Morbid obesity is associated with HCC 22 and

is a listed "Risk-Adjustment Opportunity" by TPMG. In 2016, Kaiser received approximately $2,761 for each HCC 22.

131. In June 2013, Ms. Hernandez recognized the discrepancy between Dr. Bliss' instructions and Coding Clinic's standard and instructed and required hospital coding staff under her oversight to query physicians every time there was a morbid obesity diagnosis with a BMI of 30-39.0 to confirm its compliance and accuracy.

132. To gain further insight, Ms. Hernandez notified Ms. Bryant, who agreed with the concern and submitted a question to AHA Coding Clinic on July 8, 2013 inquiring about the different standards of BMI range and co-morbidities with morbid obesity. Coding Clinic responded on September 20, 2013 (*see* Exhibit 39 at REL0000420) that the "coder cannot make the assumption based on documentation of BMI or co-morbidities alone that it is appropriate to assign a code for morbid obesity." The Centers for Disease Control ("CDC") has a healthcare industry standard that defines obesity as follows as of August 5, 2017: "Class 3: BMI of 40 or higher. Class 3 obesity is sometimes categorized as 'extreme' or 'severe' obesity." *See* Exhibit 40.

133. Ms. Bryant and Ms. Hernandez believe and therefore allege that TPMG has never altered the approach mandated by Dr. Bliss, but contradicted by Coding Clinic and the CDC, regarding the diagnosis and coding of morbid obesity, or corrected codes or ever repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding morbid obesity.

134. Ms. Bryant was also made aware of another morbid obesity documentation and coding issue in October 2013 while attending a Regional Reporting Group (RRG) meeting. The Colorado PMG physician lead, Dr. Teresa Welsh, gave a "best practice" presentation on physician querying for morbid obesity. Exhibit 41 at REL0000456-464. Ms. Bryant felt that the suggested best practice was leading, a concern which she addressed immediately with Nancy Andersen of Kaiser's NCO, who was also present at the RRG meeting. Ms. Andersen agreed with Ms. Bryant that the practice and examples shared in the presentation were improperly leading, but nothing was said during the RRG meeting to correct the presentation. Instead, Ms. Andersen sent a follow-up email to Dr. Welsh regarding the leading query practice presented at the RRG, blind

copying Ms. Bryant, with advice and guidance on the compliant way to query. There was no mention of correcting past actions, correcting the medical record, or going back and rebilling/resubmitted corrected claims. *See* Exhibit 42.

135. Kaiser data establishes that morbid obesity continued to have a high frequency of being coded in Kaiser's MA population. *See* Exhibit 18 (2014-2016 data regarding Kaiser's Medicare Advantage Program; morbid obesity data found at HCC 22).

E. *Malnutrition*

136. Ms. Bryant and Ms. Hernandez also believe and therefore allege that Kaiser is systematically over-documenting and coding protein-calorie malnutrition (ICD-9-CM codes 260-263.9 and ICD-10-CM codes E43 – E46), which also falls within an HCC category (HCC 21). There are specific codes to identify mild, moderate and severe Protein Calorie Malnutrition ("PCM"). In 2016, Kaiser received approximately $5,393 for each HCC 21

137. Kaiser's CDI querying activities improperly lead physicians to diagnose protein-calorie malnutrition, including the use of "SMARTPHRASE" acknowledgments of dietician diagnoses of PCM with a co-signature of dietary notes. TPMG CDI targeted protein-calorie malnutrition HCC 21 as one of the top risk-adjustment opportunities. Ms. Hernandez witnessed several instances of this in October and November 2012, which she discussed with Ms. Bryant, Kaiser's Coding Review Manager, and Kaiser's NCO coding group, including Janet D. Franklin and Nancy Andersen. There was general agreement among this group that leading queries are not appropriate, and that the co-signature of a physician on dietary notes is not sufficient documentation for a PCM diagnosis. Ms. Hernandez also addressed the issue with TPMG CDI's Quality Assurance manager in the hope that it would be communicated to the CDI management team. Nevertheless, to Ms. Hernandez's knowledge, the leading queries were not discontinued nor were the documentation requirements changed.

138. Ms. Bryant is aware of another concern regarding protein-calorie malnutrition documentation and coding in Kaiser's Northwest Region. The Northwest PMG's HIM Coding Manager, Sharon Beausoleil, emailed Ms. Bryant in late 2014 regarding concerns

about documentation and coding of protein-calorie malnutrition on HHS-HCC's for newborns. In particular, she was concerned with the query language being utilized by the CDI staff in the NW Region, which appeared to not be supported by clinical indicators and to be leading.

139. Ms. Beausoleil provided Ms. Bryant a short list of inpatient medical record accounts which Ms. Bryant asked one of her staff, Ms. Sherry Davis, to review to validate the protein-calorie malnutrition documentation and coding. Ms. Davis identified in her review that there was no supporting documentation or clinical indicators for a newborn malnutrition diagnosis for these records. Ms. Bryant reviewed the findings with Ms. Davis and concurred. Ms. Bryant and Ms. Davis prepared a written summary of their findings which they shared with Ms. Beausoleil via webex in March 2015. *See* Exhibit 43.

140. Shortly thereafter, Ms. Beausoleil spoke with Ms. Bryant and cautioned her that Dr. Annette Guido, Northwest PMG's Medical Director, was questioning Ms. Bryant's authority to audit the region's medical records, notwithstanding Ms. Bryant's position with Kaiser's National Revenue Cycle group. In addition, Ms. Beausoleil called after work hours and told Ms. Bryant that she (Ms. Beausoleil) was told "not to contact" her (Ms. Bryant) regarding documentation issues, and Ms. Beausoleil stated that Ms. Bryant should be very careful and "should watch her back." Ms. Bryant was gravely concerned with these warnings and with the barrier placed on her pursuing the issue further.

141. These issues continue at Kaiser to this day. In late 2016, Kaiser's TPMG CDI Director Emily Emmons contacted Ms. Bryant about a possible compliance issue regarding PCM diagnosis, documentation, and coding. *See* Exhibit 44. Ms. Emmons was concerned with dietary documentation of PCM wherein physicians appeared to be queried in a leading manner. After discussing and reviewing the documentation examples, Ms. Bryant agreed that they appeared to be leading in order to obtain a diagnosis of severe or moderate malnutrition. Ms. Bryant requested that Ms. Emmons set up a conference call with the Regional Dietary Lead and Regional Compliance. There were several emails and conference calls held on the topic which included Dietary, Regional Compliance, Regional CDI and Ms. Bryant which continued into mid-2017.

142. Moderate and Severe PCM in hospital inpatient records were a focus of Kaiser's dietary staff once the patient met some specific clinical criteria. The query language being used was directing the physicians to choose either moderate or severe PCM, the high-paying diagnoses, and no other. Ms. Bryant and Ms. Emmons advised that to be compliant, the query language should be revised to include other options such as mild, other, unspecified, clinically undetermined, etc. It was agreed by Ms. Emmons, the Dietary Lead (Jan Villarente, Regional Director), Regional Compliance (Svitlana Ozhyndovsky) and Ms. Bryant that Kaiser's dietary leadership should make changes to the query language to address the compliance concerns. Ms. Bryant believes and therefore alleges, however, that use of the leading query language had been ongoing for a year or more before it was identified and changed, and has no knowledge of corrective actions taken by the NCAL Region on prior medical records..

143. Kaiser data compiled by Ms. Bryant through her national coding quality monitoring work establishes that malnutrition continues to have a high frequency of being coded in Kaiser's MA population. Kaiser Medicare Advantage data regarding malnutrition (HCC 21) frequency from January, 2014 through April, 2016 can be found in Exhibit 18. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser has never conducted a validation of the diagnosis of protein-calorie malnutrition, and has never repaid, restated, or otherwise reimbursed amounts falsely obtained during this period from over-diagnosing and over-coding protein-calorie malnutrition. Moreover, they believe and therefore allege that there has been no documentation and coding validation or discussion regarding rebilling or resubmission of corrected claims or data.

F. *Acute Renal Failure, Acute Kidney Injury and Respiratory Failure*

144. Similarly, Ms. Bryant and Ms. Hernandez have witnessed what they believe and therefore allege is over-documentation and over-coding of the following HCC diagnoses prior to and after ICD-10 implementation: acute renal failure and acute kidney injury (ICD-9-CM 584.9 and ICD-10-CM N17.0-N17.9 code range, which correlate to HCC 135) and respiratory failure (ICD-9-CM 518.81-518.84 code range and ICD-10-CM J96.00-J96.92 code range, which correlate

to HCC 84). In 2016, Kaiser received approximately $3,600 for each HCC 135 and $2,489 for each HCC 84.

145. While in her Kaiser National Revenue Cycle role, Ms. Bryant ran frequency reports on various Kaiser regions on the diagnosis code range for respiratory failure (including MA HCCs), by payer, by region. and by setting from 2010-2016, which showed a significant increase from 2010 to 2016 with a spike in 2015. *See* Exhibit 45 (data gathered by Ms. Bryant for respiratory failure coding trend in Kaiser's NCAL and SCAL regions). Kaiser data compiled by Ms. Bryant through her national coding quality monitoring work establishes that respiratory failure has a high frequency of being coded in Kaiser's MA population. *See* Exhibit 18 (Kaiser Medicare Advantage data regarding cardio-respiratory failure and shock (HCC 84) frequency from January, 2014 through April, 2016).

G. *Other Over-Coded and Up-Coded Diagnoses*

146. **Arrhythmia for members with pacemakers.** Near the end of her employment with Kaiser, Ms. Bryant was informed and believes, and therefore alleges, that at least Kaiser's NCAL and Colorado regions (TPMG and the Colorado PMG), and perhaps other Kaiser regions, are instructing doctors to diagnose and document so that Kaiser's coders would code heart arrhythmia for members even after the members receive pacemakers to correct their arrhythmia. It would be atypical for a patient to have a pacemaker but to continue to suffer from arrhythmia, unless there is a rare pacemaker complication. Yet Kaiser routinely and improperly reports both the pacemaker status code and the cardiac arrhythmia code (HCC 96), adding thousands of dollars to the risk profile of each such member. In addition to cardiac arrhythmia, diagnoses for ventricular fibrillation and ventricular flutter (HCC 84) were also overdocumented. In 2016, Kaiser received approximately $2,231 for each HCC 96 and approximately $2,489 for HCC 84.

147. Ms. Bryant was first made aware of the issue in 2014 with respect to Kaiser's Colorado PMG, but more recently (in the fall of 2017) was informed by Ms. Andersen of Kaiser NCO that it is also evident in Kaiser's NCAL region operated by TPMG. Ms. Bryant

expressed her disagreement to physicians from the Washington and Northwest Medical Groups, who nevertheless insisted that the record should have both the pacemaker status and the arrhythmia code assigned.

148. **Major depression.** Ms. Bryant and Ms. Hernandez have also witnessed Kaiser and its various regional subsidiaries aggressively pursue the diagnosis and coding of major depression (HCC 58). *See, e.g.,* Exhibit 10 at REL0000139 (June 16, 2015 RRG WebEx presentation highlighting major depressive disorder capture). Kaiser's laser focus on this valuable code (worth approximately $2,482 per code in 2016) has led to over-coding and up-coding. In 2016, Kaiser received approximately $2,496 for each HCC 58. Moreover, Ms. Bryant is informed and believes that, in 2015, in at least Kaiser's SCAL region (SCPMG) and likely other Kaiser regions, Kaiser manipulated its electronic system for picking diagnoses to "gray out" the diagnosis of "major depression unspecified," which is not linked to an HCC, so that Kaiser doctors would not pick that diagnosis but would instead select a major depression diagnosis category that is linked to a high-paying HCC. Ms. Hernandez believes that this practice also took place in TPMG.

149. **Acute stroke.** In 2014, Ms. Bryant learned that in at least Kaiser's Colorado and Georgia regions (operated by the Colorado PMG and Mid-Atlantic PMG), Kaiser physicians and coders were assigning the "acute" stroke code for all first office visits after a stroke patient left the acute care hospital, rather than a lower-paying code for "sequela" or "late effect" stroke normally associated with post-hospital stroke recovery and follow-up. Ms. Bryant was informed and believes that the reason for this Kaiser practice of incorrectly selecting acute stroke was to maximize HCC monies. An ICD-9 and ICD-10 diagnosis code for acute stroke links to HCC 100. In 2016, Kaiser received approximately $2,398 for each HCC 100.

II. "THE KAISER WAY" IGNORES ESTABLISHED PROCEDURE, INCENTIVIZES GREED, AND CULTIVATES FRAUD

150. At every level and across regions, Kaiser is driven by a corporate culture that demands and rewards financial success from its employees. Kaiser's senior management pushes relentlessly to increase Kaiser's revenue from risk adjustment. The risk adjustment

practices described in this Complaint are attributable in large part to these demands and rewards. Ms. Bryant and Ms. Hernandez have witnessed Kaiser's profit-seeking and financial-gaming culture corrode its compliance function over many years, leading to the frauds described herein on the government and its Medicare and Medicaid programs.

A. *Kaiser's policies and procedures*

151. Kaiser consistently publishes and enforces internal company policies and procedures that contravene coding and diagnostic principles that are widely accepted and enforced within the broader coding community. To avoid detection, Kaiser sometimes labels its instructional documents as "Program Advisories" rather than "policies" in order to circumvent the implications of imposing an improper requirement. But these Advisories are not optional and are enforced like any other policy and procedure within Kaiser.

152. Many of Kaiser's proprietary policies regarding diagnosing and coding are intentionally constructed to be less restrictive than the norm in furtherance of the company's emphasis on profit over compliance. These departures from accepted policy and procedure lead directly to improper documentation, coding and overbilling. Kaiser's Permanente Medical Groups and Kaiser's Medicare Finance Department initiate and lead this corporate culture, focusing on capturing higher reimbursement without any contravening focus on the avoidance of overbilling.

153. Kaiser's National Compliance Office is ineffective, apprehensive, and slow in investigating and responding to documentation and coding compliance issues. In addition, NCO coding leadership has openly admitted to Ms. Hernandez that the Kaiser Permanente Medical Groups have significant control over chart audit selection, accuracy rates, documentation guidance, coding policy and practices, all to manipulate the capture of more HCC codes and to increase government payer reimbursement. Instead of turning to NCO, the Permanente Medical Groups ask "Medical Group Regional Compliance" staff for advice which can be manipulated easily within the region to get the desired result (*e.g.*, more HCC target capture). When NCO completes an internal audit that shows inaccurate or misleading documentation or coding, NCO is pressured and intimidated by the relevant Regional PMG to change the audit's accuracy results.

154. On a system-wide basis, Kaiser has been reluctant to perform historical code correction and billing submission when a problem or issue has been identified that should be rebilled. The culture at Kaiser perpetuates a superiority, manipulation, and intimidation by physician medical group leaders and medical group management, resulting in an inability to challenge or present a different perspective, even when backed by express, unambiguous coding guidelines, standards or HIM coding expertise, without being chastised, threatened and ridiculed.

(i) ***Query templates***

155. Coding professionals are permitted under AHIMA's Standards of Ethical Coding to query physicians/providers for clarification and additional documentation prior to code assignment when there is conflicting, incomplete, or ambiguous information in the health record regarding a significant reportable condition or procedure or other reportable data element dependent on health record documentation. Querying physicians/providers is also permitted after billing (*e.g.*, retrospectively) if performed in a timely manner.

156. But these Standards, as well as AHIMA's Guidelines for Achieving a Compliant Query Practice and AHIMA's Managing an Effective Query Process Practice Brief, forbid coding professionals and others (e.g., clinical staff, physicians, nursing staff, etc.) who query from "leading" providers to select a particular diagnosis. *See* Exhibit 46.

157. According to AHIMA's Managing an Effective Query Practice Brief, "Queries that appear to lead the provider to document a particular response could result in allegations of inappropriate upcoding. The query format should not sound presumptive, directing, prodding, probing, or as though the provider is being led to make an assumption." Exhibit 42 at REL0000511.

158. In *Health Information Management Compliance: A Model Program for Healthcare Organizations,* AHIMA's Sue Bowman writes that "Communication tools between coding personnel and physicians, such as coding summary sheets, attestation forms, or coding clarification forms (*e.g.*, physician query forms), should never be used as a substitute for appropriate physician documentation in the health record."

159. Nevertheless, some of the Kaiser regions developed sets of query "templates" for clinical documentation improvement (CDI) staff for specific HCC diagnoses to use in concurrent querying of providers that do just that. These improper query templates were used in at least Kaiser's NCAL hospital CDI and Northwest CDI, and perhaps others. There is a cultural reluctance within NCO to give direction and/or require the Kaiser Regions to utilize the Kaiser standard query form language for coding and CDI.

160. The hospital coding staff also utilizes templated physician queries, but these query templates are reviewed and constructed to ensure non-leading language for a variety of diagnoses, regardless of payer type or reimbursement impact. Most of the query reviews of language utilized were under the oversight of Ms. Bryant and guidance of Ms. Hernandez, always utilizing, communicating, and applying the AHIMA direction, guidance and practice briefs.

161. KP NCAL and Northwest CDI query templates developed by TPMG and the Northwest PMG, respectively, many of which involve diagnoses directly linked to HCCs under the Medicare Advantage program and HHS-HCCs under the Affordable Care Act, are designed to be, and are in fact, leading. Through the queries, CDI staff introduce clinical indicators for specific HCC diagnoses to the providers, who in turn routinely follow the suggestion to add a reimbursable diagnosis where none existed and should not have been added. In Kaiser's NCAL Region, the CDI queries are not made an official permanent part of the record while HIM coding queries are, thus obscuring the role of CDI and improper querying from review.

162. Although the role of CDI staff is to seek clarification from providers for documentation for specific clinical indicators, there has been inconsistent application of the Practice Brief Guidance at Kaiser. These queries are always, or almost always, directed toward an HCC diagnosis for maximizing reimbursement capture and not for overall quality documentation for all clinical situations, all payers, and all patients. In fact, Ms. Bryant recalls on several occasions a stated reluctance from Kaiser's Revenue Cycle leaders to look at documentation and coding both ways – *e,g,*, for both over- and under coding – on the basis that it is too costly and time consuming. Moreover, Kaiser's CDI program is not a "payer agnostic" approach. TPMG in Kaiser's NCAL Region, for example, limits its CDI focus to HCCs only and never expanded to

examine severity of illness (SOI) and risk of mortality (ROM) to all patients and to all payers, notwithstanding Ms. Bryant's strong recommendations,

163. Examples of the leading query templates include Kaiser's templates for: obesity/extreme or morbid obesity; protein calorie malnutrition (mild/moderate/severe); pressure ulcer; neoplasm (history versus current); emphysema; depression; adrenal mass; aortic atherosclerosis; diabetes manifestations; neutropenia; sepsis/SIRS with organ dysfunction, and others. *See* Exhibit 47 (improper query templates from Kaiser's Northwest region, operated by the Northwest PMG); Exhibit 36 (TPMG CDI Tip Sheet).

164. Moreover, certain query templates in Kaiser's Northwest Region developed by the Northwest PMG include leading language introducing a diagnosis to the physician, and not including options of "unknown," "other," "clinically undetermined" or "unspecified." They contravene AHIMA's guidance on Achieving a Compliant Query Process, which states that "*Multiple choice query formats should include clinically significant and reasonable options as supported by clinical indicators in the health record, recognizing that there may be only one reasonable option....Multiple choice query formats should also include additional options such as 'clinically undetermined' and 'other' that would allow the provider to add free text. Additional options such as 'not clinically significant' and 'integral to' may be included on the query form if appropriate.*"

(ii) *Inquiries to AHA Coding Clinic*

165. As discussed above in the Vent Dependence Status section, Kaiser chastised and reprimanded Ms. Bryant, Ms. Hernandez and other HIM coding professionals for submitting coding questions directly to the American Hospital Association Central Office for Coding Clinic, a routine and standard of practice for coding professionals across the country. Ultimately, Kaiser instituted and mandated requirements for all AHA Coding Clinic questions, routing them through a rigorous review committee comprised primarily of non-coding professionals and many layers of approval process before submission.

166. Ms. Bryant was directed that any and all coding questions must go through Kaiser's own Coding Governance Group ("CGG"), a group that was and is composed of a majority of physicians and representatives from Kaiser's Permanente Medical Groups rather than coding professionals. In December 2013, Ms. Bryant was told by Kaiser TPMG's senior physician lead Dr. Bliss that she was "putting the organization at risk" by submitting questions directly to Coding Clinic, a sentiment echoed by TPMG Director Anne Cadwell on a call that also included many regional physicians and Revenue Cycle leaders. Ms. Bryant's expertise, professional knowledge and career-long practice of submitting questions to Coding Clinic were thus called into question. Ms. Bryant commented to the group that it was her duty and responsibility as a coding professional, and a standard of practice, to submit questions for coding clarification to AHA Coding Clinic without a committee review.

167. Ms. Bryant expressed concern on the December 2013 call that this internal group lacked coding expertise, and inserted a layer of bureaucracy in an area where Kaiser's National Coding group (led by Ms. Bryant) should have independence and the ability to send unattributed questions to Coding Clinic. Her protests and professional rationale were ignored.

168. Ms. Bryant reported back to Kaiser's NCAL HIM leadership, including Ms. Hernandez and Dawna Toews, regarding this new directive. Her staff was appalled with the outcome of the meeting and felt that their credentials were at risk due to being prohibited from following ethical coding practices to seek and comply with official coding guidelines. *See* Exhibit 22. Under extreme pressure, Ms. Bryant reluctantly complied with the CGG request and worked with NCO's Nancy Andersen to develop a coding questions workflow over the coming years (started in 2014 and finalized in 2015, currently still under revision in 2017).

169. The internal coding question workflow for submitting coding questions to Coding Clinic was discussed during a March/April 2015 conference call/meeting involving NCO's Diana Medal, Nancy Andersen, Ms. Bryant and Ms. Hernandez. The group specifically discussed the restrictive and controlling nature of the CGG directive and how the physician members of the CGG were extremely apprehensive of Ms. Bryant sending questions to Coding Clinic due to their

concern that Coding Clinic's response might force Kaiser to change its HCC documentation and HCC capture practices.

170. NCO's Nancy Andersen mentioned that the CGG physician leader, Dr. Annette Guido, was behind the restriction that had been imposed and that she (Ms. Andersen) did not entirely agree with it, but that the physicians' directive had to be followed. Ms. Bryant stated her concerns with the CGG being composed mostly of physicians and not coding experts, a point with which Ms. Andersen agreed. On the same call, Ms. Hernandez discussed her concern that TPMG had been focusing on HCCs and had restricted her in the past from collaborating outside TPMG EIO (*i.e.*, with Ms. Bryant, Ms. Anderson and NCO), much less submit a question to Coding Clinic, and felt that TPMG feared that the Coding Clinic response or guidance would derail its capture efforts of HCC diagnoses. Ms. Andersen stated that she understood but "we have no choice." She stated that it was difficult to get the medical groups and CGG to understand the need to query AHA Coding Clinic directly and freely.

171. When Ms. Hernandez requested a copy of the recording of the conference call several days later, Ms. Medal stated via email that it had been deleted per the instructions of Ms. Andersen. Ms. Bryant and Ms. Hernandez believe that the recording was deleted due to the fact that many comments were made during the call, including by NCO leadership, that were highly critical of CGG's and TPMG's leadership and practices.

(iii) *Evaluation and Management ("E&M") levels – Medi-Cal Upcoding*

172. E&M coding is the process by which physician-patient encounters are translated into Current Procedural Terminology ("CPT") codes to facilitate billing to Medi-Cal and other payers. There are five E&M levels of service relevant to full encounter data submission. Choosing the proper level is critical for proper reimbursement for Medicare Part B, Medicaid (including Medi-Cal) and other payers. Coding data is also used for analysis of future payment methodology by the Medicare system, and is used to determine per member, per month rates under Medi-Cal for managed care organizations like Kaiser.

173. Kaiser's policy systematically ignores one-level E&M differences. Kaiser requires an audit corrective action plan only when the E&M level is off by two or more levels. This is a Permanente Medical Group practice across all Kaiser Regions in non-hospital settings and was a decision made by the Permanente Medical Group Federation comprised of all regional medical groups. Further, Kaiser requires internal and third-party audits to reflect accuracy/error rates using the Kaiser E&M leveling standard, rather than the CMS standard for error determination. This has the capacity, if not the likelihood, of misleading a reader of audit results into believing that Kaiser's E&M coding is substantially more accurate than it really is, and that no corrective action is required when it is.

174. When the Northwest Region's Revenue Cycle director requested Ms. Bryant's input and advice on the Northwest Region's audit approach with one-level E&M change, Ms. Bryant expressed her concerns with this practice and stated that a one-level E&M change should be counted in the accuracy rate determination. Ms. Bryant's believes that her feedback was ignored.

175. In December 2016, Ms. Bryant led a Washington Region physician practice coding validation audit utilizing a third-party vendor, under the support of the Vice President of Revenue Cycle, Doug Murphy. The findings from this audit identified E&M level changes, including one-level changes, that were counted as errors in the overall accuracy rate. When the audit findings were summarized and presented to the Washington PMG and Kaiser Revenue Cycle Senior Leadership, Ms. Bryant was questioned repeatedly on the E&M level error rate.

176. Linda Medina, Vice President of Revenue Cycle for the Southern California Region told Ms. Bryant that Kaiser has a long history with the Permanente Medical Groups of not counting a one-level E&M error in the accuracy rate and that she (Ms. Bryant) needs to get on board with this practice. Ms. Bryant told Ms. Medina and Mr. Murphy that maybe it was time for Kaiser to change its practice instead of continuing to inaccurately report audit findings, as a one-level change is an error that counts in the accuracy rate determination and is industry standard. Ms. Bryant provided Medicare audit guidance that supported this position which she provided directly to her supervisor, Mr. Murphy, and requested that it be shared with Ms. Medina and

others. Again, Ms. Bryant believes that her feedback was ignored, and further believes that validation audit's accuracy results were manipulated to exclude one-level E&M coding errors.

177. In 2017, Ms. Hernandez was informed by a TPMG EIO Manager that Kaiser is now counting **two** levels of E&M error as acceptable and does not count such errors toward the accuracy rate in audits.

B. *Kaiser's emphasis on financial outcomes*

178. At every level of the company, Kaiser emphasizes financial results over compliance and accuracy, bending the rules and utilizing gaming strategies to falsely engineer profits.

(i) *CDI program and related activities.*

179. In late 2009, Kaiser NCAL Revenue Cycle developed its "Clinical Documentation Improvement" program, which it called "Clinical Documentation Integrity" or "CDI," to ostensibly improve its clinical documentation of hospital inpatient medical encounters. This effort was followed by the SCAL and Northwest Regions in the hospital setting. In actuality, Kaiser's CDI programs strive only to improve clinical documentation insofar as it increases HCC capture and Medicare and HHS reimbursement.

180. AHIMA's guidance on CDI programs provides that they are required to address all payers, not just Medicare. In addition, CDI programs should not focus solely on reimbursement. In furtherance of this guidance, the original NCAL CDI program initially developed by Ms. Bryant in 2009 was designed to achieve a payer-agnostic focus by the end of a three-year plan. But Kaiser's CDI program, in practice, has diverged from Ms. Bryant's expertise and design and is definitively <u>not</u> "payer agnostic." It focuses almost exclusively on risk-adjusted payers, such as HHS under the ACA program and CMS under the Medicare Advantage program, and only on documentation impacting HCCs.

181. Ms. Bryant made several requests to expand Kaiser's CDI program to other payers and not to focus solely on HCC reimbursement, but was not successful. In approximately late 2010, Kaiser NCAL Revenue Cycle Vice President Dave Nyburg moved the CDI Program

from Ms. Bryant's oversight to his direct oversight. Ms. Bryant believes that this move was made due to ongoing TPMG discomfort with the direction she wanted to move the program and the pressure and resistance to Ms. Bryant's advice and guidance.

182. Moreover, in the past, Kaiser's CDI program conducted its concurrent documentation reviews by going into prior or old encounters and pulling diagnostic and clinical information to query physicians for the current encounter for HCC diagnosis capture. Again, this contravenes coding guidelines and AHIMA Standards of Ethical Coding under section 4.5: Coding professionals shall not "*Utilize health record documentation from or in other encounters to generate a provider query.*" *See* Exhibit 46.

183. For example, Ms. Hernandez received multiple inquiries from CDI leadership and CDI nursing staff as to whether they may use old lab values, clinical indicators and documentation from previous encounters and apply these to send a query about a different, current encounter. Ms. Hernandez has repeatedly told CDI leadership staff that this is not appropriate. But the repeated nature of the inquiries gave rise to Ms. Hernandez's belief that the CDI program was routinely looking backwards; it was highly unlikely that the CDI leadership was getting to every instance and every CDI employee to provide Ms. Hernandez's guidance.

184. For many years, Kaiser's CDI program, especially in the NCAL region, has consistently expressed the value of its work in terms of additional dollars captured, not in improved quality of care, patient safety, severity of illness, improved mortality scores, compliant documentation, or outcomes.

185. For example, in a July 2010 NCAL presentation "CDI Prioritization for Roll Out," Kaiser's NCAL CDI group analyzed the results of an internal audit of inpatient "HCC underpayment." The presentation quantified the impact of the HCC codes that had been "recaptured" in the audit in terms of how much additional revenue that meant for the company. The presentation did not mention compliance or identify any HCC overpayment. *See* Exhibit 48.

186. In a Kaiser NCAL "CDI Program: Update" presentation in December 2011, the company emphasized in its Key Findings that the program had generated year-to-date 2011 revenue of "$27.80 million." *See* Exhibit 11. The presentation even quantified the "Top CDI

Queries" by HCC in terms of the "Revenue Impact" to the company, with sepsis near the top of the list. CDI Program Updates have followed the same format and included these same metrics for many years.

(ii) ***Kaiser's RRG meetings and Regional Competitions for Revenue/HCC Capture.***

187. In approximately 2008-2009, Kaiser formed Regional Reporting Group ("RRG"), comprised of senior personnel from the Health Plan, Permanente Medical Groups and Revenue Cycle of each region with the focus of Medicare Advantage Finance Risk Adjustment. The RRG meetings were initially led by Dr. Simon Cohn until his retirement in 2015, after which the RRG was led by Dr. Annette Guido of Kaiser's Northwest Region, along with Hovannes Daniels, Kaiser's Medicare Finance VP under Kaiser's Health Plan.

188. The RRG meets regularly to share regional "best practices" on how to capture more HCC conditions, diagnoses, and codes, and thus to increase Kaiser revenue. This was and is the top focus of these high-level meetings. Other topics discussed are risk scores and Risk-Adjustment Data Validation (RADV) audits, regulatory changes, comparing regions to each other, and reviewing financial and HCC targets.

189. "Best practices" often contain improper and inaccurate querying, documentation, and coding practices. Certain HCC conditions and diagnoses are specifically targeted at the RRG meetings for their financial impact and discussed and compared with the other regions. Ms. Bryant recalls a RRG meeting where a regional physician leader made a presentation which contained inaccurate documentation and coding information. Ms. Bryant took her concerns about the presentation to Janet D. Franklin of Kaiser's NCO. Ms. Franklin agreed that Ms. Bryant was correct but said that that they could not say anything here at the RRG meeting in front of the Permanente Medical Groups. Ms. Bryant told Janet Franklin that she was concerned with that approach in that there was a large audience in many regions who would think that the presentation had correct information. Ms. Franklin agreed, but said that there was nothing that could be done.

190. Kaiser's various regions, including especially its NCAL (TPMG) and Southern California regions (SCPMG), compete with each other on which region manages to capture the highest number of HCCs and improved risk scores. Monthly or Bi-monthly WebEx meetings and report outs are generated showing the results of the risk-adjustment metrics, as well as goals and targets for regional HCC capture over the next period. In addition, the regions compete in the third and fourth fiscal quarters each year as to their metrics on capturing chronic conditions and HCCs, and improving scores and revenue, metrics which are also discussed and presented at RGG meetings.

(iii) *Employee and management bonuses.*

191. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser's NCAL region, including TPMG, gives bonuses to employees and leadership near year-end that are tied to the overall financial goals and success of the Kaiser region. They therefore believe and allege from their experience working in TPMG that bonuses are related, directly or indirectly, to HCC and revenue capture.

(iv) *Kaiser's regional medical groups dominate over Kaiser's compliance function.*

192. In June 2013, Nancy Andersen, Kaiser's National Compliance manager, told Ms. Hernandez that the regional Permanente Medical Groups choose what and how to be audited. She told Ms. Hernandez that "she knows where the bodies are buried," but that the National Compliance Office has no power over the Permanente Medical Groups. This is exactly the opposite of how the compliance function should operate in a compliant organization. In 2016, Ms. Andersen confirmed to Ms. Bryant that Kaiser's Permanente Medical Groups continue to be "rabid for HCCs" and that Kaiser's NCO group has no power to focus the organization on compliance.

C. *Kaiser improperly employs technology to further its HCC and revenue capture.*

(i) *Data mining.*

193. In 2014-2015, Kaiser's TPMG EIO's "data mining" team, comprised largely of out-of-country doctors, used "algorithms" in the NCAL region to identify and capture possible missed HCCs to create "add files," referred to as "missed opportunities" by TPMG. Ms. Hernandez believes and therefore alleges that this practice had been going on for many years.

194. Also in 2014-2015, Ms. Hernandez witnessed TPMG utilizing foreign doctors, who were not licensed as physicians in the United States and may not have had current foreign licenses, to access the clinic encounters. The foreign doctors would send "Dear Doctor" notes via KP Health Connect to the primary care physician asking them to add HCC diagnoses based on their reviews and using their algorithms.

195. This process was improper and led to errors. For example, as part of an NCO audit in 2015, Ms. Hernandez found documentation of sepsis added onto a clinic encounter four months after the patient was seen, with no supporting documentation as to how the HCC diagnosis was determined (*e.g.*, no lab values, signs/symptoms, treatment, clinical indicators, etc.). When Ms. Hernandez shared with her director, Anne Cadwell (TPMG EIO Director), that Ms. Hernandez agreed with NCO's finding that sepsis was improperly coded, Ms. Hernandez was told by Ms. Cadwell "never to agree" with an NCO audit, and if the topic came up, to just say "thank you." Ms. Hernandez asked what to enter in the audit response, given that she agreed with the finding. Ms. Cadwell instructed Ms. Hernandez not to talk at the audit exit call and to only speak when Ms. Cadwell asked Ms. Hernandez to say something.

(ii) ***Improper Carry-Over From Prior Years.***

196. In 2014-2015, Ms. Hernandez discovered that in Kaiser's NCAL TPMG region, Kaiser's "Business Intelligence Team" ("BIT") generated questionable "block" files and "add" files for resubmission to CMS based on algorithms. The process they used may have improperly carried over HCCs from previous years to the current year without physician validation or a face-to-face encounter.

197. Ms. Hernandez was part of the TPMG EIO Director email distribution list where medical record diagnoses files were emailed to the directors asking for approval for "add"

or "block" files, which Ms. Hernandez never approved. To Ms. Hernandez' knowledge, "add" files were created based on algorithms run by the BIT team (*e.g.*, diabetes with manifestations, etc.), and automatically carried from the previous year to the current year's problem list even where patients were not seen face-to-face as required under the Medicare Advantage program.

(iii) *Computer Assisted Coding*

198. Computer Assisted Coding (CAC) is a natural language processing technology utilized as a tool to assist the coding professional to confirm and select ICD and CPT codes based on words and language used in the medical record. CAC identifies wording and/or full sentences within the electronic health record which contains signs, symptoms, diagnoses and procedures for which a code may possibly be assigned once confirmed and validated by the coding professional. CAC was identified and implemented by Kaiser as a valuable tool and asset to increase coding productivity, coding accuracy, and HCC capture.

199. In approximately 2013, during the pilot phase of CAC implementation in Kaiser's NCAL region, Ms. Hernandez conducted auditing and validation of the resulting diagnoses and codes, along with Ms. Sheryl Roy (Regional NCAL HIM employee at the time). Ms. Hernandez and Ms. Roy determined that CAC was capturing and overcoding diagnoses with an overall poor accuracy rate (60% or less). They shared their findings with Ms. Bryant, who agreed with their concerns.

200. During a CAC quality assurance meeting, which was held via recorded webex, Ms. Bryant, Ms. Hernandez and Ms. Roy reported their audit findings and concerns to NCAL Revenue Cycle Charge Capture Manager, Gina Sandler, and Revenue Cycle Integrity Director, Diane Ott, who were members of Kaiser's CAC implementation team. Ms. Sandler typed meeting minutes during the call. Ms. Hernandez and Ms. Roy later discovered that the audit results and their concerns had been excluded from the meeting minutes. Moreover, they discovered that Ms. Sandler and Ms. Ott had manipulated the actual audit results to indicate a higher accuracy rate. Ms. Hernandez and Ms. Bryant believe and therefore allege that the audit results were manipulated and their concerns were ignored so as to avoid identification of any

problems with CAC which might delay its full implementation at Kaiser. Ms. Bryant and Ms. Hernandez voiced their concerns to NCAL Revenue Cycle Leadership and to Kaiser's NCO leadership (Ms. Anderson), but were ignored.

201. Ultimately, Kaiser's CAC implementation moved forward in 2014 on outpatient and inpatient encounters. After 18 months to two years of constant problems with CAC, the hospital coding and auditing staff expressed outrage with the continued inaccuracy and their mistrust of the CAC tool. These complaints resulted in NCAL Revenue Cycle Leadership finally discontinuing CAC in hospital outpatient encounters in 2016.

202. Ms. Bryant and Ms. Hernandez believe and therefore allege that Kaiser never went back to correct the many inaccurate codes generated by the Kaiser's flawed CAC processes.

D. *The Kaiser Defendants Acted With Intent.*

203. The Kaiser Defendants acted with intent in over-charging the United States, the State of California, and other government programs, and retaining and failing to return such overpayments. Kaiser's entire corporate culture is built around "mining for", "gaming" and "capturing" codes even when they are not validly supported or documented, training its physicians to over-diagnose and falsely document diagnoses, elevating its profits over its compliance function, and motivating employees through the setting of metrics and, upon information and belief, utilizing bonuses for successful code and revenue capture. The specific schemes described above engineered by Kaiser regarding aortic atherosclerosis, vent dependent status, protein-calorie malnutrition, sepsis and sepsis with organ dysfunction, acute renal failure and others evidence Kaiser's intentional, systematic efforts to circumvent proper documentation and coding practices and Medicare, Medicaid and Medi-Cal law. Moreover, although Kaiser has a National Compliance Office with hundreds of staff, there are huge holes and gaps in the effectiveness of its compliance program, which is subverted to the profit goals of Kaiser's medical groups.

E. *Kaiser's Fraud Was and Is Material to the Government's Payment Decision*

204. The United States and the State of California, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, their agents, employees, and co-conspirators, and as a result thereof, have paid money that they otherwise would not have paid. For example, CMS would have refused to make risk adjustment payments, in whole or in part, to the Kaiser Defendants if it had known that the Kaiser Defendants were falsifying documentation and coding as alleged in this Complaint. The fraudulent diagnostic data and coding submitted by the Kaiser Defendants constituted a substantial portion of all of the diagnostic data and coding submitted by the Kaiser Defendants to the government. Given that diagnostic data and coding is the sole determinant in the calculation of any risk adjustment payment based on a beneficiary's health status, the government's payment decision necessarily would have been different had the government known that the data and coding were false.

205. Moreover, CMS makes reconciliation payments to the Kaiser Defendants based on the diagnostic data submitted. Those payments are adjusted to account for invalid diagnoses codes that providers such as Kaiser submit. If the Kaiser Defendants had complied with their obligation to delete invalid diagnoses from RAPS, Medicare would have processed the corrected data, recalculated the risk score for the beneficiaries, and the risk adjustment reconciliation payment system would have made the corresponding payment adjustment. But when the Kaiser Defendants did not delete invalid diagnoses from RAPS, Medicare paid for the invalid diagnoses as part of its final reconciliation payment to the Kaiser Defendants. If the Kaiser Defendants had corrected their invalid diagnoses, CMS would have processed the corrected data to produce accurate risk scores for beneficiaries, which necessarily would have changed the risk adjustment payments for those beneficiaries.

206. The risk adjustment attestations submitted by the Kaiser Defendants each year are a reminder to the Kaiser Defendants of their obligation to submit valid data and to promptly correct invalid data. They also have a direct impact on the government's risk adjustment payments. For example, if CMS knew that the Kaiser Defendants' attestations were false, CMS's risk adjustment payments would have changed in that CMS would have refused to make risk adjustment payments to the Kaiser Defendants, in whole or in part.

207. The materiality of the Kaiser Defendants' fraud is further established by the fact that the United States has filed suit against other managed care organizations over similar documentation and coding fraud as alleged herein.

FIRST CLAIM FOR RELIEF

False Claims Act: Presentation of False or Fraudulent Claims

U.S.C. § 3729(a)(1)(A) (formerly 31 U.S.C. § 3729(a)(1))

208. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 208 above as though they are fully set forth herein.

209. Defendants violated 31 U.S.C. § 3729(a)(1)(A) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. 3729(b)(1)) presented or caused to be presented a false or fraudulent claim for payment or approval. Specifically, Defendants knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the Medicare Program.

210. Defendants violated former 31 U.S.C. § 3729(a)(1) as follows: Defendants knowingly presented, or caused to be presented, to the United States a false or fraudulent claim for payment or approval. Specifically, Defendants knowingly presented or caused to be presented a false or fraudulent Risk Adjustment Attestation to the United States in order to receive and retain risk adjustment payments from the Medicare Program.

211. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

212. By virtue of the said false or fraudulent claim, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

SECOND CLAIM FOR RELIEF

False Claims Act: Making or Using False Records or Statements

U.S.C. § 3729(a)(1)(B) (formerly 31 U.S.C. § 3729(a)(2))

213. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 213 above as though they are fully set forth herein.

214. Defendants violated 31 U.S.C. § 3729(a)(1)(B) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation material to a false or fraudulent claim for risk adjustment payments from the Medicare Program.

215. Defendants violated former 31 U.S.C. § 3729(a)(2) as follows: Defendants knowingly made, used, or caused to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the United States. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation to get a false or fraudulent claim for risk adjustment payments paid or approved by the Medicare Program.

216. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

217. By virtue of the said false record or statement, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

THIRD CLAIM FOR RELIEF

False Claims Act: Conspiracy

U.S.C. § 3729(a)(1)(C) (formerly 31 U.S.C. § 3729(a)(3))

218. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 218 above as though they are fully set forth herein.

219. Defendants violated 31 U.S.C. § 3729(a)(1)(C) as follows: Defendants conspired with one another to commit a violation of 31 U.S.C. § 3729(a)(1)(A), (B), and/or (G), as those violations are specifically alleged in Claims I, II, and IV of this Complaint.

220. Defendants violated former 31 U.S.C. § 3729(a)(3) as follows: Defendants conspired with one another to defraud the United States by getting a false or fraudulent claim allowed or paid. Specifically, Defendants conspired with one another to defraud the United States by getting risk adjustment payments from the Medicare Program based on a false or fraudulent claim for risk adjustment payments and/or a false or fraudulent Risk Adjustment Attestation.

221. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

222. By virtue of the said conspiracy, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

FOURTH CLAIM FOR RELIEF

False Claims Act: Reverse False Claims

U.S.C. § 3729(a)(1)(G) (formerly 31 U.S.C. § 3729(a)(7))

223. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 223 above as though they are fully set forth herein.

224. Defendants violated 31 U.S.C. § 3729(a)(1)(G) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly made, used, or caused to be made or used a false Risk Adjustment Attestation material to an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program.

225. Defendants also violated 31 U.S.C. § 3729(a)(1)(G) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) concealed or improperly avoided or decreased an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly concealed or improperly avoided or decreased an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program.

226. Defendants violated former 31 U.S.C. § 3729(a)(7) as follows: Defendants knowingly (as "knowingly" is defined by 31 U.S.C. § 3729(b)(1)) made, used, or caused to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the United States. Specifically, Defendants knowingly made, used, or caused to be made or used, a false Risk Adjustment Attestation to conceal, avoid or decrease an obligation to repay risk adjustment payments to which they were not entitled from the Medicare Program.

227. The United States, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

228. By virtue of the said false record, statement, and other acts of concealment and improper avoidance, the United States incurred damages and therefore is entitled to multiple damages under the False Claims Act, plus a civil penalty for each violation of the Act.

FIFTH CLAIM FOR RELIEF

Violation of California False Claims Act: Presentation of False or Fraudulent Claims

California Government Code § 12651(a)(1)

229. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 229 above as though they are fully set forth herein.

230. Defendants violated California Government Code § 12651(a)(1) as follows: Defendants knowingly presented or caused to be presented a false or fraudulent claim for payment or approval. Specifically, Defendants knowingly presented or caused to be presented false and excessive billings paid or approved by Medi-Cal.

231. The State of California, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

232. By virtue of the said false or fraudulent claim, the State of California incurred damages and therefore is entitled to multiple damages under the California Government Code § 12651, plus a civil penalty for each violation of the Act.

SIXTH CLAIM FOR RELIEF

Violation of California False Claims Act: Making or Using False Records or Statements

California Government Code § 12651(a)(2)

233. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 233 above as though they are fully set forth herein.

234. Defendants violated California Government Code § 12651(a)(2) as follows: Specifically, Defendants knowingly made, used, and/or caused to make or use false records and statements to get false and excessive billings paid or approved by Medi-Cal.

235. The State of California, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

236. By virtue of the said false or fraudulent claim, the State of California incurred damages and therefore is entitled to multiple damages under the California Government Code § 12651, plus a civil penalty for each violation of the Act.

SEVENTH CLAIM FOR RELIEF

Violation of California False Claims Act: Conspiracy

California Government Code § 12651(a)(3)

237. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 237 above as though they are fully set forth herein.

238. Defendants violated California Government Code § 12651(a)(3) as follows: Defendants conspired with one another to commit a violation of California Government Code § 12651(a)(1), (2) and/or (7), as those violations are specifically alleged in Claims V, VI, and VIII of this Complaint. Specifically, Defendants violated California Government Code § 12651(a)(3) as follows: Defendants conspired with one another to defraud the State of California by getting a false or fraudulent claim allowed or paid.

239. The State of California, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

240. By virtue of said conspiracy, the State of California incurred damages and therefore is entitled to multiple damages under the California Government Code § 12651, plus a civil penalty for each violation of the Act.

EIGHTH CLAIM FOR RELIEF

Violation of California False Claims Act: Reverse False Claims

California Government Code § 12651(a)(7)

241. The Relators repeat and re-allege the allegations contained in Paragraphs 1 – 241 above as though they are fully set forth herein.

242. Defendants violated California Government Code § 12651(a)(7) as follows: Defendants knowingly made, used, or caused to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State of California. Specifically, Defendants knowingly and improperly retained and concealed excessive capitated payments that Defendants received from Medi-Cal.

243. Defendants also violated California Government Code § 12651(a)(7) as follows: Defendants knowingly concealed or improperly avoided or decreased an obligation to pay or transmit money or property to the State of California. Specifically, Defendants knowingly made, used and/or caused to make or use false records and statements to conceal, avoid, or decrease their obligation to return to the Medi-Cal program the excessive capitated payments Defendants received from Medi-Cal.

244. The State of California, unaware of the falsity of the records, statements, and claims made and submitted by Defendants, its agents, employees, and co-conspirators, and as a result thereof, paid money that it otherwise would not have paid.

245. By virtue of the said false or fraudulent claim, the State of California incurred damages and therefore is entitled to multiple damages under the California Government Code § 12651, plus a civil penalty for each violation of the Act.

NINTH CLAIM FOR RELIEF

False Claims Act: Relief From Retaliatory Actions Against Defendant TPMG

U.S.C. § 3730(h)

246. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 246 above as though they are fully set forth herein.

(a) 31 U.S.C. § 3730(h), Relief From Retaliatory Actions, provides:

(i) In general.— Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee, contractor, or agent whole, if that employee, contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, or agent on behalf of the employee, contractor, or agent or associated others in furtherance of other efforts to stop 1 or more violations of this subchapter.

(ii) Relief.— Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorneys' fees. An action under this subsection may be brought in the appropriate district court of the United States for the relief provided in this subsection.

247. Ms. Hernandez was employed by the Kaiser Defendants from June 1995 through October 2015. From January 2000 forward, Ms. Hernandez's was employed in various coding leadership positions.

248. Ms. Hernandez received stellar employment reviews throughout her career with Kaiser until she was hired into Kaiser's TPMG organization. In her last year of Kaiser employment (October 2014 through October 2015), the only year that she worked at Kaiser's TPMG subsidiary, Ms. Hernandez was criticized for purported lack of communication and, at the

same time, also reprimanded for communicating her concerns about TPMG's coding and auditing functions.

249. This review came after, and was the direct result of, Ms. Hernandez observing and reporting internally several of the coding errors and systemic fraud detailed herein committed at and by Kaiser and its affiliates, including TPMG.

250. The poor review was improper retribution for Ms. Hernandez's efforts to bring to the attention of leadership the deceptive and fraudulent practices within Kaiser. She was set up to be terminated for reporting what she observed even though she had been asked by TPMG leadership to stop looking for another job. Ms. Hernandez felt harassed, disrespected, and bullied. She was subjected to threats and intimidation by TPMG leadership.

251. In October 2015, in anticipation of being terminated, and due to Kaiser TPMG's intimidation and harassment, she resigned her position with Kaiser.

252. Ms. Hernandez engaged in protected activity by, among other things, reporting to multiple Kaiser supervisors her concerns that Kaiser was submitting illegal, unlawful and/or false claims to the Government in an effort to stop Kaiser from presenting or causing to be presented to the Government false or fraudulent claims for payment or approval, and from making, using or causing to be made or used, a false record or statement material to a false or fraudulent claim.

253. Kaiser TPMG knew that Ms. Hernandez engaged in the above described protected activity.

254. Kaiser TPMG discharged, demoted, threatened, harassed, and otherwise discriminated against Ms. Hernandez as a result of her protected activities.

255. As a result of Kaiser's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

TENTH CLAIM FOR RELIEF

Violation of Cal. Lab. Code § 1102.5, *et seq.* Against Defendant TPMG

256. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 256 above as though they are fully set forth herein.

257. In violation of Cal. Lab. Code § 1102.5, Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms. Hernandez for having opposed, resisted, and complained of the acts alleged herein.

258. Defendant TPMG retaliated against Ms. Hernandez for opposing and refusing to participate in Defendant's violations of state and federal statutes and/or rules and regulations. In contesting Defendant's violations, Ms. Hernandez was engaged in protected activity. Under Cal. Lab. Code § 1102.5, Defendant TPMG is prohibited from retaliation against Ms. Hernandez for opposing any practices forbidden or made unlawful under Cal. Lab. Code § 1102.5.

259. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms. Hernandez's rights, entitling her to an award of punitive damages.

260. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

ELEVENTH CLAIM FOR RELIEF

Violation of Cal. Lab. Code § 98.6 Against Defendant TPMG

261. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 261 above as though they are fully set forth herein.

262. In violation of Cal. Lab. Code § 98.6, Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms. Hernandez for having opposed, resisted, and complained of the acts alleged herein.

263. After Ms. Hernandez complained about and objected to Kaiser's practices detailed herein and in response to such complaints and objections, Defendant TPMG subjected her to ongoing retaliation, including but not limited to ostracism and the threat of termination.

264. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms. Hernandez's rights, entitling her to an award of punitive damages.

265. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

TWELFTH CLAIM FOR RELIEF

Violation of Fair Labor Standards Act Against Defendant TPMG

29 U.S.C. § 215

266. Relator Victoria M. Hernandez repeats and re-alleges the allegations contained in Paragraphs 1 – 266 above as though they are fully set forth herein.

267. In violation of the Fair Labor and Standards Act of 1939 ("FLSA"), Defendant TPMG, by and through its principals, agents and employees, retaliated against Ms. Hernandez in constructively discharging her for having opposed, resisted, and complained of the acts alleged herein, including numerous violations of federal law and rules and regulations.

268. In making the above-described internal complaints, Ms. Hernandez was engaged in a protected activity under the FLSA. Defendant TPMG willfully continued to mask its violations after Ms. Hernandez apprised Defendant of the extent of Defendant's non-compliant

practices. Ms. Hernandez subsequently suffered an adverse employment action when she was constructively discharged from her employment by Defendant in retaliation for making said complaints and refusing to accede to Defendant's masking of its unlawful practices.

269. In taking the actions alleged herein, Defendant TPMG acted with malice, fraud and oppression, and in reckless disregard of Ms. Hernandez's rights, entitling her to an award of punitive damages.

270. As a result of Defendant TPMG's unlawful actions, Ms. Hernandez has suffered a loss of employment opportunities and earnings and a loss of future earnings and earning capacity, and Ms. Hernandez has suffered, and continues to suffer, non-monetary damages, including, but not limited to, emotional and physical distress, humiliation, embarrassment, loss of esteem, and loss of enjoyment of life.

PRAYER

WHEREFORE, *qui tam* plaintiffs Gloryanne Bryant and Victoria M. Hernandez pray for judgment against Defendants as follows:

On Claims I, II, III, and IV (False Claims Act), against all Defendants jointly and severally:

- for the amount of the United States' damages, trebled as required by law, together with the maximum civil penalties allowed by law, costs, post-judgment interest, and such other and further relief as the Court may deem appropriate;
- for Relators to be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) of the Federal False Claims Act;
- for Relators to be awarded all costs of this action, including attorneys' fees and expenses;
- and for the United States and Relators to receive all such other relief as the Court deems just and proper.

On Claims V, VI, VII, and VIII (California False Claims Act), against all Defendants jointly and severally:

- for the amount of the State of California's damages, trebled as required by law, together with the maximum civil penalties allowed by law, costs, post-judgment interest, and such other and further relief as the Court may deem appropriate;
- for Relators to be awarded the maximum amount allowed pursuant to California Government Code § 12651of the California False Claims Act;
- for Relators to be awarded all costs of this action, including attorneys' fees and expenses;
- and for the State of California and Relators to receive all such other relief as the Court deems just and proper.

Further, on Claims IX, X, XI, and XII, Plaintiff-Relator Ms. Hernandez, on her own behalf, demands that judgment be entered in her favor and against Defendant The Permanente Medical Group, Inc. granting the following relief:

- An award of back pay with prejudgment interest;
- An award of front pay in lieu of reinstatement;
- An award of general damages to compensate Ms. Hernandez for the mental and emotional distress caused by Defendant TPMG's misconduct;
- An award of punitive damages to deter and punish Defendant TPMG;
- An award of double, treble, exemplary, and/or punitive damages pursuant to 31 U.S.C. § 3730(h)(2), the California Labor Code, and the FLSA;
- An award of attorneys' fees and costs pursuant to 31 U.S.C. § 3730(h)(2), the California Labor Code, and the FLSA; and
- An award of such other and further relief as this Court deems just and proper.

DEMAND FOR JURY TRIAL

Relators hereby demand a trial by jury as to all issues.

Dated: February 28, 2018

Respectfully submitted,

GLORYANNE BRYANT and
VICTORIA M. HERNANDEZ

By _____

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UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA

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TAB 27

ORIGINAL

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SEALED BY ORDER OF THE COURT

FILED
NOV - 3 2016
SUSAN Y. SOONG
CLERK, U.S. DISTRICT COURT
NORTHERN DISTRICT OF CALIFORNIA
OAKLAND

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

OAKLAND COURTHOUSE

UNITED STATES OF AMERICA, *ex rel.* MARCIA STEIN and RODOLFO BONE,

Plaintiffs,

vs.

KAISER FOUNDATION HEALTH PLAN, INC., a California corporation, KAISER FOUNDATION HOSPITALS, a California corporation, KAISER FOUNDATION HEALTH PLAN OF COLORADO, a Colorado corporation, KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC., a Georgia corporation, KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., a Maryland corporation, KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, an Oregon corporation, KAISER FOUNDATION HEALTH PLAN OF WASHINGTON, a Washington corporation, THE PERMANENTE MEDICAL GROUP, INC., a California corporation, SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, a business entity, form unknown, COLORADO PERMANENTE MEDICAL GROUP, a Colorado corporation, THE SOUTHEAST PERMANENTE MEDICAL GROUP, a

CASE NO. 16-CV-05337-DMR

FIRST AMENDED COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, AND REQUEST FOR JURY TRIAL

[**UNDER SEAL** PER 31 U.S.C. § 3730(b)(2)]

Georgia corporation, HAWAII PERMANENTE MEDICAL GROUP, a Hawaii corporation, MID-ATLANTIC PERMANENTE MEDICAL GROUP, a Maryland corporation; NORTHWEST PERMANENTE, P.C., an Oregon corporation; GROUP HEALTH PERMANENTE, a Washington corporation, and KAISER PERMANENTE, a business entity, form unknown,

Defendants.

COME NOW, Plaintiffs and Qui Tam Relators Marcia Stein and Rodolfo Bone, individually and on behalf of the United States of America, and allege as follows:

JURISDICTION AND VENUE

1. Plaintiffs and Qui Tam Relators Marcia Stein and Rodolfo Bone (Relators) file this action on behalf and in the name of the United States of America (Government) seeking damages and civil penalties against the defendants for violations of 31 U.S.C. § 3729(a).

2. This Court's jurisdiction over the claims for violations of 31 U.S.C. § 3729(a) is based upon 31 U.S.C. § 3732(a).

3. Venue is vested in this Court under 31 U.S.C. § 3732(a) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3729(a) occurred in the Central District of California. Venue is also vested in this Court under 28 U.S.C. § 1391(b) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3729(a) occurred in the Central District of California.

THE PARTIES

4. Relators are citizens of the United States and residents of the State of California. Relators bring this action of behalf of the Government under 31 U.S.C. § 3730(b).

5. At all times relevant, defendants Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Foundation Hospitals (KFH) are and were corporations organized under the laws of California and transacted business in, among other places, the Central District of California.

6. At all times relevant, defendants Kaiser Foundation Health Plan of Colorado

(KFHPCO), Kaiser Foundation Health Plan of Georgia, Inc. (KFHPGA), Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHPMAS), Kaiser Foundation Health Plan of the Northwest (KFHPNW), and Kaiser Foundation Health Plan of Washington (KFHPWA) are and were corporations organized under the laws of Colorado, Georgia, Maryland, Oregon and Washington, respectively.

7. KFHP, KFHPCO, KFHPGA, KFHPMAS, KFHPNW and KFHPWA are collectively referred to as "Kaiser Health Plans."

8. At all times relevant, defendant The Permanente Medical Group (TPMG) is and was a corporation organized under the laws of California.

9. At all times relevant, defendants Southern California Permanente Medical Group (SCPMG) and Kaiser Permanente (KP) are and were business organizations, forms unknown, and transacted business in, among other places, the Central District of California.

10. At all times relevant, defendant Colorado Permanente Medical Group (CPMG) is and was a Colorado corporation.

11. At all times relevant, defendant The Southeast Permanente Medical Group (SEPMG) is and was a Georgia corporation.

12. At all times relevant, defendant Hawaii Permanente Medical Group (HPMG) is and was a Hawaii corporation.

13. At all times relevant, defendant Mid-Atlantic Permanente Medical Group (MAPMG) is and was a Maryland corporation.

14. At all times relevant, defendant Northwest Permanente, P.C. (NWP) is and was an Oregon corporation.

15. At all times relevant, defendant Group Health Permanente (GHP) is and was a Washington corporation.

16. Defendants TPMG, SCPMG, CPMG, SEPMG, HPMG, MAPMG, NWP, and GHP are collectively referred to as "Physician Medical Groups" or "PMGs."

17. Kaiser Permanente (KP) is a business entity, form unknown, that is, and at all times mentioned was, made up of three groups of interdependent entities, the Kaiser Health

Plans, KFH and the PMGs, through an exclusive contractual relationship, that operates as one the nation's largest integrated health care delivery system focused on providing managed health care services to HMO beneficiaries and to seniors through the federal Medicare Advantage health care program. The Kaiser Health Plans provide, among other things, infrastructure and support in Information Technology (IT), Human Resources (HR), Compliance, Coding, Health Information Management (HIM), and Finance to KFH and its regional hospitals, medical centers and clinics, and to the PMGs and their regional medical groups and medical clinics. KFH provides hospital facilities and services to the Kaiser Health Plans' HMO and Medicare Advantage beneficiaries, and has various infrastructure functions and departments, including but not limited to HIM. The PMGs provide medical, diagnostic and physician services to the Kaiser Health Plans' HMO and Medicare Advantage beneficiaries.

18. In California, there are two regional medical groups: (a) defendant SCPMG, consisting of California physicians providing medical services to KP patients in the areas of Ventura County and all counties south thereof; and (b) defendant TPMG, consisting of California physicians providing medical services to KP patients in all remaining counties north of Ventura County.

19. CPMG is a regional medical group consisting of physicians providing medical services in Colorado to KP patients.

20. SEPMG is a regional medical group consisting of physicians providing medical services in Georgia to KP patients.

21. HPMG is a regional medical group consisting of physicians providing medical services in Hawaii to KP patients.

22. MAPMG is a regional medical group consisting of physicians providing medical services in Maryland, Virginia and Washington, D.C. to KP patients.

23. NWP is a regional medical group consisting of physicians providing medical services is Oregon and Washington to KP patients.

24. GHP is a regional medical group consisting of physicians providing medical

services in Washington to KP patients.

25. Relator Marcia Stein (Stein) is an AHIMA Registered Health Information Administrator (RHIA) and was employed by both the SCPMG and KFH. At SCPMG worked at Panorama City as the clinic records administrator and worked at KFH's Panorama City, California hospital as the Regional Director of KFH's Health Information Managers from about October 1987 until about May 2011. Health Information Managers are professionals with expertise in managing health information systems, and processing, analyzing and reporting information vital to the operations of hospitals, medical groups, medical clinics and health plans. Typically, Health Information Managers are also responsible for training physicians, health care professionals and coders on utilizing the available health information systems, electronic health records (EHR) and correct coding and documentation practices.

26. While employed at KFH Hospital-Panorama City, Stein reported to both the regional SCPMG and the KFH Hospital-Panorama City's managements. On behalf of SCPMG, Stein supervised a staff of over 100 full-time employees, including coders, billers, trainers, clinic staff and legal assistants (with regard to physician malpractice claims), and was charged with implementing defendants' policies and procedures regarding medical record documentation and compliance, HIPAA security, and physician training and education. Stein attended monthly SCPMG Clinic Administrator and Regional Department meetings. Stein was also responsible for overseeing the Panorama City hospital's health information systems, coding, medical record documentation, HIPAA security, and related compliance issues, as well as being a contact person for various state and federal hospital data reporting questions or issues. Stein co-chaired the monthly regional HIM Director's meetings (for the Southern California Region), chairing the majority. Such meetings addressed coding and documentation problems with SCPMG senior leadership on behalf of other regional KFH HIM Directors.

27. Between 2010 and 2016, Rodolfo Bone (Bone) was a part employee of KFH at its South Bay hospital in Harbor City, California as a per diem coder. At the beginning of 2016 his position was moved to KFH's Southern California corporate offices in Pasadena, California where he continued as a per diem coder reporting to KFH's Regional Revenue

Cycle. Beginning in 1996 and continuing until the present, Bone has been employed full time by Good Samaritan Hospital, located in Los Angles California, as a Coding Supervisor and Coding Auditor. Bone was born and raised in the Philippines where he graduated from medical school, and was and is licensed to practice medicine in the Philippines.

MEDICARE ADVANTAGE AND RISK ADJUSTMENT

28. At all times relevant, the United States (Government) funded the Medicare program, administered by the Centers for Medicare and Medicaid Services (CMS), which provides payment of healthcare services for, among others, Americans 65 years of age and older. Medicare provides an option, Medicare Advantage (MA), in which eligible Medicare beneficiaries can enroll with a health plan or managed care organization (collectively, "MAO") contracted with CMS for a capitated rate paid by CMS that generally provides at least those services provided to standard fee-for-service (FFS) Medicare beneficiaries. (*See*, 42 U.S.C. § 1395w-21(a).)

29. At all times relevant, each of the Kaiser Health Plans had a MA contract with CMS, the federal agency that administers the Medicare program, to provide MA benefits to eligible enrollees. Eligible MA enrollees selected the Kaiser Health Plan in their locale and selected a primary care physician from a directory of PMG physicians near the enrollees' residence. The revenues from these MA contracts were a significant source of revenues for defendants. The revenues the PMGs received for the MA enrollees they serviced were also the primary source of funding for any physician bonuses that were paid.

30. At all times relevant, Section 1853(a)(3) of the Social Security Act [42 U.S.C. § 1395w-23(a)(3)] required the Government's Centers for Medicare and Medicaid Services (CMS) to risk adjust payments to Medicare Advantage organizations (MAOs), such as the Kaiser Health Plans. In general, the risk adjustment methodology relied on enrollee diagnoses, as specified by the International Classification of Disease, Ninth Revision Clinical Modification (ICD-9) Guidelines (ICD-9 Guidelines), to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee. Diagnosis codes (ICD-9 codes) collected from physicians and related information (collectively, "risk

adjustment data") submitted by MAOs, such as the Kaiser Health Plans, to CMS were used to develop Hierarchical Condition Category (HCC)[1] risk scores that are used by CMS to risk adjust the capitated payment rates paid by the Government to that particular MAO. The HCC risk scores compensated a MAO with a population of patients with more severe illnesses than normal through higher capitation rates. Likewise, a MAO with a population of patients with less severe illnesses than normal would see a downward adjustment of its capitation rates because it was servicing a healthier than normal population of patients. By risk adjusting MAO payments, CMS attempts to make appropriate and accurate payments for enrollees with differences in expected healthcare costs. Risk adjustment data records the health status and demographic characteristics of an enrollee.

31. In order to obtain an HCC risk adjustment score for a MA enrollee for a given year, the enrollee must have an encounter with a medical provider or examiner that generates a diagnosis code or codes, which were timely submitted to CMS. If a MA enrollee does not have a reported encounter with a medical provider or examiner that generates a diagnosis code or codes during the year, the following year, CMS will pay the MAO a capitated rate for that MA enrollee as though s/he was perfectly healthy, even though in prior years the MA enrollee had a number of diagnoses that resulted in significant HCC risk adjustment scores and correspondingly high capitation rates.

32. Risk adjustment data (RAD) submitted by or on behalf of a MAO to CMS must be supported by properly documented medical records from the encounter that led to the RAD. 42 C.F.R. §§ 422.310(c)(2) and (d), 422.504(l); Medicare Managed Care Manual, Ch. 7, § 40 [Medicare Advantage Organizations "must . . . [e]nsure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes must be documented in the medical record and must be documented as a result fo a face-to-face visit. . . ."]; *see also,* 79 Fed.Reg. No. 100, 29844, 29923 (May 23, 2014) ["Further, CMS has required for many years that

[1]Not all diagnoses result in a HCC risk score. Only certain diagnosis codes or combinations thereof result in HCC risk scores. CMS reviews and publishes the list of relevant ICD-9 diagnosis codes and their related HCC coefficients annually. A HCC risk score will vary upon the diagnosis codes or combinations thereof according to a matrix determined by the Government.

diagnoses that MA organizations submit for payment be supported by medical record documentation."] In order to be a properly documented medical record, the medical record entries must, among other things, (1) be the result of a MA enrollee's face-to-face encounter with a medical provider or examiner legally authorized to perform the service rendered under applicable Medicare laws, regulations and rules,[2] (2) that accurately and truthfully documents the findings necessary to support the medical diagnoses by the medical provider/examiner in accordance with applicable Medicare laws, regulations and rules,[3] and (3) signed by the medical provider/examiner as required by Medicare.[4] Further, the diagnoses must be coded in accordance with all applicable national guidelines, including but not limited to International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting, and the American Health Information Management Association (AHIMA) national guidelines for ethical coding.[5] AHIMA is a member of the ICD9CM and the ICD10CM Cooperating Parties, thus their practice briefs are considered "industry standards." Failure to meet any of these required elements results in the medical record not being properly documented and being unable to support RAD arising therefrom and invalidating the submission of such RAD (i.e., ICD-9 diagnosis codes).

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[2]*See,* Medicare Managed Care Manual, Ch. 7, § 40 ["All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. . . . "]; 42 U.S.C. § 1395x(r) , (aa)(5)(A), (aa)(6); 42 C.F.R. §§ 410.20(b), 410.74(a)(2), 410.75(b)-(c), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d).

[3]42 C.F.R. §§ 422.310(c)(2) and (d), 422.504(l)(2)-(3); CMS Pub.100-08, Medicare Program Integrity Manual, Ch. 3, §3.3.2.5; International Classification of Disease 9th Revision Guidelines (ICD-9), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d), and Medicare Managed Care Manual, Ch. 7, § 40 ["The diagnosis must be coded according to International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting."]

[4]Medicare Program Integrity Manual, Ch. 3, §3.3.2.4, made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d).

[5]42 C.F.R. § 422.310(d)(1) ["MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. . . ."]; Medicare Managed Care Manual, Ch. 7, § 40 ["The diagnosis must be coded according to International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting."]; AHIMA 2009, Amendments, Corrections ans Deletions in the electronic Health Record: Toolkit, pp. 1-8, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678; Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A)-(B).

33. MAOs do not typically submit claims for services rendered to CMS in the traditional FFS sense. The capitation payments are paid in advance, and by accepting the capitated payments, MAOs agree to be at risk for all of the health care costs for the MA enrollees assigned to it. Capitation payments are made prospectively with the data for the current calender year being used to risk adjust the capitation payments for that specific MA enrollee in the subsequent calender year. Instead of submitting traditional FFS claims, MAOs submit RAD which are used by CMS to calculate and risk adjust the capitation payments paid by CMS to the MAOs for each MA enrollee. Because the capitation payments are adjusted based upon the MAOs' submission of RAD, the submission of RAD is considered by the Government as the submission of claims for payment to CMS for purposes of enforcing civil and criminal penalties for making false claims under Social Security Act §§1128A [42 U.S.C. § 1320a–7a], 1128 B [42 U.S.C. § 1320a–7b] and the False Claims Act, 31 U.S.C. § 3729.

34. CMS has made it clear that MAOs, such as the Kaiser Health Plans, "must be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and "are expected to have effective and appropriate payment evaluation procedures and effective compliance programs as a way to avoid receiving or retaining overpayments." Additionally, "we [CMS] have always expected that MA organizations or Part D sponsors implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29,884, 29,921, 29,923-29,924 (May 14, 2014).)

35. The MA program requires MAOs provide, at a minimum, all of the benefits available under original Medicare (Parts A and B). The MA program incorporates into it all of the coverage determinations, rules and regulations of Medicare Parts A and B unless such regulations are specifically altered or superceded by the Medicare Part C regulations that specifically govern the MA program.

36. As will be explained in detail below, at various times during and between 2010 and the present, the defendants submitted false and fraudulent claims to CMS in violation of 31 U.S.C. § 3729(a) by (a) making and submitting to CMS false, inaccurate and exaggerated

diagnoses for sepsis that were not supported by properly documented medical records, (b) making and submitting to CMS false, inaccurate and exaggerated diagnoses for malnutrition that were not supported by properly documented medical records, (c) making and submitting to CMS false, inaccurate and exaggerated diagnoses for aortic atherosclerosis that were not supported by properly documented medical records, (d) making and submitting to CMS diagnoses resulting from improper and unethical leading physician queries, (e) performing medical record reviews designed to only identify and report to CMS previously unreported diagnosis codes that concealed and failed to withdraw from CMS previously reported diagnosis codes that were unsupported by the reviewed medical records, and (f) providing medically unnecessary and non-covered routine physical examinations in order to identify and submit invalid RAD for use in calculating Kaiser Health Plans' capitation payments to CMS.

37. Although the majority of Kaiser's Medicare patients are beneficiaries under the MA program, approximately 20% of Kaiser's Medicare patients are beneficiaries under original fee-for-service (FFS) Medicare, i.e., Medicare Part A and/or Part B. Defendants' fraudulent misconduct alleged below concerning sepsis and malnutrition (briefly mentioned in paragraph 36(a)-(b)) involved Kaiser's FFS Medicare patients and MA patients. Inpatient hospital facilities, such as KFH, billed CMS for FFS Medicare services by mapping ICD-9 and later ICD-10 diagnosis codes into diagnostic related groups (DRGs), major complications and co-morbidities (MCCs), each of which is assigned a monetary value by CMS depending, in part, on the county where the hospital is located. In FFS Medicare hospital billing, DRGs are primary diagnoses and MCCs are secondary diagnoses. Some but not all MCCs cause an increase in the DRG's value.

SEPSIS

38. The current lay-person definition of sepsis and sepsis with acute organ failure (collectively, "Sepsis") is "Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs." (The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3), *JAMA*, (February 23, 2016) Vol. 315, No. 8, 801, 807.) "Sepsis is not a specific illness but rather a syndrome

encompassing a still-uncertain pathobiology. At present, it can be identified by a constellation of clinical signs and symptoms in a patient with suspected infection." (*Id.* at 803.) Sepsis is characterized by "signs of inflammation (vasodilator, leukocyte accumulation, increased micro vascular permeability) occurring in tissues that are remote from the infection. Systemic inflammatory response syndrome (SIRS) is an identical clinical syndrome that complicates a noninfectious insult (e.g., acute pancreatitis, pulmonary contusion).... This response can lead to multiple organ dysfunction syndrome (MODS), which is the cause of the high mortality associated with these syndromes." (Sepsis Definitions: Time for Change, *Lancet,* (March 2, 2013), Vol. 381, No. 9868, 774–775 (See, http://doi.org/10.1016/S0140-6736(12)61815-7).)

39. The term Sepsis is usually reserved for patients that need to be admitted to the hospitals intensive care unit (ICU). (See, Sepsis Definition: Time For Change, *Lancet* (March 2, 2013) Vol. 381, No. 9868, pp. 774–775.) Patients who develop Sepsis face a substantial likelihood of death as it is one of the main causes of death among hospital patients. Sepsis has been estimated to be the cause or related to of as many as 1 out of every 2 to 3 in-patient hospital deaths. (Hospital Deaths in Patients With Sepsis From 2 Independent Cohorts, *JAMA,* (July 2, 2014) Vol. 312, No. 1, 90-92 at p. 90. (See, http://jama.jamanetwork.com/article .aspx?articleid=1873131).) During 2009, the national mean length of stay for patients who had Sepsis as their principal diagnosis was 8.8 days and 15.8 days for patients with Sepsis as a secondary diagnosis. (Agency for Healthcare Research and Quality (AHRQ), HealthCare Cost and Utilization Project (H-CUP), Statistical Brief #122, p. 4 (October 2011).)

40. During 1991, the American College of Chest Physicians (ACCP) and the Society of Critical Care Medicine (SCCM) convened a Sepsis "Consensus Conference" the purpose of which, "[I]s to propose a conceptual framework for future studies of the clinical phenomenon of organ system dysfunction in critical illness, and to lay the foundations for common terminology and criteria to describe the syndrome." (The ACCP/SCCM Consensus Conference Statement - 1991, *Chest*, (June 1992) Vol. 101, 1644, 1648.) In other words, to provide some broad definitions of Sepsis so that researches could conduct effective clinical trials. (*See,* 2001 International Sepsis Definitions Conference, *Intensive Care Med.,* (March

28, 2003) Vol. 29, 530, 531.) The 1991 Consensus Conference introduced into common parlance the term "systemic inflammatory response syndrome" (SIRS). The term provided a reference for the complex findings that result from a systemic activation of the innate immune response, regardless of cause. (*Id.*) "This systemic inflammatory response can be seen following a wide variety of insults and includes, but is not limited to, more than one of the following clinical manifestations:

– Body temperature higher than 38°C or lower than 36°C

– Heart rate higher than 90/min

– Hyperventilation evidenced by respiratory rate higher than 20/min or PaCO2lower than 32 mmHg

– White blood cell count higher than 12,000 cells/ µl or lower than 4,000/ µl

These physiologic changes should represent an acute alteration from baseline in the absence of other known causes for such abnormalities. . . ." (The ACCP/SCCM Consensus Conference Statement - 1991, *Chest*, (June 1992) Vol. 101, 1644, 1645.) The SIRS concept has been globally adopted by clinical investigators resulting in approximately 800 research articles about SIRS and/or Sepsis between 1992 and 2002.

41. The 1991 Consensus Conference introduced the concept that Sepsis is the body's inflammatory response to infection. The conference concluded that patients with elevations in at least two of four variables that are indicators of inflamation (temperature, heart rate, respiratory rate, and white blood cell count) were suspect of having SIRS, and that patients with elevations in at least two of the four variables and an infection were potential indicators of sepsis. However, the Consensus Conference instructed physicians **not** to use the SIRS criteria plus infection as a diagnostic standard, "To help identify these manifestations as sepsis, it should be determined whether they are a part of the direct systemic response to the presence of an infectious process. Also, the physiologic changes measured should represent an acute alteration from baseline **in the absence of other known causes for such abnormalities**." (Emphasis added; The ACCP/SCCM Consensus Conference Statement - 1991, *Chest*, (June 1992) Vol.101, 1644, 1646.)

42. In 2001, the definitions of sepsis and SIRS were revisited at the International Sepsis Definitions Conference sponsored by the ACCP, SCCM, the European Society of Intensive Care Medicine (ESICM), the American Thoracic Society (ATS), and the Surgical Infection Society (SIS). The 2001 International Sepsis Definitions Conference ("2001 Conference") goals included identification of ways to improve the current sepsis definitions and to identify methodologies for increasing the accuracy, reliability, and/or clinical utility of the diagnosis of sepsis. (2001 International Sepsis Definitions Conference, *Intensive Care Med.*, (March 28, 2003) Vol. 29, 530, 531.) The 2001 Conference addressed at length the short-comings of the then current sepsis and SIRS definitions. The SIRS criteria had been found to have no practical use to a clinician for diagnosing Sepsis and concluded, among other things, "[T]he specific criteria proposed in the 1992 consensus definitions are widely considered to be too nonspecific to be of utility in diagnosing a cause of the syndrome or in identifying a distinct pattern of host response."[6] (2001 International Sepsis Definitions Conference, *Intensive Care Med.*, (2003) Vol. 29, 530, 532.) The final Report from the 2001 Conference further concluded, "Unfortunately a clinically useful set of criteria for diagnosing sepsis and related conditions will necessarily be somewhat arbitrary. There is no 'gold standard' (such as the infarcted myocardium) against which the diagnostic criteria can be calibrated." (*Id.* at 532.)

43. Although the 2001 Conference did not result in a new definition of sepsis, it clarified that SIRS criteria were not intended to be used as a physician diagnostic tool but rather a starting point for researchers to identify clinical trials participants. (*Id.* at 532.) In response to the limitations noted of the SIRS definition, the 2001 Conference Report stated that clinical findings such as, "[H]emodynamic instability, arterial hypoxemia, oliguria, coagulopathy, and altered liver function tests among the list of criteria that can be used to

[6]The 2001 International Sepsis Definitions Conference cited the work of J.C. Marshall who concluded, "The four criteria that define SIRS are non-specific measures of physiologic severity, rather than distinctive manifestations of a disease process....However, the complexity of the biologic processes involved suggest that a clinical syndrome of systemic inflammation is of no more use to the clinician than a clinical syndrome of cancer." (SIRS and MODs: What is Their Relevance to the Science and Practice of Intensive Care, *Shock*, (December 2000) Vol. 12, No. 6, 586-9.

establish the diagnosis of sepsis." (*Id.* at 533.) The Report included an expansive list of possible signs, symptoms and potentially sceptic values, grouped into five main categories, General Parameters, Inflammatory Parameters Hemodynamic Parameters, Organ Dysfunction Parameters, and Tissues Perfusion Parameters, to aid physicians in making and confirming Sepsis as opposed to less severe medical conditions.[7] (*Id.* at 533-34.)

44. The Report emphasized that its expanded list of clinical findings were not specific to sepsis and therefore, like the SIRS criteria, the list could not be used as a diagnostic standard in all cases. The physician still had to determine if a medical condition other than sepsis was the cause of the patient's symptoms and/or elevated values before diagnosing sepsis or sepsis acute organ failure, when applicable, and separately determine if such organ failure was a result of Sepsis or some other cause. Other medical conditions besides Sepsis can also

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[7]The complete list of Sepsis diagnostic criteria was stated as Infection documented or suspected and some of the following:

> General parameters
> Fever (core temperature >38.3°C) Hypothermia (core temperature <36°C Heart rate >90 bpmor >2 SD above the normal value for age Tachypnea: >30 bpm Altered mental status Significant edema or positive fluid balance (>20 ml/kg over 24 h) Hyperglycemia (plasma glucose >110 mg/dl or 7.7 mM/l) in the absence of diabetes
>
> Inflammatory parameters
> Leukocytosis (white blood cell count >12,000/µl) Leukopenia (white blood cell count <4,000/µl) Normal white blood cell count with >10% immature forms Plasma C reactive protein>2 SD above the normal value Plasma procalcitonin >2 SD above the normal value
>
> Hemodynamic parameters
> Arterial hypotensionb (systolic blood pressure <90 mmHg, mean arterial pressure <70, or a systolic blood pressure decrease >40 mmHg in adults or <2 SD below normal for age) Mixed venous oxygen saturation >70%b Cardiac index >3.5 l min 1 m 2c,d
>
> Organ dysfunction parameters
> Arterial hypoxemia (PaO2/FIO2 <300) Acute oliguria (urine output <0.5 ml kg 1 h 1 or 45 mM/l for at least 2 h) Creatinine increase 0.5 mg/dl Coagulation abnormalities (international normalized ratio >1.5 or activated partial thromboplastin time >60 s) Ileus (absent bowel sounds) Thrombocytopenia (platelet count <100,000/µl) Hyperbilirubinemia (plasma total bilirubin >4 mg/dl or 70 mmol/l)
>
> Tissue perfusion parameters
> Hyperlactatemia (>3 mmol/l) Decreased capillary refill or mottling

account for increases in the 2001 Conference criteria including, but not limited to, post operative surgery recovery, minor respiratory infections, minor urinary tract infections, trauma as well as certain medications. The Report stressed, "It is important that as a practitioner 'checks off the boxes' to establish the diagnosis of sepsis; only findings that cannot be easily explained by other causes should be included." *Id.* "Most clinicians do not refer to patients as septic when they develop an uncomplicated mild upper-respiratory viral infection with slight fever and tachycardia, (i.e., a faster than normal heart rate.)" (Sepsis Definitions: Time For Change, *Lancet*, March 2, 2013, Vol. 381, No. 9868, 774–775.)

45. Between 2001 and 2010 several organized approaches to identify and treat Sepsis were proposed. The two most prominent of these organized treatment approaches were Early Goal-Directed Therapy for the treatment of Sepsis and Sceptic Shock (EGDT) published in the New England Journal of Medicine (N Engl J Med (November 8, 2001) Vol. 345, 1368-1377), and continuing since 2002, the Surviving Sepsis Campaign, a joint collaboration of the Society of Critical Care Medicine and the European Society of Intensive Care Medicine. The Surviving Sepsis Campaign (SSC) published and continuously updated Surviving Sepsis Bundles that outline the basic treatment protocols along with detailed treatment guidelines to provide institutions and physicians with a coordinated effort to measure and manage each of the five parameters for diagnosing Sepsis identified in the 2001 Conference (i.e., General Parameters, Inflammatory Parameters Hemodynamic Parameters, Organ Dysfunction Parameters, and Tissues Perfusion Parameters). During or about 2013, the SSC's Surviving Sepsis Bundles and guidelines were adopted by CMS and Center For Disease Control (CDC).

46. The SSC Surviving Sepsis Bundle states:

TO BE COMPLETED WITHIN 3 HOURS:

1) Measure lactate level
2) Obtain blood cultures prior to administration of antibiotics
3) Administer broad spectrum antibiotics
4) Administer 30 ml/kg crystalloid for hypotension or lactate 4mmol/L

"Time of presentation" is defined as the time of triage in the emergency department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements of severe sepsis or septic shock ascertained through chart review.

TO BE COMPLETED WITHIN 6 HOURS:

5) Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) 65 mm Hg
6) In the event of persistent hypotension after initial fluid administration (MAP < 65 mm Hg) or if initial lactate was 4 mmol/L, re-assess volume status and tissue perfusion and document findings according to Table 1.
7. Re-measure lactate if initial lactate elevated.

TABLE 1

DOCUMENT REASSESSMENT OF VOLUME STATUS AND TISSUE PERFUSION WITH:

EITHER:

• Repeat focused exam (after initial fluid resuscitation) including vital signs, cardiopulmonary, capillary refill, pulse, and skin findings.

OR TWO OF THE FOLLOWING:

• Measure CVP
• Measure ScvO2
• Bedside cardiovascular ultrasound
• Dynamic assessment of fluid responsiveness with passive leg raise or fluid challenge. (http://www.survivingsepsis.org/Bundles/Pages/default.aspx.)

47. The SSC guidelines and EGDT each contemplate that physicians timely diagnose Sepsis, take multiple blood samples prior to the administration of antibiotics for obtaining an accurate blood culture, monitor and managing the patients fluid retention, monitor arterial pressure via central venous catheter (i.e. an arterial catheter placed in the Vena Cava artery) administer IV fluids, measure and adjust lactate levels (a precursor to organ failure), and administer various medications including, but not limited to, antibiotics to fight the infection, and vasopressors and corticosteroids, as needed, to manage fluid retention and prevent organ failure.[8] (Early Goal-Directed Therapy for the treatment of Sepsis and Sceptic Shock, *N Engl J Med,* (November 8, 2001) Vol. 345, 1368-1377; http://www.survivingsepsis.org/Guidelines/Pages/default.aspx.) Typically, MA enrollees that have a central venous catheter inserted are admitted to or already in the ICU.

[8]In 2015, based on the best available evidence, the Surviving Sepsis Bundle was updated making the use of a central venous catheter to monitor blood oxygen or pressure levels optional instead of required.

48. The SSC's detailed treatment guidelines, provided in conjunction with the Surviving Sepsis Bundles, include but are not limited to: Initial Resuscitation and Infection Issues; Hemodynamic Support and Adjunctive Therapy; Blood Product, Immunoglobulins and Selinum Administration; Mechanical Ventilation of Sepsis-Induced Acute Respiratory Distress Syndrome (ARDS); Sedation, Analgesia, and Neuromuscular Blockade; Glucose Control; Renal Replacement Therapy; Bicarbonate Therapy; Deep Vein Thrombosis Prophylaxis; Stress Ulcer Prophylaxis; and Nutrition to address various patient responses and provide treatment options. (Id.) Administering such complex Sepsis treatments routinely take place in the hospital's ICU. (*Id.*)

49. Based on the 2001 Conference's final report, during 2003 the ICD-9 Guidelines and the ICD-9 codes were modified to include the 2001 International Sepsis Definition Conference's expanded list of sepsis and sepsis with acute organ failure, resulting in a more expansive and detailed diagnostic and coding scheme for properly documenting and coding Sepsis. The ICD-9 Guidelines explain in detail the precise sequence of steps required to properly code the various stages of Sepsis, including but not limited to, sepsis, sepsis with organ dysfunction, sepsis with multiple organ dysfunction, sepsis caused by various types of infections, and septic shock. (*ICD-9-CM Official Guidelines for Coding and Reporting*, §I.C.1.b.1.-12.) Further, the ICD-9 Guidelines repeatedly stress that coders will likely have to query physicians when documenting Sepsis to trigger proper documentation that supports the Sepsis diagnosis due the complex nature of those diseases.[9] While the ICD-9 Guidelines explain the minium information required for coders to properly record a particular ICD-9 diagnosis code, it does not explain to the physician all of the steps and criteria for making a

[9]The ICD-9 Guidelines state, "Due to the complex nature of sepsis and severe sepsis, some cases may require querying the provider prior to assignment of the codes." §I.C.1.b.1.c. "If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign code 995.92, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider." §I.C.1.b.5. "Sepsis or severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether the sepsis or severe sepsis was present on admission, the provider should be queried." §I.C.1.b.2.c.

particular diagnosis. It is not uncommon for the medical standard of care to be more detailed and complex than the ICD-9 Guidelines.

50. On or about February 23, 2016, JAMA published the Report of The Third International Sepsis Definitions Conference. This Third Sepsis Definitions Conference (Sepsis-3) adopted a new definition of Sepsis that was consistent with the current state of the medical practice and research since the 2001 Conference. "The task force sought to differentiate sepsis from uncomplicated infection and to update definitions of sepsis and septic shock to be consistent with improved understanding of the pathobiology.... The sepsis illness concept is predicated on infection as its trigger, acknowledging the current challenges in the microbiological identification of infection. . . . The task force recognized that sepsis is a syndrome without, at present, a validated criterion standard diagnostic test." (The Third International Consensus Definitions for Sepsis and Septic Shock, *JAMA* (Feb. 2016) Vol. 315, No. 8, 801, 803.) The new sepsis definition from Sepsis-3 was stated as:

> In lay terms, sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs.
>
> Patients with suspected infection who are likely to have a prolonged ICU stay or to die in the hospital can be promptly identified at the bedside with qSOFA, ie, alteration in mental status, systolic blood pressure 100 mm Hg, or respiratory rate 22/min.
>
> Septic shock is a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality.
>
> Patients with septic shock can be identified with a clinical construct of sepsis with persisting hypotension requiring vasopressors to maintain MAP 65 mm Hg and having a serum lactate level >2 mmol/L (18 mg/dL) despite adequate volume resuscitation. With these criteria, hospital mortality is in excess of 40%. Abbreviations: MAP, mean arterial pressure; qSOFA, quick SOFA; SOFA: Sequential [Sepsis-related] Organ Failure Assessment. (*Id.* at 805.)

The Sepsis-3 Report concludes that, "The current use of 2 or more SIRS criteria to identify sepsis was unanimously considered by the task force to be unhelpful. Changes in white blood cell count, temperature, and heart rate reflect inflammation, the host response to 'danger' in the form of infection or other insults. The SIRS criteria do not necessarily indicate a dysregulated, life-threatening response. SIRS criteria are present in many hospitalized patients, including those who never develop infection and never incur adverse outcomes." (*Id.*) This

conclusion is very similar to the conclusions published from the 2001 Conference. (2001 International Sepsis Definition Conference, *Intensive Care Med.* (2003) Vol. 29, 530, 532-4.) A further change was to abandon the use of the term "severe sepsis," i.e., sepsis with organ dysfunction, because all sepsis cases are severe due to their potential to cause death. Lastly, the Sepsis-3 Report recognized that Septic Shock, i.e., sepsis involving multiple organ failure, has an even higher likelihood of patient death than sepsis. In an e-mail to its staff dated March 8, 1016, KFHP unequivocally rejected the modern Sepsis-3 definitions and diagnostic recommendations.

DEFENDANTS' FRAUDULENT MISCONDUCT

51. During and between approximately 2010 to the present, SCPMG, TPMG, KFH and KFHP participated in a fraudulent scheme to up-code and falsely diagnose MA enrollees with sepsis and/or severe sepsis, i.e., sepsis with acute organ failure, (collectively referred to as "Sepsis") when Sepsis was not present. Such false Sepsis diagnoses were made in order to increase the risk adjustment scores for the MA enrollees so diagnosed and thereby increase CMS's capitation payments to KFHP. This scheme was also promoted by KFHP to falsely lower KFHP's reported Sepsis mortality rates thereby improve KFHP's reputation and prestige as a quality hospital provider. This fraudulent scheme concerned the identification and treatment of Sepsis for KFHP's MA enrollees that presented in the emergency room (ER) of KFH hospitals and was accomplished by (a) KFHP, PMG and SCPMG and KFH implementing unwritten policies that prohibited coders employed by KFHP, KFH, SCPMG and TPMG, (individually and collectively referred to as "Kaiser's coders") from performing physician queries for Sepsis diagnoses as required by the ICD-9 Guidelines, (b) implementing unwritten policies requiring Kaiser's coders to code ICD-9 diagnosis codes for Sepsis based solely on the physician's instructions to code Sepsis instead of relying on the supporting clinical findings documented in the medical record, (c) using an improper Sepsis diagnostic standard that overstated the frequency of Sepsis diagnoses, (d), aggressively diagnosing Sepsis as part of a strategy to lower the reported Sepsis mortality rate at KFH hospitals throughout California, and (e) KFHP, TPMG and SCPMG, as an express condition of receiving capitation payments from

CMS, routinely and annually falsely certifying that such ICD-9 diagnosis codes for Sepsis were accurate, complete and truthful to their best knowledge, information and belief, required by CMS as a condition of receiving payment, when KFHP, TPMG and SCPMG knew or should have known that such certifications were false.

52. During or about 2008 and 2009, TPMG and SCPMG adopted unwritten policies instructing Kaiser's coders to code Sepsis based upon a physician's instruction to code Sepsis and prohibiting Kaiser's coders from performing coding queries regarding Sepsis diagnoses. Kaiser's coders are required to perform coding queries by the ICD-9 Guidelines and AHIMA's Ethical Coding Guidelines when such queries are needed to trigger clinical documentation required to properly support or to properly rule out a Sepsis diagnosis.

53. In 2009, several KFHP HIM directors from Southern California KFH hospitals including the HIM Director for KFH Hospital-Woodland Hills, Vivian Wachs, Registered Health Information Technician (RHIT), informed Stein, co-chair of the Southern California Region monthly HIM meetings, and all of the HIM Directors in attendance, that their local SCPMG physician leadership was insisting that Sepsis be coded at the physician's discretion and without supporting clinical findings properly documented in the medical record as required by the ICD-9 Guidelines and by CMS. (42 C.F.R. §422.310(b)-(d); CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq.) In response, Stein requested and was granted permission by Dr. Kirk Tamaddon, SCPMG's Chief Regional Physician Liaison, who chaired the SCPMG regional meetings, to make a presentation on Sepsis coding guidelines and Sepsis medical record documentation requirements at the October 2009, SCPMG physician leadership meeting.[10] In addition to Dr. Tamaddon, the meeting was attended by at several SCPMG Regional Medical Directors, and several Regional Operational Directors, approximately 15 SCPMG Physician Liaisons and/or physician representatives and 20 SCPMG Data Quality Managers and Encounter Coding Specialists.

54. Stein's presentation explained, among other things, that all of the symptoms and

[10]Physician Liaisons are responsible for implementing monitoring and communicating to physicians and staff the PMG's regional directives regarding coding and documentation.

clinical findings that supported a diagnosis of Sepsis and all clinical findings and test results that support a diagnoses of organ dysfunction caused by Sepsis had to be documented in the medical records. Additionally, because of the complexity of the diagnoses, it was likely that Kaiser's coder needed to clarify the clinical findings and symptoms by making queries to physicians intended to trigger clarifying responses of the medical record's supporting documentation. Shortly after Stein finished her presentation, Dr. Albert Dreskin, SCPMG's Woodland Hill's Physician Liaison, informed the attendees to disregard the presentation Stein had just given, falsely asserting that SCPMG physicians had no requirement to provide additional clinical documentation for a Sepsis diagnoses because Sepsis was a clinical decision therefore all that was required was for the physician to write Sepsis. Dr. Dreskin concluded his remarks by reminding the attendees that diagnosing Sepsis was worth a lot of money to the defendants because it increased the MA enrollees' risk adjustment scores. In fact, the submission of the ICD-9 diagnosis code for sepsis resulted in a HCC risk score of.754 which increased the capitation payments for each such diagnosed MA enrollee by approximately $8,500 for the next year.

55. Following the October 2009 SCPMG physician leadership meeting and continuing through to the present, SCPMG physician and coding leadership routinely insisted that Sepsis be coded whenever the physician wrote the word Sepsis in the medical record and prohibited Kaiser's coders from making coding queries to clarify the supporting medical record documentation. Such coding instructions and query restrictions violate ICD-9 Guidelines and AHIMA ethical coding guidelines. The blatantly improper coding practice was unique to the defendants' coding and documentation of Sepsis. Kaiser's coders did not have such coding instructions or query restrictions with regards to any other diagnoses. Stein witnessed these improper Sepsis coding policies at KFH Hospital-Panorama City and was informed by other HIMs that such polices were adopted by the defendants throughout KP's Southern California region.

56. Throughout the term of his employment at KFH Hospital-South Bay, Bone had been instructed that he was **not** to query physicians regarding Sepsis diagnoses and was

required to code Sepsis as instructed by the physician regardless of the medical record documentation. Bone had learned from other coders that such Sepsis coding instructions and query restrictions had been adopted by the defendants throughout KP's Southern California region. Stein and Bone are informed and believe, and upon such information and belief alleges, that the SCPMG's policy to prohibit physician queries of Sepsis diagnoses and to require Kaiser's coders to code Sepsis based on the physician's instructions (as opposed to the supporting clinical findings documented in the medical record) originated with TPMG and then was implemented by SCPMG during or about 2009.

57. As part of KP's national agenda to lower its reported Sepsis mortality rates at KFH hospitals, during or about 2009, KFHP and TPMG implemented Sepsis identification and treatment protocols that were then implemented by SCPMG on or about 2011 and eventually by all PMGs. These Sepsis treatment protocols were purportedly based upon the EGDT treatment protocols. These Sepsis diagnostic criteria improperly used the Sepsis definition promulgated at the 1991 Consensus Conference, i.e., Sepsis is SIRS plus infection, as a diagnostic standard, even though by 2009 it was well established the SIRS criteria could not be properly used as a diagnostic standard. Specifically, defendants' Sepsis diagnostic standard required an elevated value in two or more SIRS criteria plus an infection to diagnose Sepsis.

58. As discussed above in paragraph 40, the 1991 Sepsis definition was adopted to assist researchers identify subjects to participate in clinical trials and promote Sepsis research. By 2001 it was well established that Sepsis could not be diagnosed just be using the SIRS criteria plus infection (i.e., whenever two or more SIRS criteria were elevated and the patient had an infection) because such criteria applies to many patients who are suffering less severe conditions than Sepsis. Instead, the SIRS criteria potentially diagnosed Sepsis only when no other possible explanation or medical condition that accounted for the elevated levels. (The ACCP/SCCM Consensus Conference Statement - 1991, *Chest,* June 1992, Vol.101, 1644, 1646.) The 2001 Conference published an expanded list of criteria to diagnose Sepsis but concluded that these criteria, like the SIRS criteria, were not specific to Sepsis so such criteria could not be adopted as a diagnostic "gold standard" that could be used conclusively in every

instance. The physician still had to make a judgment call to determine if the symptoms were the result of the patient having a life threatening inflammatory response to infection that potentially threatened to shut down organs resulting in death, i.e., Sepsis, or had some less severe medical condition that explained the abnormal criteria values.

59. Defendants, in adopting a diagnostic standard based on two elevated SIRS criteria, ignored the then current standard of medical care by not including the well accepted expanded criteria from the 2001 Conference to diagnose Sepsis and to diagnose Sepsis with acute organ failure. (2001 International Sepsis Definitions Conference, *Intensive Care Med.* (2003) Vol. 29, 530, 532.) By 2009, such the 2001 Conference Sepsis diagnostic criteria had become, the very well accepted, Surviving Sepsis Bundles and related guidelines endorsed by CMS, the CDC and internationally. Defendants' Sepsis diagnostic standard also disregards the 2001 Conference's conclusions which unequivocally stated that the SIRS criteria were overly broad, too sensitive and nonspecific for sepsis making them unsuitable for use as a diagnostic standard. A conclusion that also was well accepted by the then concurrent and future medical literature.

60. Despite these flaws, Defendants nonetheless adopted the SIRS criteria as a diagnostic standard for KP's national Sepsis program knowing that using the SIRS diagnostic standard results in false and inaccurate Sepsis diagnoses. KP's physician training materials regarding diagnosing Sepsis failed to instruct KP's physicians **not** to diagnose Sepsis if the elevated SIRS criteria were due to a condition other than Sepsis, failed to instruct physicians to perform timely blood draws, i.e., prior to the administration of antibiotics, so accurate blood cultures are obtained (required to identify blood-born pathogens) and fails to discuss or incorporate any of the additional Sepsis diagnostic criteria from the 2001 International Sepsis Definitions Conference that physicians are suppose to use in making a Sepsis diagnosis.

61. KP's adoption of improper Sepsis specific coding policies, (i.e., policies that required Kaiser's coders to code Sepsis based on the physician's instruction and also prohibited Kaiser's coders from making coding queries regarding Sepsis diagnoses), ensured that the Kaiser Health Plans submitted false and inaccurate Sepsis diagnoses to CMS as valid RAD.

Such improper coding policies were and are unique to Sepsis and violate the ICD-9 Guidelines and AHIMA ethical coding Guidelines. For all other syndromes, diseases, illnesses or injuries, Kaiser's coders were able to perform coding queries without restrictions. Sepsis is the only diagnoses that Kaiser's coders were not allowed to use coding queries to clarify the supporting documentation in the medical record.

62. During and between 2010 and 2014, while working at KFH Hospital-South Bay, Bone coded approximately three to four Sepsis diagnoses a week for MA enrollees that were not admitted to the ICU or the hospital but were discharged home after being put in an observation bed for between 3 to 48 hours. Such MA enrollees were not treated aggressively for Sepsis per KP's Sepsis treatment protocols, including but not limited to, failing to insert a central venous catheter not was not inserted and blood draws were not taken prior to the administration of antibiotics to obtain blood cultures. During this time period, Bone also routinely coded Sepsis diagnoses for MA enrollees who were not admitted to the ICU but were admitted to the hospital for a brief stay of up to three days. Such MA enrollees typically were not treated aggressively for Sepsis per KP's Sepsis treatment protocols, including but not limited to, failing to insert a central venous catheter and failing to perform blood draws prior to the administration of antibiotics to obtain blood cultures. Bone observed, that the medical records of MA enrollees diagnosed with Sepsis, but not admitted to the hospital and MA enrollees admitted to the hospital for a brief stay but were not treated for Sepsis aggressively, did not have sufficient clinical findings documented in their medical records that supported the Sepsis diagnoses.

63. The fact that MA enrollees that were diagnosed with Sepsis in the ER but discharged without being admitted to the ICU or the hospital is a strong indication that such MA enrollees did not have Sepsis, and that such Sepsis diagnosis and coding were false. It is not credible that an MA enrollee is diagnosed with sepsis and/or sepsis with acute organ failure does not require an admission to the ICU for treatment let alone is discharged without ever being admitted to the hospital. Rather, such MA enrollees did not have Sepsis and the ER observations confirmed this fact allowing the physician to confidently send the MA enrollee

home without admission to the hospital or ICU. The above reasoning also applies to the Kaiser Health Plans' MA enrollees that were not admitted to hospital ICU but instead just admitted to hospital for a brief stay, of one to three days, that did not receive aggressive treatment for Sepsis according to KP's treatment protocols prior to being discharged home.

64. As a result of KP's emphasis on diagnosing Sepsis and adopting an improper and overly broad Sepsis diagnostic standard, the number of Sepsis diagnoses by PMG and SCPMG physicians, between 2009 and 2013, increased dramatically at all California KFH hospitals; as much as, between 200% to 300% at some facilities. This increase in the number of Sepsis diagnoses had the effect of dramatically lowering KFH California Hospital's reported Sepsis mortality rates. The reported Sepsis mortality rates were a ratio comparing the number of Sepsis cases diagnosed at KFH Hospitals to the number of patients that expired as a result of having Sepsis. As such, the reported Sepsis mortality ratio was easy to manipulate by increasing the number of Sepsis diagnoses with false Sepsis diagnoses. By 2013, KP claimed that its reported Sepsis mortality rate had dropped to approximately 9% and its average length of stay for such cases had dropped to 3.5 days. . (An Innovative Approach to Sepsis Prevention Saves Lives, (Dec 6, 2013) https://businesshealth.kaiserpermanente. org/insights /sepsis-prevention.) KP's reported Sepsis mortality rate and average length of stay during 2010 through 2013 are unrealistic numbers and an indication that the Kaiser Health Plans submitted false Sepsis diagnoses. As discussed below in greater detail, at least one KP physician complained, challenging the validity of KP's reported sepsis mortality rates. A recent landmark study comparing the difference in effectiveness between EGDT treatment protocols and traditional treatment methods, when properly implemented using hospital systems with best practices, achieved sepsis mortality rates of 19%-20%. (A Randomized Trial of Protocol-Based Care for Early Septic Shock, The ProCESS Investigators, *N Engl J Med* (July 24, 2014); Vol. 370, 1683, 1690.) For 2010, the national mean length of stay for MA enrollees with Sepsis as a primary diagnosis was 9 days and 15 days for those with Sepsis as a secondary diagnosis. (AHRQ, H-CUP Statistical Brief #122, p.4 (October 2011).)

65. In November 2010, KP's management identified KFH Hospital-Panorama City

as being an outlier for its reported Sepsis mortality rates of 25% despite noting, that all by all other quality measures, the facility was one of KFH's very best hospitals. The e-mail instructed executives responsible for KFH Hospital Panorama City to solve this problem by identifying more cases of Sepsis. Dr. Chiara Conrado, KFH-Panorama City Hospital's Pulmonary and Intensive Care Specialist, responded complaining that the sepsis mortality rates from other KFH facilities was not believable, that the data used was not verified for accuracy, that Kaiser's coders and physicians incorrectly diagnose and code sepsis and that the KP's reported Sepsis mortality rates for 2010 were lower than what other significant studies achieved and therefore KP's data was not credible.

66. Dr. Conrado received no response to her complaints. At all times relevant defendants were required to maintain an effective compliance program designed to identify and ameliorate Medicare fraud waste and abuse (FWA). (42 C.F.R. §422.503(b)(4)(vi); Medicare Managed Care Manual, Ch.21 §§30-50 et seq.) Pursuant to statutory and CMS requirements, defendants' compliance officer was required to initiate a timely investigation into Dr. Conrado's accusations regarding the potential Medicare FWA issues raised by Dr. Conrado's complaints but failed to do so. (42 C.F.R.§422.503(b)(4)(vi); CMS Publication 100-16, Medicare Managed Care Manual, Ch. 21 §Ch.21 §50.7.1.)[11], [12]

67. KP's use of an overly broad and improper Sepsis diagnostic standard imposes on KFHP, TMPG, SCPMG and KFH, a duty to exercise reasonable diligence to identify, and redact false and incorrect Sepsis diagnoses from the RAD submitted to CMS. This duty is an integral part of the Medicare Advantage's regulatory framework intended to help MAOs, such

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[11] 42 C.F.R. §422.504(b)(4)(vi) states in part: [Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse.]

[12] Medicare Managed Care Manual, Ch.21 §50.7.1 – Conducting a Timely and Reasonable Inquiry of Detected Offenses, states in part, "Sponsors must conduct a timely and well-documented reasonable inquiry into any compliance incident or issue involving potential Medicare program noncompliance or potential FWA. . . . It may be discovered through a hotline, a website, an enrollee complaint. . . . Regardless of how the noncompliance or FWA is identified, sponsors must initiate a reasonable inquiry as quickly as possible, but not later than 2 weeks after the date the potential noncompliance or potential FWA incident was identified."

as KFHP, avoid the submission of false and fraudulent claims to CMS and avoid the receipt and retention of improper overpayments from CMS. (42 C.F.R. §§ 422.326(c), 422.503(b)(4)(iv), 422.504(l)(2); CMS Publication 100-16, Medicare Managed Care Manual, Ch.7 §40 et seq. and Ch.21 §§30-50 et seq.; 79 Fed.Reg. 29844, 29923-24 (March 23, 2014).)

68. KFHP failed to use reasonable diligence in its selection of its Sepsis diagnostic standard and also by failing to identify and redact false and unsupported Sepsis diagnoses from the RAD submitted to CMS. As an express condition of receiving its monthly capitation payments on behalf of MA enrollees, KFHP certified based on its best knowledge, information and belief that the RAD it submitted to CMS was accurate, truthful and complete. (42 C.F.R. §422.504(l)(2).) Because KFHP did not attempt to identify and redact the potentially false and fraudulent Sepsis diagnoses obtained from its contracted medical groups, KFHP's statutorily required certifications were false. KFHP's best knowledge, information and belief were that many of the Sepsis diagnoses were inaccurate, untruthful and incomplete, and were not supported by the clinical documentation in the medical record as required by CMS. (CMS Publication 100-16, Medicare Managed Care Manual, Ch.7 §40 et seq.) Furthermore, without a process to identify known potentially inaccurate Sepsis diagnoses, KFHP had no legitimate basis for making such a certification. (See, 79 Fed.Reg. 29844, 29923-24 (March 23, 2014).)

69. During and between approximately 2008 until the present, KFH hospital facilities, including all those in California, utilized the above-described false sepsis diagnoses and documentation practices to up-code their FFS Medicare hospital claims that KFH submitted to CMS on behalf of its FFS Medicare patients. The false and fraudulent sepsis ICD-9 and later ICD-10 diagnosis codes where mapped to the KFH hospital's master claim bill, CMS form UB-04 as DRG 871 or 872 and submitted to CMS, resulting in false and fraudulent claims in violation of the FCA. Each such false sepsis claim resulted in KFH receiving approximately $7,000 to $12,000 of additional revenue from CMS.

70. Stein is informed and believes and upon such information and belief alleges, that between 2010 until her departure in 2011, the Kaiser Health Plans, KFH and PMGs adopted and implemented the Sepsis diagnosis, coding and treatment policies described above and in

paragraphs 53 through 56 as national policies and procedures.

71. Bone is informed and believes, and upon such information and belief alleges, that throughout the term of his employment (2010 until the present) the Kaiser Health Plans, KFH and PMGs adopted and implemented the unwritten Sepsis diagnosis, coding and treatment policies described above and in paragraphs 53 through 56 as national policies and procedures.

MALNUTRITION

72. During and between approximately 2006 until on or about December 11, 2013, SCPMG, TPMG, KFH and KFHP participated in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA enrollees in order to increase the risk adjustment scores for the MA enrollees so diagnosed. This fraudulent scheme was conducted at all KFH Hospitals throughout California and involved the diagnoses and coding of malnutrition and severe malnutrition based upon assessments performed by dieticians employed by KFH. The KFH dietician used a rubber stamp on the MA enrollee's medical record indicating that in his/her opinion the MA enrollee suffered from malnutrition or severe malnutrition. SCPMG and TPMG physicians then countersigned the stamp in the MA enrollees' medical record. Based solely on the presence of the physician's countersignature of the dietician's rubber stamp, Kaiser's coders recorded the ICD-9 diagnosis codes for malnutrition or severe malnutrition as indicated by the rubber stamp. KFHP submitted to CMS these malnutrition and severe malnutrition ICD-9 diagnosis codes as RAD for use in calculating that MA enrollees' risk adjustment scores, which increased CMS's capitated payments to defendants.

73. Valid RAD must be the result of a face-to-face encounter with a physician or other qualified clinician that has been identified by CMS as an acceptable source of RAD. (CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq., §120.1.1, Table 19; 42 C.F.R. 422.310(b)-(d).) In order for RAD to be valid for submission to CMS, each ICD-9 diagnosis code submitted must have the appropriate clinical findings documented in the MA enrollee's medical record. (CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq.; 42 C.F.R. § 422.310(b)-(d).) KFH Hospitals' use of the dietician's stamp for

diagnosing and documenting malnutrition fails on both accounts, there is no face-to-face-encounter with a qualified physician where the physician makes a diagnoses of malnutrition, nor does the dietician's rubber stamp substitute for physician documenting in the medical record a diagnosis of malnutrition or the clinical indicators and clinical findings reviewed and observed necessary to support the malnutrition or severe malnutrition diagnosis.

74. The Medicare Managed Care Manual, Ch. 7, §120.1.1, Table 19, lists physician speciality types and other clinicians that are acceptable sources of RAD. Dieticians are not included in this list. KP's dieticians cannot make medical diagnosis on behalf of MA enrollees. The physicians' countersignatures of the dietician's stamp does not constitute a valid physician diagnosis or medical record documentation of such.

75. Kaiser's coders did not record the ICD-9 diagnosis code for malnutrition or severe malnutrition when the physician's countersignature was missing from the stamp. In those instances, the medical record was routed back to the physician for his/her countersignature. Physician's counter-signatures that were initially missing from the dieticians's stamp were routinely "rubber stamped" without question and countersigned but no entry showing that the physician made a diagnosis of malnutrition was made in the medical record itself.

76. The ICD-9 code book contains the following malnutrition diagnosis codes: 260 Kwashiorkor; 261 Nutritional marasmus; 262 Other severe, protein-calorie malnutrition; 263.0 Malnutrition of moderate degree; 263.1 Malnutrition of mild degree; 263.2 Arrested development following protein-calorie malnutrition; 263.8 Other protein-calorie malnutrition; and 263.9 Unspecified protein-calorie malnutrition. Each of these distinct ICD-9 diagnosis codes for malnutrition require specific and appropriate supporting clinical findings in order to be properly documented and submitted as a valid diagnoses and valid RAD.

77. Clinical findings, such as the number of folds in the patients' skin, the size of their triceps, their body mass index, weight changes over time, dietary intake, wasting of muscle and debility, albumin and pre-albumin blood test, digestive difficulties or digestive diseases, absorption problems, eating disorders and feeding method (i.e. oral or tubal feeding)

are examples of clinical findings that treating physicians were required to record in the MA enrollees' medical record as the result of a face-to-face encounter as part of documenting a diagnosis of malnutrition or severe malnutrition. Without appropriate clinical findings, Kaiser's coders were unable to determine which malnutrition ICD-9 diagnosis code to record.

78. During on or about December 13, 2013, KFH disseminated instructions prohibiting the continued practice of allowing physicians to countersign a dieticians stamp as a method of diagnosing and documenting malnutrition. The instruction states, among other things, "It is not appropriate to have physicians counter-sign the dieticians stamp as a means of establishing the diagnosis by the physician." (Citing, CMS 2008 Risk Adjustment Data Technical Assistance for Medicare Advantage Organizations Resource Guide.) KHF and KFHP's new policy required the treating physician to document the appropriate clinical findings in the MA enrollees' medical records to support malnutrition diagnoses.

79. 42 C.F.R. § 422.326, the Medicare Advantage Overpayment Report and Return regulation, requires KFHP to notify CMS within 60 days from the time it knew or should have known that it received an overpayment and make arrangements with CMS for the return of such overpayments. KFHP violated 42 C.F.R. § 422.326 by failing and refusing to exercise reasonable diligence with respect to the identification and return of overpayments resulting from the improper diagnosing, documenting and coding of malnutrition and severe malnutrition of its MA enrollees as described above. Failing to notify CMS of the receipt of an overpayment within 60 days is an obligation under the False Claims Act and subjects KFHP to FCA liability under 31 U.S.C. §3729(a). KFHP's and/or the other defendants' policy change regarding the diagnoses, documentation and coding of malnutrition is evidence that KFHP was aware that it submitted invalid malnutrition RAD to CMS that resulted in the receipt and retention of overpayments during prior periods.

80. During and between 2006 and at December 11, 2013, KFHP, SCPMG, TPMG and KFH knowingly submitted or caused to be submitted false and fraudulent malnutrition diagnoses to CMS as valid RAD for use in calculating KFHP's capitation payments. Such submissions of false malnutrition diagnoses resulted in false and fraudulent claims in violation

of the FCA. The impact of KFHP's false malnutrition diagnoses and upcoding is profound. In Los Angeles County, each fraudulent diagnosis of malnutrition increased the subsequent CMS's capitation payments for that MA enrollee by approximately $9,000 per year. During the time frame referenced above, KFHP submitted to CMS tens of thousands of such fraudulent malnutrition diagnoses on behalf of KFHP's MA enrollees.

81. During and between 2006 until approximately December 11, 2013, KFH hospital facilities, including all those in California, allowed physicians to improperly countersign dieticians' stamps as a means of diagnosing and documenting malnutrition for Medicare FFS patients. The false and fraudulent malnutrition ICD-9 diagnosis codes were mapped to the KFH hospital's master claim bill, CMS form UB-04, as MCCs (i.e., secondary diagnoses increasing the DRG's value) and submitted to CMS resulting in false claims in violation of the FCA. KFH received between $1,000 to $5,000 of additional revenue per patient discharge from CMS as a result of the false malnutrition claims. KFHP and KFH made no effort to notify CMS of the overpayments that resulted from the submission of such false and fraudulent Medicare FFS malnutrition claims, although per 42 C.F.R. §401.305, KFHP was obligated to report and timely return such overpayments to CMS.

82. Stein and Bone are informed and believe, and upon such information and belief allege, that the above-described improper diagnosis, coding and documentation practices for malnutrition described above in paragraphs 72 through 81 are, and since 2006 were, national polices and procedures, and performed in the same improper manner nationwide by Kaiser Health Plans, KFH and the PMGs.

AORTIC ATHEROSCLEROSIS

83. Aortic atherosclerosis is a chronic condition that results in the build up of arterial plaque or fatty deposits in the patient's aorta. Treatment typically involves a medication regimen of statin family drugs (also used to lower cholesterol) and life style changes, such as diet and exercise. Severe cases can cause fatal episodes of coronary artery disease, while less severe conditions can be tolerated by some patients as long as the disease does not rapidly progress. Aortic atherosclerosis can be detected and diagnosed from a typical chest x-ray.

84. During and between 2007 until on or about April 4, 2016, KFH and the Kaiser Health Plans instructed their coders to code the ICD-9 and later ICD-10 diagnosis code associated with aortic atherosclerosis (AA) any time the physician noted the presence of AA or listed AA in the patient's medical record. This instruction applied MA patients admitted to Kaiser inpatient facilities in, among other states, California. Pursuant to these instructions, Kaiser's coders coded KFH's MA patients with an AA diagnosis based simply upon the physician's notation of AA in the medical record, without the medical record reflecting that the patient was treated for his/her AA condition.

85. Kaiser's coding and documentation of AA was not in compliance with the ICD-9 and later ICD-10 Coding and Documentation Guidelines, which requires the patient to have received treatment for a chronic condition, such as AA, in order to validly code the ICD-9 or ICD-10 diagnosis code for such chronic condition, and prohibits coding based upon an abnormal test result, such as from an x-ray. The bare notation of AA in the medical record or noting the presence of AA without documentation of the medical services provided to treat the AA condition is insufficient documentation to support the submission of an AA diagnosis code to CMS as RAD for use in calculating KFHP's capitation payments. As a result of the foregoing, KFHP submitted RAD that included the improperly diagnosed and documented AA for use in calculating KFHP's capitation payments. The submission of such RAD to CMS resulted false and fraudulent claims in violation of the FCA. AA has a HCC risk score of approximately .300 resulting in increased prospective capitation payments of approximately $2000-$3000 for each enrollee for which KFHP submitted improperly diagnosed or documented AA RAD.

86. On or about April 4, 2016, KFH issued the following instructions regarding the coding of AA:

> After having gone through a clinical review at the time of updating the list of examples of systemic conditions, AA was determined not to meet the definition of a systemic condition and does not appear on the final list of examples of systemic conditions. The clinician must do more than just list this condition. There must be documentation to show how it impacted the current encounter. It will be up to the region to decide if they want to query the provider

> about this condition when it is only listed. Without a query and additional documentation from the provider to show it impacted the encounter it cannot be coded.

87. After April 4, 2016 instruction regarding coding and documentation of AA was disseminated, the ICD-10 diagnosis code for AA were recorded by Kaiser coders when medical record documented treatment for AA, as opposed to the condition simply being identified. This change is consistent with the ICD-10 Coding and Documentation Guidelines, Section III(B) and Section IV(I) Chronic Diseases, which states:

> Section III(B) Abnormal Findings - "Abnormal findings and other diagnostic results are not coded and reported unless the provider indicates their clinical significance."
>
> Section IV(I) Chronic Diseases - "Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)"

88. Prior to the April 4, 2016 instruction, KFH and the Kaiser Health Plans regularly monitored the coding of AA for their hospital patients to ensure that every time AA was noted in the medical record, AA was coded by Kaiser's coders, but did not ensure that such AA coded diagnoses met the requirements for coding AA under the ICD-9 and later the ICD-10 Coding and Documentation Guidelines. On at least two occasions during the course of Bone's employment, KFH's internal auditors notified him that he failed to properly code AA diagnoses where the only documentation in the medical record was that AA had been observed as a result of a chest x-ray, but no treatment for AA had been documented. Bone was required to fix the problem by coding the ICD-9 diagnosis code for AA for such encounters.

89. All RAD to be submitted to CMS for use in calculating the Kaiser Health Plans' capitation payments must be the result of face-to-face physician encounters that are supported by properly documented medical records. All medical record documentation must be performed in accordance with ICD-9 and later ICD-10 Coding and Documentation Guidelines. (Medicare Managed Care Manual, Ch. 7 §40, et seq.) As a result of the foregoing, all of the ICD-9 and/or ICD-10 AA diagnosis codes that where inaccurately coded because, among other reasons, the patient's medical record does not reflect the patient receiving contemporaneous treatment for AA, are invalid for submission to CMS as RAD for use in calculating the Kaiser

Health Plans' capitation payments and resulted in the submission of false claims.

90. The Kaiser Health Plans made no attempt to determine the amount of the overpayments it received from CMS resulting from the submission of falsely diagnosed and improperly documented AA diagnoses and failed to notify CMS of the receipt of overpayments nor attempt to refund the same as required by 42 C.F.R §422.326.

REFRESH FRAUDS

91. As will be explained in greater detail below, between 2010 and the present, KFHP, KFH, TPMG and SCPMG and the remaining PMGs submitted or caused to be submitted false and fraudulent RAD resulting from KFHP's practice of "refreshing" missing HCC diagnosis codes. These frauds were accomplished by (a) routinely and intentionally making improper late medical record entries, (b) amending the medical record without valid face-to-face encounters, (c) failing to include the supporting clinical documentation in the amended medical record required to support the new HCC diagnosis codes, (d) performing improper written leading physician queries, (e) improperly making diagnoses from problem lists, (f) concealing the frauds by illegally destroying the written queries, and (g) deceiving MA enrollees to obtain medically unnecessary and non-covered medical services.

92. At all times relevant, CMS allowed MAOs an additional period of time (Data Lag Period) after the end of the payment year to submit additional valid RAD and withdraw previously submitted invalid RAD arising from services rendered during that payment year. The end of the Data Lag Period was the final RAD cutoff date after which CMS no longer accepted any new or withdrawn RAD for that payment year, and CMS used the RAD for that payment year to risk adjust the MAO's capitation payments for the next payment year. When the HCC risk adjustment model was relatively new, the Data Lag Period was two years after the end of the payment year. Over time, CMS shortened the Data Lag Period to 13 months after the end of the payment year.

93. After the end of the payment year, but before the end of the Data Lag Period, MAOs such as KFHP can retrospectively review the medical records of its MA enrollees to ensure that the RAD submitted to CMS was properly supported by medical records and

withdraw unsupported diagnosis codes. MAOs can also submit to CMS previously unreported HCC diagnosis codes if the medical record supports such additional diagnoses, or in certain cases, make an amendment to the medical record based on the last face-to-face encounter the physician had during the payment year if the physician has a recollection of the face-to-face encounter and there is sufficient clinical findings in the existing medical record to make such a diagnoses.

94. Beginning in 2006 and continuing to the present, KFHP, KFH, TPMG, SCPMG and the other PMGs implemented an improper program designed to identify "missing" HCC diagnosis codes and have the physicians "refresh" the missing HCC diagnoses. KFHP considered HCC diagnoses to be missing when the HCC diagnoses had been submitted to CMS as RAD arising from services rendered during the last closed payment year, but had not been submitted in the subsequent payment year subject to a pending Data Lag Period (e.g., if 2010 was the last closed payment year, 2011 is the subsequent payment year with a Lag Data Period pending between January 1, 2012 through January 31, 2013). KFHP, KFH, TPMG and SCPMG, with the assistance of KFH staff, engaged in several different tactics to have the physicians "refresh" the missing HCC diagnoses. The progress and success of the refresh program was internally well documented, and tracked the MA enrollees' medical records, the HCC diagnoses to be "refreshed," the physicians who "refreshed" the HCC diagnoses, the HCC diagnosis codes submitted to CMS as RAD as a result of the refresh process, and the increased risk adjustment scores resulting from the refresh process. KFHP's refresh process resulted in increased risk adjustment scores of 5 to 6 points per MA enrollee program wide, resulting in about $400 million to $500 million in additional annual capitation revenue per year.

95. The refresh process started with KFHP's contracted medical groups compiling a "hit-list" of high value HCC risk adjustment scores and their related ICD-9 diagnosis codes ("HCC diagnoses") from which to work from. The hit-list included, but was not limited to, all of the complications related to diabetes, and the different manifestations and complications of coronary disease, chronic kidney disease, old myocardial infarction, and cancer. Each year, KFHP performed a computer search to data-mine the RAD submissions from the last closed

payment year to identify the MA enrollees with a history of hit-list HCC diagnoses, and used those results to determine which MA enrollees' medical records did not have such hit-list HCC diagnoses submitted in the subsequent payment year subject to a pending Data Lag Period. After Kaiser's coders reviewed the last closed payment year's medical records confirm the existence of the past hit-list HCC diagnoses, Kaiser's coders then sent written leading queries to the MA enrollees' attending physicians with a list of the missing HCC diagnoses. The leading physician queries instructed the physicians to "refresh" (i.e., add) the missing HCC diagnosis to a particular MA enrollee's medical record. Kaiser's coders then met with the physicians to ensure that the hit-list HCC diagnoses were refreshed. Most of TPMG and SCPMG physicians readily complied with Kaiser's coders' requests and added the hit-list HCC diagnoses identified in the Kaiser's coders' leading queries.

96. All RAD that MAOs, such as the Kaiser Health Plans, submit to CMS must be the result of a face-to-face physician encounter and must be supported by a medical record documented in accordance with ICD-9 Guidelines. (Medicare Managed Care Manual, Ch. 7 §40 et seq.; 42 C.F.R. §422.310(d).) An addendum is new documentation used to add information to an original entry. Addenda should be timely and bear the current date and reason for the additional information to an original entry. (AHIMA (2015) Amendments, Corrections and Deletions in the Electronic Health Record Tool Kit, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678.)

97. CMS's rule governing late medical entries states, "All services provided to beneficiaries **are expected to be documented in the medical record at the time they are rendered**. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service." (Emphasis added.) (Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A) and made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b), 422.310(d).) Similarly, AHIMA Guidelines state, "When documenting an omission, validate the source of additional information as much as possible. Late entries should be documented

as soon as possible. While there is no time limit for writing a late entry, the more time that passes, the less reliable the entry becomes."[13] (AHIMA (2015) Maintaining a Legally Sound Health Record: Paper and Electronic, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_028509.hcsp?dDocName=bok1_028509.)

98. The "refreshed" HCC diagnoses were invalid as RAD for submission to CMS by the Kaiser Health Plans because they violated the requirements described in the preceding two paragraphs. First, the refreshed HCC diagnoses were not the result of a face-to-face encounter. In order to document an omission via a late entry amendment, the physician must have a specific recollection of the subject face-to-face encounter with the MA enrollee. As the encounters being "refreshed" were between 6 to 12 months before the hit-list addenda were added to the medical records, the physicians did not have specific detailed recollections of the encounter required to add clinical findings in support of hit-list HCC diagnoses being added.

99. Second, the addenda themselves were not supported by required clinical documentation in the medical record in accordance with ICD-9 Guidelines. This is apparent on the face of the addenda which consist of just the addition of the hit-list HCC diagnoses, signed and dated by the physician. Physicians who executed the addenda did not review the medical record entries (i.e., the portion being amended) to confirm that the medical record contained the necessary clinical findings to support the new HCC diagnoses, nor did they include language in the addenda that identified the reasons for the late entry nor any required clinical findings to support adding the new HCC diagnoses as required by the ICD-9 and AHIMA coding and documentation guidelines. The mere conclusion of the new HCC diagnoses, without the supporting clinical findings necessary to support the conclusion, is not an acceptable method of medical record documentation. Additionally, such incomplete documentation does not indicate that it is "related to a service that was provided" during the prior encounter as required by CMS's rule for late entries. (Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A).) Therefore, such improperly "refreshed" HCC diagnoses codes

[13]For reference, 42 C.F.R. § 482.24(c)(4)(viii) requires hospitals to complete the medical record entries of the final diagnoses within 30 days of discharge.

should not have been submitted to CMS as RAD.

100. Typically, the hundreds of employee physicians, including but not limited to Drs. Steven Steinberg, Margabanhu Ramanathan, Edward Brosnan, David Wong, Sivakumar, and Young Cho, who worked for KFHP's contracted medical groups, responded to the leading queries by signing any "refresh" addenda that their employers requested via the leading physician queries and problem lists.

101. The addenda refreshing HCC diagnoses were also invalid because they (a) failed to provide an explanation regarding why the late entry needed to be made as required by the AHIMA standards for making addenda, (b) failed to identify the services rendered during the subject encounter that the refreshed HCC diagnoses are related to as required by CMS's rules for late entries, and (c) failed to identify the clinical findings required to support the new HCC diagnosis codes as required by the ICD-9 Guidelines.

102. "To support why a query was initiated, all queries must include the clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested."[14] (AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p.2; http://ahima.org/library.) The Kaiser's coders' queries used for refreshing missing HCC diagnoses did not contain any clinical indicators or explanations in support of why they was initiated. Kaiser's coders only reviewed the problem list of missing HCC diagnoses and the prior year's medical record visit to confirm that the HCC diagnoses identified by the computer data mining was present. The medical record visit to be refreshed was not reviewed by the Kaiser's coders and thus they had no basis to make the queries.

103. Defendants' refreshing of HCC diagnoses relied on using invalid, leading physician queries that instructed physicians which HCC diagnoses to add to the medical records. "A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure." (AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p. 2;

[14]AHIMA is a member of the ICD9CM and the ICD10CM Cooperating Parties, thus their practice briefs are considered "industry standards" for coding and query policy and procedure.

http://ahima.org/library.) AHIMA sets the national standards regarding coding and documentation, and as such its policies are incorporated into the medical record documentation requirements by CMS. (42 C.F.R. § 422.310(d).) The AHIMA guidelines do not allow leading queries because they result in inaccurate and/or false medical record documentation. After the leading queries were used by TPMG and SCPMG physicians, the queries were illegally destroyed.

104. At all times mentioned, CMS required the Defendants to maintain the medical record on some type of retrievable format for at least ten years. No part of the medical record is supposed to be destroyed. CMS and AHIMA requirements make it clear that if the physician query results in adding new diagnoses, then the query becomes part of the medical record and must be maintained for use in auditing the validity of the diagnoses contained therein. (Medicare Quarterly Compliance Newsletter, Vol 2, Issue 3 at p. 13 (April 2012); https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medqtrlycomp_newsletter_icn907927.pdf.) Further, AHIMA Guidelines strongly recommend that the queries to physicians be preserved as part of the medical record and if a different policy is adopted, then the query must be maintained as business record. (AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p. 4; http://ahima.org/library.)

105. At all times mentioned, KFH's medical record retention policy included Kaiser's coders' queries as part of the medical record. At al times mentioned, the Kaiser Health Plans allowed their contracted medical groups, including TPMG and SCPMG, to adopt different and conflicting medical record retention policies that improperly failed to preserve Kaiser's coders' queries as part of the medical record or as a business record. Instead, Kaiser's coders' queries were destroyed immediately after the queries had been reviewed by the physicians. The Kaiser Health Plans always had the ability to require their exclusively contracted medical groups, including TPMG and SCPMG, to adopt unified policies for medical record retention, query practices, late entries into the medical records and medical record documentation. CMS's regulations mandates that the Kaiser Health Plans' contracts contain such rights and provisions.

(42 C.F.R. § 422.504(i)(3)(iii).)

106. Realtors are informed and believe, and based upon such information and belief allege, that the Kaiser Health Plans knowingly allowed its exclusively contracted medical groups, including TPMG and SCPMG, to adopt conflicting policies for using leading queries, preserving queries as part of the medical record, making late entries and amendments to the medical record, and medical record documentation expressly for the purpose of committing the Medicare frauds described in this complaint.

107. During or about 2006, several HIM managers, such as Sarah Lynch, the HIM Director KFH-Hospital, Orange County, and Jennifer Squires, Encounter Coding Manager, vigorously protested the required use of leading queries and their immediate destruction after the physicians had "refreshed" the medical record. Ms. Lynch was informed by her supervisor, that SCPMG and Kaiser requested that Ms. Lynch be terminated for complaining about the use and destruction of leading queries and was informed by her supervisor that in order to avoid termination Ms. Lynch had to refrain from further complaints regarding these issues. Ms. Lynch's complaints regarding leading queries and destruction of medical records should have triggered a compliance investigation by the Kaiser Health Plans to identify the Medicare FWA caused by the leading Kaiser coders' queries complained of and issued appropriate corrective action plans. (42 C.F.R. § 422.503(b)(4)(vi); Medicare Managed Care Manual, Ch. 21 §30-50, et seq.)

108. In a number of instances, the MA enrollees had not been seen by their PCP during the open payment year and/or had not been seen during the current year. These MA enrollees' medical records could not be refreshed with a late entry addenda because there was no face-to-face encounter, and therefore no medical record entry during the relevant time period to amend. TPMG and SCPMG contacted these MA enrollees and falsely informed them that they needed to schedule a follow-up visit with their primary care physician (PCP). In addition, there were MA enrollees who had been seen during the open payment year, but for whom no HCC diagnoses were identified during those encounters. These MA enrollees were also scheduled for a follow up visit for the sole purpose of identifying HCC diagnoses to submit to CMS.

109. The RAD obtained from the physician followup encounters to refresh the MA enrollees' hit-list HCC diagnoses were invalid because the RAD was obtained from medically unnecessary and uncovered services. Among the services that are specifically excluded from original Medicare are routine physicals and medically unnecessary services. (42 C.F.R. § 411.15(a)(1),(k), and made applicable to Medicare Advantage by 42 C.F.R. § 422.101(b)(1)-(2).) The improper followup visits that the Kaiser Health Plans and their contracted medical groups, including TPMG and SCPMG performed, were in fact routine physicals or otherwise medically unnecessary services because the MA enrollees were deceived into having the exam, the MA enrollees had no medical complaint that required followup, and the true secret purpose of the visit was specifically to "refresh" certain hit-list HCC diagnoses that the Kaiser Health Plans had identified. The Kaiser Health Plans cannot submit to CMS improperly obtained, non-covered and excluded services as valid RAD. (42 C.F.R. § 422.310(c).)

110. Although the Kaiser Health Plans cover routine physicals as a supplemental benefit, such coverage is limited to exams that are, "[M]edically appropriate preventative care in accordance with generally accepted professional standards of practice." The Kaiser Health Plans' Evidence of Coverage (2011) at p. 51, available at: https://www.sjretirement.com/Uploads/PF/2011%20Kaiser %20Hawaii %20KPSA% 20EOC.pdf.) As will be explained in greater detail below, because the purpose of the visit was to deceitfully obtain hit-list HCC diagnoses, the refresh followup visits do no meet The Kaiser Health Plans' coverage criteria under its supplemental benefits. Further, the services the MA enrollees received during such physician encounters to "refresh" their prior HCC diagnoses were not documented as a covered routine physical by the Kaiser Health Plans, TPMG, SCPMG and the other PMGs, but were falsely documented as some other type of consultative visit. Because the MA enrollees' physician visits to refresh old HCC diagnoses were medically unnecessary, the services were not covered under the Kaiser Health Plans' MA plans, and the Kaiser Health Plans could not legally submit RAD to CMS arising from such services.

111. On or about, 2006 Stein was present at a meeting with SCPMG regional physician leadership from the Panorama City Medical Clinic, including but not limited to Drs.

Zollner, Hoffman, Steinberg, and Candac Lumeg. Present by telephone were the SCPMG physician leaders, from the Santa Clarita Medical Clinic. The purpose of the meeting was to discuss the data-mining results provided by SCPMG's Pasadena headquarters that identified MA enrollees who needed a current physician encounter in order for their HCC diagnoses to be refreshed. A telephone call script had been provided by defendants that was used to schedule the appointments with the MA enrollees and was read out loud for the meeting participants. The call script informed the MA enrollees that they needed to come in for a follow up visit for the HCC condition that had been identified by defendants. This statement was false. The SCPMG physician leaders candidly admitted that the follow-up exams were medically unnecessary and being used as pretext; the true purpose of the visits was for the PCPs to refresh the hit-list HCC diagnoses.

112. During this meeting it was decided that Mary Stefanec, RN, Department Administrator for Internal Medicine, would be responsible for supervising staff to contact the identified enrollees assigned to physicians located at the SCPMG medical clinics in Panorama City and convince such MA enrolles to come in for the purported follow-up visits. Similar meetings were schedule throughout California.

113. None of the MA enrollees were informed the that the true purpose of the visit was for the Kaiser Health Plans' contracted medical groups to "refresh" prior HCC diagnoses so that the Kaiser Health Plans would receive a higher capitation payment from CMS. Instead, the MA enrollees were deceived into scheduling medically unnecessary routine physicals by being falsely informed that their medical condition required a follow-up visit. These untrue MA enrollee solicitations violated CMS's regulations that prohibit making untrue or misleading statements to enrollees. (42 C.F.R. § 422.752(a)(5)(ii).)

114. Beginning in 2006 and continuously thereafter, Kaiser Health Plans, KFH and the PMGs annually scheduled tens of thousands of MA enrollee visits for the purpose of "refreshing" prior hit-list HCC diagnoses by falsely claiming such visits were medically necessary follow-up visits. The true purpose of the MA enrollees' medical appointments was for the Kaiser Health Plans' contracted medical groups to collect HCC diagnoses for

submission to CMS by the Kaiser Health Plans. The untruthful statements to the MA enrollees constituted a false statement material to a false or fraudulent claim in violation of 31 U.S.C. § 3729(a)(1)(B).

FIRST CLAIM FOR RELIEF

(Violation of 31 U.S.C. §3729(a) against all Defendants: False Sepsis Claims)

115. Relator realleges and incorporates by reference paragraphs 1 through 71 of this complaint as though fully set forth at length.

116. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

117. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A)&(B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

118. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by (a) conspiring violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

119. The Kaiser Health Plans knew or should have known that they had improperly received and retained excessive payments for Medicare FFS patients for whom the Kaiser Health Plans routinely submitted to CMS Sepsis diagnoses that were falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 401.305.

120. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 401.305.

121. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 401.305.

122. Defendants the Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS Sepsis diagnoses that were routinely and repeatedly falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 422.326.

123. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

124. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

125. The Kaiser Health Plans are, and at all times mentioned were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) Because the Kaiser Health Plans adopted overly broad Sepsis diagnostic standards, they had an obligation to establish a process to identify and redact or withdraw incorrect Sepsis diagnosis codes from the RAD they submitted to CMS. The Kaiser Health Plans did not adopt any such process to identify and redact or withdraw incorrect Sepsis ICD-9 diagnosis codes from the RAD they submitted to CMS and failed to do so. As a result of the Kaiser Health Plans' failure and refusal to reasonably attempt to meet this obligation, it had no

legitimate basis for certifying that the Sepsis ICD-9 diagnosis codes it submitted to CMS were accurate, complete and truthful RAD.

126. Defendants were obligated to conduct a Medicare FWA investigation in response to Dr. Conrado's repeated complaints that sepsis was being inaccurately diagnosed and coded. The Kaiser Health Plans and their first tier contracted entities failed and refused to conduct such a compliance investigation, rendering the Kaiser Health Plans' compliance program, as it pertains to the submission of false Sepsis diagnosis codes, ineffective. Because the Kaiser Health Plans had an ineffective compliance program, they had no legitimate basis on which to certify the accuracy, completeness and truthfulness of the Sepsis ICD-9 diagnosis codes they submitted as RAD to CMS between 2010 to the present. (42 C.F.R. §§ 422.503(b)(4)(vi), 422.504(i)(3)(iii)&(l); Medicare Managed Care Manual, Ch. 21 §50.7.1; 79 Fed.Reg. 29884, 29923-24 (May 14, 2014).)

127. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for Sepsis that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid defendant Kaiser Health Plans at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

128. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(G) by knowingly concealing or knowingly and improperly avoiding or decreasing their obligation to pay or transmit to the Government the overpayments made by CMS as a result of the submission of false and unsupported Sepsis diagnoses to CMS.

129. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the ICD-9 diagnosis codes for Sepsis submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

130. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

131. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

132. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

SECOND CLAIM FOR RELIEF

(For violations of 31 U.S.C. § 3729(a) against all Defendants: False Malnutrition Claims)

133. Relator realleges and incorporates by reference paragraphs 1 through 37 and paragraphs 72 through 82 of this complaint as though fully set forth at length.

134. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

135. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A)&(B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by

CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

136. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by (a) conspiring violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

137. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans and KFH knew or should have known that they had improperly received and retained excessive FFS Medicare payments from CMS for services rendered to FFS Medicare beneficiaries based on malnutrition diagnoses that were falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 401.305.

138. At all times mentioned, the Kaiser Health Plans and Kaiser Foundation Hospitals failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 401.305.

139. At all times mentioned, the Kaiser Health Plans and the Kaiser Foundation Hospitals acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 401.305.

140. At all times mentioned during the six years prior to the filing of this action, defendant Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS malnutrition diagnoses that were routinely and repeatedly falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 422.326.

141. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

142. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and

deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

143. The Kaiser Health Plans are, and at all times mentioned were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) KFHP had an obligation to establish a process to identify and redact or withdraw incorrect or unsupported malnutrition diagnosis codes from the RAD it submitted to CMS. KFHP did not adopt any such process to identify and redact or withdraw incorrect or unsupported malnutrition ICD-9 diagnosis codes from the RAD it submitted to CMS and failed to do so. As a result of KFHP's failure and refusal to reasonably attempt to meet this obligation, it had no legitimate basis for certifying that the malnutrition ICD-9 diagnosis codes it submitted to CMS were accurate, complete and truthful RAD.

144. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for malnutrition that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid defendant KFHP at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

145. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the ICD-9 diagnosis codes for malnutrition submitted to CMS as RAD were

accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

146. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

147. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

148. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

THIRD CLAIM FOR RELIEF

(For violations of 31 U.S.C. § 3729(a) against all Defendants: False Aortic Atherosclerosis Claims)

149. Relator realleges and incorporates by reference paragraphs 1 through 37 and paragraphs 83 through 91 of this complaint as though fully set forth at length.

150. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

151. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A)&(B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims

paid or approved by CMS.

152. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

153. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

154. The Kaiser Health Plans are, and at all times mentioned were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) KFHP had an obligation to establish a process to identify and redact or withdraw incorrect or unsupported malnutrition diagnosis codes from the RAD it submitted to CMS. KFHP did not adopt any such process to identify and redact or withdraw incorrect or unsupported aortic atherosclerosis ICD-9 diagnosis codes from the RAD it submitted to CMS and failed to do so. As a result of KFHP's failure and refusal to reasonably attempt to meet this obligation, it had no legitimate basis for certifying that the aortic atherosclerosis ICD-9 diagnosis codes it submitted to CMS were accurate, complete and truthful RAD.

155. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for aortic atherosclerosis that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid defendant KFHP at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent

claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

156. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the ICD-9 diagnosis codes for aortic atherosclerosis submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

157. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

158. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

159. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

FOURTH CLAIM FOR RELIEF

(For violations of 31 U.S.C. § 3729(a) against all Defendants: False Refresh Claims)

160. Relator realleges and incorporates by reference paragraphs 1 through 37 and paragraphs 90 through 113of this complaint as though fully set forth at length.

161. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

162. At all times mentioned during the six years prior to the filing of this action,

defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A)&(B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

163. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by (a) conspiring violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

164. At all times mentioned, defendant the Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS HCC diagnoses that were routinely and repeatedly falsely and fraudulently "refreshed", diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 422.326.

165. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

166. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

167. The Kaiser Health Plans are, and at all times mentioned during the six years prior to the filing of this action were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) The Kaiser Health Plans had an obligation to establish a process to identify and redact or withdraw incorrect or unsupported "refreshed" HCC diagnosis codes from the RAD it submitted to CMS. The Kaiser Health Plans did not adopt any such process to identify and redact or withdraw incorrect or

unsupported "refreshed" ICD-9 diagnosis codes from the RAD they submitted to CMS and failed to do so. As a result of the Kaiser Health Plans' failure and refusal to reasonably attempt to meet this obligation, they had no legitimate basis for certifying that the "refreshed" ICD-9 diagnosis codes they purportedly added to their MA enrollees' medical records and submitted to CMS were accurate, complete and truthful RAD.

168. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for improperly and invalid "refreshed" ICD-9 diagnosis codes that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid the Kaiser Health Plans at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

169. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the "refreshed" ICD-9 diagnosis codes submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

170. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

171. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

172. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs and Qui Tam Relators pray for relief as follows:

FOR THE FIRST CLAIM FOR RELIEF

1. Treble the Government's damages according to proof;

2. Civil penalties according to proof;

3. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE SECOND CLAIM FOR RELIEF

4. Treble the Government's damages according to proof;

5. Civil penalties according to proof;

6. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE THIRD CLAIM FOR RELIEF

7. Treble the Government's damages according to proof;

8. Civil penalties according to proof;

9. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE FOURTH CLAIM FOR RELIEF

10. Treble the Government's damages according to proof;

11. Civil penalties according to proof;

12. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

///

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FOR ALL CLAIMS FOR RELIEF

13. Attorney's fees, expenses, and costs; and

14. Such other and further relief as the Court deems just and proper.

THE ZINBERG LAW FIRM
A Professional Corporation

THE HANAGAMI LAW FIRM
A Professional Corporation

Dated: November 3, 2016

By: _____
William K. Hanagami
Attorneys for Plaintiffs and Qui Tam Relators,
Marcia Stein and Rodolfo Bone

REQUEST FOR JURY TRIAL

Plaintiffs and Qui Tam Relators hereby request a trial by jury.

THE ZINBERG LAW FIRM
A Professional Corporation

THE HANAGAMI LAW FIRM
A Professional Corporation

Dated: November 3, 2016

By: _____
William K. Hanagami
Attorneys for Plaintiffs and Qui Tam Relators,
Marcia Stein and Rodolfo Bone

PROOF OF SERVICE

STATE OF CALIFORNIA)
)
COUNTY OF LOS ANGELES)

I, the undersigned, certify and declare that I am over the age of 18 years, employed in the County of Los Angeles, State of California, and not a party to the above-entitled cause.

On November 3, 2016, I served a true copy of:

FIRST AMENDED COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, AND REQUEST FOR JURY TRIAL

by depositing it in the United States Mail at Woodland Hills, California in a sealed envelope with the postage thereon fully prepaid addressed to the following:

Arthur S. Di Dio U.S. DEPARTMENT OF JUSTICE Ben Franklin Station P.O. Box 261 Washington, DC 20044	Attorneys for United States of America
Erica Blachman Hitchings OFFICE OF THE UNITED STATES ATTORNEY 450 Golden Gate Avenue, 11th Floor San Francisco, CA 94102-3421	Attorneys for United States of America
Abram J. Zinberg THE ZINBERG LAW FIRM, A.P.C. 412 Olive Avenue, Suite 528 Huntington Beach, CA 92648-5142	Co-Counsel for Relators, Marcia Stein and Rudolfo Bone

Executed on November 3, 2016 at Woodland Hills, California.

I hereby certify that I am a member of the Bar of the United States District Court, Northern District of California.

I hereby certify under the penalty of perjury that the foregoing is true and correct.

William K. Hanagami

TAB 28

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Attorneys for Plaintiffs and Qui Tam Relators

2016 MAY 16 AM 10:26
CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CALIF.
LOS ANGELES
BY

N/S

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA [UNDER SEAL],

Plaintiffs,

vs.

[UNDER SEAL],

Defendants.

CASE NO.:
CV 16-03331 R (SSx)

COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT; [UNDER SEAL]

[**UNDER SEAL** PER 31 U.S.C. § 3730(b)(2)]

[UNDER SEAL]

PAID
MAY 16 2016

ORIGINAL

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Marcia Stein and Rodolfo Bone

FILED
2016 MAY 16 AM 10:28
CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CALIF.
LOS ANGELES
BY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* MARCIA STEIN and RODOLFO BONE,

Plaintiffs,

vs.

KAISER FOUNDATION HEALTH PLAN, INC., a California corporation, KAISER FOUNDATION HOSPITALS, a California corporation, KAISER FOUNDATION HEALTH PLAN OF COLORADO, a Colorado corporation, KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC., a Georgia corporation, KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC., a Maryland corporation, KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, an Oregon corporation, KAISER FOUNDATION HEALTH PLAN OF WASHINGTON, a Washington corporation, THE PERMANENTE MEDICAL GROUP, INC., a California corporation, SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, a business entity, form unknown, COLORADO PERMANENTE MEDICAL GROUP, a Colorado corporation, THE SOUTHEAST PERMANENTE MEDICAL GROUP, a Georgia corporation, HAWAII

CASE NO.
CV16-03331 R (SSx)

COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, AND REQUEST FOR JURY TRIAL

[**UNDER SEAL** PER 31 U.S.C. § 3730(b)(2)]

PAID
MAY 16 2016
Clerk, US District Court
COURT USE

PERMANENTE MEDICAL GROUP, a Hawaii corporation, MID-ATLANTIC PERMANENTE MEDICAL GROUP, a Maryland corporation; NORTHWEST PERMANENTE, P.C., an Oregon corporation; GROUP HEALTH PERMANENTE, a Washington corporation, and KAISER PERMANENTE, a business entity, form unknown,

Defendants.

COME NOW, Plaintiffs and Qui Tam Relators Marcia Stein and Rodolfo Bone, individually and on behalf of the United States of America, and allege as follows:

JURISDICTION AND VENUE

1. Plaintiffs and Qui Tam Relators Marcia Stein and Rodolfo Bone (Relators) file this action on behalf and in the name of the United States of America (Government) seeking damages and civil penalties against the defendants for violations of 31 U.S.C. § 3729(a).

2. This Court's jurisdiction over the claims for violations of 31 U.S.C. § 3729(a) is based upon 31 U.S.C. § 3732(a).

3. Venue is vested in this Court under 31 U.S.C. § 3732(a) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3729(a) occurred in the Central District of California. Venue is also vested in this Court under 28 U.S.C. § 1391(b) because at least one of the defendants transacts business in the Central District of California and many acts constituting violations of 31 U.S.C. § 3729(a) occurred in the Central District of California.

THE PARTIES

4. Relators are citizens of the United States and residents of the State of California. Relators bring this action of behalf of the Government under 31 U.S.C. § 3730(b).

5. At all times relevant, defendants Kaiser Foundation Health Plan, Inc. (KFHP) and Kaiser Foundation Hospitals (KFH) are and were corporations organized under the laws of California and transacted business in, among other places, the Central District of California.

6. At all times relevant, defendants Kaiser Foundation Health Plan of Colorado

(KFHPCO), Kaiser Foundation Health Plan of Georgia, Inc. (KFHPGA), Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (KFHPMAS), Kaiser Foundation Health Plan of the Northwest (KFHPNW), and Kaiser Foundation Health Plan of Washington (KFHPWA) are and were corporations organized under the laws of Colorado, Georgia, Maryland, Oregon and Washington, respectively.

7. KFHP, KFHPCO, KFHPGA, KFHPMAS, KFHPNW and KFHPWA are collectively referred to as "Kaiser Health Plans."

8. At all times relevant, defendant The Permanente Medical Group (TPMG) is and was a corporation organized under the laws of California.

9. At all times relevant, defendants Southern California Permanente Medical Group (SCPMG) and Kaiser Permanente (KP) are and were business organizations, forms unknown, and transacted business in, among other places, the Central District of California.

10. At all times relevant, defendant Colorado Permanente Medical Group (CPMG) is and was a Colorado corporation.

11. At all times relevant, defendant The Southeast Permanente Medical Group (SEPMG) is and was a Georgia corporation.

12. At all times relevant, defendant Hawaii Permanente Medical Group (HPMG) is and was a Hawaii corporation.

13. At all times relevant, defendant Mid-Atlantic Permanente Medical Group (MAPMG) is and was a Maryland corporation.

14. At all times relevant, defendant Northwest Permanente, P.C. (NWP) is and was an Oregon corporation.

15. At all times relevant, defendant Group Health Permanente (GHP) is and was a Washington corporation.

16. Defendants TPMG, SCPMG, CPMG, SEPMG, HPMG, MAPMG, NWP, and GHP are collectively referred to as "Physician Medical Groups" or "PMGs."

17. Kaiser Permanente (KP) is a business entity, form unknown, that is, and at all times mentioned was, made up of three groups of interdependent entities, the Kaiser Health

Plans, KFH and the PMGs, through an exclusive contractual relationship, that operates as one the nation's largest integrated health care delivery system focused on providing managed health care services to HMO beneficiaries and to seniors through the federal Medicare Advantage health care program. The Kaiser Health Plans provide, among other things, infrastructure and support in Information Technology (IT), Human Resources (HR), Compliance, Coding, Health Information Management (HIM), and Finance to KFH and its regional hospitals, medical centers and clinics, and to the PMGs and their regional medical groups and medical clinics. KFH provides hospital facilities and services to the Kaiser Health Plans' HMO and Medicare Advantage beneficiaries, and has various infrastructure functions and departments, including but not limited to HIM. The PMGs provide medical, diagnostic and physician services to the Kaiser Health Plans' HMO and Medicare Advantage beneficiaries.

18. In California, there are two regional medical groups: (a) defendant SCPMG, consisting of California physicians providing medical services to KP patients in the areas of Ventura County and all counties south thereof; and (b) defendant TPMG, consisting of California physicians providing medical services to KP patients in all remaining counties north of Ventura County.

19. CPMG is a regional medical group consisting of physicians providing medical services in Colorado to KP patients.

20. SEPMG is a regional medical group consisting of physicians providing medical services in Georgia to KP patients.

21. HPMG is a regional medical group consisting of physicians providing medical services in Hawaii to KP patients.

22. MAPMG is a regional medical group consisting of physicians providing medical services in Maryland, Virginia and Washington, D.C. to KP patients.

23. NWP is a regional medical group consisting of physicians providing medical services is Oregon and Washington to KP patients.

24. GHP is a regional medical group consisting of physicians providing medical

services in Washington to KP patients.

25. Relator Marcia Stein (Stein) is an AHIMA Registered Health Information Administrator (RHIA) and was employed by both the SCPMG and KFH. At SCPMG worked at Panorama City as the clinic records administrator and worked at KFH's Panorama City, California hospital as the Regional Director of KFH's Health Information Managers from about October 1987 until about May 2011. Health Information Managers are professionals with expertise in managing health information systems, and processing, analyzing and reporting information vital to the operations of hospitals, medical groups, medical clinics and health plans. Typically, Health Information Managers are also responsible for training physicians, health care professionals and coders on utilizing the available health information systems, electronic health records (EHR) and correct coding and documentation practices.

26. While employed at KFH Hospital-Panorama City, Stein reported to both the regional SCPMG and the KFH Hospital-Panorama City's managements. On behalf of SCPMG, Stein supervised a staff of over 100 full-time employees, including coders, billers, trainers, clinic staff and legal assistants (with regard to physician malpractice claims), and was charged with implementing defendants' policies and procedures regarding medical record documentation and compliance, HIPAA security, and physician training and education. Stein attended monthly SCPMG Clinic Administrator and Regional Department meetings. Stein was also responsible for overseeing the Panorama City hospital's health information systems, coding, medical record documentation, HIPAA security, and related compliance issues, as well as being a contact person for various state and federal hospital data reporting questions or issues. Stein co-chaired the monthly regional HIM Director's meetings (for the Southern California Region), chairing the majority. Such meetings addressed coding and documentation problems with SCPMG senior leadership on behalf of other regional KFH HIM Directors.

27. Between 2010 and 2016, Rodolfo Bone (Bone) was a part employee of KFH at its South Bay hospital in Harbor City, California as a per diem coder. At the beginning of 2016 his position was moved to KFH's Southern California corporate offices in Pasadena, California where he continued as a per diem coder reporting to KFH's Regional Revenue

Cycle. Beginning in 1996 and continuing until the present, Bone has been employed full time by Good Samaritan Hospital, located in Los Angles California, as a Coding Supervisor and Coding Auditor. Bone was born and raised in the Philippines where he graduated from medical school, and was and is licensed to practice medicine in the Philippines.

MEDICARE ADVANTAGE AND RISK ADJUSTMENT

28. At all times relevant, the United States (Government) funded the Medicare program, administered by the Centers for Medicare and Medicaid Services (CMS), which provides payment of healthcare services for, among others, Americans 65 years of age and older. Medicare provides an option, Medicare Advantage (MA), in which eligible Medicare beneficiaries can enroll with a health plan or managed care organization (collectively, "MAO") contracted with CMS for a capitated rate paid by CMS that generally provides at least those services provided to standard fee-for-service (FFS) Medicare beneficiaries. (*See,* 42 U.S.C. § 1395w-21(a).)

29. At all times relevant, each of the Kaiser Health Plans had a MA contract with CMS, the federal agency that administers the Medicare program, to provide MA benefits to eligible enrollees. Eligible MA enrollees selected the Kaiser Health Plan in their locale and selected a primary care physician from a directory of PMG physicians near the enrollees' residence. The revenues from these MA contracts were a significant source of revenues for defendants. The revenues the PMGs received for the MA enrollees they serviced were also the primary source of funding for any physician bonuses that were paid.

30. At all times relevant, Section 1853(a)(3) of the Social Security Act [42 U.S.C. § 1395w-23(a)(3)] required the Government's Centers for Medicare and Medicaid Services (CMS) to risk adjust payments to Medicare Advantage organizations (MAOs), such as the Kaiser Health Plans. In general, the risk adjustment methodology relied on enrollee diagnoses, as specified by the International Classification of Disease, Ninth Revision Clinical Modification (ICD-9) Guidelines (ICD-9 Guidelines), to prospectively adjust capitation payments for a given enrollee based on the health status of the enrollee. Diagnosis codes (ICD-9 codes) collected from physicians and related information (collectively, "risk

adjustment data") submitted by MAOs, such as the Kaiser Health Plans, to CMS were used to develop Hierarchical Condition Category (HCC)[1] risk scores that are used by CMS to risk adjust the capitated payment rates paid by the Government to that particular MAO. The HCC risk scores compensated a MAO with a population of patients with more severe illnesses than normal through higher capitation rates. Likewise, a MAO with a population of patients with less severe illnesses than normal would see a downward adjustment of its capitation rates because it was servicing a healthier than normal population of patients. By risk adjusting MAO payments, CMS attempts to make appropriate and accurate payments for enrollees with differences in expected healthcare costs. Risk adjustment data records the health status and demographic characteristics of an enrollee.

31. In order to obtain an HCC risk adjustment score for a MA enrollee for a given year, the enrollee must have an encounter with a medical provider or examiner that generates a diagnosis code or codes, which were timely submitted to CMS. If a MA enrollee does not have a reported encounter with a medical provider or examiner that generates a diagnosis code or codes during the year, the following year, CMS will pay the MAO a capitated rate for that MA enrollee as though s/he was perfectly healthy, even though in prior years the MA enrollee had a number of diagnoses that resulted in significant HCC risk adjustment scores and correspondingly high capitation rates.

32. Risk adjustment data (RAD) submitted by or on behalf of a MAO to CMS must be supported by properly documented medical records from the encounter that led to the RAD. 42 C.F.R. §§ 422.310(c)(2) and (d), 422.504(l); Medicare Managed Care Manual, Ch. 7, § 40 [Medicare Advantage Organizations "must . . . [e]nsure the accuracy and integrity of risk adjustment data submitted to CMS. All diagnosis codes must be documented in the medical record and must be documented as a result fo a face-to-face visit. . . ."]; *see also,* 79 Fed.Reg. No. 100, 29844, 29923 (May 23, 2014) ["Further, CMS has required for many years that

[1]Not all diagnoses result in a HCC risk score. Only certain diagnosis codes or combinations thereof result in HCC risk scores. CMS reviews and publishes the list of relevant ICD-9 diagnosis codes and their related HCC coefficients annually. A HCC risk score will vary upon the diagnosis codes or combinations thereof according to a matrix determined by the Government.

diagnoses that MA organizations submit for payment be supported by medical record documentation."] In order to be a properly documented medical record, the medical record entries must, among other things, (1) be the result of a MA enrollee's face-to-face encounter with a medical provider or examiner legally authorized to perform the service rendered under applicable Medicare laws, regulations and rules,[2] (2) that accurately and truthfully documents the findings necessary to support the medical diagnoses by the medical provider/examiner in accordance with applicable Medicare laws, regulations and rules,[3] and (3) signed by the medical provider/examiner as required by Medicare.[4] Further, the diagnoses must be coded in accordance with all applicable national guidelines, including but not limited to International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting, and the American Health Information Management Association (AHIMA) national guidelines for ethical coding.[5] AHIMA is a member of the ICD9CM and the ICD10CM Cooperating Parties, thus their practice briefs are considered "industry standards." Failure to meet any of these required elements results in the medical record not being properly documented and being unable to support RAD arising therefrom and invalidating the submission of such RAD (i.e., ICD-9 diagnosis codes).

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[2]*See,* Medicare Managed Care Manual, Ch. 7, § 40 ["All diagnosis codes submitted must be documented in the medical record and must be documented as a result of a face-to-face visit. . . . "]; 42 U.S.C. § 1395x(r) , (aa)(5)(A), (aa)(6); 42 C.F.R. §§ 410.20(b), 410.74(a)(2), 410.75(b)-(c), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d).

[3]42 C.F.R. §§ 422.310(c)(2) and (d), 422.504(l)(2)-(3); CMS Pub.100-08, Medicare Program Integrity Manual, Ch. 3, §3.3.2.5; International Classification of Disease 9th Revision Guidelines (ICD-9), made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d), and Medicare Managed Care Manual, Ch. 7, § 40 ["The diagnosis must be coded according to International Classification of Diseases, (ICD) Clinical Modification Guidelines for Coding and Reporting."]

[4]Medicare Program Integrity Manual, Ch. 3, §3.3.2.4, made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b)(2) and 422.310(d).

[5]42 C.F.R. § 422.310(d)(1) ["MA organizations must submit data that conform to CMS' requirements for data equivalent to Medicare fee-for-service data, when appropriate, and to all relevant national standards. . . ."]; Medicare Managed Care Manual, Ch. 7, § 40 ["The diagnosis must be coded according to International Classification of Diseases (ICD) Clinical Modification Guidelines for Coding and Reporting."]; AHIMA 2009, Amendments, Corrections ans Deletions in the electronic Health Record: Toolkit, pp. 1-8, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678; Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A)-(B).

33. MAOs do not typically submit claims for services rendered to CMS in the traditional FFS sense. The capitation payments are paid in advance, and by accepting the capitated payments, MAOs agree to be at risk for all of the health care costs for the MA enrollees assigned to it. Capitation payments are made prospectively with the data for the current calender year being used to risk adjust the capitation payments for that specific MA enrollee in the subsequent calender year. Instead of submitting traditional FFS claims, MAOs submit RAD which are used by CMS to calculate and risk adjust the capitation payments paid by CMS to the MAOs for each MA enrollee. Because the capitation payments are adjusted based upon the MAOs' submission of RAD, the submission of RAD is considered by the Government as the submission of claims for payment to CMS for purposes of enforcing civil and criminal penalties for making false claims under Social Security Act §§1128A [42 U.S.C. § 1320a–7a], 1128 B [42 U.S.C. § 1320a–7b] and the False Claims Act, 31 U.S.C. § 3729.

34. CMS has made it clear that MAOs, such as the Kaiser Health Plans, "must be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and "are expected to have effective and appropriate payment evaluation procedures and effective compliance programs as a way to avoid receiving or retaining overpayments." Additionally, "we [CMS] have always expected that MA organizations or Part D sponsors implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29,884, 29,921, 29,923-29,924 (May 14, 2014).)

35. The MA program requires MAOs provide, at a minimum, all of the benefits available under original Medicare (Parts A and B). The MA program incorporates into it all of the coverage determinations, rules and regulations of Medicare Parts A and B unless such regulations are specifically altered or superceded by the Medicare Part C regulations that specifically govern the MA program.

36. As will be explained in detail below, at various times during and between 2010 and the present, the defendants submitted false and fraudulent claims to CMS in violation of 31 U.S.C. § 3729(a) by (a) making and submitting to CMS false, inaccurate and exaggerated

diagnoses for sepsis that were not supported by properly documented medical records, (b) making and submitting to CMS false, inaccurate and exaggerated diagnoses for malnutrition that were not supported by properly documented medical records, (c) making and submitting to CMS diagnoses resulting from improper and unethical leading physician queries, (d) performing medical record reviews designed to only identify and report to CMS previously unreported diagnosis codes that concealed and failed to withdraw from CMS previously reported diagnosis codes that were unsupported by the reviewed medical records.

SEPSIS

37. The current lay-person definition of sepsis and sepsis with acute organ failure (collectively, "Sepsis") is "Sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs." (The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3), *JAMA*, (February 23, 2016) Vol. 315, No. 8, 801, 807.) "Sepsis is not a specific illness but rather a syndrome encompassing a still-uncertain pathobiology. At present, it can be identified by a constellation of clinical signs and symptoms in a patient with suspected infection." (*Id.* at 803.) Sepsis is characterized by "signs of inflammation (vasodilator, leukocyte accumulation, increased micro vascular permeability) occurring in tissues that are remote from the infection. Systemic inflammatory response syndrome (SIRS) is an identical clinical syndrome that complicates a noninfectious insult (e.g., acute pancreatitis, pulmonary contusion).... This response can lead to multiple organ dysfunction syndrome (MODS), which is the cause of the high mortality associated with these syndromes." (Sepsis Definitions: Time for Change, *Lancet,* (March 2, 2013), Vol. 381, No. 9868, 774–775 (See, http://doi.org/10.1016/S0140-6736(12)61815-7).)

38. The term Sepsis is usually reserved for patients that need to be admitted to the hospitals intensive care unit (ICU). (See, Sepsis Definition: Time For Change, *Lancet* (March 2, 2013) Vol. 381, No. 9868, pp. 774–775.) Patients who develop Sepsis face a substantial likelihood of death as it is one of the main causes of death among hospital patients. Sepsis has been estimated to be the cause or related to of as many as 1 out of every 2 to 3 in-patient hospital deaths. (Hospital Deaths in Patients With Sepsis From 2 Independent Cohorts, *JAMA,*

(July 2, 2014) Vol. 312, No. 1, 90-92 at p. 90. (See, http://jama.jamanetwork.com/article.aspx?articleid=1873131).) During 2009, the national mean length of stay for patients who had Sepsis as their principal diagnosis was 8.8 days and 15.8 days for patients with Sepsis as a secondary diagnosis. (Agency for Healthcare Research and Quality (AHRQ), HealthCare Cost and Utilization Project (H-CUP), Statistical Brief #122, p. 4 (October 2011).)

39. During 1991, the American College of Chest Physicians (ACCP) and the Society of Critical Care Medicine (SCCM) convened a Sepsis "Consensus Conference" the purpose of which, "[I]s to propose a conceptual framework for future studies of the clinical phenomenon of organ system dysfunction in critical illness, and to lay the foundations for common terminology and criteria to describe the syndrome." (The ACCP/SCCM Consensus Conference Statement - 1991, *Chest*, (June 1992) Vol. 101, 1644, 1648.) In other words, to provide some broad definitions of Sepsis so that researches could conduct effective clinical trials. (*See,* 2001 International Sepsis Definitions Conference, *Intensive Care Med.,* (March 28, 2003) Vol. 29, 530, 531.) The 1991 Consensus Conference introduced into common parlance the term "systemic inflammatory response syndrome" (SIRS). The term provided a reference for the complex findings that result from a systemic activation of the innate immune response, regardless of cause. (*Id.*) "This systemic inflammatory response can be seen following a wide variety of insults and includes, but is not limited to, more than one of the following clinical manifestations:

– Body temperature higher than 38°C or lower than 36°C

– Heart rate higher than 90/min

– Hyperventilation evidenced by respiratory rate higher than 20/min or PaCO2lower than 32 mmHg

– White blood cell count higher than 12,000 cells/ µl or lower than 4,000/ µl

These physiologic changes should represent an acute alteration from baseline in the absence of other known causes for such abnormalities. . . ." (The ACCP/SCCM Consensus Conference Statement - 1991, *Chest*, (June 1992) Vol. 101, 1644, 1645.) The SIRS concept has been globally adopted by clinical investigators resulting in approximately 800 research articles

about SIRS and/or Sepsis between 1992 and 2002.

40. The 1991 Consensus Conference introduced the concept that Sepsis is the body's inflammatory response to infection. The conference concluded that patients with elevations in at least two of four variables that are indicators of inflamation (temperature, heart rate, respiratory rate, and white blood cell count) were suspect of having SIRS, and that patients with elevations in at least two of the four variables and an infection were potential indicators of sepsis. However, the Consensus Conference instructed physicians **not** to use the SIRS criteria plus infection as a diagnostic standard, "To help identify these manifestations as sepsis, it should be determined whether they are a part of the direct systemic response to the presence of an infectious process. Also, the physiologic changes measured should represent an acute alteration from baseline **in the absence of other known causes for such abnormalities**." (Emphasis added; The ACCP/SCCM Consensus Conference Statement - 1991, *Chest,* (June 1992) Vol.101, 1644, 1646.)

41. In 2001, the definitions of sepsis and SIRS were revisited at the International Sepsis Definitions Conference sponsored by the ACCP, SCCM, the European Society of Intensive Care Medicine (ESICM), the American Thoracic Society (ATS), and the Surgical Infection Society (SIS). The 2001 International Sepsis Definitions Conference ("2001 Conference") goals included identification of ways to improve the current sepsis definitions and to identify methodologies for increasing the accuracy, reliability, and/or clinical utility of the diagnosis of sepsis. (2001 International Sepsis Definitions Conference, *Intensive Care Med.,* (March 28, 2003) Vol. 29, 530, 531.) The 2001 Conference addressed at length the short-comings of the then current sepsis and SIRS definitions. The SIRS criteria had been found to have no practical use to a clinician for diagnosing Sepsis and concluded, among other things, "[T]he specific criteria proposed in the 1992 consensus definitions are widely considered to be too nonspecific to be of utility in diagnosing a cause of the syndrome or in

identifying a distinct pattern of host response."[6] (2001 International Sepsis Definitions Conference, *Intensive Care Med.*, (2003) Vol. 29, 530, 532.) The final Report from the 2001 Conference further concluded, "Unfortunately a clinically useful set of criteria for diagnosing sepsis and related conditions will necessarily be somewhat arbitrary. There is no 'gold standard' (such as the infarcted myocardium) against which the diagnostic criteria can be calibrated." (*Id.* at 532.)

42. Although the 2001 Conference did not result in a new definition of sepsis, it clarified that SIRS criteria were not intended to be used as a physician diagnostic tool but rather a starting point for researchers to identify clinical trials participants. (*Id.* at 532.) In response to the limitations noted of the SIRS definition, the 2001 Conference Report stated that clinical findings such as, "[H]emodynamic instability, arterial hypoxemia, oliguria, coagulopathy, and altered liver function tests among the list of criteria that can be used to establish the diagnosis of sepsis." (*Id.* at 533.) The Report included an expansive list of possible signs, symptoms and potentially sceptic values, grouped into five main categories, General Parameters, Inflammatory Parameters Hemodynamic Parameters, Organ Dysfunction Parameters, and Tissues Perfusion Parameters, to aid physicians in making and confirming Sepsis as opposed to less severe medical conditions.[7] (*Id.* at 533-34.)

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[6]The 2001 International Sepsis Definitions Conference cited the work of J.C. Marshall who concluded, "The four criteria that define SIRS are non-specific measures of physiologic severity, rather than distinctive manifestations of a disease process....However, the complexity of the biologic processes involved suggest that a clinical syndrome of systemic inflammation is of no more use to the clinician than a clinical syndrome of cancer." (SIRS and MODs: What is Their Relevance to the Science and Practice of Intensive Care, *Shock,* (December 2000) Vol. 12, No. 6, 586-9.

[7]The complete list of Sepsis diagnostic criteria was stated as Infection documented or suspected and some of the following:

> General parameters
> Fever (core temperature >38.3°C) Hypothermia (core temperature <36°C Heart rate >90 bpmor >2 SD above the normal value for age Tachypnea: >30 bpm Altered mental status Significant edema or positive fluid balance (>20 ml/kg over 24 h) Hyperglycemia (plasma glucose >110 mg/dl or 7.7 mM/l) in the absence of diabetes
>
> Inflammatory parameters
> Leukocytosis (white blood cell count >12,000/μl) Leukopenia (white blood cell count <4,000/μl) Normal white blood cell count with >10%

43. The Report emphasized that its expanded list of clinical findings were not specific to sepsis and therefore, like the SIRS criteria, the list could not be used as a diagnostic standard in all cases. The physician still had to determine if a medical condition other than sepsis was the cause of the patient's symptoms and/or elevated values before diagnosing sepsis or sepsis acute organ failure, when applicable, and separately determine if such organ failure was a result of Sepsis or some other cause. Other medical conditions besides Sepsis can also account for increases in the 2001 Conference criteria including, but not limited to, post operative surgery recovery, minor respiratory infections, minor urinary tract infections, trauma as well as certain medications. The Report stressed, "It is important that as a practitioner 'checks off the boxes' to establish the diagnosis of sepsis; only findings that cannot be easily explained by other causes should be included." *Id.* "Most clinicians do not refer to patients as septic when they develop an uncomplicated mild upper-respiratory viral infection with slight fever and tachycardia, (i.e., a faster than normal heart rate.)" (Sepsis Definitions: Time For Change, *Lancet*, March 2, 2013, Vol. 381, No. 9868, 774–775.)

44. Between 2001 and 2010 several organized approaches to identify and treat Sepsis were proposed. The two most prominent of these organized treatment approaches were Early Goal-Directed Therapy for the treatment of Sepsis and Sceptic Shock (EGDT) published in the New England Journal of Medicine (N Engl J Med (November 8, 2001) Vol. 345, 1368-

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immature forms Plasma C reactive protein>2 SD above the normal value Plasma procalcitonin >2 SD above the normal value

Hemodynamic parameters
Arterial hypotensionb (systolic blood pressure <90 mmHg, mean arterial pressure <70, or a systolic blood pressure decrease >40 mmHg in adults or <2 SD below normal for age) Mixed venous oxygen saturation >70%b Cardiac index >3.5 l min 1 m 2c,d

Organ dysfunction parameters
Arterial hypoxemia (PaO2/FIO2 <300) Acute oliguria (urine output <0.5 ml kg 1 h 1 or 45 mM/l for at least 2 h) Creatinine increase 0.5 mg/dl Coagulation abnormalities (international normalized ratio >1.5 or activated partial thromboplastin time >60 s) Ileus (absent bowel sounds) Thrombocytopenia (platelet count <100,000/µl) Hyperbilirubinemia (plasma total bilirubin >4 mg/dl or 70 mmol/l)

Tissue perfusion parameters
Hyperlactatemia (>3 mmol/l) Decreased capillary refill or mottling

1377), and continuing since 2002, the Surviving Sepsis Campaign, a joint collaboration of the Society of Critical Care Medicine and the European Society of Intensive Care Medicine. The Surviving Sepsis Campaign (SSC) published and continuously updated Surviving Sepsis Bundles that outline the basic treatment protocols along with detailed treatment guidelines to provide institutions and physicians with a coordinated effort to measure and manage each of the five parameters for diagnosing Sepsis identified in the 2001 Conference (i.e., General Parameters, Inflammatory Parameters Hemodynamic Parameters, Organ Dysfunction Parameters, and Tissues Perfusion Parameters). During or about 2013, the SSC's Surviving Sepsis Bundles and guidelines were adopted by CMS and Center For Disease Control (CDC).

45. The SSC Surviving Sepsis Bundle states:

TO BE COMPLETED WITHIN 3 HOURS:

1) Measure lactate level
2) Obtain blood cultures prior to administration of antibiotics
3) Administer broad spectrum antibiotics
4) Administer 30 ml/kg crystalloid for hypotension or lactate 4mmol/L

"Time of presentation" is defined as the time of triage in the emergency department or, if presenting from another care venue, from the earliest chart annotation consistent with all elements of severe sepsis or septic shock ascertained through chart review.

TO BE COMPLETED WITHIN 6 HOURS:

5) Apply vasopressors (for hypotension that does not respond to initial fluid resuscitation) to maintain a mean arterial pressure (MAP) 65 mm Hg
6) In the event of persistent hypotension after initial fluid administration (MAP < 65 mm Hg) or if initial lactate was 4 mmol/L, re-assess volume status and tissue perfusion and document findings according to Table 1.
7. Re-measure lactate if initial lactate elevated.

TABLE 1

DOCUMENT REASSESSMENT OF VOLUME STATUS AND TISSUE PERFUSION WITH:

EITHER:

• Repeat focused exam (after initial fluid resuscitation) including vital signs, cardiopulmonary, capillary refill, pulse, and skin findings.

OR TWO OF THE FOLLOWING:

• Measure CVP

- Measure ScvO2
- Bedside cardiovascular ultrasound
- Dynamic assessment of fluid responsiveness with passive leg raise or fluid challenge. (http://www.survivingsepsis.org/Bundles/Pages/default.aspx.)

46. The SSC guidelines and EGDT each contemplate that physicians timely diagnose Sepsis, take multiple blood samples prior to the administration of antibiotics for obtaining an accurate blood culture, monitor and managing the patients fluid retention, monitor arterial pressure via central venous catheter (i.e. an arterial catheter placed in the Vena Cava artery) administer IV fluids, measure and adjust lactate levels (a precursor to organ failure), and administer various medications including, but not limited to, antibiotics to fight the infection, and vasopressors and corticosteroids, as needed, to manage fluid retention and prevent organ failure.[8] (Early Goal-Directed Therapy for the treatment of Sepsis and Sceptic Shock, *N Engl J Med,* (November 8, 2001) Vol. 345, 1368-1377; http://www.survivingsepsis.org/Guidelines/Pages/default.aspx.) Typically, MA enrollees that have a central venous catheter inserted are admitted to or already in the ICU.

47. The SSC's detailed treatment guidelines, provided in conjunction with the Surviving Sepsis Bundles, include but are not limited to: Initial Resuscitation and Infection Issues; Hemodynamic Support and Adjunctive Therapy; Blood Product, Immunoglobulins and Selinum Administration; Mechanical Ventilation of Sepsis-Induced Acute Respiratory Distress Syndrome (ARDS); Sedation, Analgesia, and Neuromuscular Blockade; Glucose Control; Renal Replacement Therapy; Bicarbonate Therapy; Deep Vein Thrombosis Prophylaxis; Stress Ulcer Prophylaxis; and Nutrition to address various patient responses and provide treatment options. (Id.) Administering such complex Sepsis treatments routinely take place in the hospital's ICU. (*Id.*)

48. Based on the 2001 Conference's final report, during 2003 the ICD-9 Guidelines and the ICD-9 codes were modified to include the 2001 International Sepsis Definition Conference's expanded list of sepsis and sepsis with acute organ failure, resulting in a more

[8]In 2015, based on the best available evidence, the Surviving Sepsis Bundle was updated making the use of a central venous catheter to monitor blood oxygen or pressure levels optional instead of required.

expansive and detailed diagnostic and coding scheme for properly documenting and coding Sepsis. The ICD-9 Guidelines explain in detail the precise sequence of steps required to properly code the various stages of Sepsis, including but not limited to, sepsis, sepsis with organ dysfunction, sepsis with multiple organ dysfunction, sepsis caused by various types of infections, and septic shock. (*ICD-9-CM Official Guidelines for Coding and Reporting*, §I.C.1.b.1.-12.) Further, the ICD-9 Guidelines repeatedly stress that coders will likely have to query physicians when documenting Sepsis to trigger proper documentation that supports the Sepsis diagnosis due the complex nature of those diseases.[9] While the ICD-9 Guidelines explain the minium information required for coders to properly record a particular ICD-9 diagnosis code, it does not explain to the physician all of the steps and criteria for making a particular diagnosis. It is not uncommon for the medical standard of care to be more detailed and complex than the ICD-9 Guidelines.

49. On or about February 23, 2016, JAMA published the Report of The Third International Sepsis Definitions Conference. This Third Sepsis Definitions Conference (Sepsis-3) adopted a new definition of Sepsis that was consistent with the current state of the medical practice and research since the 2001 Conference. "The task force sought to differentiate sepsis from uncomplicated infection and to update definitions of sepsis and septic shock to be consistent with improved understanding of the pathobiology.... The sepsis illness concept is predicated on infection as its trigger, acknowledging the current challenges in the microbiological identification of infection. . . . The task force recognized that sepsis is a syndrome without, at present, a validated criterion standard diagnostic test." (The Third International Consensus Definitions for Sepsis and Septic Shock, *JAMA* (Feb. 2016) Vol. 315,

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[9]The ICD-9 Guidelines state, "Due to the complex nature of sepsis and severe sepsis, some cases may require querying the provider prior to assignment of the codes." §I.C.1.b.1.c. "If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign code 995.92, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider." §I.C.1.b.5. "Sepsis or severe sepsis may be present on admission but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether the sepsis or severe sepsis was present on admission, the provider should be queried." §I.C.1.b.2.c.

No. 8, 801, 803.) The new sepsis definition from Sepsis-3 was stated as:

> In lay terms, sepsis is a life-threatening condition that arises when the body's response to an infection injures its own tissues and organs.
>
> Patients with suspected infection who are likely to have a prolonged ICU stay or to die in the hospital can be promptly identified at the bedside with qSOFA, ie, alteration in mental status, systolic blood pressure 100 mm Hg, or respiratory rate 22/min.
>
> Septic shock is a subset of sepsis in which underlying circulatory and cellular/metabolic abnormalities are profound enough to substantially increase mortality.
>
> Patients with septic shock can be identified with a clinical construct of sepsis with persisting hypotension requiring vasopressors to maintain MAP 65 mm Hg and having a serum lactate level >2 mmol/L (18 mg/dL) despite adequate volume resuscitation. With these criteria, hospital mortality is in excess of 40%. Abbreviations: MAP, mean arterial pressure; qSOFA, quick SOFA; SOFA: Sequential [Sepsis-related] Organ Failure Assessment. (*Id.* at 805.)

The Sepsis-3 Report concludes that, "The current use of 2 or more SIRS criteria to identify sepsis was unanimously considered by the task force to be unhelpful. Changes in white blood cell count, temperature, and heart rate reflect inflammation, the host response to 'danger' in the form of infection or other insults. The SIRS criteria do not necessarily indicate a dysregulated, life-threatening response. SIRS criteria are present in many hospitalized patients, including those who never develop infection and never incur adverse outcomes." (*Id.*) This conclusion is very similar to the conclusions published from the 2001 Conference. (2001 International Sepsis Definition Conference, *Intensive Care Med.* (2003) Vol. 29, 530, 532-4.) A further change was to abandon the use of the term "severe sepsis," i.e., sepsis with organ dysfunction, because all sepsis cases are severe due to their potential to cause death. Lastly, the Sepsis-3 Report recognized that Septic Shock, i.e., sepsis involving multiple organ failure, has an even higher likelihood of patient death than sepsis. In an e-mail to its staff dated March 8, 1016, KFHP unequivocally rejected the modern Sepsis-3 definitions and diagnostic recommendations.

DEFENDANTS' FRAUDULENT MISCONDUCT

50. During and between approximately 2010 to the present, SCPMG, TPMG, KFH and KFHP participated in a fraudulent scheme to up-code and falsely diagnose MA enrollees with sepsis and/or severe sepsis, i.e., sepsis with acute organ failure, (collectively referred to

as "Sepsis") when Sepsis was not present. Such false Sepsis diagnoses were made in order to increase the risk adjustment scores for the MA enrollees so diagnosed and thereby increase CMS's capitation payments to KFHP. This scheme was also promoted by KFHP to falsely lower KFHP's reported Sepsis mortality rates thereby improve KFHP's reputation and prestige as a quality hospital provider. This fraudulent scheme concerned the identification and treatment of Sepsis for KFHP's MA enrollees that presented in the emergency room (ER) of KFH hospitals and was accomplished by (a) KFHP, PMG and SCPMG and KFH implementing unwritten policies that prohibited coders employed by KFHP, KFH, SCPMG and TPMG, (individually and collectively referred to as "Kaiser's coders") from performing physician queries for Sepsis diagnoses as required by the ICD-9 Guidelines, (b) implementing unwritten policies requiring Kaiser's coders to code ICD-9 diagnosis codes for Sepsis based solely on the physician's instructions to code Sepsis instead of relying on the supporting clinical findings documented in the medical record, (c) using an improper Sepsis diagnostic standard that overstated the frequency of Sepsis diagnoses, (d), aggressively diagnosing Sepsis as part of a strategy to lower the reported Sepsis mortality rate at KFH hospitals throughout California, and (e) KFHP, TPMG and SCPMG, as an express condition of receiving capitation payments from CMS, routinely and annually falsely certifying that such ICD-9 diagnosis codes for Sepsis were accurate, complete and truthful to their best knowledge, information and belief, required by CMS as a condition of receiving payment, when KFHP, TPMG and SCPMG knew or should have known that such certifications were false.

51. During or about 2008 and 2009, TPMG and SCPMG adopted unwritten policies instructing Kaiser's coders to code Sepsis based upon a physician's instruction to code Sepsis and prohibiting Kaiser's coders from performing coding queries regarding Sepsis diagnoses. Kaiser's coders are required to perform coding queries by the ICD-9 Guidelines and AHIMA's Ethical Coding Guidelines when such queries are needed to trigger clinical documentation required to properly support or to properly rule out a Sepsis diagnosis.

52. In 2009, several KFHP HIM directors from Southern California KFH hospitals including the HIM Director for KFH Hospital-Woodland Hills, Vivian Wachs, Registered

Health Information Technician (RHIT), informed Stein, co-chair of the Southern California Region monthly HIM meetings, and all of the HIM Directors in attendance, that their local SCPMG physician leadership was insisting that Sepsis be coded at the physician's discretion and without supporting clinical findings properly documented in the medical record as required by the ICD-9 Guidelines and by CMS. (42 C.F.R. §422.310(b)-(d); CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq.) In response, Stein requested and was granted permission by Dr. Kirk Tamaddon, SCPMG's Chief Regional Physician Liaison, who chaired the SCPMG regional meetings, to make a presentation on Sepsis coding guidelines and Sepsis medical record documentation requirements at the October 2009, SCPMG physician leadership meeting.[10] In addition to Dr. Tamaddon, the meeting was attended by at several SCPMG Regional Medical Directors, and several Regional Operational Directors, approximately 15 SCPMG Physician Liaisons and/or physician representatives and 20 SCPMG Data Quality Managers and Encounter Coding Specialists.

53. Stein's presentation explained, among other things, that all of the symptoms and clinical findings that supported a diagnosis of Sepsis and all clinical findings and test results that support a diagnoses of organ dysfunction caused by Sepsis had to be documented in the medical records. Additionally, because of the complexity of the diagnoses, it was likely that Kaiser's coder needed to clarify the clinical findings and symptoms by making queries to physicians intended to trigger clarifying responses of the medical record's supporting documentation. Shortly after Stein finished her presentation, Dr. Albert Dreskin, SCPMG's Woodland Hill's Physician Liaison, informed the attendees to disregard the presentation Stein had just given, falsely asserting that SCPMG physicians had no requirement to provide additional clinical documentation for a Sepsis diagnoses because Sepsis was a clinical decision therefore all that was required was for the physician to write Sepsis. Dr. Dreskin concluded his remarks by reminding the attendees that diagnosing Sepsis was worth a lot of money to the defendants because it increased the MA enrollees' risk adjustment scores. In fact, the

[10]Physician Liaisons are responsible for implementing monitoring and communicating to physicians and staff the PMG's regional directives regarding coding and documentation.

submission of the ICD-9 diagnosis code for sepsis resulted in a HCC risk score of.754 which increased the capitation payments for each such diagnosed MA enrollee by approximately $8,500 for the next year.

54. Following the October 2009 SCPMG physician leadership meeting and continuing through to the present, SCPMG physician and coding leadership routinely insisted that Sepsis be coded whenever the physician wrote the word Sepsis in the medical record and prohibited Kaiser's coders from making coding queries to clarify the supporting medical record documentation. Such coding instructions and query restrictions violate ICD-9 Guidelines and AHIMA ethical coding guidelines. The blatantly improper coding practice was unique to the defendants' coding and documentation of Sepsis. Kaiser's coders did not have such coding instructions or query restrictions with regards to any other diagnoses. Stein witnessed these improper Sepsis coding policies at KFH Hospital-Panorama City and was informed by other HIMs that such polices were adopted by the defendants throughout KP's Southern California region.

55. Throughout the term of his employment at KFH Hospital-South Bay, Bone had been instructed that he was **not** to query physicians regarding Sepsis diagnoses and was required to code Sepsis as instructed by the physician regardless of the medical record documentation. Bone had learned from other coders that such Sepsis coding instructions and query restrictions had been adopted by the defendants throughout KP's Southern California region. Stein and Bone are informed and believe, and upon such information and belief alleges, that the SCPMG's policy to prohibit physician queries of Sepsis diagnoses and to require Kaiser's coders to code Sepsis based on the physician's instructions (as opposed to the supporting clinical findings documented in the medical record) originated with TPMG and then was implemented by SCPMG during or about 2009.

56. As part of KP's national agenda to lower its reported Sepsis mortality rates at KFH hospitals, during or about 2009, KFHP and TPMG implemented Sepsis identification and treatment protocols that were then implemented by SCPMG on or about 2011 and eventually by all PMGs. These Sepsis treatment protocols were purportedly based upon the EGDT

treatment protocols. These Sepsis diagnostic criteria improperly used the Sepsis definition promulgated at the 1991 Consensus Conference, i.e., Sepsis is SIRS plus infection, as a diagnostic standard, even though by 2009 it was well established the SIRS criteria could not be properly used as a diagnostic standard. Specifically, defendants' Sepsis diagnostic standard required an elevated value in two or more SIRS criteria plus an infection to diagnose Sepsis.

57. As discussed above in paragraph 39, the 1991 Sepsis definition was adopted to assist researchers identify subjects to participate in clinical trials and promote Sepsis research. By 2001 it was well established that Sepsis could not be diagnosed just be using the SIRS criteria plus infection (i.e., whenever two or more SIRS criteria were elevated and the patient had an infection) because such criteria applies to many patients who are suffering less severe conditions than Sepsis. Instead, the SIRS criteria potentially diagnosed Sepsis only when no other possible explanation or medical condition that accounted for the elevated levels. (The ACCP/SCCM Consensus Conference Statement - 1991, *Chest,* June 1992, Vol.101, 1644, 1646.) The 2001 Conference published an expanded list of criteria to diagnose Sepsis but concluded that these criteria, like the SIRS criteria, were not specific to Sepsis so such criteria could not be adopted as a diagnostic "gold standard" that could be used conclusively in every instance. The physician still had to make a judgment call to determine if the symptoms were the result of the patient having a life threatening inflammatory response to infection that potentially threatened to shut down organs resulting in death, i.e., Sepsis, or had some less severe medical condition that explained the abnormal criteria values.

58. Defendants, in adopting a diagnostic standard based on two elevated SIRS criteria, ignored the then current standard of medical care by not including the well accepted expanded criteria from the 2001 Conference to diagnose Sepsis and to diagnose Sepsis with acute organ failure. (2001 International Sepsis Definitions Conference, *Intensive Care Med.* (2003) Vol. 29, 530, 532.) By 2009, such the 2001 Conference Sepsis diagnostic criteria had become, the very well accepted, Surviving Sepsis Bundles and related guidelines endorsed by CMS, the CDC and internationally. Defendants' Sepsis diagnostic standard also disregards the 2001 Conference's conclusions which unequivocally stated that the SIRS criteria were overly

broad, too sensitive and nonspecific for sepsis making them unsuitable for use as a diagnostic standard. A conclusion that also was well accepted by the then concurrent and future medical literature.

59. Despite these flaws, Defendants nonetheless adopted the SIRS criteria as a diagnostic standard for KP's national Sepsis program knowing that using the SIRS diagnostic standard results in false and inaccurate Sepsis diagnoses. KP's physician training materials regarding diagnosing Sepsis failed to instruct KP's physicians **not** to diagnose Sepsis if the elevated SIRS criteria were due to a condition other than Sepsis, failed to instruct physicians to perform timely blood draws, i.e., prior to the administration of antibiotics, so accurate blood cultures are obtained (required to identify blood-born pathogens) and fails to discuss or incorporate any of the additional Sepsis diagnostic criteria from the 2001 International Sepsis Definitions Conference that physicians are suppose to use in making a Sepsis diagnosis.

60. KP's adoption of improper Sepsis specific coding policies, (i.e., policies that required Kaiser's coders to code Sepsis based on the physician's instruction and also prohibited Kaiser's coders from making coding queries regarding Sepsis diagnoses), ensured that the Kaiser Health Plans submitted false and inaccurate Sepsis diagnoses to CMS as valid RAD. Such improper coding policies were and are unique to Sepsis and violate the ICD-9 Guidelines and AHIMA ethical coding Guidelines. For all other syndromes, diseases, illnesses or injuries, Kaiser's coders were able to perform coding queries without restrictions. Sepsis is the only diagnoses that Kaiser's coders were not allowed to use coding queries to clarify the supporting documentation in the medical record.

61. During and between 2010 and 2014, while working at KFH Hospital-South Bay, Bone coded approximately three to four Sepsis diagnoses a week for MA enrollees that were not admitted to the ICU or the hospital but were discharged home after being put in an observation bed for between 3 to 48 hours. Such MA enrollees were not treated aggressively for Sepsis per KP's Sepsis treatment protocols, including but not limited to, failing to insert a central venous catheter not was not inserted and blood draws were not taken prior to the administration of antibiotics to obtain blood cultures. During this time period, Bone also

routinely coded Sepsis diagnoses for MA enrollees who were not admitted to the ICU but were admitted to the hospital for a brief stay of up to three days. Such MA enrollees typically were not treated aggressively for Sepsis per KP's Sepsis treatment protocols, including but not limited to, failing to insert a central venous catheter and failing to perform blood draws prior to the administration of antibiotics to obtain blood cultures. Bone observed, that the medical records of MA enrollees diagnosed with Sepsis, but not admitted to the hospital and MA enrollees admitted to the hospital for a brief stay but were not treated for Sepsis aggressively, did not have sufficient clinical findings documented in their medical records that supported the Sepsis diagnoses.

62. The fact that MA enrollees that were diagnosed with Sepsis in the ER but discharged without being admitted to the ICU or the hospital is a strong indication that such MA enrollees did not have Sepsis, and that such Sepsis diagnosis and coding were false. It is not credible that an MA enrollee is diagnosed with sepsis and/or sepsis with acute organ failure does not require an admission to the ICU for treatment let alone is discharged without ever being admitted to the hospital. Rather, such MA enrollees did not have Sepsis and the ER observations confirmed this fact allowing the physician to confidently send the MA enrollee home without admission to the hospital or ICU. The above reasoning also applies to the Kaiser Health Plans' MA enrollees that were not admitted to hospital ICU but instead just admitted to hospital for a brief stay, of one to three days, that did not receive aggressive treatment for Sepsis according to KP's treatment protocols prior to being discharged home.

63. As a result of KP's emphasis on diagnosing Sepsis and adopting an improper and overly broad Sepsis diagnostic standard, the number of Sepsis diagnoses by PMG and SCPMG physicians, between 2009 and 2013, increased dramatically at all California KFH hospitals; as much as, between 200% to 300% at some facilities. This increase in the number of Sepsis diagnoses had the effect of dramatically lowering KFH California Hospital's reported Sepsis mortality rates. The reported Sepsis mortality rates were a ratio comparing the number of Sepsis cases diagnosed at KFH Hospitals to the number of patients that expired as a result of having Sepsis. As such, the reported Sepsis mortality ratio was easy to manipulate by

increasing the number of Sepsis diagnoses with false Sepsis diagnoses. By 2013, KP claimed that its reported Sepsis mortality rate had dropped to approximately 9% and its average length of stay for such cases had dropped to 3.5 days. . (An Innovative Approach to Sepsis Prevention Saves Lives, (Dec 6, 2013) https://businesshealth.kaiserpermanente. org/insights /sepsis-prevention.) KP's reported Sepsis mortality rate and average length of stay during 2010 through 2013 are unrealistic numbers and an indication that the Kaiser Health Plans submitted false Sepsis diagnoses. As discussed below in greater detail, at least one KP physician complained, challenging the validity of KP's reported sepsis mortality rates. A recent landmark study comparing the difference in effectiveness between EGDT treatment protocols and traditional treatment methods, when properly implemented using hospital systems with best practices, achieved sepsis mortality rates of 19%-20%. (A Randomized Trial of Protocol-Based Care for Early Septic Shock, The ProCESS Investigators, *N Engl J Med* (July 24, 2014); Vol. 370, 1683, 1690.) For 2010, the national mean length of stay for MA enrollees with Sepsis as a primary diagnosis was 9 days and 15 days for those with Sepsis as a secondary diagnosis. (AHRQ, H-CUP Statistical Brief #122, p.4 (October 2011).)

64. In November 2010, KP's management identified KFH Hospital-Panorama City as being an outlier for its reported Sepsis mortality rates of 25% despite noting, that all by all other quality measures, the facility was one of KFH's very best hospitals. The e-mail instructed executives responsible for KFH Hospital Panorama City to solve this problem by identifying more cases of Sepsis. Dr. Chiara Conrado, KFH-Panorama City Hospital's Pulmonary and Intensive Care Specialist, responded complaining that the sepsis mortality rates from other KFH facilities was not believable, that the data used was not verified for accuracy, that Kaiser's coders and physicians incorrectly diagnose and code sepsis and that the KP's reported Sepsis mortality rates for 2010 were lower than what other significant studies achieved and therefore KP's data was not credible.

65. Dr. Conrado received no response to her complaints. At all times relevant defendants were required to maintain an effective compliance program designed to identify and ameliorate Medicare fraud waste and abuse (FWA). (42 C.F.R. §422.503(b)(4)(vi); Medicare

Managed Care Manual, Ch.21 §§30-50 et seq.) Pursuant to statutory and CMS requirements, defendants' compliance officer was required to initiate a timely investigation into Dr. Conrado's accusations regarding the potential Medicare FWA issues raised by Dr. Conrado's complaints but failed to do so. (42 C.F.R.§422.503(b)(4)(vi); CMS Publication 100-16, Medicare Managed Care Manual, Ch. 21 §Ch.21 §50.7.1.)[11], [12]

66. KP's use of an overly broad and improper Sepsis diagnostic standard imposes on KFHP, TMPG, SCPMG and KFH, a duty to exercise reasonable diligence to identify, and redact false and incorrect Sepsis diagnoses from the RAD submitted to CMS. This duty is an integral part of the Medicare Advantage's regulatory framework intended to help MAOs, such as KFHP, avoid the submission of false and fraudulent claims to CMS and avoid the receipt and retention of improper overpayments from CMS. (42 C.F.R. §§ 422.326(c), 422.503(b)(4)(iv), 422.504(l)(2); CMS Publication 100-16, Medicare Managed Care Manual, Ch.7 §40 et seq. and Ch.21 §§30-50 et seq.; 79 Fed.Reg. 29844, 29923-24 (March 23, 2014).)

67. KFHP failed to use reasonable diligence in its selection of its Sepsis diagnostic standard and also by failing to identify and redact false and unsupported Sepsis diagnoses from the RAD submitted to CMS. As an express condition of receiving its monthly capitation payments on behalf of MA enrollees, KFHP certified based on its best knowledge, information and belief that the RAD it submitted to CMS was accurate, truthful and complete. (42 C.F.R. §422.504(l)(2).) Because KFHP did not attempt to identify and redact the potentially false and fraudulent Sepsis diagnoses obtained from its contracted medical groups, KFHP's statutorily required certifications were false. KFHP's best knowledge, information and belief were that

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[11] 42 C.F.R. §422.504(b)(4)(vi) states in part: [Adopt and implement an effective compliance program, which must include measures that prevent, detect, and correct non-compliance with CMS' program requirements as well as measures that prevent, detect, and correct fraud, waste, and abuse.]

[12] Medicare Managed Care Manual, Ch.21 §50.7.1 – Conducting a Timely and Reasonable Inquiry of Detected Offenses, states in part, "Sponsors must conduct a timely and well-documented reasonable inquiry into any compliance incident or issue involving potential Medicare program noncompliance or potential FWA. . . . It may be discovered through a hotline, a website, an enrollee complaint. . . . Regardless of how the noncompliance or FWA is identified, sponsors must initiate a reasonable inquiry as quickly as possible, but not later than 2 weeks after the date the potential noncompliance or potential FWA incident was identified."

many of the Sepsis diagnoses were inaccurate, untruthful and incomplete, and were not supported by the clinical documentation in the medical record as required by CMS. (CMS Publication 100-16, Medicare Managed Care Manual, Ch.7 §40 et seq.) Furthermore, without a process to identify known potentially inaccurate Sepsis diagnoses, KFHP had no legitimate basis for making such a certification. (See, 79 Fed.Reg. 29844, 29923-24 (March 23, 2014).)

68. Stein is informed and believes and upon such information and belief alleges, that between 2010 until her departure in 2011, the Kaiser Health Plans, KFH and PMGs adopted and implemented the Sepsis diagnosis, coding and treatment policies described above and in paragraphs 52 through 55 as national policies and procedures.

69. Bone is informed and believes, and upon such information and belief alleges, that throughout the term of his employment (2010 until the present) the Kaiser Health Plans, KFH and PMGs adopted and implemented the unwritten Sepsis diagnosis, coding and treatment policies described above and in paragraphs 52 through 55 as national policies and procedures.

MALNUTRITION

70. During and between approximately 2010 until mid-2014, SCPMG, TPMG, KFH and KFHP participated in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA enrollees in order to increase the risk adjustment scores for the MA enrollees so diagnosed. This fraudulent scheme was conducted at all KFH Hospitals throughout California and involved the diagnoses and coding of malnutrition and severe malnutrition based upon assessments performed by dieticians employed by KFH. The KFH dietician used a rubber stamp on the MA enrollee's medical record indicating that in his/her opinion the MA enrollee suffered from malnutrition or severe malnutrition. SCPMG and TPMG physicians then countersigned the stamp in the MA enrollees' medical record. Based solely on the presence of the physician's countersignature of the dietician's rubber stamp, Kaiser's coders recorded the ICD-9 diagnosis codes for malnutrition or severe malnutrition as indicated by the rubber stamp. KFHP submitted to CMS these malnutrition and severe malnutrition ICD-9 diagnosis codes as RAD for use in calculating that MA enrollees' risk adjustment scores, which increased CMS's capitated payments to defendants.

71. Valid RAD must be the result of a face-to-face encounter with a physician or other qualified clinician that has been identified by CMS as an acceptable source of RAD. (CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq., §120.1.1, Table 19; 42 C.F.R. 422.310(b)-(d).) In order for RAD to be valid for submission to CMS, each ICD-9 diagnosis code submitted must have the appropriate clinical findings documented in the MA enrollee's medical record. (CMS Publication 100-16, Medicare Managed Care Manual, Ch. 7 §40 et seq.; 42 C.F.R. § 422.310(b)-(d).) KFH Hospitals' use of the dietician's stamp for diagnosing and documenting malnutrition fails on both accounts, there is no face-to-face-encounter with a qualified physician where the physician makes a diagnoses of malnutrition, nor does the dietician's rubber stamp substitute for physician documenting in the medical record a diagnosis of malnutrition or the clinical indicators and clinical findings reviewed and observed necessary to support the malnutrition or severe malnutrition diagnosis.

72. The Medicare Managed Care Manual, Ch. 7, §120.1.1, Table 19, lists physician speciality types and other clinicians that are acceptable sources of RAD. Dieticians are not included in this list. KP's dieticians cannot make medical diagnosis on behalf of MA enrollees. The physicians' countersignatures of the dietician's stamp does not constitute a valid physician diagnosis or medical record documentation of such.

73. Kaiser's coders did not record the ICD-9 diagnosis code for malnutrition or severe malnutrition when the physician's countersignature was missing from the stamp. In those instances, the medical record was routed back to the physician for his/her countersignature. Physician's counter-signatures that were initially missing from the dieticians's stamp were routinely "rubber stamped" without question and countersigned but no entry showing that the physician made a diagnosis of malnutrition was made in the medical record itself.

74. The ICD-9 code book contains the following malnutrition diagnosis codes: 260 Kwashiorkor; 261 Nutritional marasmus; 262 Other severe, protein-calorie malnutrition; 263.0 Malnutrition of moderate degree; 263.1 Malnutrition of mild degree; 263.2 Arrested development following protein-calorie malnutrition; 263.8 Other protein-calorie malnutrition;

and 263.9 Unspecified protein-calorie malnutrition. Each of these distinct ICD-9 diagnosis codes for malnutrition require specific and appropriate supporting clinical findings in order to be properly documented and submitted as a valid diagnoses and valid RAD.

75. Clinical findings, such as the number of folds in the patients' skin, the size of their triceps, their body mass index, weight changes over time, dietary intake, wasting of muscle and debility, albumin and pre-albumin blood test, digestive difficulties or digestive diseases, absorption problems, eating disorders and feeding method (i.e. oral or tubal feeding) are examples of clinical findings that treating physicians were required to record in the MA enrollees' medical record as the result of a face-to-face encounter as part of documenting a diagnosis of malnutrition or severe malnutrition. Without appropriate clinical findings, Kaiser's coders were unable to determine which malnutrition ICD-9 diagnosis code to record.

76. During approximately mid-2014, KFHP and/or KFH realized that their existing practice of relying on the dietician's stamp to diagnose and document malnutrition was incorrect. KFHP's new policy required the treating physician to document the appropriate clinical findings in the MA enrollees' medical records to support malnutrition diagnoses. KFHP made no effort to determine all of the instances, prior to mid-2014,that malnutrition was incorrectly diagnosed or improperly documented in the MA enrollee's medical record. Further, KFHP concealed from, and failed to notify, CMS that KFHP had been overpaid as a result of submitting such invalid and unsupported malnutrition diagnoses as RAD to CMS.

77. 42 C.F.R. § 422.326, the Medicare Advantage Overpayment Report and Return regulation, requires KFHP to notify CMS within 60 days from the time it knew or should have known that it received an overpayment and make arrangements with CMS for the return of such overpayments. KFHP violated 42 C.F.R. § 422.326 by failing and refusing to exercise reasonable diligence with respect to the identification and return of overpayments resulting from the improper diagnosing, documenting and coding of malnutrition and severe malnutrition of its MA enrollees as described above. Failing to notify CMS of the receipt of an overpayment within 60 days is an obligation under the False Claims Act and subjects KFHP to FCA liability under 31 U.S.C. §3729(a). KFHP's and/or the other defendants' policy change regarding the

diagnoses, documentation and coding of malnutrition is evidence that KFHP was aware that it submitted invalid malnutrition RAD to CMS that resulted in the receipt and retention of overpayments during prior periods.

78. During and between 2010 and at least mid-2014, KFHP, SCPMG, TPMG and KFH knowingly submitted or caused to be submitted false and fraudulent malnutrition diagnoses to CMS as valid RAD in order to increase such enrollees' HCC risk adjustment scores and thereby the capitation payments received from CMS. The impact of KFHP's false malnutrition diagnoses and upcoding is profound. In Los Angeles County, each fraudulent diagnosis of malnutrition increased the subsequent CMS's capitation payments for that MA enrollee by approximately $9,000 per year. During the time frame referenced above, KFHP submitted to CMS tens of thousands improper malnutrition diagnoses for KFHP's MA enrollees.

79. Stein and Bone are informed and believe, and upon such information and belief allege, that the above-described improper diagnosis, coding and documentation practices for malnutrition described above in paragraphs 72 through 78 are, and since 2010 were, national polices and performed in the same improper manner nationwide by Kaiser Health Plans, KFH and the PMGs.

REFRESH FRAUDS

80. As will be explained in greater detail below, between 2010 and the present, KFHP, KFH, TPMG and SCPMG and the remaining PMGs submitted or caused to be submitted false and fraudulent RAD resulting from KFHP's practice of "refreshing" missing HCC diagnosis codes. These frauds were accomplished by (a) routinely and intentionally making improper late medical record entries, (b) amending the medical record without valid face-to-face encounters, (c) failing to include the supporting clinical documentation in the amended medical record required to support the new HCC diagnosis codes, (d) performing improper written leading physician queries, (e) improperly making diagnoses from problem lists, (f) concealing the frauds by illegally destroying the written queries, and (g) deceiving MA enrollees to obtain medically unnecessary and non-covered medical services.

81. At all times relevant, CMS allowed MAOs an additional period of time (Data Lag Period) after the end of the payment year to submit additional valid RAD and withdraw previously submitted invalid RAD arising from services rendered during that payment year. The end of the Data Lag Period was the final RAD cutoff date after which CMS no longer accepted any new or withdrawn RAD for that payment year, and CMS used the RAD for that payment year to risk adjust the MAO's capitation payments for the next payment year. When the HCC risk adjustment model was relatively new, the Data Lag Period was two years after the end of the payment year. Over time, CMS shortened the Data Lag Period to 13 months after the end of the payment year.

82. After the end of the payment year, but before the end of the Data Lag Period, MAOs such as KFHP can retrospectively review the medical records of its MA enrollees to ensure that the RAD submitted to CMS was properly supported by medical records and withdraw unsupported diagnosis codes. MAOs can also submit to CMS previously unreported HCC diagnosis codes if the medical record supports such additional diagnoses, or in certain cases, make an amendment to the medical record based on the last face-to-face encounter the physician had during the payment year if the physician has a recollection of the face-to-face encounter and there is sufficient clinical findings in the existing medical record to make such a diagnoses.

83. Beginning in 2006 and continuing to the present, KFHP, KFH, TPMG, SCPMG and the other PMGs implemented an improper program designed to identify "missing" HCC diagnosis codes and have the physicians "refresh" the missing HCC diagnoses. KFHP considered HCC diagnoses to be missing when the HCC diagnoses had been submitted to CMS as RAD arising from services rendered during the last closed payment year, but had not been submitted in the subsequent payment year subject to a pending Data Lag Period (e.g., if 2010 was the last closed payment year, 2011 is the subsequent payment year with a Lag Data Period pending between January 1, 2012 through January 31, 2013). KFHP, KFH, TPMG and SCPMG, with the assistance of KFH staff, engaged in several different tactics to have the physicians "refresh" the missing HCC diagnoses. The progress and success of the refresh

program was internally well documented, and tracked the MA enrollees' medical records, the HCC diagnoses to be "refreshed," the physicians who "refreshed" the HCC diagnoses, the HCC diagnosis codes submitted to CMS as RAD as a result of the refresh process, and the increased risk adjustment scores resulting from the refresh process. KFHP's refresh process resulted in increased risk adjustment scores of 5 to 6 points per MA enrollee program wide, resulting in about $400 million to $500 million in additional annual capitation revenue per year.

84. The refresh process started with KFHP's contracted medical groups compiling a "hit-list" of high value HCC risk adjustment scores and their related ICD-9 diagnosis codes ("HCC diagnoses") from which to work from. The hit-list included, but was not limited to, all of the complications related to diabetes, and the different manifestations and complications of coronary disease, chronic kidney disease, old myocardial infarction, and cancer. Each year, KFHP performed a computer search to data-mine the RAD submissions from the last closed payment year to identify the MA enrollees with a history of hit-list HCC diagnoses, and used those results to determine which MA enrollees' medical records did not have such hit-list HCC diagnoses submitted in the subsequent payment year subject to a pending Data Lag Period. After Kaiser's coders reviewed the last closed payment year's medical records confirm the existence of the past hit-list HCC diagnoses, Kaiser's coders then sent written leading queries to the MA enrollees' attending physicians with a list of the missing HCC diagnoses. The leading physician queries instructed the physicians to "refresh" (i.e., add) the missing HCC diagnosis to a particular MA enrollee's medical record. Kaiser's coders then met with the physicians to ensure that the hit-list HCC diagnoses were refreshed. Most of TPMG and SCPMG physicians readily complied with Kaiser's coders' requests and added the hit-list HCC diagnoses identified in the Kaiser's coders' leading queries.

85. All RAD that MAOs, such as the Kaiser Health Plans, submit to CMS must be the result of a face-to-face physician encounter and must be supported by a medical record documented in accordance with ICD-9 Guidelines. (Medicare Managed Care Manual, Ch. 7 §40 et seq.; 42 C.F.R. §422.310(d).) An addendum is new documentation used to add information to an original entry. Addenda should be timely and bear the current date and

reason for the additional information to an original entry. (AHIMA (2015) Amendments, Corrections and Deletions in the Electronic Health Record Tool Kit, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_044678.hcsp?dDocName=bok1_044678.)

86. CMS's rule governing late medical entries states, "All services provided to beneficiaries **are expected to be documented in the medical record at the time they are rendered**. Occasionally, certain entries related to services provided are not properly documented. In this event, the documentation will need to be amended, corrected, or entered after rendering the service." (Emphasis added.) (Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A) and made applicable to Medicare Advantage by 42 C.F.R. §§ 422.101(b), 422.310(d).) Similarly, AHIMA Guidelines state, "When documenting an omission, validate the source of additional information as much as possible. Late entries should be documented as soon as possible. While there is no time limit for writing a late entry, the more time that passes, the less reliable the entry becomes."[13] (AHIMA (2015) Maintaining a Legally Sound Health Record: Paper and Electronic, http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_028509.hcsp?dDocName=bok1_028509.)

87. The "refreshed" HCC diagnoses were invalid as RAD for submission to CMS by the Kaiser Health Plans because they violated the requirements described in the preceding two paragraphs. First, the refreshed HCC diagnoses were not the result of a face-to-face encounter. In order to document an omission via a late entry amendment, the physician must have a specific recollection of the subject face-to-face encounter with the MA enrollee. As the encounters being "refreshed" were between 6 to 12 months before the hit-list addenda were added to the medical records, the physicians did not have specific detailed recollections of the encounter required to add clinical findings in support of hit-list HCC diagnoses being added.

88. Second, the addenda themselves were not supported by required clinical documentation in the medical record in accordance with ICD-9 Guidelines. This is apparent

[13]For reference, 42 C.F.R. § 482.24(c)(4)(viii) requires hospitals to complete the medical record entries of the final diagnoses within 30 days of discharge.

on the face of the addenda which consist of just the addition of the hit-list HCC diagnoses, signed and dated by the physician. Physicians who executed the addenda did not review the medical record entries (i.e., the portion being amended) to confirm that the medical record contained the necessary clinical findings to support the new HCC diagnoses, nor did they include language in the addenda that identified the reasons for the late entry nor any required clinical findings to support adding the new HCC diagnoses as required by the ICD-9 and AHIMA coding and documentation guidelines. The mere conclusion of the new HCC diagnoses, without the supporting clinical findings necessary to support the conclusion, is not an acceptable method of medical record documentation. Additionally, such incomplete documentation does not indicate that it is "related to a service that was provided" during the prior encounter as required by CMS's rule for late entries. (Medicare Program Integrity Manual, Ch. 3, §3.3.2.5(A).) Therefore, such improperly "refreshed" HCC diagnoses codes should not have been submitted to CMS as RAD.

89. Typically, the hundreds of employee physicians, including but not limited to Drs. Steven Steinberg, Margabanhu Ramanathan, Edward Brosnan, David Wong, Sivakumar, and Young Cho, who worked for KFHP's contracted medical groups, responded to the leading queries by signing any "refresh" addenda that their employers requested via the leading physician queries and problem lists.

90. The addenda refreshing HCC diagnoses were also invalid because they (a) failed to provide an explanation regarding why the late entry needed to be made as required by the AHIMA standards for making addenda, (b) failed to identify the services rendered during the subject encounter that the refreshed HCC diagnoses are related to as required by CMS's rules for late entries, and (c) failed to identify the clinical findings required to support the new HCC diagnosis codes as required by the ICD-9 Guidelines.

91. "To support why a query was initiated, all queries must include the clinical indicator(s) that show why a more complete or accurate diagnosis or procedure is requested."[14]

[14]AHIMA is a member of the ICD9CM and the ICD10CM Cooperating Parties, thus their practice briefs are considered "industry standards" for coding and query policy and procedure.

(AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p.2; http://ahima.org/library.) The Kaiser's coders' queries used for refreshing missing HCC diagnoses did not contain any clinical indicators or explanations in support of why they was initiated. Kaiser's coders only reviewed the problem list of missing HCC diagnoses and the prior year's medical record visit to confirm that the HCC diagnoses identified by the computer data mining was present. The medical record visit to be refreshed was not reviewed by the Kaiser's coders and thus they had no basis to make the queries.

92. Defendants' refreshing of HCC diagnoses relied on using invalid, leading physician queries that instructed physicians which HCC diagnoses to add to the medical records. "A leading query is one that is not supported by the clinical elements in the health record and/or directs a provider to a specific diagnosis or procedure." (AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p. 2; http://ahima.org/library.) AHIMA sets the national standards regarding coding and documentation, and as such its policies are incorporated into the medical record documentation requirements by CMS. (42 C.F.R. § 422.310(d).)The AHIMA guidelines do not allow leading queries because they result in inaccurate and/or false medical record documentation. After the leading queries were used by TPMG and SCPMG physicians, the queries were illegally destroyed.

93. At all times mentioned, CMS required the Defendants to maintain the medical record on some type of retrievable format for at least ten years. No part of the medical record is supposed to be destroyed. CMS and AHIMA requirements make it clear that if the physician query results in adding new diagnoses, then the query becomes part of the medical record and must be maintained for use in auditing the validity of the diagnoses contained therein. (Medicare Quarterly Compliance Newsletter, Vol 2, Issue 3 at p. 13 (April 2012); https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/medqtrlycomp_newsletter_icn907927.pdf.) Further, AHIMA Guidelines strongly recommend that the queries to physicians be preserved as part of the medical record and if a different policy is adopted, then the query must be maintained as business record.

(AHIMA Practice Brief, Guidelines for Achieving a Compliant Query Practice (9-13-2015) at p. 4; http://ahima.org/library.)

94. At all times mentioned, KFH's medical record retention policy included Kaiser's coders' queries as part of the medical record. At al times mentioned, the Kaiser Health Plans allowed their contracted medical groups, including TPMG and SCPMG, to adopt different and conflicting medical record retention policies that improperly failed to preserve Kaiser's coders' queries as part of the medical record or as a business record. Instead, Kaiser's coders' queries were destroyed immediately after the queries had been reviewed by the physicians. The Kaiser Health Plans always had the ability to require their exclusively contracted medical groups, including TPMG and SCPMG, to adopt unified policies for medical record retention, query practices, late entries into the medical records and medical record documentation. CMS's regulations mandates that the Kaiser Health Plans' contracts contain such rights and provisions. (42 C.F.R. § 422.504(i)(3)(iii).)

95. Realtors are informed and believe, and based upon such information and belief allege, that the Kaiser Health Plans knowingly allowed its exclusively contracted medical groups, including TPMG and SCPMG, to adopt conflicting policies for using leading queries, preserving queries as part of the medical record, making late entries and amendments to the medical record, and medical record documentation expressly for the purpose of committing the Medicare frauds described in this complaint.

96. During or about 2006, several HIM managers, such as Sarah Lynch, the HIM Director KFH-Hospital, Orange County, and Jennifer Squires, Encounter Coding Manager, vigorously protested the required use of leading queries and their immediate destruction after the physicians had "refreshed" the medical record. Ms. Lynch was informed by her supervisor, that SCPMG and Kaiser requested that Ms. Lynch be terminated for complaining about the use and destruction of leading queries and was informed by her supervisor that in order to avoid termination Ms. Lynch had to refrain from further complaints regarding these issues. Ms. Lynch's complaints regarding leading queries and destruction of medical records should have triggered a compliance investigation by the Kaiser Health Plans to identify the Medicare FWA

caused by the leading Kaiser coders' queries complained of and issued appropriate corrective action plans. (42 C.F.R. § 422.503(b)(4)(vi); Medicare Managed Care Manual, Ch. 21 §30-50, et seq.)

97. In a number of instances, the MA enrollees had not been seen by their PCP during the open payment year and/or had not been seen during the current year. These MA enrollees' medical records could not be refreshed with a late entry addenda because there was no face-to-face encounter, and therefore no medical record entry during the relevant time period to amend. TPMG and SCPMG contacted these MA enrollees and falsely informed them that they needed to schedule a follow-up visit with their primary care physician (PCP). In addition, there were MA enrollees who had been seen during the open payment year, but for whom no HCC diagnoses were identified during those encounters. These MA enrollees were also scheduled for a follow up visit for the sole purpose of identifying HCC diagnoses to submit to CMS.

98. The RAD obtained from the physician followup encounters to refresh the MA enrollees' hit-list HCC diagnoses were invalid because the RAD was obtained from medically unnecessary and uncovered services. Among the services that are specifically excluded from original Medicare are routine physicals and medically unnecessary services. (42 C.F.R. § 411.15(a)(1),(k), and made applicable to Medicare Advantage by 42 C.F.R. § 422.101(b)(1)-(2).) The improper followup visits that the Kaiser Health Plans and their contracted medical groups, including TPMG and SCPMG performed, were in fact routine physicals or otherwise medically unnecessary services because the MA enrollees were deceived into having the exam, the MA enrollees had no medical complaint that required followup, and the true secret purpose of the visit was specifically to "refresh" certain hit-list HCC diagnoses that the Kaiser Health Plans had identified. The Kaiser Health Plans cannot submit to CMS improperly obtained, non-covered and excluded services as valid RAD. (42 C.F.R. § 422.310(c).)

99. Although the Kaiser Health Plans cover routine physicals as a supplemental benefit, such coverage is limited to exams that are, "[M]edically appropriate preventative care in accordance with generally accepted professional standards of practice." The Kaiser Health Plans' Evidence of Coverage (2011) at p. 51, available at: https://www.sjretirement.com/

Uploads/PF/2011%20Kaiser %20Hawaii %20KPSA% 20EOC.pdf.) As will be explained in greater detail below, because the purpose of the visit was to deceitfully obtain hit-list HCC diagnoses, the refresh followup visits do no meet The Kaiser Health Plans' coverage criteria under its supplemental benefits. Further, the services the MA enrollees received during such physician encounters to "refresh" their prior HCC diagnoses were not documented as a covered routine physical by the Kaiser Health Plans, TPMG, SCPMG and the other PMGs, but were falsely documented as some other type of consultative visit. Because the MA enrollees' physician visits to refresh old HCC diagnoses were medically unnecessary, the services were not covered under the Kaiser Health Plans' MA plans, and the Kaiser Health Plans could not legally submit RAD to CMS arising from such services.

100. On or about, 2006 Stein was present at a meeting with SCPMG regional physician leadership from the Panorama City Medical Clinic, including but not limited to Drs. Zollner, Hoffman, Steinberg, and Candac Lumeg. Present by telephone were the SCPMG physician leaders, from the Santa Clarita Medical Clinic. The purpose of the meeting was to discuss the data-mining results provided by SCPMG's Pasadena headquarters that identified MA enrollees who needed a current physician encounter in order for their HCC diagnoses to be refreshed. A telephone call script had been provided by defendants that was used to schedule the appointments with the MA enrollees and was read out loud for the meeting participants. The call script informed the MA enrollees that they needed to come in for a follow up visit for the HCC condition that had been identified by defendants. This statement was false. The SCPMG physician leaders candidly admitted that the follow-up exams were medically unnecessary and being used as pretext; the true purpose of the visits was for the PCPs to refresh the hit-list HCC diagnoses.

101. During this meeting it was decided that Mary Stefanec, RN, Department Administrator for Internal Medicine, would be responsible for supervising staff to contact the identified enrollees assigned to physicians located at the SCPMG medical clinics in Panorama City and convince such MA enrolles to come in for the purported follow-up visits. Similar meetings were schedule throughout California.

102. None of the MA enrollees were informed the that the true purpose of the visit was for the Kaiser Health Plans' contracted medical groups to "refresh" prior HCC diagnoses so that the Kaiser Health Plans would receive a higher capitation payment from CMS. Instead, the MA enrollees were deceived into scheduling medically unnecessary routine physicals by being falsely informed that their medical condition required a follow-up visit. These untrue MA enrollee solicitations violated CMS's regulations that prohibit making untrue or misleading statements to enrollees. (42 C.F.R. § 422.752(a)(5)(ii).)

103. Beginning in 2006 and continuously thereafter, Kaiser Health Plans, KFH and the PMGs annually scheduled tens of thousands of MA enrollee visits for the purpose of "refreshing" prior hit-list HCC diagnoses by falsely claiming such visits were medically necessary follow-up visits. The true purpose of the MA enrollees' medical appointments was for the Kaiser Health Plans' contracted medical groups to collect HCC diagnoses for submission to CMS by the Kaiser Health Plans. The untruthful statements to the MA enrollees constituted a false statement material to a false or fraudulent claim in violation of 31 U.S.C. § 3729(a)(1)(B).

FIRST CLAIM FOR RELIEF

(Violation of 31 U.S.C. §3729(a) against all Defendants: False Sepsis Claims)

104. Relator realleges and incorporates by reference paragraphs 1 through 69 of this complaint as though fully set forth at length.

105. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

106. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A)&(B) by (a) knowingly

presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

107. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by (a) conspiring violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

108. Defendants the Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS Sepsis diagnoses that were routinely and repeatedly falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 422.326.

109. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

110. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

111. The Kaiser Health Plans are, and at all times mentioned were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) Because the Kaiser Health Plans adopted overly broad Sepsis diagnostic standards, they had an obligation to establish a process to identify and redact or withdraw incorrect Sepsis diagnosis codes from the RAD they submitted to CMS. The Kaiser Health Plans did not adopt any such process to identify and redact or withdraw incorrect Sepsis ICD-9 diagnosis codes from the RAD they submitted to CMS and failed to do so. As a result of the

Kaiser Health Plans' failure and refusal to reasonably attempt to meet this obligation, it had no legitimate basis for certifying that the Sepsis ICD-9 diagnosis codes it submitted to CMS were accurate, complete and truthful RAD.

112. Defendants were obligated to conduct a Medicare FWA investigation in response to Dr. Conrado's repeated complaints that sepsis was being inaccurately diagnosed and coded. The Kaiser Health Plans and their first tier contracted entities failed and refused to conduct such a compliance investigation, rendering the Kaiser Health Plans' compliance program, as it pertains to the submission of false Sepsis diagnosis codes, ineffective. Because the Kaiser Health Plans had an ineffective compliance program, they had no legitimate basis on which to certify the accuracy, completeness and truthfulness of the Sepsis ICD-9 diagnosis codes they submitted as RAD to CMS between 2010 to the present. (42 C.F.R. §§ 422.503(b)(4)(vi), 422.504(i)(3)(iii)&(l); Medicare Managed Care Manual, Ch. 21 §50.7.1; 79 Fed.Reg. 29884, 29923-24 (May 14, 2014).)

113. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for Sepsis that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid defendant Kaiser Health Plans at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

114. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(G) by knowingly concealing or knowingly and improperly avoiding or decreasing their obligation to pay or transmit to the Government the overpayments made by CMS as a result of the submission of

false and unsupported Sepsis diagnoses to CMS.

115. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the ICD-9 diagnosis codes for Sepsis submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

116. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

117. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

118. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

SECOND CLAIM FOR RELIEF

(For violations of 31 U.S.C. § 3729(a) against all Defendants: False Malnutrition Claims)

119. Relator realleges and incorporates by reference paragraphs 1 through 36 and paragraphs 70 through 79 of this complaint as though fully set forth at length.

120. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

121. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A)&(B) by (a) knowingly

presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

122. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by (a) conspiring violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

123. At all times mentioned during the six years prior to the filing of this action, defendant Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS malnutrition diagnoses that were routinely and repeatedly falsely and fraudulently diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 422.326.

124. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

125. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

126. The Kaiser Health Plans are, and at all times mentioned were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) KFHP had an obligation to establish a process to identify and redact or withdraw incorrect or unsupported malnutrition diagnosis codes from the RAD it submitted to CMS. KFHP did not adopt any such process to identify and redact or withdraw incorrect or unsupported malnutrition ICD-9 diagnosis codes from the RAD it submitted to CMS and failed

to do so. As a result of KFHP's failure and refusal to reasonably attempt to meet this obligation, it had no legitimate basis for certifying that the malnutrition ICD-9 diagnosis codes it submitted to CMS were accurate, complete and truthful RAD.

127. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for malnutrition that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid defendant KFHP at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

128. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the ICD-9 diagnosis codes for malnutrition submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

129. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

130. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

131. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

THIRD CLAIM FOR RELIEF

(For violations of 31 U.S.C. § 3729(a) against all Defendants: False Refresh Claims)

132. Relator realleges and incorporates by reference paragraphs 1 through 36 and paragraphs 80 through 103 of this complaint as though fully set forth at length.

133. At all times mentioned during the six years prior to the filing of this action, the Kaiser Health Plans periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*) to CMS to obtain overpayments from CMS. Likewise, at all times mentioned during the six years prior to the filing of this action, KFH and the PMGs periodically, and at least annually, submitted knowingly false and fraudulent certifications required under 42 C.F.R. § 422.504(*l*)(3) to assist the Kaiser Health Plans obtain overpayments from CMS.

134. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(A)&(B) by (a) knowingly presenting or causing to be presented, false or fraudulent claims for payment or approval by CMS, and (b) knowingly making, using, or causing to be made or used, false records or statements material to false or fraudulent claims to CMS to get such false and fraudulent claims paid or approved by CMS.

135. At all times mentioned during the six years prior to the filing of this action, defendants routinely and repeatedly violated 31 U.S.C. § 3729(a)(1)(C) by (a) conspiring violate 31 U.S.C. § 3729(a)(1)(A) and/or (B).

136. At all times mentioned, defendant the Kaiser Health Plans knew or should have known that they had improperly received and retained excessive capitation payments for MA enrollees for whom the Kaiser Health Plans submitted to CMS HCC diagnoses that were routinely and repeatedly falsely and fraudulently "refreshed", diagnosed and coded, and were lacking adequate supporting medical record documentation in violation of 42 C.F.R. § 422.326.

137. At all times mentioned, the Kaiser Health Plans failed to exercise reasonable diligence to identify and promptly notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

138. At all times mentioned, the Kaiser Health Plans acted with reckless disregard and deliberate ignorance in failing to identify and notify CMS of such overpayments in violation of 42 C.F.R. § 422.326.

139. The Kaiser Health Plans are, and at all times mentioned during the six years prior to the filing of this action were, required to "be continuously diligent regarding the accuracy and completeness of payment-related data they submit to CMS" and further expected to "implement, during the routine course of business, appropriate payment evaluation procedures in order to meet the requirement of certifying the data they submit to CMS for purposes of payment." (79 Fed.Reg. 29884, 29921, 29923-24 (May 14, 2014).) The Kaiser Health Plans had an obligation to establish a process to identify and redact or withdraw incorrect or unsupported "refreshed" HCC diagnosis codes from the RAD it submitted to CMS. The Kaiser Health Plans did not adopt any such process to identify and redact or withdraw incorrect or unsupported "refreshed" ICD-9 diagnosis codes from the RAD they submitted to CMS and failed to do so. As a result of the Kaiser Health Plans' failure and refusal to reasonably attempt to meet this obligation, they had no legitimate basis for certifying that the "refreshed" ICD-9 diagnosis codes they purportedly added to their MA enrollees' medical records and submitted to CMS were accurate, complete and truthful RAD.

140. At all times mentioned during the six years prior to the filing of this action, Relators are informed and believe, and upon such information and belief allege, that as a result of the false claims, concealments and use of false records and statements, CMS paid more than it would have paid had defendants properly and truthfully diagnosed, coded, documented, reported and revealed and withdrawn the false diagnosis codes for improperly and invalid "refreshed" ICD-9 diagnosis codes that it submitted to CMS, and that those diagnosis codes that were unsupported by their required documentation in the respective medical records. Relators are informed and believe, and upon such information and belief allege, that CMS overpaid the Kaiser Health Plans at least $500 million more than CMS would have as a result of the defendants' submission of false and fraudulent claims, concealments and use of false records and statements to get such false claims approved and paid by CMS.

141. At all times mentioned during the six years prior to the filing of this action, the defendants routinely violated 31 U.S.C. § 3729(a)(1)(G) by repeatedly and annually falsely certifying that the "refreshed" ICD-9 diagnosis codes submitted to CMS as RAD were accurate, complete and truthful based upon the defendants' best knowledge, information and belief, and/or knowingly concealing or knowingly and improperly avoiding or decreasing defendants' obligation to pay or transmit CMS's overpayments to the Government.

142. As a result of defendants' conduct, defendants are liable to the Government for three times the amount of damages sustained by the Government as a result of the false and fraudulent claims alleged above.

143. As a result of defendants' conduct, 31 U.S.C. § 3729(a) provides that defendants are liable to the Government for civil penalties for each such false and fraudulent claim for payment.

144. Relators are also entitled to recover their attorney's fees, costs and expenses from defendants pursuant to 31 U.S.C. § 3730(d).

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs and Qui Tam Relators pray for relief as follows:

FOR THE FIRST CLAIM FOR RELIEF

1. Treble the Government's damages according to proof;

2. Civil penalties according to proof;

3. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR THE SECOND CLAIM FOR RELIEF

4. Treble the Government's damages according to proof;

5. Civil penalties according to proof;

6. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

///

FOR THE THIRD CLAIM FOR RELIEF

7. Treble the Government's damages according to proof;

8. Civil penalties according to proof;

9. A relator's award of up to 30% of the amounts recovered by or on behalf of the Government;

FOR ALL CLAIMS FOR RELIEF

10. Attorney's fees, expenses, and costs; and

11. Such other and further relief as the Court deems just and proper.

THE ZINBERG LAW FIRM
A Professional Corporation

THE HANAGAMI LAW FIRM
A Professional Corporation

Dated: May 16, 2016

By: _____
William K. Hanagami
Attorneys for Plaintiffs and Qui Tam Relators,
Marcia Stein and Rodolfo Bone

REQUEST FOR JURY TRIAL

Plaintiffs and Qui Tam Relators hereby request a trial by jury.

THE ZINBERG LAW FIRM
A Professional Corporation

THE HANAGAMI LAW FIRM
A Professional Corporation

Dated: May 16, 2016

By: _____
William K. Hanagami
Attorneys for Plaintiffs and Qui Tam Relators,
Marcia Stein and Rodolfo Bone

No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
VOLUME 8 of 9

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ORIGINAL

FILED
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CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CAL.
LOS ANGELES
BY:

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

UNITED STATES OF AMERICA *ex. rel.*, NASER AREFI, AJITH KUMAR and PRIME HEALTHCARE SERVICES, INC.,

Plaintiffs,

vs.

KAISER FOUNDATION HEALTH PLAN,INC., a California corporation; KAISER FOUNDATION HEALTH PLAN OF COLORADO, a Colorado corporation; KAISER FOUNDATION HEALTH PLAN OF GEORGIA, INC., a Georgia corporation; KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, an Oregon corporation; KAISER FOUNDATION HOSPITALS, a California corporation; SOUTHERN CALIFORNIA PERMANENTE MEDICAL GROUP, a California corporation; THE PERMANENTE MEDICAL GROUP, a California corporation; COLORADO PERMANENTE MEDICAL GROUP, P.C. a Colorado corporation; THE SOUTHEAST PERMANENTE MEDICAL GROUP, a Georgia

CASE NO. CV15-07050 R6K(JCx)

COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, 31 U.S.C. §§ 3729-3733

(FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. §§ 3730(B)(2))

DEMAND FOR JURY TRIAL

(1)

PAID
SEP -4 2015
Clerk, U.S. District Court

NELSON HARDIMAN LLP

corporation; HAWAII PERMANENTE MEDICAL GROUP, a Hawaiian corporation; and NORTHWEST PERMANENTE, P.C., an Oregon corporation,

Defendants.

Plaintiff United States of America ("United States"), by and through Relators Naser Arefi, Ajith Kumar, and Prime Healthcare Services, Inc., allege as follows:

INTRODUCTION

1. Naser Arefi, Ajith Kumar and Prime Healthcare Services, Inc. (collectively "Relators") bring this action on behalf of the United States of America against Defendants Kaiser Foundation Health Plan, Inc. and its regional subsidiaries ("Kaiser"), Kaiser Foundation Hospitals and its regional subsidiaries ("Kaiser Foundation Hospitals"), and the Kaiser Permanente Medical Groups ("Kaiser Medical Groups") (collectively the "Kaiser Defendants") for treble damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729-3733 ("FCA") for submitting fraudulent claims and statements to the Medicare Part C managed care program for risk adjustment payments based on false diagnoses of major medical conditions (e.g., diabetes, cancer, heart disease, kidney failure, respiratory failure, major psychiatric disorders) for tens of thousands of Medicare beneficiaries enrolled in Kaiser's Medicare Advantage managed care plans.

2. Between 2008 and 2013, this massive Kaiser fraud scheme has conservatively caused the Medicare program to improperly pay more than $14 billion ($14,455,832,951) and possibly as high as $26 billion in risk adjustment overpayments to Kaiser that the plan falsely claimed reflected the additional cost of treating patients with major medical conditions that was not adequately compensated by the monthly fixed or "capitated" fee paid by to Kaiser for each

Medicare beneficiary enrolled in Kaiser's Medicare Advantage managed care plans. In fact, Kaiser did not actually need or use any of this enormous amount of taxpayer dollars to treat Medicare beneficiaries because the diagnoses of major medical conditions reported by Kaiser to justify such risk adjustment payments were fabrications based on the Kaiser Defendants' after-the-fact medical record reviews, use of diagnostic criteria that find no support in medical literature or accepted standards of medical or coding practice, and systemic manipulation and pressuring of Kaiser physicians to cooperate with the scheme by over-diagnosing patients with severe medical conditions that either did not exist at time of a face-to-face physician encounter or were not being currently treated. These practices by Kaiser Defendants also violated CMS's requirement that any major medical condition be diagnosed, treated and documented by a physician based on a face-to-face patient encounter occurring in the year in which the risk adjustment payment was claimed, not on retrospective mining of clinical data that was often many years old and did not reflect the Medicare enrollee's current medical condition.

3. While Kaiser is a Health Maintenance Organization ("HMO") that is supposed to manage and improve the health of Medicare enrollees and thereby reduce the cost of their care, Kaiser Defendants' fraud scheme creates a false picture of a Medicare managed care population that is getting sicker and sicker and has caused the cost of care per Kaiser Medicare enrollee to be approximately 70% more on average than the cost of care for a traditional Medicare patient. In particular, Kaiser has claimed billions of dollars in risk adjustment payments for Medicare enrollees who supposedly have severe medical conditions – including diabetes with chronic complications, kidney failure, vascular disease, angina, polyneuropathy, malnutrition, congestive heart failure, major depression, metastatic cancer and acute leukemia, septicemia, and proliferative diabetic retinopathy/vitreous hemorrhage – at rates that are at least double and, in some cases, more than ten times higher than the rates reported by other California

hospitals for traditional Medicare patients with the same conditions. This action is brought to end this Kaiser fraud scheme and compel the Kaiser Defendants to reimburse the federal government for the billions of dollars in risk adjustment overpayments made by CMS based on their submission of false and fraudulent diagnostic data to CMS regarding the medical conditions of Medicare Advantage enrollees.

JURISDICTION AND VENUE

4. This Court has subject matter jurisdiction under 28 U.S.C. §§ 1331, 1345, and 3732. The Court may exercise personal jurisdiction over Defendants under 31 U.S.C. § 3732(a) because the FCA authorizes nationwide service of process, Defendants Kaiser, Kaiser Foundation Hospitals, and Southern California Permanente Medical Group conduct business in this District, and the other Defendants are related U.S. corporations that transact business in and have the required minimal contacts with the United States.

5. Venue is proper in this District under 31 U.S.C. § 3732 and 28 U.S.C. § 1391(b) because Defendant Southern California Permanente Medical Group's principal place of business is in this District, Defendants Kaiser and Kaiser Foundation Hospitals transact business in this District, and the fabrication of ICD-9-CM diagnoses for Medicare Advantage giving rise to this action occurred in part in this District.

6. Prior to filing this complaint, Relators voluntarily disclosed to the United States the information on which the allegations and transactions described in this action are based.

PARTIES

Plaintiff and Relators

7. Relators bring this action on behalf of Plaintiff United States and its agency, the United States Department of Health and Human Services ("DHHS") and its component, the Center for Medicare & Medicaid Services ("CMS"), which

administers the Medicare Program. At all times material to this action, CMS has been an agency within the DHHS and has administered the Medicare Advantage program, which paid benefits from funds provided by the Federal Government. CMS provided Medicare benefits to qualified recipients, which included payment of claims to Defendant Kaiser and the Kaiser Plans for their provision of benefits to Medicare Advantage members.

8. Relator Naser Arefi is a former employee of Kaiser and current employee of a subsidiary of Relator Prime Healthcare Services, Inc. He is a foreign medical school graduate (Tehran University Of Medical Science & Health Service, 1997), certified clinical documentation specialist (Association of Clinical Documentation Improvement Specialists (ACDIS), 2015), certified coding specialist (American Health Information Management Association (AHIMA), 2011), and a certified professional in healthcare management (McKesson Corporation, 2010). Between September 2011 and April 2014, Arefi was employed as a Clinical Documentation Consultant ("CDC") by the Permanente Medical Group ("TPMG"), the Kaiser Medical Group for Northern California. As a Kaiser CDC, Arefi worked for the Auditing and Coding Services ("ACS") group of TPMG's Encounter Information Operations ("EIO") Department, conducting data mining for additional diagnoses in the electronic health records of Medicare enrollees pursuant to Kaiser algorithms which he was involved in developing. As a TPMG CDC, Arefi has direct insider knowledge of the Kaiser fraud scheme described in this disclosure, including with respect to the Kaiser Defendants' (a) use of the KP HealthConnect system to improperly steer physicians to select CMT diagnosis terms mapped by the plan to HCC-qualifying ICD-9-CM diagnosis codes, (b) data mining for additional ICD-9-CM diagnoses of severe medical conditions not made by the treating Kaiser physician or clinically supported by the Medicare enrollee's medical condition, and (c) use of physician queries to induce treating physicians to add such false and after-the-fact ICD-9-CM diagnoses to the

Medicare enrollees' electronic charts so that Kaiser can report them as current HCC conditions to CMS.

9. Relator Ajith Kumar is the Vice President of Reimbursement Management at relator Prime Healthcare Services, Inc. and an expert in Medicare coding and reimbursement. He has a medical degree from India known as an M.B.B.S. (Annamalai University, India, 2000), a masters in healthcare administration (University of La Verne, California, 2002), and is pursuing a masters in health information management (Claremont Graduate University, California). Kumar also holds the following certifications: Certified Clinical Documentation Specialist (Association of Clinical Documentation Improvement Specialists (ACDIS), 2008), Certified Case Manager (The Commission for Case Manager Certification (CCMC), 2013), Certified Coding Specialist (American Health Information Management Association (AHIMA), 2008), Certified Coding Specialist – Physician Based (AHIMA, 2008), Certified Documentation Improvement Practitioner (AHIMA, 2011), Certified ICD-10-CM/PCS Trainer (AHIMA, 2011), Certified in Healthcare Compliance (Health Care Compliance Association (HCCA), 2012), Certified Health Data Analyst (AHIMA, 2012), Certified Healthcare Finance Professional (Healthcare Financial Management Association (HFMA), 2012), Certified in Healthcare Privacy and Security (AHIMA, 2012), Certified Healthcare Technology Specialist in Clinician/Practitioner Consultant Examination and Practice Workflow and Information Management Redesign (North Virginia Community College (NOVA) and AHIMA, 2012), Certified HIPPA Professional (HIPPA Academy, 2010), Certified Strata™ IT Fundamentals (CompTIA, 2013), Certified Healthcare IT Technician (CompTIA, 2015), Certified Professional Coder (American Association of Professional Coders (AAPC), 2009), Certified Professional Coder – Hospital (now, Certified Outpatient Coder) (AAPC, 2009), Certified Professional in Healthcare Information and Management Systems (Healthcare Information and

Management Systems Society (HIMSS), 2012), CPMA, Certified Professional Medical Auditor (American Association of Professional Coders (AAPC), 2013), Certified Professional in Healthcare Management (McKesson Corporation, 2010), Certified Professional in Healthcare Quality (National Association for Healthcare Quality, 2012), Health Information Technology – Implementation Manager (Cypress College, 2011), Health Information Technology Professional (HIT Pro™) in Clinical/ Practitioner Consultant (NOVA, AHIMA, The Office of the National Coordinator for Health Information Technology (ONC), 2012), HIT Pro™ in Practice Workflow & Information Management Redesign Specialist (NOVA/ AHIMA/ONC, 2012), Health Information Technology – Trainer (Cypress College, 2011), and Registered Health Information Technician (AHIMA, 2013). As an expert in Medicare reimbursement and health information management, Kumar performed and supervised the complex statistical analysis needed to (a) compare Kaiser's reported rates of ICD-9-CM diagnoses qualifying as HCCs with those reported by traditional Medicare providers and other Medicare Advantage plans, and (b) calculate the estimated amount of risk adjustment overpayments made by CMS to Kaiser based on the plan's submission of false and fabricated ICD-9-CM diagnosis codes for Medicare enrollees qualifying as HCCs with those reported by traditional Medicare providers and other Medicare Advantage plans.

10. Relator Prime Healthcare Services, Inc. ("Prime"), and the Prime Healthcare Foundation own and operate 35 acute care hospitals, 15 in California and 19 in ten other states (Alabama, Indiana, Kansas, Michigan, Missouri, Nevada, New Jersey, Pennsylvania, Rhode Island and Texas.) A significant number of the patients treated by Prime hospitals are Medicare beneficiaries covered under Parts A, B and C of the program. As a result, Prime is an organization with comprehensive expertise in Medicare program requirements governing services to Medicare beneficiaries and the billing of those services to the Medicare program, including Kaiser's services to Medicare enrollees, some of whom are treated by

Prime for emergency medical conditions.

Defendants Kaiser and Kaiser Plans

11. Defendant Kaiser Foundation Health Plan, Inc. ("Kaiser") is a California corporation qualified to do business in the States of California and Hawaii as a health maintenance organization ("HMO") with its principal place of business in Oakland in the County of Alameda, California, and is also a Medicare Advantage Organization that is regulated by CMS and provides health care services to Medicare beneficiaries enrolled in one of its Medicare Advantage plans. Kaiser is the parent company of Defendant Kaiser Foundation Hospitals, Inc. and controls the services provided to Medicare Advantage enrollees outside of California and Hawaii through three regional subsidiaries (Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Inc., and Kaiser Foundation Health Plan of the Northwest) that also offer Medicare Advantage plans. Kaiser is also authorized and registered under the laws of Colorado, Georgia, Oregon and Washington to conduct business as a foreign corporation in those three states.

12. Defendant Kaiser Foundation Health Plan of Colorado is a Colorado corporation qualified to do business in the State of Colorado as an HMO with its principal place of business in Denver County, Colorado. This HMO is also a Medicare Advantage Organization that is regulated by CMS and provides health care services to Medicare beneficiaries enrolled in one of its Medicare Advantage plans and, on information and belief, is a wholly owned subsidiary of Kaiser.

13. Defendant Kaiser Foundation Health Plan of Georgia, Inc. is a Georgia corporation qualified to do business in the State of Georgia as an HMO with its principal office located in Atlanta in Fulton County, Georgia. This HMO is also a Medicare Advantage Organization that is regulated by CMS and provides health care services to Medicare beneficiaries enrolled in one of its Medicare Advantage plans and, on information and belief, is a wholly owned subsidiary of Kaiser.

14. Defendant Kaiser Foundation Health Plan of the Northwest is an

Oregon corporation qualified to do business as an HMO in the states of Oregon and Washington with its principal office located in Portland in Multnomah County, Oregon. This HMO is also a Medicare Advantage Organization that is regulated by CMS and provides health care services to Medicare beneficiaries enrolled in one of its Medicare Advantage plans and, on information and belief, is a wholly owned subsidiary of Kaiser.

15. Defendants Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Inc., and Kaiser Foundation Health Plan of the Northwest are collectively referred to as "the Kaiser Plans."

Defendant Kaiser Foundation Hospitals

16. Defendant Kaiser Foundation Hospitals is a California corporation qualified to do business in the State of California with its principal place of business in Oakland in the County of Alameda, California, that owns and operates 38 acute care hospitals (most in California, but including single hospitals in Hawaii and Oregon) and over 600 medical offices in California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia.

17. Defendant Kaiser Hospitals is a wholly owned subsidiary of Defendant Kaiser and is also authorized and registered under the laws of Colorado, Georgia, Hawaii, Oregon, and Washington to conduct business as a foreign corporation in those states.

Defendants Kaiser Medical Groups

18. Defendant The Permanente Medical Group, Inc. is a for profit California corporation qualified to do business in the State of California with its principal office located in Oakland in the County of Alameda, California that contracts with Kaiser to provide physicians to staff Kaiser hospitals and facilities and provide professional services to Medicare Advantage enrollees in Northern California.

19. Defendant Southern California Permanente Medical Group is a for

profit California corporation qualified to do business in the State of California as a medical group with its principal office located in Pasadena in the County of Los Angeles, California that contracts with Kaiser to provide physicians to staff Kaiser hospitals and facilities and provide professional services to Medicare Advantage enrollees in Southern California.

20. Defendant Colorado Permanente Medical Group, P.C. is a for profit Colorado corporation qualified to do business in the State of Colorado as a medical group with its principal office located in Denver in Denver County, Colorado that contracts with Kaiser and/or Kaiser Foundation Health Plan of Colorado to provide physicians to staff Kaiser hospitals and facilities and provide professional services to Medicare Advantage enrollees in Colorado.

21. Defendant The Southeast Permanente Medical Group is a for profit Georgia corporation qualified to do business in the State of Georgia as a medical group with its principal office located in Atlanta in Fulton County, Georgia that contracts with Kaiser and/or Kaiser Foundation Health Plan of Georgia, Inc. to provide physicians to staff Kaiser hospitals and facilities and provide professional services to Medicare Advantage enrollees in Georgia.

22. Defendant Hawaii Permanente Medical Group is a for profit Hawaiian corporation qualified to do business in the State of Hawaii as a medical group with its principal office located in Honolulu in Honolulu County, Hawaii that contracts with Kaiser to provide physicians to staff Kaiser hospitals and facilities and provide professional services to Medicare Advantage enrollees in Hawaii.

23. Defendant Northwest Permanente, P.C. is a for profit Oregon corporation qualified to do business in the state of Oregon and Washington as a medical group with its principal office located in Portland in Multnomah County, Oregon that contracts with Kaiser and/or Kaiser Foundation Health Plan of the Northwest to provide physicians to staff Kaiser hospitals and facilities and provide professional services to Medicare Advantage enrollees in Oregon and Washington.

24. Defendants The Permanente Medical Group, Colorado Permanente Medical Group, P.C., The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, and Northwest Permanente, P.C. are collectively referred to as "the Kaiser Medical Groups."

25. The Kaiser Medical Groups employ physicians to provide professional physician and ancillary medical services to Kaiser Medicare Advantage enrollees in California, Colorado, Georgia, Hawaii, and Oregon, both inside and outside of Kaiser hospitals and other facilities, pursuant to agreements with Kaiser or one of the Kaiser Plans in exchange for both capitation payments (a fixed amount per enrollee assigned to the Kaiser Medical Group per month) and a share of Kaiser's or a Kaiser Plan's net revenue.

Defendants as Co-Schemers

26. Although Kaiser, the Kaiser Plans, Kaiser Foundation Hospitals, and the Kaiser Medical Groups are regulated by different state and federal agencies and subject to different regulatory schemes and legal obligations as separate entities, they function as a single and fully integrated organization akin to a partnership, joint venture, association and/or enterprise. Kaiser owns and controls the Kaiser Plans and Kaiser Foundation Hospitals as subsidiaries, and Kaiser and the Kaiser Plans maintain agreements for the Kaiser Medical Groups to staff the Kaiser hospitals and other facilities with physicians and to provide medical management services to the Kaiser hospitals and other facilities, and also to provide professional and ancillary medical services to Kaiser members, including Medicare Advantage enrollees, inside and outside of Kaiser hospitals. In particular, Kaiser issues and implements system-wide policies and procedures for the Kaiser Plans, Kaiser Foundation Hospitals, and Kaiser Medical Groups regarding services provided to Medicare Advantage enrollees, including with respect to medical record documentation, diagnosis coding, and CMS's risk adjustment process.

27. At all relevant times, each Defendant was acting as an agent,

representative, partner, joint-venturer, or co-schemer of the other Defendants, and, in committing the wrongful acts and omissions described in this Complaint, was acting within the course and scope of that agency, representation, partnership, joint venture, or scheme. At all relevant times, each Defendant acted in concert with each and every other Defendant, and intended to and did knowingly participate in the events, acts, transactions practices and courses of conduct described in this Complaint, and, in committing the acts and omissions described in this Complaint, each Defendant caused, aided, abetted, facilitated, encouraged, authorized, permitted and/or ratified the wrongful acts and omissions of the other Defendants.

FACTUAL ALLEGATIONS

Medicare Advantage Plans

28. The Medicare program is a federally run health insurance program benefitting those who are age 65 and older and the disabled. Enacted in 1965, the program initially consisted of Medicare Parts A and B, both insurance programs that cover inpatient and outpatient services, respectively. Under Parts A and B, Medicare pays providers enrolled in these fee-for-service ("FFS") programs based on set fees for each service (or bundle of services) that they provide.

29. In 1997, Congress enacted Medicare Part C, under which Medicare beneficiaries can elect to enroll in a Medicare Advantage plan, a managed care plan administered by a private insurance company that has entered into a contract with CMS to be a Medicare Advantage Organization ("MAO"). Medicare Advantage plans provide all Medicare Parts A and B benefits, and most offer additional benefits beyond those covered under the original Medicare program. Under its federal contract, the MAO is paid a monthly fixed or "capitated" fee by the federal government to care for each Medicare Advantage plan enrollee regardless of the amount or type of health care services the member actually uses. Over the past few years there has been an upward trend in enrollment in the Medicare Advantage program. Currently, about 27% of Medicare beneficiaries are enrolled in Medicare

Advantage plans, with the majority enrolled in Medicare Advantage HMOs.

30. Initially, CMS's capitated payments to MAOs were based solely upon enrollee demographic information, such as age and gender. In 2000, to improve the accuracy and fairness of payments, and to mitigate "cream-skimming" by Medicare Advantage plans (i.e., the preferential selection of the healthiest, low-cost/high return enrollees), CMS began implementing a new Medicare Advantage plan payment model – known as the CMS-Hierarchical Condition Category model ("CMS-HCC") – that uses demographic and diagnostic information to adjust the payment for each plan enrollee by assigning a "risk score" to each enrollee based on the health risk of each plan enrollee and the predicted expenditures for that enrollee in the following year relative to the national average. Under this CMS-HCC model, CMS's risk adjustment payments to a MAO are higher for plan enrollees with major medical conditions (e.g., high risk scores) and lower for healthy enrollees (e.g., low risk scores). This new risk adjustment reimbursement model became fully effective in 2007. *See Medicare Managed Care Manual* ("MMCM"), Pub. # 100-16, ("MMCM"), Ch. 7, §§ 20, 50, 70, 70.5.1, Ch. 8, § 50.

31. In order to obtain Medicare risk adjustment payments, CMS requires a MAO to submit accurate diagnosis codes from the International Classification of Diseases, 9th Edition, Clinical Modification ("ICD-9-CM") for each condition that is supported by the enrollee's medical record. Under the CMS-HHC model, the primary indicator of each enrollee's health status is the ICD-9-CM diagnosis codes assigned by Medicare Advantage plan providers to the enrollee and reported by the MAO in Risk Adjustment Processing System ("RAPS") files submitted at least quarterly to CMS through the agency's Front End Risk Adjustment System (FERAS) and RAPS Databases. Healthy enrollees will have no ICD-9-CM diagnoses codes, while less healthy enrollees may have multiple ICD-9-CM diagnosis codes. The MAO's reported diagnosis codes drive the risk scores assigned by CMS to Medicare Advantage enrollees for a particular year and those

risk scores in turn drive CMS's risk adjustment payments to the MAO for those enrollees during the next year. *See* MMCM, Ch. 7, §§ 110, 120, 120.1.1, 120.2, 120.2.3, 120.2.7.

32. The ICD-9-CM diagnosis codes reported by the MAO to CMS must be documented in the Medicare Advantage enrollee's medical record by the treating physician based on a face-to-face encounter with the enrollee during the relevant data collection period. The MAO's reported diagnosis codes must only describe medical conditions that existed at the time of the face-to-face encounter and were the clinical reason for the enrollee's treatment or management. *See* MMCM, Ch. 7, §§ 40, 120, 120.1.1, 120.2.3, 130. "Medical history alone may not be used as a source of diagnoses for risk adjustment purposes. For a chronic condition to be accepted for risk adjustment, the patient must have a face-to-face visit each year with a provider/physician who assesses and documents that condition." *See* CMS Customer Service and Support Center ("CSSC") 2013 National Technical Assistance, *Risk Adjustment 101 Participant Guide*, p. 17 (2013).

33. For example, a Medicare Advantage enrollee's prescription for an angiotensin-converting enzyme ("ACE") inhibitor, alone, is insufficient by itself to support a MAO's report to CMS of a diagnosis of congestive heart failure ("CHF"). Instead, CMS requires that the enrollee's medical record document a physician's diagnosis of CHF during the data collection period. Likewise, a laboratory test showing one reading of high blood sugar is not sufficient "clinical evidence" of diabetes because the medical record needs to document a physician's diagnosis of diabetes during the data collection period. Therefore, MAOs cannot submit diagnosis codes taken from prior data collection periods (even for chronic conditions) nor base them on certain types of lab results or medical records – such as radiology and lab reports – because these records do not reflect a diagnosis by a treating physician based on a face-to-face encounter with the Medicare Advantage enrollee during the current data collection period. *See* MMCM, Ch. 7, §§ 120.1.1

34. CMS groups the ICD-9-CM diagnosis codes that it receives from the MAO plan into separate disease categories known as Hierarchal Condition Categories or HCCs. The HCCs are based upon the type of disease and the costs of treating that disease. A plan enrollee may have one or more HCCs. Based on the enrollee's HCCs and demographics, CMS calculates a "risk score" for the enrollee which determines the risk adjustment payment – consisting of the Medicare Advantage plan's base capitation rate multiplied by the enrollee's risk score – to be made to the MAO for that plan enrollee for the next year. The higher an enrollee's risk score, the higher the risk adjustment payment. Generally, only ICD-9-CM codes associated with major medical conditions (e.g., diabetes, cancer, heart disease, kidney failure, respiratory failure, major psychiatric disorders,) will result in increased CMS risk adjustment payments to the MAO. The CMS-HCC models "are prospective in the sense that they use diagnosis information from a base year to predict costs for the next year." *See* MMCM, Ch. 7, §§ 70, 70.1, 110, Ch. 8, § 50.

35. By way of example, in 2009, CMS would assign an HCC for renal failure (HCC 131) to a Medicare Advantage enrollee if a MAO reported ICD-9-CM diagnosis code 584.5 (acute renal failure with lesion of tubular necrosis), 584.6 (acute renal failure with lesion of renal cortical necrosis), 584.7(acute renal failure with lesion of renal medullary (papillary)), 584.8 (acute renal failure with other specified pathological lesion in kidney), 584.9 (acute renal failure unspecified), 585.1 (chronic kidney disease stage I), 585.2(chronic kidney disease stage II), 585.3 (chronic kidney disease stage III), 585.4 (chronic kidney disease stage IV), 585.5 (chronic kidney disease stage V), 585.6 (end stage renal disease), 585.9 (chronic kidney disease unspecified), or 586 (renal failure unspecified).

36. Each calendar year, CMS adjusts each Medicare Advantage plan enrollee's risk score based on the array of ICD-9-CM diagnoses reported in the MAO's claims during the prior year. If the provider claims for the enrollee during

that year do not contain the same ICD-9-CM diagnosis codes supporting the prior risk score, then CMS will lower the enrollee's applicable risk score for the next year. As stated in the Medicare Managed Care Manual, "Beneficiary risk scores are used to adjust each plan's base payment rate for member health status. The risk score is computed for each beneficiary for a given year and applied prospectively. The risk score follows the beneficiary for one calendar year." *See* MMCM, Ch. 8, § 50.

37. The MAO's reporting of ICD-9-CM diagnoses for plan enrollees determines what HCC codes are assigned by CMS to the Medicare Advantage plan enrollees. CMS is unable to verify the accuracy of ICD-9-CM diagnosis codes when the MAO submits them because the agency is not provided with supporting medical documentation at the time of such submission. Instead, CMS relies upon the MAO to submit accurate and medically supported ICD-9-CM codes diagnoses in the first instance, and also to delete any diagnoses later determined by the MAO to be incorrect because the MAO's reporting of unsupported ICD-9-CM codes for major medical conditions will improperly increase CMS's risk adjustment payments to the MAO.

38. Each year, the MAO must sign an attestation form attesting upon best knowledge, information, and belief that the ICD-9-CM diagnosis codes and other risk adjustment information submitted to CMS were accurate, complete, and truthful. The attestation form also contains an acknowledgment by the MAO that the diagnoses submitted directly affect the calculation of CMS risk adjustment payments to the MAO's Medicare Advantage plans. In addition, CMS provides MAOs with a one-time per calendar year opportunity to reconcile risk adjustment payments. *See* 42 C.F.R. § 422.504(l).

The Kaiser Medicare Advantage Plans

39. Kaiser is the largest managed care organization in the United States with 9.6 million members in nine states and the District of Columbia, although

approximately 7.5 million (78%) of its enrollees are in California, the state where Kaiser originated and is currently headquartered. Kaiser is the organizational hub of a unique single and integrated health care delivery system that delivers covered services to plan members, including Medicare beneficiaries, through the Kaiser Hospitals and Kaiser Medical Groups. The Kaiser organization operates approximately 38 hospitals, over 600 multi-specialty medical offices with diagnostic imaging, laboratory, and pharmacy services, and provides professional medical services through more than 15,000 Kaiser physicians. In 2014, Kaiser reported net income of $3.1 billion on $56.4 billion in operating revenue.

40. Since at least 2005, Kaiser and the Kaiser Plans have been MAOs pursuant to contracts with CMS under Medicare Part C and have offered multiple Medicare Advantage managed care plans to Medicare beneficiaries, including individual or general enrollment plans and employer group waiver plans. Under these MAO contracts, Kaiser is paid a monthly fixed or "capitated" fee by the Medicare program to care for each Medicare beneficiary enrolled in one of its Medicare Advantage plans. Approximately thirty percent (30%) of Kaiser's annual operating revenue comes from the Medicare Advantage program.

41. At all relevant times, as MAOs, Kaiser and the Kaiser Plans have delivered covered health care services to HMO members and Medicare Advantage enrollees through a unique Kaiser health care delivery system under which such services are delivered by the Kaiser Medical Groups and Kaiser Foundation Hospitals and clinics as part of a single and integrated enterprise. Kaiser acts as the organizational hub of this health care delivery system and implements system-wide policies and procedures governing services provided to Medicare Advantage enrollees, including with respect to medical record documentation, diagnosis coding, and CMS's risk adjustment process. Kaiser Foundation Hospitals, a wholly owned subsidiary of Kaiser, owns and operates all of Kaiser's hospitals and other healthcare facilities. Kaiser and the Kaiser Plans have exclusive contracts with the

Kaiser Medical Groups to provide physicians to staff Kaiser hospitals and facilities and to provide professional medical services to Medicare Advantage plan enrollees, typically in exchange for capitation payments (a fixed amount per enrollee assigned to the medical group) and a share in Kaiser's annual profits.

Kaiser's Medicare Advantage Fraud

42. Between January 1, 2008 and December 31, 2013, and continuing through the present, the Kaiser Defendants devised and implemented an elaborate scheme to defraud the Medicare program by reporting false ICD-9-CM diagnoses to CMS for Medicare Advantage plan enrollees in order to inflate the number of HCCs for such enrollees and thereby fraudulently increase CMS's risk adjustment payments to Kaiser and the Kaiser Plans for such enrollees. This scheme damaged, and continues to damage, the United States by causing CMS to pay more in risk adjustment payments to Kaiser than the amounts to which Kaiser is entitled.

43. As part of their scheme to report false ICD-9-CM diagnoses to CMS, the Kaiser Defendants used KP HealthConnect, a health information and billing system that integrates each Medicare Advantage enrollee's electronic health record ("EHR") with Kaiser's electronic claims processing and billing functions across all Kaiser hospitals and other facilities, to manipulate Kaiser physicians into documenting more severe medical conditions for Medicare Advantage enrollees that could then be reported by Kaiser to CMS for the purpose of calculating each enrollee's risk score. Specifically, Kaiser Defendants mandated that plan physicians document the Medicare beneficiaries' diagnoses in their EHR using a proprietary and home-grown set of 28,000 diagnosis terms (double the number of ICD-9-CM codes) known as Convergent Medical Terminology ("CMT"), and, more colloquially, as Kaiser's " secret sauce." By divorcing CMT diagnostic terms from ICD-9-CM diagnoses, Kaiser, rather than the physicians, controlled which ICD-9-CM diagnoses were ultimately reported to CMS for Medicare beneficiaries as the supposed equivalent of the CMT diagnostic terms actually selected by the

treating physicians.

44. In furtherance of its fraud scheme, the Kaiser Defendants also improperly induced Kaiser physicians to select those CMT diagnosis terms that Kaiser had "mapped" or cross-referenced to more severe ICD-9-CM codes than those actually supported by the Medicare enrollee's medical condition through a variety of means. First, when a Kaiser physician selected a CMT diagnostic term for a Medicare enrollee, a KP HealthConnect "workflow tool" prompted and steered the physician to a more specific set of CMT diagnostic terms from which the physician was required to select additional diagnostic terms, many of which had been mapped by Kaiser to more severe ICD-9-CM codes that will support assignment of an HCC by CMS. Through this EHR software program, the Kaiser Defendants manipulated and directed the Kaiser physician's diagnostic decisions, thereby improperly increasing the probability that the physician would select a CMT diagnostic term that Kaiser could "translate" into an ICD-9-CM diagnosis that would then be falsely reported to CMS as an HCC severe medical condition.

45. In addition, the Kaiser Defendants' coding departments employed teams of documentation specialists who used KP HealthConnect to retroactively "data mine" the Medicare enrollees' electronic health records, including diagnostic test results, going as far back as fifteen years for clinical signs and symptoms to support additional HCCs in the current year. Known as Clinical Documentation Specialists ("CDS"), these Kaiser reviewers (many of whom had foreign medical licenses) were expressly tasked by Kaiser with performing reviews of the Medicare enrollees' electronic records to "accurately identify [the] presence of medical conditions not diagnosed or captured in electronic health record" and any "coding opportunity by using the predefined Risk Adjustment data mining parameters." These Kaiser reviewers improperly identified HCC diagnoses that were not made by the treating physician at the time of the required face-to-face encounter with the Medicare enrollee.

46. Further, the Kaiser Defendants directed their data mining teams to identify such HCCs using "clinical" algorithms or decision trees that were not based on generally accepted standards of medical or coding practice. Instead, the risk adjustment algorithm for each HCC diagnosis directed that the diagnosis be made based on signs and symptoms and diagnostic testing results in the enrollee's electronic chart that could support a multitude of other diagnoses; testing standards that were more liberal than the generally accepted diagnostic standard; and historical diagnoses or signs that did not show that the condition was still present years later. Examples of these bogus HCC algorithms (examples of which are attached as Exhibit 1) used to identify diagnoses not made by the treating physician in the current year included the following:

a. In the case of angina pectoris (stable angina) and old myocardial infarction (MI) (HCC 83), a physician query was sent if the Medicare enrollee's electronic chart showed a diagnosis of coronary artery disease ("CAD") and an old MI "look[ing] back as far as possible," even though accepted diagnosis guidelines require current chest pain on exertion or emotional stress and current CAD confirmed through lab tests, ECG, chest x-ray, and/or stress ECG.

b. In the case of bronchiectasis (HCC 112), a physician query was sent if the Medicare enrollee's electronic chart showed an x-ray finding of bronchiectasis in the current year even though Medicare coding guidelines explicitly prohibit HCC coding based on radiology reports because such reports do not reflect a diagnosis by the treating physician after a face-to-face encounter with the enrollee.

c. In the case of cachexia (wasting syndrome) (HCC 21), a physician query was sent if the Medicare enrollee's electronic chart showed a weight loss of greater than 5% in the past year and, in the past three years, a Body Mass Index ("BMI") of between 18.5 and 20 and a diagnosis of HIV/Aids, cancer, chronic obstructive pulmonary disease ("COPD"), rheumatoid arthritis, heart

failure, end stage liver disease, end stage renal disease, chronic kidney disease, tuberculosis or Alzheimers/dementia even though a BMI of 18.5 to 20 is a healthy weight and a diagnosis of cachexia requires a current (not past) chronic illness, as well as a number of other symptoms – such as reduced muscle strength, fatigue, anorexia, low fat-free mass index, and abnormal biochemistry (e.g., inflammation, anemia, low albumin) – in order to distinguish wasting syndrome from other weight loss caused by starvation, age-related loss of muscle mass, primary depression, malnutrition, malabsorption and hyperthyroidism.

d. In the case of chronic hepatitis (HCC 27 or 29), a physician query was sent even if the Medicare enrollee's electronic chart showed no hepatitis diagnosis or treatment, but included a positive or reactive quantitative or qualitative hepatitis test anytime or "any" positive or reactive hepatitis genotype test "looking back as far as possible," even if the patient had not undergone any monitoring or treatment for "active" hepatitis after such positive/reactive test, and even though a positive result by itself is typically insufficient to diagnose chronic hepatitis because tests detect antibodies from old hepatitis cases that no longer cause any actual liver inflammation.

e. In the case of chronic kidney disease ("CKD"), Stages 3, 4 and 5 (HCCs 131 or 138, 134-137), a physician query was sent if the Medicare enrollee's electronic chart included an abnormal glomerular filtration rate ("GFR") for two consecutive tests separated by three months at any time in the last three years, even though abnormal GFR results, without kidney damage, may be caused by conditions other than CKD (e.g., vegetarian diets, unilateral nephrectomy, extracellular fluid volume depletion, and systemic illnesses associated with reduced kidney perfusion, such as heart failure and cirrhosis), and kidney function (and GFR) can fluctuate, be temporarily impaired, and improve substantially over a period of three years.

f. In the case of diabetes with chronic kidney failure (HCC 18 or

15, 16, 18), a physician query was sent if the Medicare enrollee's electronic chart showed a diagnosis of type 2 diabetes in the past three years along with two positive proteinuria or microalbuminuria lab tests at any time during the past three years even though the patient's kidney function could have improved during this period.

g. In the case of dyslipidemia, mixed hyperlipidemia and hyperlipidemia (HCC 16 or 18), a physician query was sent if the Medicare enrollee's electronic chart included laboratory test results showing abnormal levels of low density lipoprotein ("LDL") or high-density lipoprotein ("HDL") cholesterol at any time in the past even though such values often fluctuate dramatically day-to-day, month-to-month and year-to-year depending on the patient's diet and lifestyle and do not necessarily indicate any cholesterol disorder.

h. In the case of major depression (HCC 55 or 58), a physician query was sent if the Medicare enrollee's electronic chart showed a diagnosis of depression within the past three years and the use of an anti-depressant within the past 12 months, even if the patient was not taking the medication currently and any depression had been resolved and was not being actively treated.

i. In the case of major obesity (HCC 22), a physician query was sent if the Medicare enrollee's electronic chart included a BMI between 35.0 and 39.9 at the most recent visit in the last three years and a diagnosis in the last three years of diabetes, CAD, sleep apnea, hypertension, hyperlipidemia, or osteoarthritis, even though HCC 22 required a current BMI of greater than 40 and a person may have lost significant weight loss in the last three years.

j. In the case of respiratory failure (HCC 79 or 84), a physician query was sent if the Medicare enrollee's electronic chart documented that the patient was on oxygen for two consecutive months as far back as three years even though such oxygen may have been used to treat other respiratory conditions such as pneumonia, acute bronchitis, and COPD, and despite the fact that a diagnosis of

respiratory failure is generally only made when arterial blood gas tests show that the arterial Pa O2 has fallen below 60 mm Hg (hypoxemia) and/or the arterial Pa CO2 has risen above 50 mm Hg (hypercapnia).

47. Since HCC diagnoses for Medicare enrollees made by persons other than the treating physician are not reportable to CMS, the Kaiser Defendants directed their CDSs to send leading and coercive "physician queries" to improperly induce the treating physician to change the electronic record of the Medicare enrollee's most recent face-to face encounter by adding or substituting the HCC diagnosis identified by the CDSs as a current medical condition that is being actively treated by the physician. If a Kaiser physician failed to respond or did not agree with the query's suggestion of an HCC diagnosis, the Kaiser data mining team identified the query in the KP HealthConnect system as a "stop prompt," conducted a second review of the Medicare enrollee's electronic record to find additional support for the query's suggested HCC diagnosis, and then sent a repeat query to the Kaiser physician. If the Kaiser physician again refused to follow the query's suggested HCC diagnosis, the query was then usually escalated to the Kaiser medical director overseeing that particular Kaiser physician for further review.

76. In order to satisfy CMS's requirement that HCCs be based on a face-to-face physician encounter, the Kaiser Defendants also encouraged Medicare enrollees to visit a physician for an "annual check-up" before the end of each fiscal year so that more HCCs can be added to the enrollee's record for that year. If Medicare enrollees declined to come to a Kaiser facility, the Kaiser Defendants offered to send a physician to the enrollee's home to conduct this check-up. The primary purpose of these annual "check-ups" for Medicare enrollees was to provide an unnecessary patient encounter during the data collection period that would permit the Kaiser Defendants to add HCC conditions to the enrollees' records so that Kaiser could report them to CMS and increase its risk adjustment payments.

77. As further inducement for Kaiser physicians to document CMT diagnostic terms mapping to HCCs, the Kaiser Medical Groups also paid bonuses to Kaiser physicians based, in part, on the quantity of HCC-qualifying diagnoses that they ended up documenting for Medicare enrollees regardless of whether such diagnoses were in fact supported by the enrollees' medical conditions.

78. In furtherance of their Medicare Advantage diagnosis upcoding scheme, the Kaiser Defendants also implemented certain policies in California to ensure that Medicare Advantage enrollees would be primarily treated by Kaiser physicians so that their diagnoses could be manipulated and upcoded as described above, including the following:

a. Although Kaiser is required to cover emergency services provided to Medicare Advantage enrollees by non-Kaiser hospitals, the plan entered into contracts with ambulance providers (including the Los Angeles Fire Department ("LAFD")) under which Kaiser paid such providers to by-pass the nearest hospital emergency room and transport Medicare Advantage enrollees to a Kaiser hospital. Since 1998, Kaiser had contracts with LAFD under which the plan paid LAFD a fee ranging from $100 to $135 for each Kaiser patient transported by ambulance more than three miles to a Kaiser hospital, rather than to the nearest emergency room. Between 1998 and 2012, Kaiser has paid LAFD $5.2 million dollars for transporting over 40,000 Kaiser patients past the nearest emergency room to a Kaiser hospital; and

b. In addition, if a Medicare Advantage enrollee sought treatment for an emergency medical condition at a non-Kaiser hospital in California, Kaiser would improperly pressure the hospital to transfer the enrollee to Kaiser hospital even when the non-Kaiser treating physician had determined that the enrollee was not stable for transfer and could be medically harmed by the transfer.

Kaiser's Medicare Advantage Enrollees' Astonishingly High Rates of Severe Medical Conditions Supporting HCCs

79. While Kaiser and the Kaiser Plans are HMOs tasked with the ostensible goal of keeping its Medicare enrollees healthy, the Kaiser Defendants' scheme to fraudulently obtain Medicare risk adjustment payments resulted in astonishingly high rates of HCC diagnoses being reported by the plans for their Medicare enrollees to CMS and a dramatic increase in the incidence of such HCC conditions compared to traditional Medicare patients after CMS fully implemented its CMS-HCC model in 2007. Kaiser's medically unexplainable rates of serious medical conditions – especially those resulting in high-value HCCs – for its Medicare enrollee population in California included the following:

k. Between 2008 and 2013, Kaiser Medicare enrollees were diagnosed with proliferative diabetic retinopathy and vitreous hemorrhage (HCC 119 or 122) at an average rate that was 3,427% that of traditional Medicare.

l. Between 2008 and 2013, Kaiser Medicare enrollees were diagnosed with diabetes with chronic complications (HCC 15, 16 and 18) at an average rate that was 497% that of traditional Medicare. This Kaiser statistic is particularly unexplainable because if the HMO was appropriately managing patients with diabetes mellitus, those patients are less likely to develop complications, let alone chronic ones. In addition, Kaiser has reported far fewer Medicare enrollees with diabetes without complication (under the less financially lucrative HCC 19) compared to traditional Medicare (44% less), confirming that the plan has been upcoding its Medicare diabetes patients to higher HCCs.

m. Between 2008 and 2013, Kaiser Medicare enrollees were diagnosed with angina pectoris (HCC 83 or 88) at an average rate that was 324% that of traditional Medicare, with a dramatic 637% increase in 2012, the year that CMS increased the weight of this HCC from 0.290 to 0.366.

n. Between 2008 and 2013, Kaiser Medicare enrollees were

diagnosed with vascular disease (HCC 105 or 108) at a steadily increasing rate that was on average 315% that of traditional Medicare.

o. Between 2008 and 2013, Kaiser Medicare enrollees were diagnosed with major depressive, bipolar, and paranoid disorders (HCC 55 or 58) at an ever-increasing rate that was on average 188% that of traditional Medicare.

p. Between 2008 and 2013, Kaiser Medicare enrollees were diagnosed with malnutrition (HCC 21) at rate that was on average 182% that of traditional Medicare.

q. Between 2008 and 2013, Kaiser Medicare enrollees were diagnosed with septicemia (HCC 2) at an average rate that was 113% that of traditional Medicare. *See* Analysis of Kaiser & Traditional Medicare HCCs (2008 - 2013) After Applying National Factor, attached as Exhibit 3; Analysis of Kaiser & Traditional Medicare HCCs (2008 - 2013) Minus Associated Disease Groups, attached as Exhibit 4.

80. The Kaiser Defendants' fraud scheme is also reflected in Kaiser's under-reporting of HCCs (as would be expected for HMO patients) for serious medical conditions which are difficult to fabricate because they have definitive physical signs and symptoms that are generally not subject to physician interpretation or debate. By way of examples, between 2008 and 2013, when compared to traditional Medicare patients, Kaiser Medicare enrollees in California were less frequently diagnosed with schizophrenia (HCC 54 or 57, at 85% less); cystic fibrosis (HCC 107 or 110, at 71% less); severe head injury (HCC 154 or 156, at 61% less); extensive third-degree burns (HCC 150 or 162, at 60% less); respiratory dependence/tracheostomy status (HCC 77 or 82, at 42% less); quadriplegia (HCC 67 or 70, at 43% less); diabetes without complication (HCC 19, at 44% less); cerebral palsy and other paralytic syndromes (HCC 101 or 74, at 45% less); HIV/AIDS (HCC 1, at 47% less); artificial openings for feeding or elimination (HCC 176 or 188, at 37% less); seizure disorders and convulsions

(HCC 74 or 79, at 31% less); and coma, brain compression/anoxic damage (HCC 75 or 80, at 25% less).

81. Kaiser's fraudulent gaming of the HCC system is also reflected by the massive and medically unexplainable increase in severe medical conditions reported for Kaiser Medicare enrollees after CMS implemented the HCC model. For example, between 2008 and 2013, the number of Kaiser enrollees diagnosed with vascular disease increased by a jaw-dropping 218%. Likewise, during the same period, Kaiser reported a 216% increase in enrollees with protein–calorie malnutrition, a 132% increase in enrollees with septicemia and sepsis, a 122% increase in enrollees with coma and brain compression, and a 115% increase in enrollees with immunity disorders. In addition, Medicare beneficiaries with diabetes who enrolled with Kaiser developed complications, including rare complications like diabetic retinopathy and vitreous hemorrhage (bleeding in eye), at a rate five times higher than if they had stayed in traditional Medicare. These enormous spikes in diagnosis rates for severe medical conditions paints an entirely implausible picture of Kaiser enrollees getting sicker and sicker even though the HMO's whole model is designed to reduce health care costs by actively managing the Medicare enrollees so that their health improves, rather than getting worse at rates more associated with an epidemic.

82. By fraudulently increasing the HCCs assigned to its Medicare enrollees, the Kaiser Defendants increased patients' risk scores and profiles and thereby caused CMS to make incorrect higher risk adjustment payments to Kaiser for such enrollees. In addition, because the HCCs were not medically supported, the enrollees "recovered" from such HCCs faster than usual, resulting in higher favorable quality of care indices – including decreased mortality and complication rates – that falsely suggested that Kaiser and the Kaiser were successfully treating serious medical conditions more effectively than other Medicare Advantage plans. As an ironic result, Kaiser's fraud scheme significantly contributed to its receipt of

CMS's highest "5 Star" rating for a Medicare Advantage plan, which also caused Kaiser to be paid annual bonuses ($380 million in 2012) that the HMO did not deserve.

83. On or about September 5, 2008, March 6, 2009, September 4, 2009, January 31, 2010, March 5, 2010, September 3, 2010, January 31, 2011, March 4, 2011, September 2, 2011, January 31, 2012, March 2, 2012, September 7, 2012, January 31, 2013, March 1, 2013, September 6, 2013, January 31, 2014, and March 7, 2014, the Kaiser Defendants submitted, or caused to be submitted, false claims to CMS for risk adjustment payments – consisting of RAPS files submitted to CMS by Kaiser and the Kaiser Plans through the agency's FERAS and RAPS Databases – that contained false ICD-9-CM diagnoses for Kaiser Medicare Advantage enrollees supporting risk adjustment payments by CMS for such enrollees.

84. In 2010, 2011, 2012, and 2013, 2014, and 2015, the Kaiser Defendants submitted, or caused to be submitted, false statements to CMS – consisting of an annual written "Attestation of Risk Adjustment Data Information Relating to CMS Payment to a Medicare Advantage Organization" submitted by Kaiser and the Kaiser Plans to CMS – that falsely certified and attested that the risk adjustment information, including ICD-9-CM diagnoses, submitted by Kaiser for the year covered by the attestation (e.g., the 2015 attestation covered the RAP data for dates of service between January 1, 2013 and December 31, 2013) was accurate, complete, and truthful when, in truth and fact, the Kaiser RAP data for each year contained false ICD-9-CM diagnoses for Medicare Advantage enrollees supporting risk adjustment payments by CMS for such enrollees.

CMS's Risk Adjustment Overpayments to Kaiser

85. Between 2008 and 2013, the Kaiser Defendants systemically assigned more severe ICD-9-CM diagnosis codes to Medicare enrollees than supported by the enrollees' actual medical conditions and reported such false codes in quarterly RAPS files to CMS in order to cause CMS to incorrectly assign HCCs or higher

HCCs to such enrollees. Through this fraud scheme, the Kaiser Defendants caused CMS to make incorrect risk adjustment payments to Kaiser and the Kaiser Plans for such Medicare enrollees totaling more than fourteen billion dollars.

86. Relators calculated the massive loss caused by Kaiser Defendants' fraud scheme based on the variance between Kaiser's reported number of Medicare enrollees with certain HCC medical conditions and the incidence of such conditions for traditional Medicare patients in California hospitals. The specific methodology is described in the Appendix attached as Exhibit 2. By way of examples, Kaiser's false HCC reporting included estimated Medicare overpayments for its inpatient enrollees in California for the following HCCs:

a. Approximately $717,284,358.41 in overpayments for diabetes with chronic complication (HCC 15,16 and 18) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 497% of that reported by other California hospitals for traditional Medicare patients with the same medical condition;

b. Approximately $286,099,138.28 for renal failure (HCCs 131,135, 136, 137, 138, 139 and 140) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 136% of that reported by other California hospitals for traditional Medicare patients with the same medical condition;

c. Approximately $241,599,578.86 for vascular disease and complications (HCCs 104 and 105, or 107 and 108) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 225% of that reported by other California hospitals for traditional Medicare patients with the same medical condition;

d. Approximately $158,184,582.50 for angina pectoris (HCC 83 or 88) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 324% of that reported by other California hospitals for traditional Medicare patients with the same medical condition;

e. Approximately $173,176,160.18 for polyneuropathy (HCC 71 or 75) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 274% of that reported by other California hospitals for traditional Medicare patients with the same medical condition;

f. Approximately $149,556,111.63 for protein-calorie malnutrition (HCC 21) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 182% of that reported by other California hospitals for traditional Medicare patients with the same medical condition;

g. Approximately $131,551,146.90 for congestive heart failure (HCC 80 or 85) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 122% of that reported by other California hospitals for traditional Medicare patients with the same medical condition.

h. Approximately $151,213,947.82 for major depressive, bipolar, and paranoid disorders (HCC 55 or 58) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 188% of that reported by other California hospitals for traditional Medicare patients with the same medical condition.

i. Approximately $93,213,680.84 for metastatic cancer and acute leukemia (HCC 7 or 8) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 128% of that reported by other California hospitals for traditional Medicare patients with the same medical condition;

j. Approximately $88,903,003.18 for septicemia, sepsis, and systemic inflammatory response syndrome/shock (HCC 2) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was 113% of that reported by other California hospitals for traditional Medicare patients with the same medical condition; and

k. Approximately $55,874,976.41 for proliferative diabetic retinopathy and vitreous hemorrhage (HCC 119 or 122) incorrectly assigned by Kaiser to Medicare enrollees at an average rate that was a staggering 3,427% of that

reported by other California hospitals for traditional Medicare patients with the same medical condition.

87. Including these and the other HCCs falsely reported by Kaiser and the Kaiser Plans results in estimated risk adjustment overpayments of $14,455,832,951. CMS's $14 billion overpayment to Kaiser and the Kaiser Plans is a low estimate because of the highly conservative treatment of the HCC variance data by Relators and, additionally, because only data from Kaiser's Medicare enrollees in California was analyzed by Relators. Specifically, between 2008 and 2013, the difference between Kaiser's average per patient payment ($1,157.19) and traditional Medicare's average per patient payment ($698.69) translates into an estimated overpayment of $26,726,510, 919, a substantially higher figure than Relators' more conservative loss calculation based on HCC variances. *See* Summary of Kaiser HCC Overpayments, attached as Exhibit 5.

FIRST CAUSE OF ACTION

FALSE CLAIMS ACT: PRESENTATION OF FALSE CLAIMS

(31 U.S.C. § 3729(A)(1))

(Against All Defendants)

88. Plaintiff United States hereby repleads and incorporates by reference each and every allegation contained in paragraphs 1 through 87, above, as though fully set forth in this paragraph.

89. Between January 1, 2008 and the present, Defendants knowingly presented or caused to be presented false or fraudulent claims for Medicare Advantage risk adjustment payments to the United States.

90. By virtue of the false or fraudulent claims 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 a civil penalty for each violation.

SECOND CAUSE OF ACTION

FALSE CLAIMS ACT: MAKING OR USING FALSE RECORD OR STATEMENT

(31 U.S.C. § 3729(A)(2))

(Against All Defendants)

91. Plaintiff United States hereby repleads and incorporates by reference each and every allegation contained in paragraphs 1 through 90, above, as though fully set forth in this paragraph.

92. Between January 1, 2008 and the present, Defendants knowingly made, used or caused to be made or used, false records or statements, including false RAPS files and annual "Attestations of Risk Adjustment Data Information Relating to CMS Payment to a Medicare Advantage Organization," to get the United States to pay false and fraudulent claims for Medicare Advantage risk adjustment payments.

93. By virtue of the false or fraudulent records or statements 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 a civil penalty for each violation.

PRAYER FOR RELIEF

WHEREFORE, Relator, on behalf of the United States, demands and prays that judgment be entered in favor of the United States against Defendants, as follows:

a. Defendants pay an amount equal to three times the amount of damages the United States has sustained because of Defendants' actions, plus a civil penalty against Defendants of not less than $5,500 and not more than $11,000 for each violation of 31 U.S.C. § 3729;

b. Relator be awarded the maximum amount allowed pursuant to 31U.S.C. § 3730(d);

c. Defendants cease and desist from violating the False Claims Act, 31 U.S.C. § 3729, *et seq.*;

d. Relator be awarded all costs of this action, including attorneys' fees, expenses, and costs pursuant to 31 U.S.C. § 3730(d); and

e. The United States and Relator be granted all such other relief as the Court deems just and proper.

DATED: September 4, 2015

Respectfully submitted,

MARK S. HARDIMAN
NELSON HARDIMAN LLP.

By: _____
Mark S. Hardiman

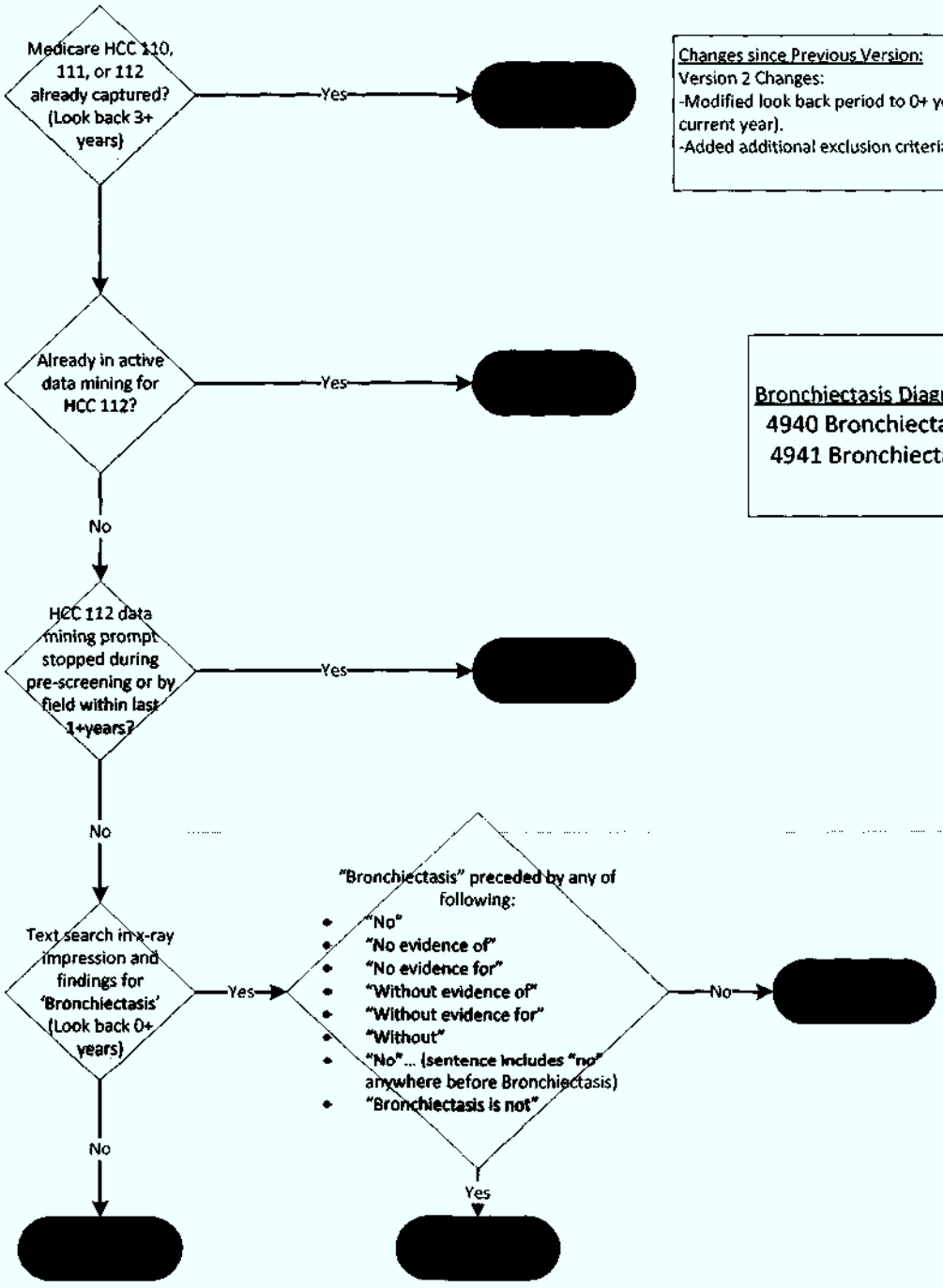
Attorneys for Relators

EXHIBIT 1

☐ Pre-screened
☒ Not pre-screened
☐ Partially pre-screened

BRONCHIECTASIS
FINAL v.2- 10/28/13

☒ CMS HCC 112
☐ HHS
☐ CalPEGS



Changes since Previous Version:
Version 2 Changes:
-Modified look back period to 0+ years (January of current year).
-Added additional exclusion criteria (text parsing)

Bronchiectasis Diagnoses (HCC 112):
4940 Bronchiectas w/o ac exac
4941 Bronchiectasis w ac exac

This purpose of this algorithm is to identify patients who may have clinical evidence of chronic Bronchiectasis but do not already have a Cystic Fibrosis code or "Fibrosis of Lung & Other Chronic Lung Disorders" diagnosis captured. This algorithm is not intended for training to the clinical diagnosis criteria for the condition.

Cachexia- Final v.5 – 12/20/2013

- ☐ Pre-screened
- ☐ Not pre-screened
- ☒ Partially pre-screened

☒ CMS	HCC 21
☒ ACA	CC 23 Adult/Child
☒ CalPERS	ICD9 Code 799.4

Already captured?
CMS: Chronic HCC 21
ACA: Chronic CC 23
CalPERS: ICD9 Code: 799.4
(Look back 3+ years)

No → Cachexia data mining prompt stopped during pre-screening or by field within last 2 rolling years?

No → Already in active data mining for Cachexia?

Yes → [redacted]

Yes → [redacted]

Yes → [redacted]

No → Diagnosed with any of following:
- 650-659.xx: Normal Pregnancy & Other Indications for Care in Pregnancy, Labor, & Delivery
- 660.xx-669.xx: Complications Occurring Mainly in the Course of Labor & Delivery
- 634.xx: Spontaneous Abortion
- V24.x: Postpartum care and examination

(Look back 1+ year)

Yes → [redacted]

No → Age < 20 years?

Yes → Following ICD9 captured? V85.51- BMI, pediatric, less than 5th percentile for age (Look back 1+ years)?

Yes → [redacted]

Group A: Pre-screening

No → [redacted]

No → Height > 4 feet and < 8 feet and weight > 60 lbs? (at most recent visit)

No → [redacted]

Yes → Weight Loss > 5% (most recent weight within 1 years & weight loss within 1 year)

No → [redacted]

Yes → BMI <= 18.5? (Look back 3+ years)

Yes → Diagnosed with any of following comorbidities****:
- HIV/Aids (HCC 1)
- Active CA dx (HCC 8-12)

(Look back 3+ years)

Yes → [redacted]

Group B: No pre-screening

No → [redacted]

Group C: To be pre-screened

No → BMI between 18.5 and 20.0? (Look back 3+ years)

Yes → Diagnosed with any of following comorbidities****:
- HIV/Aids (HCC 1)
- Active CA dx (HCC 8-12)

(Look back 3+ years)

No → Diagnosed with any of following comorbidities****:
- COPD (HCC 111)
- Rheumatoid Arthritis (HCC 40)
- Heart Failure (HCC 85)
- End Stage Liver Disease (HCC 27)
- ESRD (HCC 134)
- Chronic Kidney Disease*
- Tuberculosis **
- Alzheimers & Dementia***

(Look back 3+ years)

No → [redacted]

Yes → [redacted]

Group E: To be pre-screened

No → Weight Loss > 10% (most recent weight within 6 months & weight loss within 6 months)

Yes → BMI <= 25? (Look back 3+ years)

No → [redacted]

Yes → [redacted]

Group D: No pre-screening

Changes since Previous Version:
Version 5 Changes:
- Added ACA and CalPERS criteria to algorithm

This purpose of this algorithm is to identify patients who may have clinical evidence of Cachexia but do not already have a Cachexia diagnosis or Protein Calorie Malnutrition diagnosis (for CMS of ACA) captured. This algorithm is not intended for training to the clinical diagnosis criteria for the condition.

*CKD / Renal Failure ICD9 Codes:
403.01 Mal hyp kid w cr kid V
403.11 Ben hyp kid w cr kid V
403.91 Hyp kid NOS w cr kid V
404.02 Mal hy ht/kd st V w/o hf
404.03 Mal hyp ht/kd stg V w hf
404.12 Ben hy ht/kd st V w/o hf
404.13 Ben hyp ht/kd stg V w hf
404.92 Hy ht/kd NOS st V w/o hf
404.93 Hyp ht/kd NOS st V w hf
584.5 Ac kidny fail, tubr necr
584.6 Ac kidny fail, cort necr
584.7 Ac kidny fail, medu necr
584.8 Acute kidney failure NEC
584.9 Acute kidney failure NOS
585.1 Chro kidney dis stage I
585.2 Chro kidney dis stage II
585.3 Chr kidney dis stage III
585.4 Chr kidney dis stage IV
585.5 Chron kidney dis stage
V585.6 End stage renal disease
585.9 Chronic kidney dis NOS
586 Renal failure NOS
753.14 Polycyst kid-autosom rec

**Tuberculosis ICD9 Codes:
010.0 Primary tuberculous infection
010.1 Tuberculous pleurisy in primary progressive tuberculosis
010.8 Other primary progressive tuberculosis
010.9 Primary tuberculous infection, unspecified
011 Pulmonary tuberculosis
011.0 Tuberculosis of lung, infiltrative
011.1 Tuberculosis of lung, nodular
011.2 Tuberculosis of lung with cavitation
012 Other respiratory tuberculosis
013 Tuberculosis of meninges and central nervous system
014 Tuberculosis of intestines, peritoneum, and mesenteric glands
015 Tuberculosis of bones and joints
016 Tuberculosis of genitourinary system
017 Tuberculosis of other organs
018 Miliary tuberculosis
018.8 Other specified miliary tuberculosis
018.9 Miliary tuberculosis, unspecified

***Dementia ICD9 Codes:

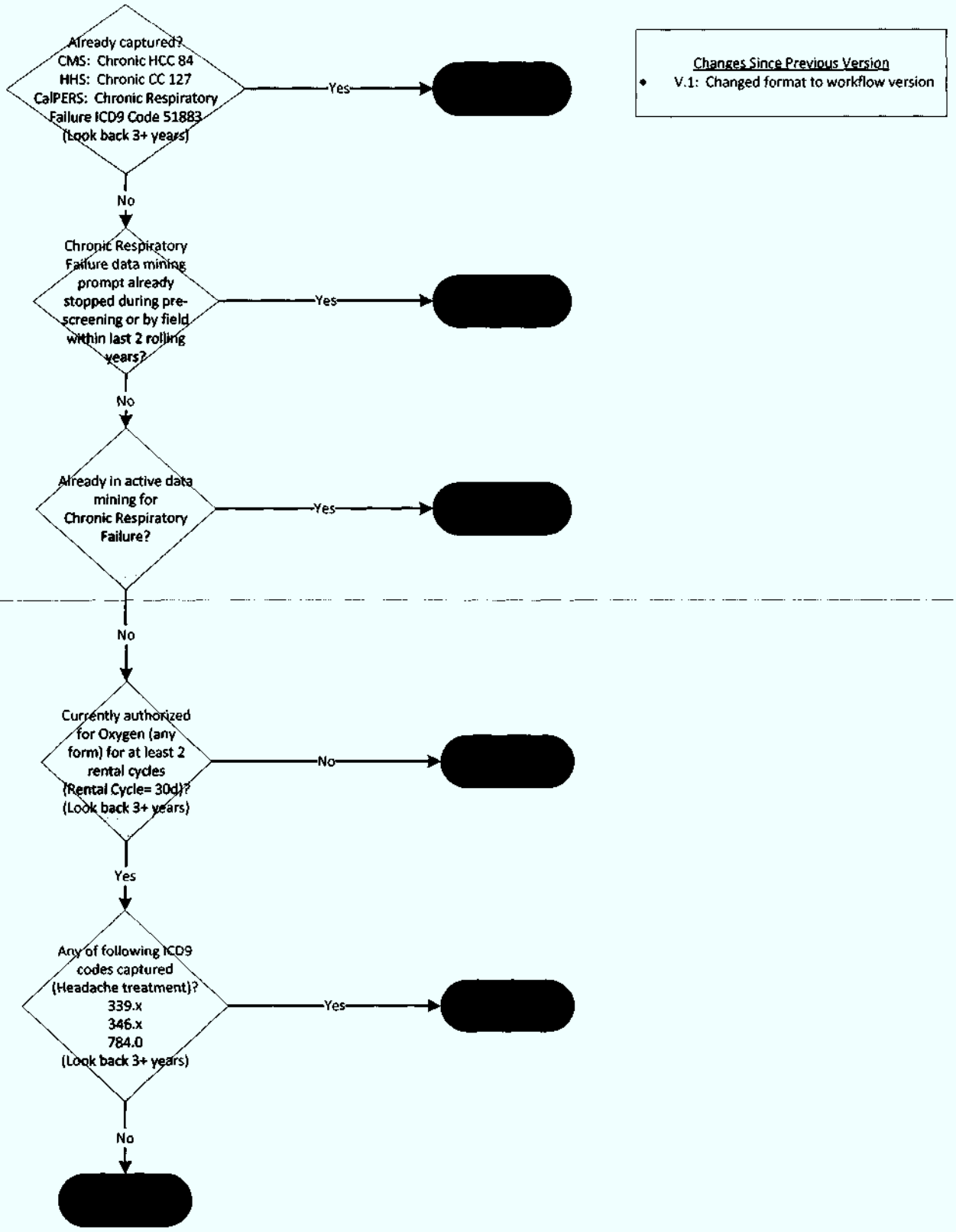
331.0 Alzheimer's disease
331.11 Pick's disease
331.1 Frontotemporal dementia
331.2 Senile degeneration of brain

**** For other co-morbidities identified by HCC, use CMS Model.

CHRONIC RESPIRATORY FAILURE
FINAL v.1- 12/10/2013

☒ Pre-screened	
☐ Not pre-screened	
☐ Partially pre-screened	

☒	CMS	HCC 84
☒	HHS	CC 127 Adult/Child
☒	CalPERS	ICD 518.83



Changes Since Previous Version
- V.1: Changed format to workflow version

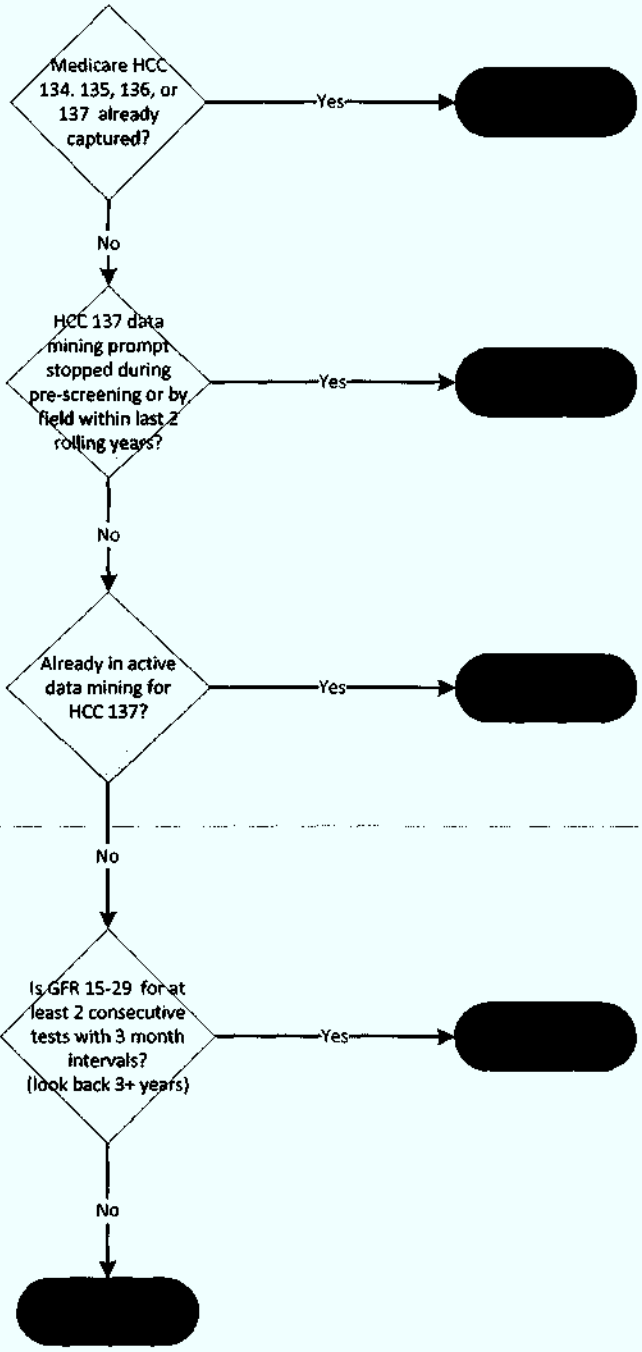
This purpose of this algorithm is to identify patients who may have clinical evidence of Chronic Respiratory Failure but do not already have a Chronic Respiratory diagnosis captured. This algorithm is not intended for training to the clinical diagnosis criteria for the condition.

*Chronic Respiratory ICD Code (CMS HCC 84 / HHS CC 127)
51883 CHR RESPIRATORY FAILURE

☒ Pre-screened
☐ Not pre-screened
☐ Partially pre-screened

CHRONIC KIDNEY DISEASE (CKD), STAGE 4
FINAL v.1 – 1/22/2014

☒ CMS HCC 137
☐ ACA –
☐ CalPERS –



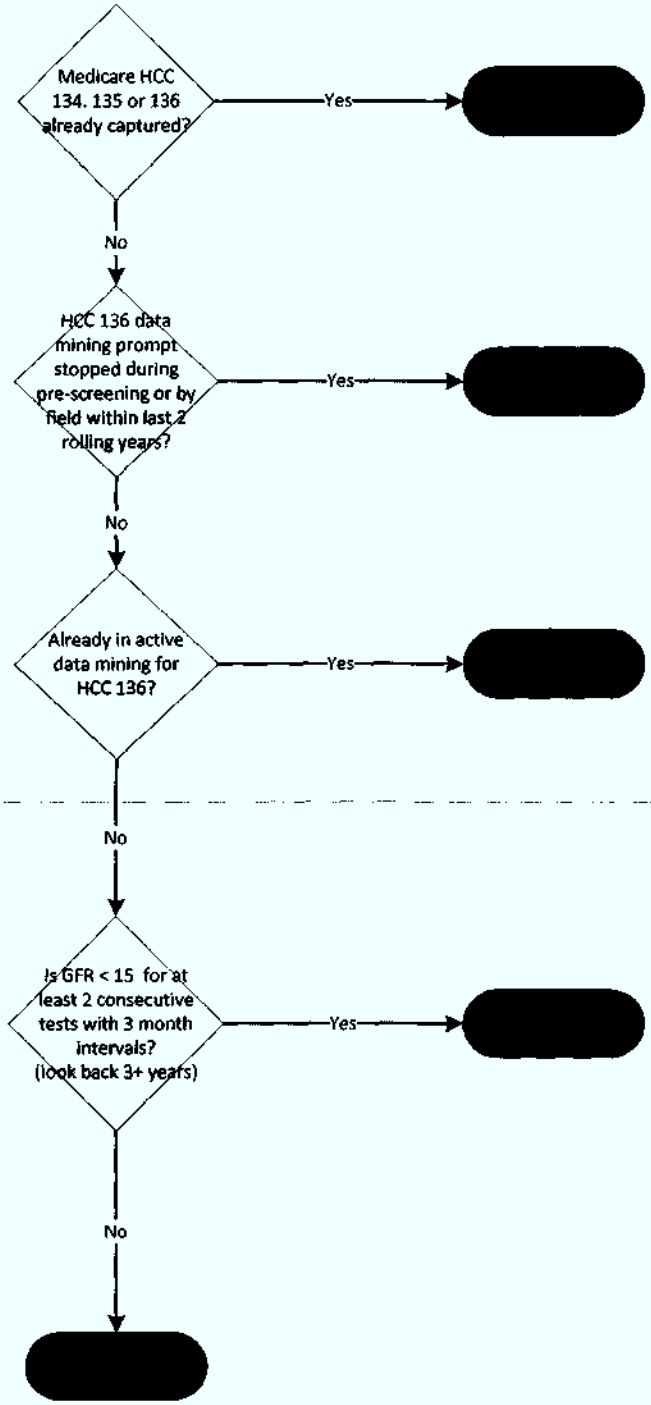
HCCs in Category Name: Kidney
HCC 134: Dialysis Status
HCC 135: Acute Renal Failure
HCC 136: CKD (Stage 5)
HCC 137: CKD, Severe (Stage 4)

This purpose of this algorithm is to identify patients who may have clinical evidence of CKD, Stage 4, but do not already have CKD or a more Severe Kidney Diagnosis captured. This algorithm is not intended for training to the clinical diagnosis criteria for the condition.

☒ Pre-screened
☐ Not pre-screened
☐ Partially pre-screened

CHRONIC KIDNEY DISEASE (CKD)- STAGE 5
FINAL v.1 – 1/22/2014

☒ CMS HCC 136
☐ ACA --
☐ CalPERS --

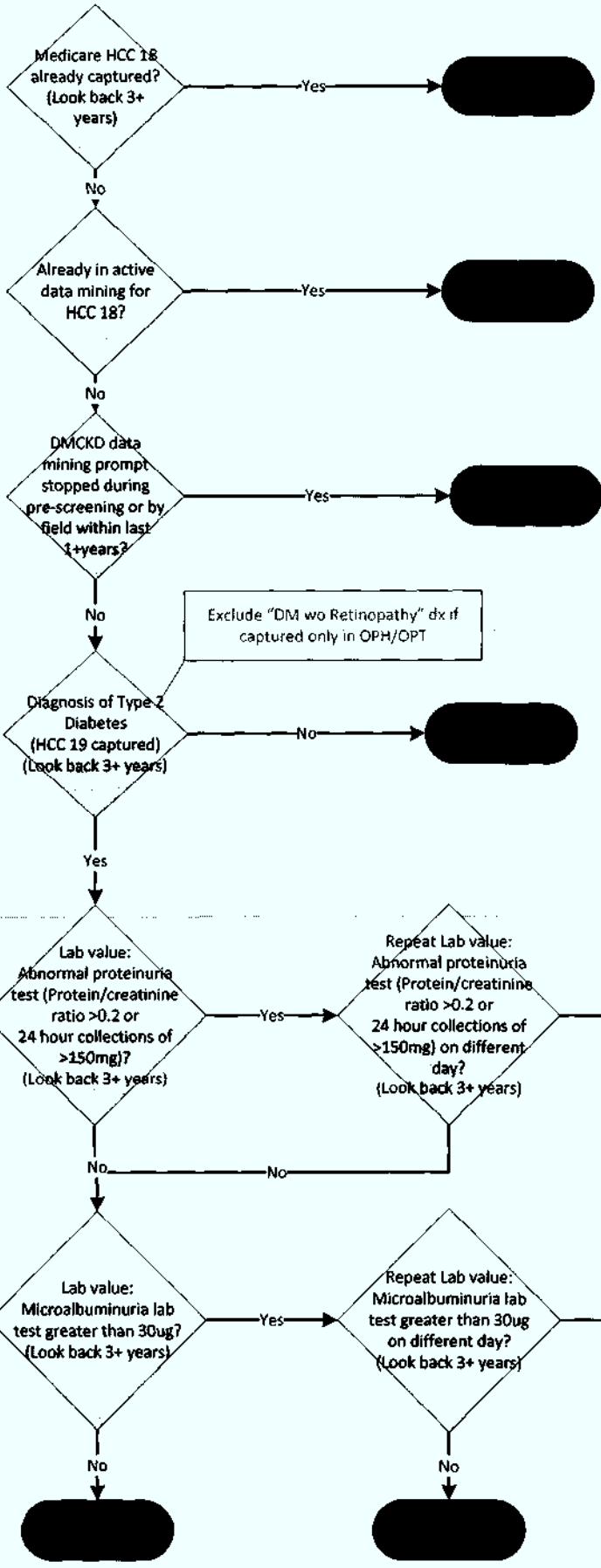


HCCs in Category Name: Kidney
HCC 134: Dialysis Status
HCC 135: Acute Renal Failure
HCC 136: CKD (Stage 5)
HCC 137: CKD, Severe (Stage 4)

This purpose of this algorithm is to identify patients who may have clinical evidence of CKD, Stage 5, but do not already have CKD or a more Severe Kidney Disease captured. This algorithm is not intended for training to the clinical diagnosis criteria for the condition.

DM w/ Diabetic CKD- FINAL v.1- 9/18/13

☒	CMS	HCC 18
☐	HHS	–
☐	CalPERS	–



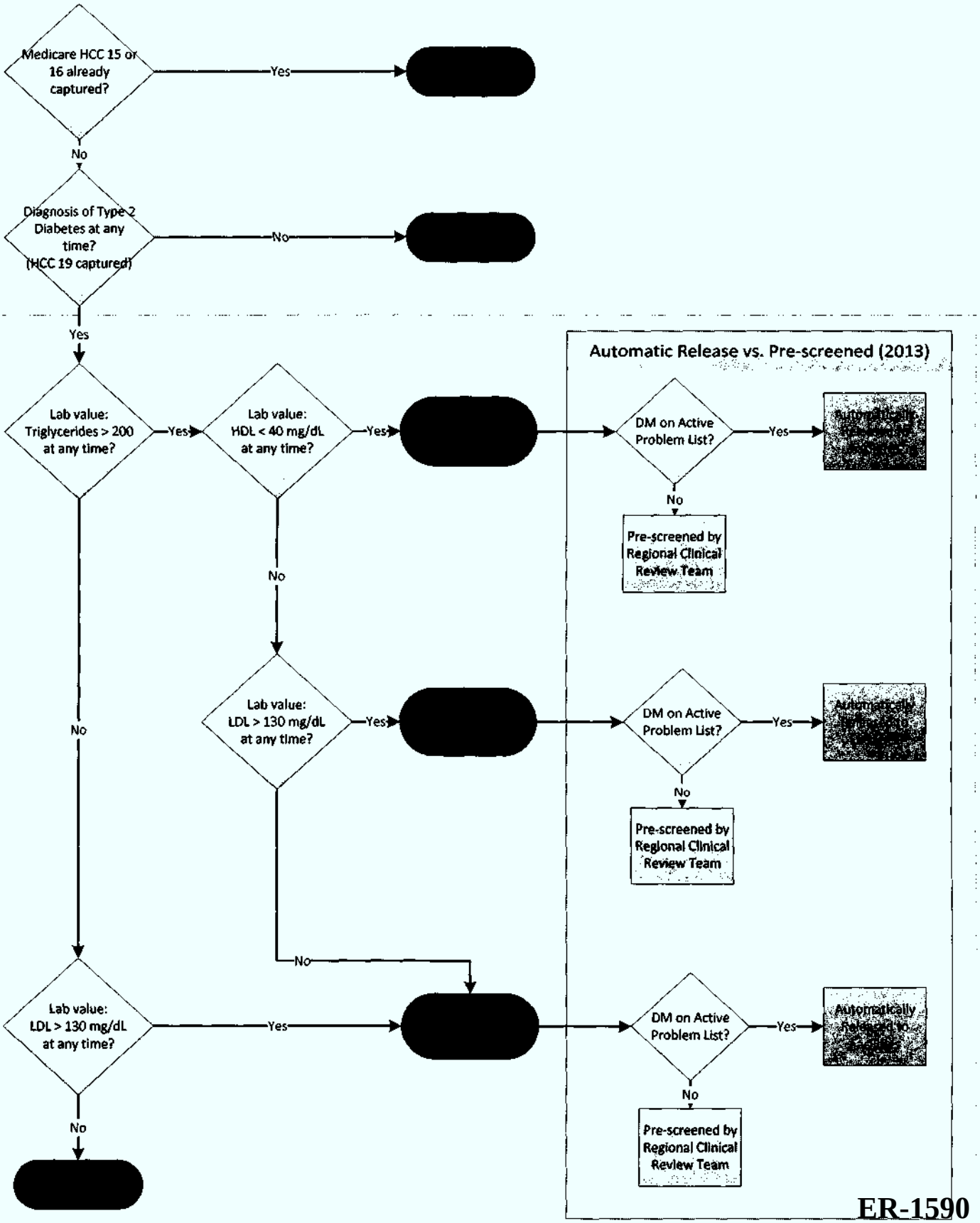
Changes from previous version:

V.1:

- Added requirement for at least 2 abnormal lab values
- Modified criteria for identifying patients with Diabetes

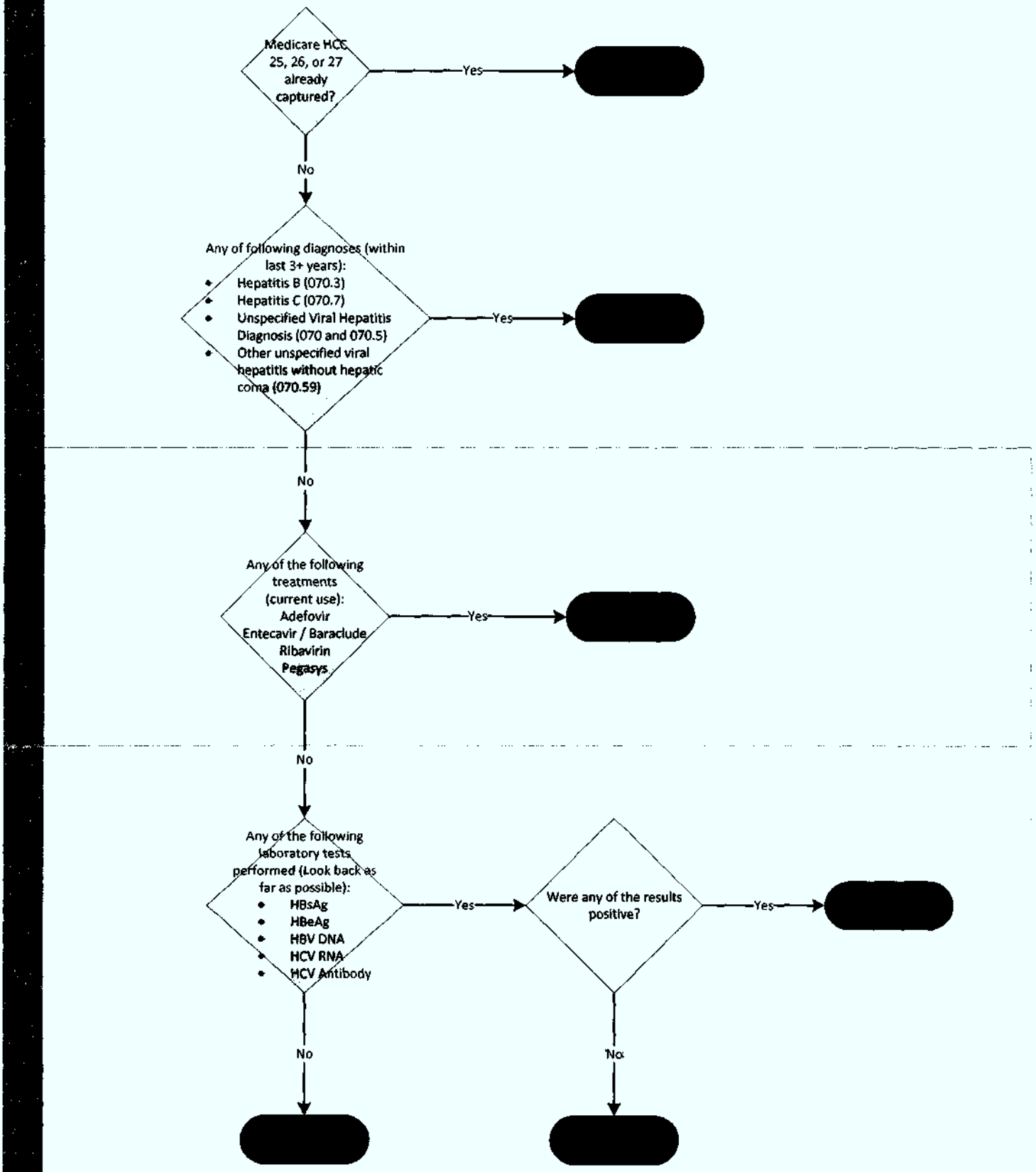
This purpose of this algorithm is to identify patients who may have clinical evidence of Diabetes w/ Diabetic CKD but do not already have a chronic Diabetes complication already captured. This algorithm is not intended for training to the clinical diagnosis criteria for the condition.

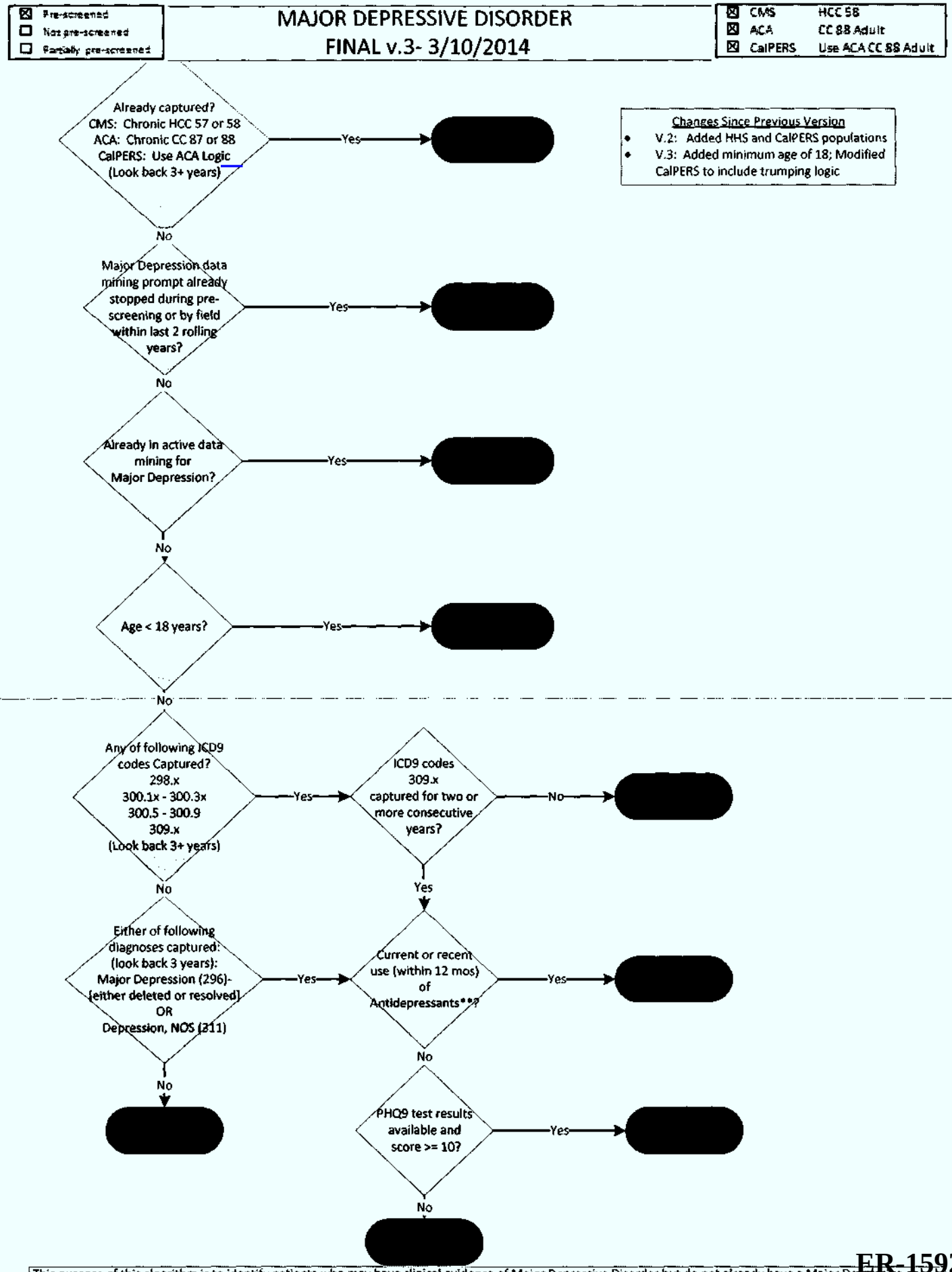
DM 2 w/ Lipids
(Dyslipidemia, Mixed Hyperlipidemia, & Hyperlipidemia)
HCC 16



ER-1590

CHRONIC HEPATITIS
HCC 27




Pre-screened
Not pre-screened
Partially pre-screened
MAJOR DEPRESSIVE DISORDER
FINAL v.3- 3/10/2014
CMS HCC 58
ACA CC 88 Adult
CalPERS Use ACA CC 88 Adult
Already captured?
CMS: Chronic HCC 57 or 58
ACA: Chronic CC 87 or 88
CalPERS: Use ACA Logic
(Look back 3+ years)
Yes
No
Changes Since Previous Version
V.2: Added HHS and CalPERS populations
V.3: Added minimum age of 18; Modified CalPERS to include trumping logic
Major Depression data mining prompt already stopped during pre-screening or by field within last 2 rolling years?
Yes
No
Already in active data mining for Major Depression?
Yes
No
Age < 18 years?
Yes
No
Any of following ICD9 codes Captured?
298.x
300.1x - 300.3x
300.5 - 300.9
309.x
(Look back 3+ years)
Yes
No
ICD9 codes 309.x captured for two or more consecutive years?
No
Yes
Either of following diagnoses captured: (look back 3 years):
Major Depression (296)- [either deleted or resolved]
OR
Depression, NOS (311)
Yes
No
Current or recent use (within 12 mos) of Antidepressants**?
Yes
No
PHQ9 test results available and score >= 10?
Yes
No
This purpose of this algorithm is to identify patients who may have clinical evidence of Major Depressive Disorder but do not already have a Major Depressive Disorder diagnosis captured. This algorithm is not intended for training to the clinical diagnosis criteria for the condition.

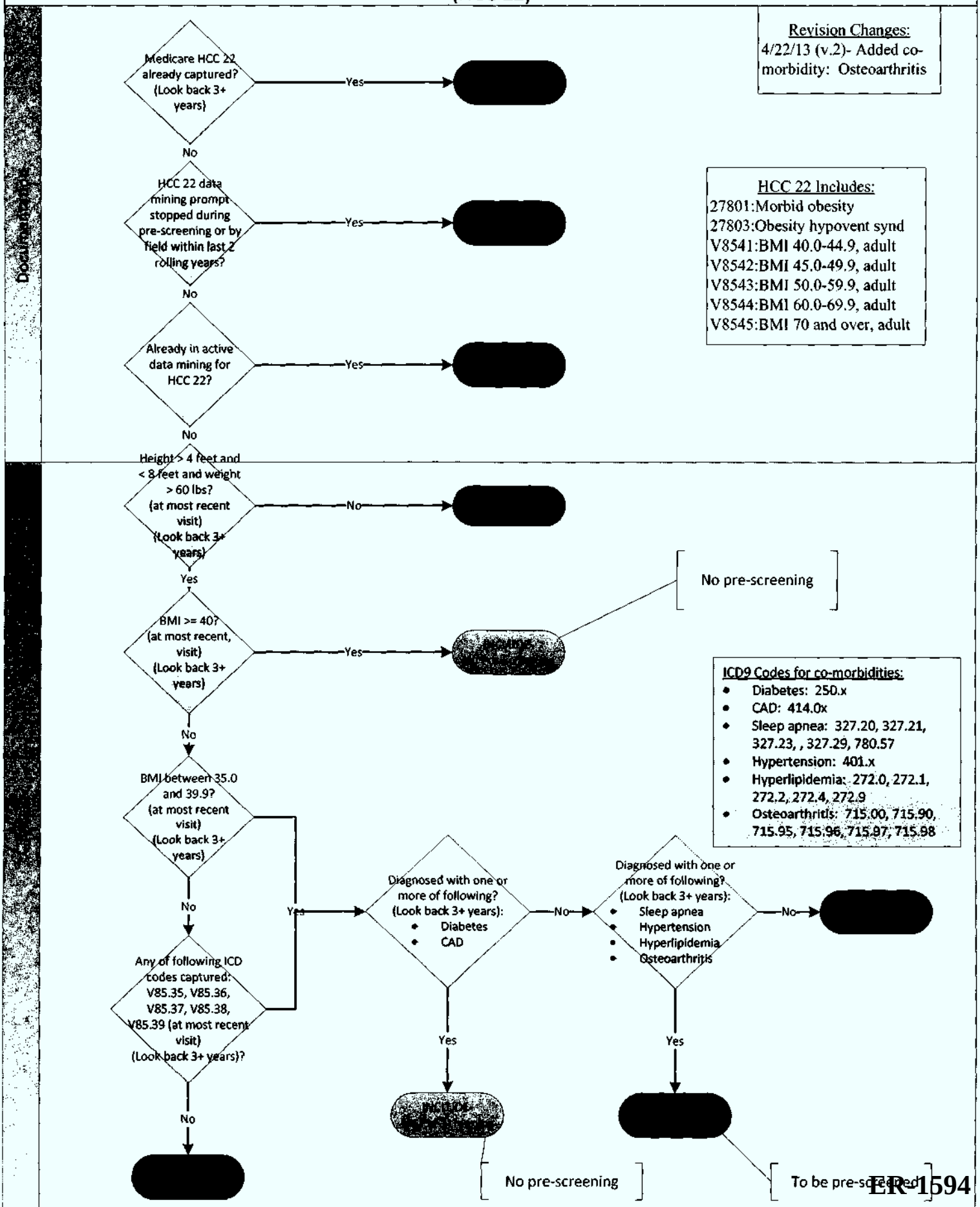
*Major Depressive Disorder ICD Codes (CMS HCC 58 / HHS CC 88)

29620 MDD ONE EPIS-NOS
29621 MDD ONE EPIS-MILD
29622 MDD ONE EPIS-MODERATE
29623 MDD ONE EPIS-SEVERE
29624 MDD ONE EPIS-SEV W PSYCH
29625 MDD ONE EPIS-PART REMISS
29626 MDD ONE EPIS-FULL REMISS
29630 RECURRENT MDD-UNSPEC
29631 RECURRENT MDD-MILD
29632 RECURRENT MDD-MOD
29633 RECURRENT MDD-SEVERE
29634 RECURRENT MDD-SEV PSYCH
29635 RECUR MDD-PART REMISS
29636 RECUR MDD-FULL REMISS

**Antidepressant Meds List:

AMOXAPINE
ANAFRANIL
ASENDIN
BENACTYZINE HYDROCHLORIDE
BENACTYZINE/MEPROBAMATE
BUPROPION HCL
BUPROPION HYDROCHLORIDE
CITALOPRAM HYDROBROMIDE
CLOMIPRAMINE HCL
CLOMIPRAMINE HYDROCHLORIDE
DESVENLAFAXINE
DULOXETINE HCL
EFFEXOR
ESCITALOPRAM OXALATE
FLUOXETINE HCL
FLUOXETINE HYDROCHLORIDE
FLUVOXAMINE
FLUVOXAMINE MALEATE
ISOCARBOXAZID
LUDIOMIL
MAPROTILINE
MIRTAZAPINE
NEFAZODONE
NEFAZODONE HCL
OLANZAPINE/FLUOXETINE
PARGYLINE HCL
PARGYLINE HYDROCHLORIDE
PARNATE
PAROXETINE HCL
PAROXETINE MESYLATE
PHENELZINE SULFATE
PROZAC
SERTRALINE HCL
SERTRALINE HYDROCHLORIDE
TRANYLCYPROMINE SULFATE
VENLAFAXINE HCL
ZOLOFT
ARIPIPRAZOLE
ABILIFY
SELEGILINE
EMSAM
AMITRIPTYLINE
ELAVIL
DESIPRAMINE
NORPRAMIN
DOXEPIN
SINEQUAN
IMIPRAMINE
TOFRANIL
NORTRIPTYLINE
PAMELOR
PROTRIPTYLINE
VIVACTIL
SURMONTIL
TRIMIPRAMINE

Severe Obesity- FINAL v.2 4/22/2013
(HCC 22)



STABLE ANGINA FINAL v.1 – 6/12/2013
CMS HCC 88 (Formerly 83)

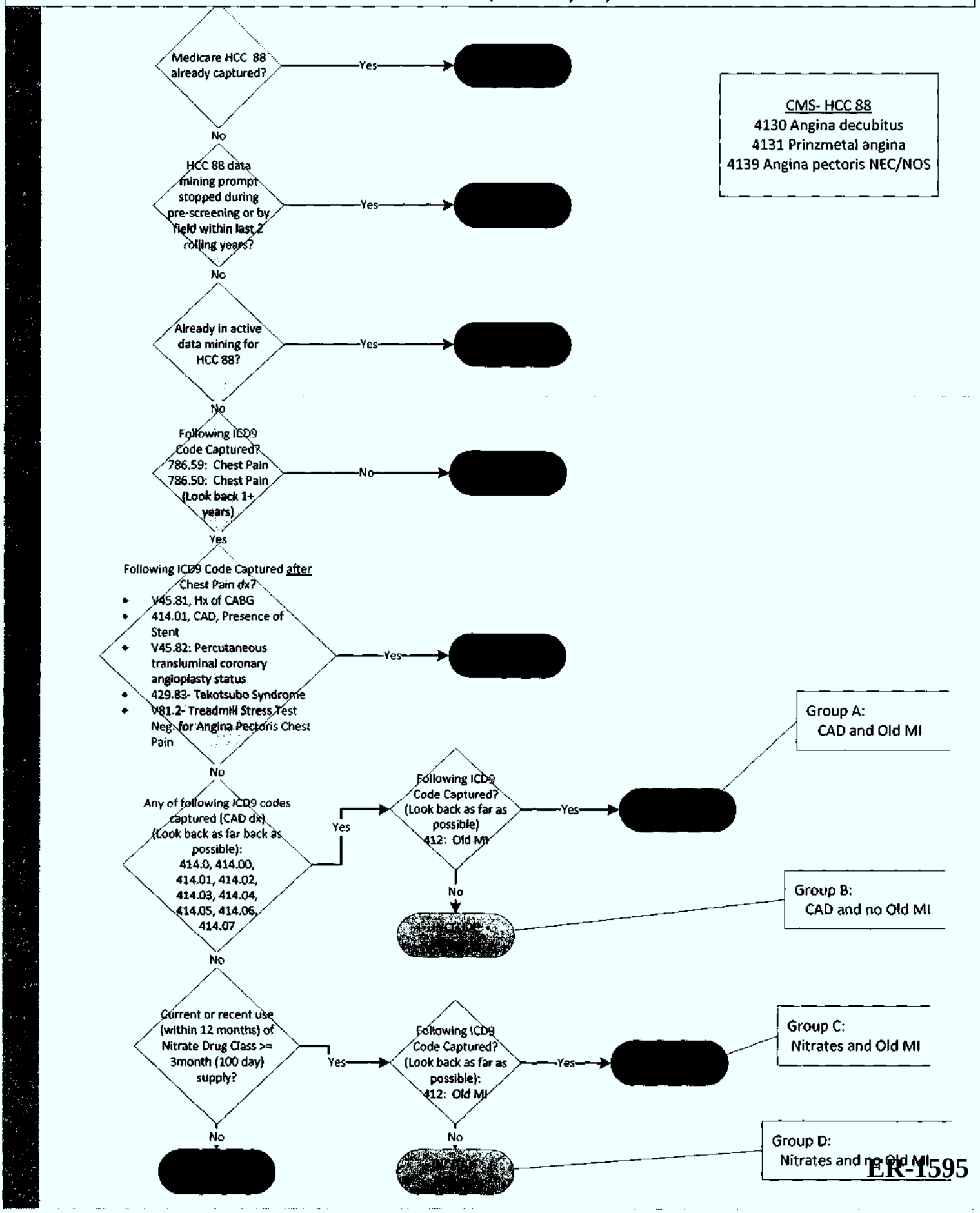


EXHIBIT 2

APPENDIX A

RELATORS' STATISTICAL ANALYSIS OF KAISER HCC DIAGNOSIS RATES AND CALCULATION OF KAISER RISK ADJUSTMENT OVERPAYMENTS

Relators PRIME HEALTHCARE SERVICES, INC. and AJITH KUMAR used the following statistical analysis methodology to identify KAISER's rates of reported ICD-9-CM diagnoses for Medicare enrollees that qualified as HCCs and to calculate the estimated amount of risk adjustment overpayments received by KAISER based on its submission of false HCC claims to CMS.

A. HCC Coding Frequencies and Inpatient Discharge Claims

After downloading CMS's HCC categories and the corresponding ICD-9-CM diagnosis codes from the CMS website, Relators obtained inpatient discharge data for all California hospitals for the years 2009-2012 from the Office of Statewide Health Planning and Development ("OSHPD") using speedtrack.com that showed the ICD-9-CM diagnosis codes for all the hospital patients. Relators then removed non-Medicare patients and ICD-9-CM codes that were not in an HCC category from this OSHPD data set and used pivot tables to organize the remaining ICD-9-CM codes reported for Medicare patients by their respective HCC categories. The relators then filtered this ICD-9-CM/HCC data for Medicare patients by hospital type (based on their National Provider Identifiers) and arranged the ICD-9-CM diagnosis codes into the following four classifications of hospital care for Medicare patients: (1) KAISER Hospitals – Medicare Advantage (managed care); (2) KAISER Hospitals – Traditional Medicare (fee for service); (3) Non-KAISER Hospitals – Medicare Advantage; and (4) Non-KAISER Hospitals – Traditional Medicare.

Relators placed this information onto a Microsoft Excel worksheet, along with the HCC Category, HCC Description, HCC Weight, and Total Claims. The ICD-9-CM diagnosis codes for each HCC Category were then organized into these four classifications of hospital care for Medicare patients, and frequencies or occurrence rates for each HCC Category and all four classifications for the years 2009-2012 were calculated obtained by dividing the number of occurrences for that particular HCC Category by the total number of claims reported for that class.

B. Kaiser Overpayments Based on Over-Reported Inpatient Cases

Relators identified cases in which the particular HCC was reported by KAISER more or less frequently than expected based on comparison to other hospitals ("Over and Under-Reported Cases") by subtracting the "Expected Cases" for that HCC category from the actual number of cases reported by the KAISER for the same HCC Category. The estimated reimbursement for these cases, as well as any credits for fewer-than-expected (i.e., Under-Reported Cases), was then calculated.

Using HCC 15 and 2010 data, the following example illustrates the methodology used by Relators across all HCCs and fiscal years:[21]

2010 Occurrence Rates Diabetes with Renal or Peripheral Circulatory Manifestation1 (HCC 15)
Total KAISER Medicare Advantage Claims = 157,505 Actual Occurrences of HCC 15 = 38,908 HCC 15 Occurrence Rate = 38,980 / 157,575 = **24.7%**
Total Non-KAISER Traditional Medicare Claims = 912,901[22] Actual Occurrences of HCC 15 = 41,460 HCC 15 Occurrence Rate = 41,460 / 912,901 = **4.5%**
2010 KAISER Medicare Advantage Over-Reported HCC 15 Cases
Expected KAISER Cases Compared to Non-KAISER Traditional Medicare = 4.5% of 157,505 = 7,088. KAISER Over-Reported Cases of HCC 15 = 38,908 – 7088 = 31,820 KAISER Over-Reported Cases of HCC 15 After Applying Readmission Rate of 19%[23] = 31,820 x 19% = **25,774**.
2010 KAISER HCC 15 Estimated Overpayment Adjusted for Readmission Rate
2010 KAISER HCC 15 Estimated Overpayment Based on Traditional Medicare = 25,774 x (0.459[24] x $7,463[25]) = **$88,289,275**.[26]

[21] Note that the calculations performed in this example will vary slightly compared to the actual data/results in the analysis due to rounding conventions applied for the purposes of illustration.

[22] This figure does not include KAISER traditional Medicare claims.

[23] To account for the possible readmission of some patients, which would inflate the total number of KAISER Over-Reported Cases, a conservative readmission rate of 19% was used to adjust (and reduce) the total number of Over-Reported Cases used to calculate CMS's estimated risk adjustment overpayments.

[24] This is the mathematical weight designated by CMS for HCC 15 in 2010.

[25] This is the CMS national factor applied by CMS for all risk adjustment calculations in a given calendar year.

[26] This number does not include deductions made for associated HCCs that were dropped before obtaining final overpayment figures.

C. Calculation of Kaiser HCC Occurrence Rates

Relators also compared the ICD-9-CM/HCC coding frequencies for KAISER's Medicare Advantage patients with the frequencies of same ICD-9-CM codes reported for traditional Medicare patients. The below chart show the average KAISER rates relative to Traditional Medicare for each HCC category based on 2008-2013 data.[27]

KAISER MEDICARE ADVANTAGE CODING RATE VS. TRADITIONAL MEDICARE								
HCC #	HCC Description	2008	2009	2010	2011	2012	2013	Average
119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	3,411%	3,776%	3,970%	3,379%	3,053%	2,975%	**3,427%**
15	Diabetes with Renal or Peripheral Circulatory Manifestation	521%	522%	544%	548%	n/a	537%	**535%**
18	Diabetes with Ophthalmologic or Unspecified Manifestation	532%	511%	528%	532%	n/a	553%	**531%**
16	Diabetes with Neurologic or Other Specified Manifestation	372%	407%	429%	451%	n/a	500%	**432%**
83	Angina Pectoris/Old Myocardial Infarction	239%	253%	272%	275%	637%	265%	**324%**
105	Vascular Disease	170%	212%	269%	301%	401%	539%	**315%**
71	Polyneuropathy	294%	310%	315%	316%	89%	320%	**274%**
55	Major Depressive, Bipolar, and Paranoid Disorders	129%	166%	186%	206%	216%	226%	**188%**
21	Protein-Calorie Malnutrition	107%	165%	180%	195%	211%	236%	**182%**
10	Breast, Prostate, Colorectal / Other Cancers and Tumors	164%	162%	162%	159%	161%	159%	**161%**
132	Nephritis	237%	183%	163%	154%	109%	97%	**157%**

[27] Because the HCC classifications for 2012 (only) used certain unique categories, some 2012 frequency HCC data could not be included within this average; this included HCCs 16, 18, and 15 (diabetes with neurologic, ophthalmologic or renal/peripheral circulatory manifestation, respectively), which did not exist in 2012; and HCC 164 (major complications of medical care and trauma), which was deleted for 2012 only.

KAISER MEDICARE ADVANTAGE CODING RATE VS. TRADITIONAL MEDICARE								
HCC #	HCC Description	2008	2009	2010	2011	2012	2013	Average
33	Inflammatory Bowel Disease	149%	155%	162%	156%	157%	152%	**155%**
9	Lymphatic, Head and Neck, Brain / Other Major Cancers	137%	134%	129%	131%	162%	129%	**137%**
38	Rheumatoid Arthritis / Inflammatory Connective Tissue Disease	133%	139%	139%	136%	135%	139%	**137%**
131	Renal Failure	138%	131%	130%	131%	159%	128%	**136%**
104	Vascular Disease with Complications	122%	123%	130%	135%	159%	136%	**134%**
100	Hemiplegia/Hemiparesis	130%	134%	134%	133%	136%	139%	**134%**
149	Chronic Ulcer of Skin, Except Decubitus	138%	137%	132%	135%	128%	132%	**134%**
95	Cerebral Hemorrhage	131%	125%	126%	130%	133%	145%	**132%**
81	Acute Myocardial Infarction	135%	121%	128%	130%	132%	127%	**129%**
7	Metastatic Cancer and Acute Leukemia	132%	132%	131%	141%	92%	141%	**128%**
92	Specified Heart Arrhythmias	125%	124%	128%	128%	128%	134%	**128%**
82	Unstable Angina and Other Acute Ischemic Heart Disease	105%	104%	109%	121%	142%	186%	**128%**
96	Ischemic or Unspecified Stroke	126%	119%	124%	120%	124%	131%	**124%**
80	Congestive Heart Failure	125%	122%	123%	123%	121%	119%	**122%**
32	Pancreatic Disease	104%	113%	118%	121%	127%	135%	**120%**
164	Major Complications of Medical Care and Trauma	112%	109%	121%	130%	n/a	119%	**118%**
158	Hip Fracture/Dislocation	115%	118%	115%	120%	120%	119%	**118%**
27	Chronic Hepatitis	111%	112%	117%	120%	121%	120%	**117%**

KAISER MEDICARE ADVANTAGE CODING RATE VS. TRADITIONAL MEDICARE								
HCC #	HCC Description	2008	2009	2010	2011	2012	2013	Average
8	Lung, Upper Digestive Tract, and Other Severe Cancers	112%	117%	116%	120%	118%	112%	**116%**
2	Septicemia/Shock	80%	88%	105%	125%	141%	137%	**113%**
157	Vertebral Fractures without Spinal Cord Injury	114%	114%	109%	105%	112%	118%	**112%**
69	Spinal Cord Disorders/Injuries	100%	108%	111%	121%	118%	107%	**111%**
148	Decubitus Ulcer of Skin	124%	101%	102%	104%	102%	120%	**109%**
31	Intestinal Obstruction/Perforation	104%	101%	106%	110%	113%	114%	**108%**
155	Major Head Injury	96%	96%	102%	111%	111%	121%	**106%**
72	Multiple Sclerosis	106%	109%	104%	106%	109%	103%	**106%**
177	Amputation Status, Lower Limb/Amputation Complications	107%	112%	110%	103%	99%	102%	**106%**
45	Disorders of Immunity	113%	107%	115%	111%	88%	94%	**105%**
79	Cardio-Respiratory Failure and Shock	83%	92%	103%	113%	112%	121%	**104%**
37	Bone/Joint/Muscle Infections/Necrosis	97%	92%	95%	101%	107%	106%	**100%**
17	Diabetes with Acute Complications	86%	92%	98%	101%	100%	100%	**96%**
44	Severe Hematological Disorders	93%	84%	84%	83%	105%	100%	**91%**
108	Chronic Obstructive Pulmonary Disease	103%	92%	90%	87%	86%	86%	**91%**
130	Dialysis Status	94%	94%	92%	91%	83%	81%	**89%**
25	End-Stage Liver Disease	84%	81%	89%	92%	92%	92%	**88%**

KAISER MEDICARE ADVANTAGE CODING RATE VS. TRADITIONAL MEDICARE								
HCC #	HCC Description	2008	2009	2010	2011	2012	2013	Average
51	Drug/Alcohol Psychosis	87%	89%	89%	87%	89%	83%	**87%**
112	Pneumococcal Pneumonia, Emphysema, Lung Abscess	81%	83%	83%	90%	89%	96%	**87%**
73	Parkinson's and Huntington's Diseases	89%	90%	91%	83%	85%	83%	**87%**
70	Muscular Dystrophy	79%	97%	101%	82%	92%	66%	**86%**
26	Cirrhosis of Liver	85%	83%	86%	86%	86%	87%	**85%**
174	Major Organ Transplant Status	68%	77%	80%	90%	92%	77%	**81%**
52	Drug/Alcohol Dependence	73%	76%	81%	83%	82%	79%	**79%**
78	Respiratory Arrest	71%	78%	62%	73%	84%	85%	**75%**
75	Coma, Brain Compression/Anoxic Damage	65%	58%	63%	80%	91%	93%	**75%**
161	Traumatic Amputation	79%	85%	74%	50%	66%	78%	**72%**
5	Opportunistic Infections	72%	67%	70%	67%	73%	74%	**71%**
74	Seizure Disorders and Convulsions	70%	70%	70%	68%	67%	69%	**69%**
111	Aspiration and Specified Bacterial Pneumonias	70%	64%	62%	64%	63%	67%	**65%**
68	Paraplegia	62%	59%	63%	70%	66%	63%	**64%**
176	Artificial Openings for Feeding or Elimination	64%	68%	68%	65%	68%	48%	**63%**
77	Respirator Dependence/Tracheostomy Status	64%	66%	65%	55%	53%	43%	**58%**
67	Quadriplegia, Other Extensive Paralysis	66%	63%	62%	57%	49%	47%	**57%**

KAISER MEDICARE ADVANTAGE CODING RATE VS. TRADITIONAL MEDICARE								
HCC #	HCC Description	2008	2009	2010	2011	2012	2013	Average
19	Diabetes without Complication	55%	59%	58%	55%	55%	51%	**56%**
101	Cerebral Palsy and Other Paralytic Syndromes	69%	56%	59%	56%	35%	56%	**55%**
1	HIV/AIDS	45%	45%	53%	59%	56%	59%	**53%**
150	Extensive Third-Degree Burns	26%	26%	46%	42%	72%	27%	**40%**
154	Severe Head Injury	44%	49%	33%	56%	29%	27%	**40%**
107	Cystic Fibrosis	26%	23%	34%	27%	22%	42%	**29%**
54	Schizophrenia	16%	14%	15%	15%	16%	15%	**15%**

D. Adjustment of Kaiser Overpayments Based on "Associated" HCCs

As previously described, relators obtained 2008-2013 inpatient claim data from OSHPD that included all HCC ICD-9-CM diagnoses reported for all claims by a particular hospital during each year. However, under Medicare Part C, some HCCs ICD-9-CM diagnoses would not count towards risk adjustment because certain disease hierarchies require that "associated" HCCs reported for the *same* patient be "dropped" for the purposes of risk-adjustment.

Consequently, if relators estimated total risk adjustment payments based on HCC occurrences alone, this would inaccurately inflate the actual reimbursement paid. For example, if a Medicare patient was diagnosed with end-stage renal disease (HCC 27), the CMS's 2012 preliminary disease hierarchies would eliminate other HCCs for cirrhosis of liver (HCC 28), chronic hepatitis (HCC 29) and coma (HCC 80) from CMS's calculation of the risk-adjustment payment for that patient because the additional payment for treatment of end-stage renal disease was deemed sufficient to compensate a Medicare Advantage plan for a patient who also had these other medical conditions. However, since the OSHPD coding occurrences were pooled and not patient-specific, relators could not determine where multiple HCC codes may have been reported for a particular patient.

To account for the possibility of associated HCCs that would have been dropped prior to submission to CMS, relators took a highly conservative approach and dropped or reduced all associated HCCs when calculating CMS estimated risk adjustment payments to KAISER. For example, in the case of end-stage renal disease (HCC 27), relators eliminated all associated HCCs (HCCs 28, 29 and 80) where appropriate from the entire KAISER data set. Before relators' correction, KAISER's 2012 HHCs for end-stage renal disease and associated HCCs were as follows:

HCC#	HCC Description	HCC Weight	Total Occurrences
27	End-Stage Liver Disease	0.637	3,291
28	Cirrhosis of Liver	0.343	3,470
29	Chronic Hepatitis	0.343	2,867
80	Coma, Brain Compression/Anoxic Damage	0.103	2,079

After relators dropped the associated HCCs, the total numbers of KAISER HCC 227 occurrences actually counted for the purpose of calculating CMS's estimated risk adjustment payments to CMS were as follows:

HCC#	HCC Description	HCC Weight	Total Occurrences
27	End-Stage Liver Disease	0.637	3,291
28	Cirrhosis of Liver	0.343	179
29	Chronic Hepatitis	0.343	~~2,867~~
80	Coma, Brain Compression/Anoxic Damage	0.103	~~2,079~~

In this example, relators accounted for HCCs associated with end-stage liver disease by reducing HCC 28 to 179 occurrences because there were exactly 179 more cases reported for HCC 28 than HCC 27 (3,291 subtracted from 3,470), indicating that cirrhosis of liver was reported in *at least* 179 cases where end-stage liver disease could not have also been diagnosed on any underlying claim. In the case of HCCs 29 and 80, relators dropped these HCCs entirely because there were fewer HCC 29 and 90 cases relative to HCC 27 cases and relators made the highly conservative assumption that HCC 29 or 90 *may* have been reported together with HCC 27 on each individual patient claim.

It should be noted that relators' decision to drop associated HCCs in this manner almost certainly results in a significant underestimate of the actual risk adjustment payments that KAISER received. By treating all associated HCCs as though they were in fact reported on the same claim, as in the example of HCC 27 above, many independent occurrences of HCCs 28, 29, and 80 were almost certainly and unnecessarily eliminated. In particular, it is unlikely that in each of KAISER's 3,291 HCC 27 claims, HCCs 28, 29 and 80 were also present. As a result, KAISER has received the benefit of having its risk adjustment payments for certain HCCs eliminated from relators' overpayment estimates when those HCCs were not in fact associated with the HCC under CMS's HCC certain disease hierarchies.

E. Calculation of Kaiser Overpayments and Extrapolation to Entire California Medicare Advantage Patient Population

While relators have used inpatient discharge data to determine coding frequencies and estimate overpayments based on such data, this methodology does not capture the full extent of KAISER's fraud because it does not include KAISER's entire Medicare Advantage patient population and excludes outpatient encounters. To account for this limitation, relators

extrapolated its findings from KAISER's inpatient admissions to the plan's entire Medicare Advantage population.

Specifically, KAISER's total Medicare inpatient admissions were adjusted downward using a 19% readmission rate and this total, approximating the actual number of Medicare enrollees admitted by KAISER for each fiscal year, was then compared to the corresponding total risk adjustment payments – after deducting all associated HCCs and including both Over and Under-Reported Cases – for that year and a ratio was derived. This ratio was then applied to KAISER's entire Medicare Advantage risk population for each year based on actual membership numbers obtained from CMS. For 2008 - 2013, this methodology resulted in the following estimated risk adjustment overpayment by CMS to KAISER:

Fiscal Year	KAISER Total Risk Population	KAISER Members Admitted Patients	Overpayment Based on Admitted Patients	Overpayment Based on Entire Risk Population
2008	704,200	118,511	$221,938,790.21	$1,318,774,595.33
2009	740,173	121,543	$220,790,544.07	$1,344,571,052.05
2010	782,182	127,579	$294,696,317.65	$1,806,771,922.75
2011	825,836	124,663	$368,416,004.26	$2,440,589,423.44
2012	894,377	119,599	$545,227,919.09	$4,077,285,851.85
2013	926,127	121,963	$456,684,863.81	$3,467,840,106.14
TOTAL:			$2,107,754,439.10	$14,455,832,951.57

Note that KAISER's total Medicare Advantage risk population only included enrollees in California. Since KAISER provides services to Medicare enrollees in other states, relators' estimated risk adjustment overpayments to KAISER is lower than CMS's total overpayments to KAISER for its national Medicare Advantage risk population.

F. Kaiser Compared to Traditional Medicare & Other 5-Star Medicare Advantage Plans

Relators' data is consistent with and is validated by independent analyses of Kaiser's costs per member per month ("PMPM") for MA plan enrollees, which was derived from publicly available Medicare premium and total risk population information, as compared to the average PMPM for traditional Medicare providers and other 5-Star California MA plans between 2008 and 2013:

Year	Kaiser MA PMPM	CMS Cost for FFS PMPM	Excess Annual Payment to Kaiser FFS (annualized)
2008	$1,161.02	$671.39	$4,137,536,433.79
2009	$1,179.57	$683.01	$4,410,443,334.02

2010	$1,153.93	$701.30	$4,248,444,069.26
2011	$1,114.87	$715.20	$3,960,744,987.72
2012	$1,158.46	$707.71	$4,837,699,495.62
2013	$1,175.30	$713.55	$5,131,642,599.06
TOTAL:			**$26,726,510,919.48**

Year	Kaiser MA PMPM	CMS 5-Star MA Plans' PMPM (average)	Excess Payment to Kaiser MA (annualized)
2008	$1,161.02	$803.87	$3,018,038,035.66
2009	$1,179.57	$835.06	$3,059,901,044.76
2010	$1,153.93	$839.09	$2,955,090,095.47
2011	$1,114.87	$839.09	$2,732,954,257.46
2012	$1,158.46	$863.96	$3,160,745,851.04
2013	$1,175.30	$867.34	$3,422,485,930.32
TOTAL:			**$18,349,215,214.72**

EXHIBIT 3

PRIME HEALTHCARE SERVICES
HCC CODING - KAISER VS. ALL OTHER CALIFORNIA HOSPITALS
BASED ON 2008 OSHPD DATA

Total Claims 486,319 307,263 78,790 641,298

National Payor Benchmarks (Rate) $7,963 68.00%

HCC4	HIV/AIDS																				
HCC 10	Breast, Prostate, Colorectal and Other Cancers and Tumors	0.726	705	654	42	4,067	0.2%	0.2%	0.4%	0.5%	($948)	$457	($1,397,566.72)	55	$900,246.94	12.9%	($1,688,352.72)	44	$343,200.04	0.0%	-0.2%
HCC 11	Metastatic/Hematologic	0.241	19,336	24,806	854	90,105	9.2%	7.6%	8.5%	9.6%	5,260	$850	$8,358,282.93	2327	$4,835,051.17	8.21%	$7,570,654.78	2087	$3,954,398.45	8.6%	9.0%
HCC 160	Hemophilia/Hemophilia Not	0.086	14,016	26,858	29,578	80,309	14.0%	8.0%	692.6%	9.7%	7,352	$40	$1,826,835.56	2970	$1,460,519.75	2.72%	$4,287,359.44	2405	$1,166,831.09	2.0%	2.3%
HCC 161	Congenital Polio and Other Spastic Syndromes	0.000	992	1,158	5,857	9,285	0.4%	0.3%	52.6%	0.6%	(2966)	$0	$0.00	80	$0.00	12.96%	$0.00	73	$0.00	0.1%	-0.2%
HCC 165	Vascular Disease with Complications	0.496	6,745	12,058	29,272	28,015	5.6%	3.6%	287.3%	9.2%	2,051	$308	$2,682,966.41	524	$1,536,709.04	8.5%	$3,145,207.83	425	$1,668,458.73	0.4%	0.7%
HCC 166	Vascular Disease	0.954	20,446	64,249	171,841	199,085	20.8%	16.1%	2093.6%	31.2%	12,575	$100	$15,390,636.41	8988	$4,464,980.53	10.78%	$11,466,615.88	5605	$6,859,238.09	1.7%	0.6%
HCC 107	Cystic Fibrosis	0.992	24	53	572	552	0.0%	0.0%	8.6%	0.1%	(69)	$201	($168,094.41)	30	$28,640.29	0.56%	($138,207.66)	8	$88,350.07	0.0%	0.0%
HCC 111	Aspiration and Specified Bacterial Pneumonias	0.827	58,263	78,878	249,473	217,014	23.8%	23.8%	3150.9%	24.3%	8,066	$206	$2,967,020.74	2953	$7,200,838.70	8.62%	$2,108,577.68	2393	$5,833,989.96	2.0%	0.1%
HCC 112	Pneumococcal Pneumonia, Empyema, Lung Abscess	0.844	8,495	21,474	64,294	65,249	8.5%	6.4%	837.2%	9.2%	16,958	$401	($48,212,958.42)	382	$824,600.20	15.23%	($5,858,462,842.65)	887	$908,426.24	0.1%	-2.2%
HCC 113	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.468	878	1,989	6,747	6,662	0.6%	0.6%	66.2%	0.7%	(2902)	$831	($385,470.57)	35	$23,388.03	4.26%	($231,238.29)	27	$17,494.40	0.0%	-0.1%
HCC 128	Diabetes Status3	0.527	2,259	2,922	630	908	0.5%	0.7%	5.2%	0.0%	(193)	$328	($64,124.15)	1253	$4,924,030.65	1.79%	$6,985,967.36	1019	$3,988,458.73	0.3%	1.8%
HCC 130	Diabetes Status0	0.000	5,928	10,331	29,799	30,142	4.8%	3.8%	366.6%	4.3%	(378)	$0	$0.00	1496	$0.00	13.06%	$0.00	1231	$0.00	1.0%	-0.3%
HCC 131	Renal Failure5	0.000	68,889	129,841	577,994	643,304	47.8%	38.5%	3318.8%	39.3%	19,972	$0	$0.00	19588	$0.00	15.44%	$0.00	83007	$0.00	9.3%	13.0%
HCC 148	Decubitus Ulcer of Skin	0.295	6,978	8,929	16,181	95,814	4.2%	3.9%	153.6%	1.8%	5,908	$860	$7,591,932.89	2200	$4,787,012.34	3.84%	$6,349,457.53	1748	$3,863,219.92	1.5%	2.4%
HCC 149	Chronic Ulcer of Skin, Except Decubitus	0.479	18,501	27,705	76,158	78,606	10.6%	8.2%	767.2%	9.5%	3,023	$295	$10,694,350.45	9486	$12,390,339.91	2.44%	$8,862,423.62	3825	$8,867,820.69	2.4%	2.1%
HCC 169	Chronic Ulcer of Skin, Except Decubitus	0.298	5,466	9,183	24,727	24,251	3.1%	2.7%	242.7%	2.7%	1,516	$148	$1,704,687.39	3482	$3,643,564.89	1.22%	$2,990,254.09	1301	$2,161,285.13	1.0%	0.8%
HCC 15	Diabetes with Renal or Peripheral Circulatory Manifestation	0.468	58,005	72,495	2,906	68,544	23.9%	23.3%	28.5%	7.6%	46,876	$290	$363,013,225.56	26564	$92,381,455.22	35.90%	$332,048,812.70	23597	$74,829,362.75	38.3%	32.0%
HCC 180	Traumatic Traumatic Complete Lesion of Cervical Spinal Cord	0.000	0	81	71	71	0.0%	0.0%	0.1%	0.0%	(6)	$0	$0.00	-2	$0.00	(.01%)	$0.00	-1	$0.00	0.0%	0.0%
HCC 154	Severe Head Injury	0.000	28	143	873	360	0.0%	0.0%	2.3%	0.0%	(34)	$0	$0.00	-38	$0.00	1.27%	$0.00	-29	$0.00	0.0%	0.0%
HCC 155	Major Head Injury	0.000	1,889	4,088	40,873	40,570	8.1%	8.2%	104.6%	5.2%	(479)	$0	$0.00	-134	$0.00	1.82%	$0.00	-108	$0.00	0.1%	-0.1%
HCC 157	Vertebral Fractures without Spinal Cord Injury	0.106	2,700	6,961	12,730	14,579	1.8%	1.7%	144.6%	1.5%	536	$68	$271,369.11	884	$349,818.34	3.70%	$288,953.16	149	$123,353.34	0.1%	0.2%
HCC 158	Hip Fracture/Dislocation	0.000	4,852	14,790	36,376	36,087	3.8%	3.5%	258.4%	2.5%	620	$0	$0.00	-263	$0.00	5.02%	$0.00	-233	$0.00	-0.2%	0.4%
HCC 48	Coagulation Defects and Other Specified Hematological Disorders	0.468	48,616	69,978	2,666	62,561	34.0%	19.6%	25.4%	9.2%	36,458	$290	$825,638,574.46	23100	$73,795,325.69	29.49%	$302,559,349.47	17139	$58,725,613.73	10.5%	24.9%
HCC 161	Traumatic Amputation	0.224	81	151	47	47	0.0%	0.0%	0.5%	0.0%	(13)	$828	($3,726.41)	0	$605.24	(.01%)	($2,706.77)	-0	$490.25	0.0%	0.0%
HCC 159	Major Complications of Spinal Cord and Trauma	0.249	9,492	20,050	62,827	62,320	6.9%	5.9%	518.4%	5.8%	998	$128	$1,833,216.39	702	$1,204,785.43	2.69%	$1,322,088.73	647	$1,056,774.69	0.5%	0.7%
HCC 17	Diabetes with Acute Complications	0.495	965	1,297	75	5,196	0.4%	0.4%	0.6%	0.5%	(960)	$290	($304,402.58)	33	$76,230.74	1.78%	($239,884.68)	18	$63,399.30	0.0%	-0.1%
HCC 170	Major Organ Transplant Status	0.352	501	1,001	4,590	4,562	0.3%	0.3%	43.0%	0.5%	(240)	$295	($647,221.85)	67	$180,637.48	(1.96%)	($524,249.70)	54	$146,348.90	0.0%	-0.1%
HCC 176	Amputation Status, Lower Limb/Amputation Complications	0.845	5,705	7,097	38,216	35,953	2.9%	2.4%	355.4%	4.0%	(1,556)	$524	($1,807,265.25)	227	$1,489,241.29	(2.73%)	($10,736,624.58)	192	$1,206,896.43	0.3%	1.4%
HCC 177	Amputation Status, Upper Limb/Amputation Complications	0.224	3,315	5,964	19,458	19,137	2.3%	1.8%	180.0%	2.1%	209	$138	$290,025.71	728	$1,287,812.22	1.70%	$893,520.82	598	$686,937.88	0.5%	0.1%
HCC 46	Disorders of the Eye with Complications	0.486	18,705	22,736	675	21,647	12.6%	6.6%	9.6%	3.4%	25,193	$290	$50,836,742.78	9962	$35,554,338.52	12.30%	$49,791,761.64	7840	$25,526,484.68	8.2%	10.4%
HCC 47	Disorders of the Eye without Complications	0.252	88,977	100,913	6,087	650,597	60.2%	56.6%	98.5%	33.1%	(48,197)	$360	($69,481,559.77)	23920	($45,837,487.25)	439.04%	($74,877,971.21)	-89375	($37,384,048.59)	-28.3%	-32.8%
HCC 2	Septicemia/Shock	0.782	12,202	28,054	1,264	84,335	8.4%	8.3%	12.6%	10.6%	(8,009)	$474	($17,172,634.74)	187	$667,027.84	(2.44%)	($25,309,895.82)	98	$540,793.98	0.1%	-2.3%
HCC 8	Protein-Calorie Malnutrition	0.905	49,040	19,161	702	57,850	6.9%	5.1%	6.9%	6.4%	649	$246	$5,933,053.43	1750	$5,100,123.56	1.28%	$3,549,973.28	1401	$4,133,099.92	1.7%	0.6%
HCC 9	End Stage Liver Disease	0.788	2,891	4,744	105	18,649	1.6%	1.4%	1.5%	1.9%	(444)	$438	($2,545,805.68)	334	$1,338,795.03	(1.60%)	($2,082,102.79)	189	$1,084,423.99	0.2%	-0.3%
HCC 27	Cirrhosis of Liver	0.368	2,748	5,591	217	18,995	1.9%	1.7%	3.1%	2.2%	(639)	$226	($1,291,694.21)	324	$878,490.00	(.08%)	($3,051,133.33)	267	$721,512.90	0.2%	-0.3%
HCC 28	Chronic Hepatitis	0.385	2,451	5,224	211	12,196	1.5%	1.0%	2.1%	1.9%	213	$226	$586,804.84	784	$1,124,152.64	1.74%	$432,078.93	635	$1,220,563.64	0.5%	0.1%
HCC 29	Intestinal Obstruction/Perforation	0.548	7,171	16,142	660	40,540	3.9%	3.6%	4.6%	4.7%	297	$317	$203,014.57	170	$443,824.83	1.96%	($426,141.30)	138	$359,468.00	0.1%	0.2%
HCC 30	Pancreatic Disease	0.599	5,282	11,190	458	31,328	3.6%	3.3%	4.5%	3.5%	397	$172	$407,664.40	455	$940,667.70	1.60%	$330,804.17	359	$743,965.14	0.3%	0.3%
HCC 31	Inflammatory Bowel Disease	0.265	1,297	2,584	87	5,847	0.9%	0.7%	0.9%	0.6%	429	$326	$443,094.45	286	$561,693.72	1.07%	$682,009.80	232	$458,809.92	0.2%	0.0%
HCC 37	Bone/Joint/Muscle Infections/Necrosis	0.482	2,058	4,158	148	14,001	1.5%	1.2%	1.8%	2.2%	(658)	$300	($334,490.67)	407	($1,463,657.72)	4.52%	($1,099,879.54)	330	($1,885,562.75)	0.3%	0.0%
HCC 38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.295	12,269	22,812	861	66,951	8.3%	6.8%	6.7%	6.3%	3,012	$145	($5,336,548.15)	2272	($8,951,307.66)	2.44%	($4,243,318.52)	1461	($3,200,558.28)	1.6%	2.1%
HCC 84	Severe Hematological Disorders	0.497	9,041	8,270	173	20,202	2.3%	1.9%	2.7%	2.2%	(3,148)	$297	($888,667,930.56)	322	($1,145,345.62)	(.01%)	($687,847.83)	289	($921,827.85)	0.2%	-0.2%
HCC 40	Disorders of Immunity	0.445	1,882	3,005	56	9,155	1.1%	0.9%	0.5%	1.0%	196	$278	($647,432.86	386	($1,255,169.90	1.59%	($554,490.05	306	($1,036,659.18	0.2%	0.3%
HCC 5	Opportunistic Infections	0.478	985	1,427	53	5,853	0.5%	0.4%	0.5%	0.6%	(362)	$298	($993,233.42)	47	($168,535.05	(.02%)	($534,299.66)	36	($236,583.73	0.0%	-0.2%
HCC 54	Drug/Alcohol Psychosis	0.000	2,328	4,198	260	10,558	0.6%	0.7%	2.0%	1.6%	(356)	$0	$0.00	566	$0.00	(.04%)	($0.00)	420	$0.00	0.1%	-0.2%
HCC 55	Drug/Alcohol Dependence	0.000	5,261	11,142	806	49,951	2.1%	1.9%	6.3%	5.5%	(2,145)	$0	$0.00	1118	$0.00	(1.73%)	$0.00	894	$0.00	0.6%	-1.5%
HCC 64	Substantiness	0.369	1,548	3,578	40,773	81,485	3.1%	3.8%	196.4%	6.8%	(8,393)	$239	($21,578,238.75)	-3	($7,423.98)	(0.74%)	($37,478,423.98)	-2	($8,019.93)	0.0%	-5.7%
HCC 66	Major Depressive, Bipolar, and Paranoid Disorders	0.906	16,121	24,422	77,872	77,004	11.0%	7.2%	764.1%	8.5%	5,623	$292	$8,327,339.80	5579	$12,719,040.90	2.93%	$6,791,094.67	4419	$10,295,329.13	3.6%	2.3%
HCC 67	Quadriplegia, Other Extensive Paralysis	0.587	698	1,941	8,498	8,594	0.8%	0.5%	83.4%	0.9%	(4635)	$210	($4,823,800.28)	883	$409,028.65	(.43%)	($950,688.23)	337	($531,351.58	0.1%	-0.3%
HCC 68	Paraplegia	0.291	586	1,071	5,580	5,550	0.4%	0.3%	54.8%	0.6%	(2431)	$181	($1,744,937.43)	98	$106,584.57	(.27%)	($693,423.73	79	($159,233.53	0.1%	-0.2%
HCC 69	Spinal Cord Dysfunctions	0.162	1,005	1,845	8,854	8,749	0.7%	0.6%	86.8%	0.7%	(8)	$95	($674.40)	267	($101,867.12	(.01%)	($548.27)	216	($265,094.57	0.2%	0.0%
HCC 7	Metastatic Cancer and Acute Leukemia	0.5880	13,980	25,874	678	65,310	9.5%	7.7%	6.7%	9.2%	3,848	$353	($4,179,639.86	2685	($1,881,267.68	2.78%	($1,495,472.69	2175	($1,220,444.82	2.8%	1.2%
HCC 70	Quadriplegic Cerebral Palsy	0.000	81	148	478	477	0.0%	0.0%	4.7%	0.1%	(108)	$0	$0.00	80	$0.00	(.13%)	$0.00	61	$0.00	0.0%	0.0%
HCC 71	Paraplegic Cerebral Palsy	0.253	23,454	30,059	88,912	87,025	19.9%	9.1%	492.8%	5.2%	14,830	$857	$27,583,004.69	9345	$17,269,851.96	12.09%	$22,665,349.23	7407	$23,885,584.73	6.3%	10.2%
HCC 72	Spinal Muscular Atrophy	0.174	730	1,296	4,288	4,238	0.8%	0.4%	42.2%	0.5%	43	$108	$54,574.73	168	$218,080.32	.34	$44,205.53	136	$176,644.98	0.1%	0.0%
HCC 73	Parkinson's and Huntington's Diseases	0.088	5,726	12,756	40,218	39,648	5.0%	3.8%	384.7%	4.4%	(7,815)	$35	($5,485,441.28)	205	($135,828.38	(4.95%)	($3,393,909.06)	156	($220,039.79	0.0%	-0.5%
HCC 74	Seizure Disorders and Convulsions	0.165	8,614	18,957	28,580	75,404	5.9%	5.4%	153.3%	8.6%	(8,643)	$465	($4,483,840.79)	653	($603,831.40	(2.94%)	($3,634,983.04)	595	($651,103.66	0.4%	-1.5%
HCC 75	Coma, Brain Compression/Anoxic Damage	0.000	1,643	2,004	9,209	9,818	0.7%	0.9%	98.3%	1.1%	(553)	$0	$0.00	-136	$0.00	(.04%)	$0.00	-125	$0.00	-0.1%	-0.0%
HCC 77	Respiration Dependence/Tracheostomy Status	1.340	1,998	3,782	19,420	19,181	1.6%	1.2%	190.7%	2.2%	(1,882)	$246	($538,703,401.72)	256	($3,631,657.20	(.69%)	($8,346,035.40)	190	($3,041,490.33	0.2%	-0.8%
HCC 78	Respiratory Arrest	0.884	75	986	656	647	0.1%	0.1%	6.4%	0.1%	(106)	$631	($3,209,530.49)	-33	($681,881.95)	0.24%	($478,829.08)	-9	($67,239.84)	0.0%	0.0%
HCC 79	Cardio-Respiratory Failure and Shock	0.484	15,342	38,195	184,233	172,908	16.9%	17.3%	1822.6%	12.5%	(5,060)	$290	($160,628,490.57)	-1209	($4,581,845.51)	(2.48%)	($8,808,028.60)	-1060	($2,670,898.09)	-0.9%	-2.2%
HCC 8	Lung, Upper Digestive Tract and Other Severe Cancers	0.9480	5,858	11,954	274	30,638	3.9%	3.5%	2.7%	3.4%	688	$293	($2,888,318.64	690	($2,107,037.58	4.99%	($1,315,197.94	603	($1,700,884.24	0.3%	0.4%
HCC 80	Congestive Heart Failure	0.931	111,345	208,709	555,341	547,410	68.9%	67.8%	5449.9%	40.2%	22,983	$144	($56,953,340.39	13158	($22,864,432.26	28.33%	($31,193,788.04	10458	($18,374,974.01	9.0%	15.4%
HCC 81	Acute Myocardial Infarction	0.474	8,744	18,494	51,261	30,784	8.6%	4.9%	308.7%	3.4%	(1,758)	$285	($8,298,280.46	-408	($8,443,731.65)	3.42%	($5,097,635.37	-334	($3,173,863.62)	-0.2%	3.7%
HCC 82	Unstable Angina and Other Acute Ischemic Heart Disease	0.479	3,523	8,735	20,913	20,828	2.4%	2.4%	205.7%	3.3%	175	$795	($687,586.57	-743	($923,035.60)	1.41%	($500,561.95	613	($247,859.60)	0.1%	0.1%
HCC 83	Angina Pectoris/Old Myocardial Infarction	0.936	37,457	45,445	72,220	70,758	28.8%	23.5%	708.7%	9.9%	(5,951)	$184	($35,235,222.38	3729	($21,031,509.59	32.82%	($28,540,771.95	2760	($23,829,537.80	5.2%	10.9%
HCC 9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	0.490	8,847	18,261	338	38,838	5.0%	5.0%	3.3%	4.9%	(2,281)	$250	($7,148,106.00	1863	($4,447,788.53	3.93%	($5,790,864.08	1201	($3,602,715.18	0.9%	2.6%
HCC 92	Specified Heart Arrhythmias	0.498	49,912	85,709	219,087	218,558	30.0%	28.6%	1450.8%	34.0%	(8,757)	$123	($2,940,284.18	2407	($1,556,240.30	7.06%	($10,483,870.25	1849	($2,680,635.65	1.6%	8.0%
HCC 96	Cerebral Hemorrhage	0.178	1,847	3,481	7,434	7,203	1.3%	1.0%	75.0%	0.8%	(42)	$109	($474,711.93	37	($48,758.61	.29	($284,132.66	30	($29,494.24	0.0%	0.2%
HCC 108	Ischemic or Unspecified Stroke	0.473	4,829	10,687	13,648	28,648	3.1%	2.1%	138.4%	2.5%	(93)	$808	($1,188,915.73	78	($320,884.59	.71	($1,007,539.42	35	($589,937.81	-0.2%	0.7%

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PRIME HEALTHCARE SERVICES
HCC CODING - KAISER VS. ALL OTHER CALIFORNIA HOSPITALS
BASED ON 2009 OSHPD DATA

		Total Claims	150,663	340,653	10,405	500,671							National Factor		57.4%						
													Readmission Rate		29.8%						
1	HIV/AIDS	0.007	338	586	38	4,214	0.2%	0.2%	0.4%	0.5%	($88)	$601	($2,893,338.79)	60	$493,740.19	($451)	($2,270,704.43)	49	$351,329.55	0.0%	-0.3%
2	Septicemia/Shock	0.764	14,080	29,065	2,530	95,431	9.4%	8.5%	15.1%	10.7%	($1,595)	$475	($10,919,130.69)	892	$6,088,493.70	($1,561)	($8,844,479.86)	723	$4,121,647.50	0.6%	-1.3%
3	Opportunistic Infections	0.298	658	1,536	56	5,846	0.4%	0.5%	0.5%	0.7%	($22)	$178	($692,185.46)	-13	($58,670.41)	($61)	($860,870.78)	-15	($63,312.08)	0.0%	-0.2%
4	Metastatic Cancer and Acute Leukemia	0.824	18,456	25,408	836	51,781	7.9%	6.3%	6.3%	9.8%	2,775	$537	$17,066,186.39	2024	$12,510,353.68	2,248	$13,823,772.96	1648	$10,133,286.44	3.4%	3.8%
5	Lung, Upper Digestive Tract, and Other Severe Cancers	0.47	5,358	10,866	291	36,236	3.4%	3.2%	2.7%	2.9%	741	$296	$2,958,108.35	956	$1,348,911.52	800	$7,104,487.77	288	$4,081,132.32	0.2%	0.5%
6	Lymphoma, Myeloma, and Non-Kaposi Skin and Other Cancers	0.368	9,131	9,879	226	12,786	3.4%	2.9%	2.2%	2.5%	1,291	$239	$3,545,776.77	851	$2,337,952.45	1,046	$2,872,078.19	690	$1,895,741.48	0.6%	0.9%
7	Breast, Prostate, Cytotoxic and Other Cancers and Tumors	0.182	12,100	23,542	597	44,567	8.1%	6.6%	5.9%	5.0%	4,643	$133	$6,312,789.19	2301	$2,990,217.47	3,765	$5,113,368.24	1783	$2,422,076.15	1.5%	3.1%
8	Diabetes with Renal or Peripheral Circulatory Manifestation	0.459	34,538	42,337	1,774	89,430	23.0%	12.4%	17.5%	6.4%	27,998	$285	$86,667,486.13	15994	$54,786,203.54	22,822	$37,490,420.93	12955	$44,176,824.88	10.7%	18.6%
9	Diabetes with Neurologic or Other Specified Manifestation	0.469	32,607	40,715	1,715	47,910	21.7%	11.9%	17.0%	5.3%	24,592	$285	$84,249,161.59	14668	$50,315,185.86	19,919	$68,234,530.81	11898	$40,755,383.98	9.8%	16.4%
10	Diabetes with Acute Complication	0.458	541	1,085	96	3,518	0.4%	0.3%	0.9%	0.4%	(48)	$285	($163,064.25)	63	$317,496.74	($91)	($312,068.84)	51	$176,171.55	0.0%	0.0%
11	Diabetes with Ophthalmologic or Unspecified Manifestation	0.469	18,761	13,006	565	13,133	7.5%	3.8%	5.4%	1.5%	9,059	$285	$31,032,907.75	5537	$18,967,345.37	7,358	$25,136,655.28	4385	$15,263,549.75	3.7%	6.0%
12	Diabetes without Complication	0.248	26,569	78,329	2,457	286,586	17.7%	23.0%	23.2%	29.8%	(18,122)	$154	($33,541,482.98)	-7905	($14,627,982.84)	(24,679)	($27,168,600.73)	-9402	($10,348,066.10)	-5.3%	-12.1%
13	Protein-Calorie Malnutrition	0.874	17,979	27,920	1,150	64,940	12.0%	8.0%	11.1%	7.3%	7,092	$233	$16,795,533.59	5956	$36,622,788.86	5,245	$16,634,384.40	4524	$13,464,442.27	4.0%	4.7%
14	End-Stage Liver Disease	0.856	2,347	4,764	257	17,099	1.6%	1.4%	2.5%	1.9%	(636)	$407	($2,862,182.78)	320	$1,975,579.42	(665)	($3,172,376.15)	178	$871,219.23	0.1%	-0.4%
15	Cirrhosis of Liver	0.384	2,882	5,969	264	20,758	1.9%	1.8%	2.5%	2.5%	(598)	$239	($5,713,593.43)	255	$750,901.31	(484)	($1,388,010.68)	207	$589,046.78	0.2%	-0.4%
16	Chronic Hepatitis	0.384	2,382	3,553	215	12,723	1.6%	1.0%	2.1%	1.4%	249	$239	$713,781.14	319	$2,347,683.28	302	$578,862.70	964	$1,901,823.43	0.5%	0.2%
17	Intestinal Obstruction/Perforation	0.345	7,267	16,477	497	42,857	4.8%	4.8%	4.9%	4.8%	82	$235	$212,886.85	15	$39,888.35	67	$391,628.86	13	$81,309.69	0.0%	0.1%
18	Pancreatic Disease	0.309	3,501	6,968	240	18,570	2.3%	2.0%	2.4%	2.1%	196	$192	$913,753.61	414	$1,001,784.34	321	$749,100.43	352	$811,406.40	0.3%	0.3%
19	Inflammatory Bowel Disease	0.266	1,398	2,377	87	5,378	0.9%	0.7%	0.9%	0.8%	491	$127	$751,819.00	347	$530,704.86	398	$608,973.39	281	$429,870.94	0.2%	0.1%
20	Bone/Joint/Muscle Infections/Necrosis	0.407	2,107	4,008	179	13,860	1.4%	1.2%	1.7%	1.5%	(181)	$309	($670,814.56)	344	$1,275,604.69	(148)	($548,339.76)	279	$1,031,399.37	0.2%	-0.1%
21	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	0.316	7,963	14,703	395	34,127	5.3%	4.3%	3.8%	3.8%	2,241	$134	$3,592,101.46	1493	$2,394,945.35	1,816	$2,913,657.06	1259	$2,019,420.54	1.0%	1.5%
22	Severe Hematological Disorders	0.489	3,051	6,294	246	29,299	2.0%	1.8%	2.4%	2.4%	(580)	$307	($2,059,070.93)	241	($686,708.63)	($451)	($1,567,847.64)	196	$788,182.58	0.2%	-0.4%
23	Disorders of Immunity	0.427	1,110	2,027	67	6,203	0.7%	0.6%	0.7%	0.7%	90	$266	$224,476.05	228	$684,645.16	57	$181,825.60	177	$562,500.57	0.1%	0.0%
24	Drug/Alcohol Psychosis3	0	2,984	3,653	172	13,325	1.3%	1.1%	1.7%	1.5%	(240)	$0	$0.00	186	$0.00	(134)	$0.00	333	$0.00	0.3%	-0.2%
25	Drug/Alcohol Dependence3	0	4,388	8,260	507	34,297	2.9%	2.4%	5.0%	3.8%	(1,396)	$0	$0.00	749	$0.00	(1,006)	$0.00	607	$0.00	0.5%	-0.9%
26	Schizophrenia	0.384	827	2,164	101	17,605	0.8%	0.6%	1.0%	4.1%	(5,228)	$238	($13,957,785.89)	-66	($177,011.65)	(4,316)	($11,305,806.50)	-55	($143,379.43)	0.0%	-3.6%
27	Major Depressive, Bipolar, and Paranoid Disorders	0.283	13,891	19,298	688	49,965	9.2%	5.7%	6.6%	5.0%	5,515	$182	$12,058,731.02	5198	$11,603,577.79	4,467	$9,767,571.85	4372	$9,560,857.51	3.6%	3.7%
28	Quadriplegic, Other Extensive Paralysis	0.424	547	972	65	5,145	0.4%	0.3%	0.6%	0.5%	(143)	$270	($1,020,866.68)	119	$386,159.57	(256)	($826,918.37)	97	$312,789.26	0.1%	-0.2%
29	Paraplegia	0.424	585	1,055	39	5,900	0.4%	0.3%	0.4%	0.7%	(468)	$270	($1,508,849.13)	103	$331,908.47	($371)	($1,196,800.85)	84	$270,965.86	0.1%	-0.3%
30	Spinal Cord Disorders/Injuries	0.226	1,010	1,735	71	5,755	0.7%	0.5%	0.7%	0.8%	73	$140	$472,933.48	274	$480,813.67	59	$96,576.06	222	$373,259.07	0.2%	0.0%
31	Muscular Dystrophy3	0	79	168	7	486	0.1%	0.0%	0.1%	0.1%	(3)	$0	$0.00	7	$0.00	(2)	$0.00	6	$0.00	0.0%	0.0%
32	Polyneuropathy	0.226	24,808	39,279	1,140	47,951	16.5%	9.6%	11.2%	5.3%	38,869	$140	$26,234,919.67	10862	$37,063,696.82	13,630	$22,854,084.93	8234	$13,821,564.42	6.8%	11.2%
33	Multiple Sclerosis	0.146	767	1,328	75	4,209	0.5%	0.4%	0.7%	0.5%	61	$90	$86,429.81	183	$197,542.86	50	$63,808.15	148	$160,009.40	0.1%	0.0%
34	Parkinson's and Huntington's Diseases	0.069	3,022	6,508	193	19,976	2.0%	1.9%	1.9%	2.3%	(327)	$57	($324,494.66)	159	$108,370.34	(265)	($381,775.39)	128	$87,779.98	0.1%	-0.2%
35	Seizure Disorders and Convulsions	0.177	5,621	12,066	649	48,055	3.8%	3.5%	6.4%	5.4%	(2,964)	$180	($5,149,902.65)	968	$485,691.42	(3,591)	($5,550,934.68)	297	$398,790.05	0.2%	-1.6%
36	Coma, Brain Compression/Anoxic Damage3	0	1,089	3,265	252	11,250	0.7%	0.9%	2.5%	2.3%	(797)	$0	$0.00	-304	$0.00	(666)	$0.00	-246	$0.00	-0.2%	-0.5%
37	Respirator Dependence/Tracheostomy Status	1.559	1,421	2,584	187	12,918	0.9%	0.8%	1.8%	2.6%	(748)	$900	($6,702,540.48)	248	$1,789,739.73	(656)	($7,045,057.76)	194	$2,259,686.75	0.2%	-0.5%
38	Respiratory Arrest	1.235	80	186	11	534	0.1%	0.1%	0.1%	0.1%	(29)	$768	($221,171.04)	-2	($17,220.27)	(25)	($171,230.54)	-2	($13,873.90)	0.0%	0.0%
39	Cardio-Respiratory Failure and Shock	0.445	17,986	42,371	1,842	146,842	12.0%	12.4%	18.1%	13.1%	(1,602)	$297	($35,339,711.38)	-961	($2,196,617.20)	(1,297)	($4,305,966.22)	-936	($1,779,259.03)	-0.4%	-1.1%
40	Congestive Heart Failure	0.220	72,306	147,053	4,609	353,438	48.0%	43.1%	46.1%	39.5%	13,054	$142	$22,262,814.67	7589	$21,913,227.08	10,574	$17,952,379.88	8367	$10,459,733.93	5.1%	8.7%
41	Acute Myocardial Infarction	0.424	5,996	15,570	482	29,295	4.0%	4.6%	4.7%	3.3%	8,045	$264	$3,306,320.86	-886	($2,836,199.20)	846	$2,678,119.90	-726	($2,293,397.49)	-0.6%	0.7%
42	Unstable Angina and Other Acute Ischemic Heart Disease	0.424	3,320	7,187	191	19,078	2.2%	2.4%	1.8%	2.1%	870	$264	$431,800.58	-250	($791,335.32)	105	$331,396.79	-203	($640,981.63)	-0.2%	0.1%
43	Angina Pectoris/Old Myocardial Infarction	0.28	29,254	66,847	1,486	68,874	19.5%	19.7%	13.0%	7.7%	17,708	$160	$38,324,363.14	8637	$23,602,134.18	14,343	$23,042,653.14	6996	$15,346,618.68	5.3%	11.8%
44	Specified Heart Arrhythmias	0.297	45,378	98,464	2,647	218,824	30.2%	28.9%	26.0%	24.4%	8,695	$129	$13,431,879.49	2049	$3,159,375.24	7,049	$10,879,660.39	1657	$2,559,098.94	1.4%	5.8%
45	Cerebral Hemorrhage	0.179	1,537	3,587	169	7,342	1.0%	1.1%	1.7%	0.8%	106	$111	$408,892.20	-42	($95,618.34)	248	$331,289.68	94	($75,070.86)	0.0%	0.1%
46	Ischemic or Unspecified Stroke	0.179	4,551	10,787	418	22,765	3.0%	3.2%	4.2%	2.5%	735	$111	$981,723.59	-896	($262,297.52)	595	$794,822.38	-159	($212,457.79)	-0.5%	0.5%
47	Hemiplegia/Hemiparesis	0.058	7,992	14,166	693	38,850	5.3%	4.2%	6.7%	4.0%	2,016	$34	$586,626.16	1758	$512,160.33	1,833	$435,867.19	1424	$414,355.77	1.2%	1.3%
48	Cerebral Palsy and Other Paralytic Syndromes3	0	421	923	43	4,512	0.3%	0.3%	0.4%	0.5%	(373)	$0	$0.00	-15	$0.00	(270)	$0.00	-12	$0.00	0.0%	-0.1%
49	Vascular Diseases with Complications	0.452	5,327	11,009	376	25,900	3.6%	3.2%	3.7%	2.9%	985	$300	$1,543,318.22	485	$1,744,744.98	798	$1,470,082.87	393	$1,413,243.40	0.3%	0.7%
50	Vascular Disease	0.165	38,324	88,755	2,823	109,013	24.2%	17.2%	17.9%	12.4%	19,220	$108	$23,868,813.39	10967	$12,886,859.10	15,564	$19,171,080.80	8478	$10,429,975.87	7.0%	12.8%
51	Cystic Fibrosis	0.651	16	25	0	434	0.0%	0.0%	0.0%	0.0%	(53)	$302	($254,499.99)	-6	$27,979.12	(43)	($203,906.81)	-5	$42,820.00	0.0%	0.0%
52	Chronic Obstructive Pulmonary Disease	0.359	29,837	67,578	1,898	195,124	24.0%	19.8%	18.7%	21.8%	(2,776)	$223	($7,432,459.93)	186	$623,859.51	(2,249)	($6,018,342.55)	358	$624,407.20	0.1%	-1.9%
53	Aspiration and Specified Bacterial Pneumonias	0.873	5,436	12,751	568	50,670	3.6%	3.7%	5.5%	5.7%	(3,066)	$386	($13,074,048.90)	-878	($753,348.48)	(2,477)	($10,394,057.96)	-142	($608,589.55)	-0.1%	-2.0%
54	Pneumococcal Pneumonia, Emphysema, Lung Abscess	0.161	750	1,727	64	5,369	0.5%	0.5%	0.6%	0.6%	(150)	$113	($302,727.08)	-10	($13,576.38)	(122)	($164,208.94)	-8	($10,986.96)	0.0%	-0.1%
55	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	0.497	3,683	3,064	188	487	2.1%	0.9%	1.8%	0.1%	3,001	$379	$1,137,368.24	1795	$6,493,594.50	2,431	$9,087,218.15	1405	$5,211,209.11	1.2%	2.0%
56	Dialysis Status	1.718	6,597	13,295	738	42,063	4.4%	3.9%	7.1%	8.4%	(455)	53,068	($5,828,576.27)	1639	$21,018,012.92	(368)	($4,721,148.78)	1326	$17,024,560.46	1.1%	-0.3%
57	Renal Failure	0.388	76,605	144,367	5,203	348,713	51.1%	42.3%	52.0%	39.6%	18,145	$244	$52,542,815.67	13089	$37,843,921.83	16,698	$42,559,680.53	10586	$30,653,576.69	8.7%	12.1%
58	Nephritis	0.258	9,006	8,233	215	38,320	9.3%	2.4%	2.1%	1.8%	2,270	$157	$4,386,179.52	1391	$2,677,286.33	1,854	$3,421,605.41	1327	$2,428,101.92	0.9%	1.5%
59	Decubitus Ulcer of Skin	0.466	19,618	37,046	1,820	115,944	13.1%	10.9%	17.9%	13.0%	101	$304	$780,139.12	3135	$12,078,579.78	160	$591,412.69	2701	$9,777,979.62	2.2%	0.1%
60	Chronic Ulcer of Skin, Except Decubitus	0.241	4,870	8,166	341	21,235	3.2%	2.4%	3.3%	2.4%	1,310	$150	$2,956,299.00	1276	$2,295,367.71	1,064	$1,908,607.25	1014	$1,859,168.55	0.9%	0.9%
61	Extensive Third-Degree Burns3	0	3	36	0	69	0.0%	0.0%	0.0%	0.0%	(9)	$0	$0.00	-4	$0.00	(7)	$0.00	-3	$0.00	0.0%	0.0%
62	Severe Head Injury3	0	30	180	1	367	0.0%	0.0%	0.0%	0.0%	(32)	$0	$0.00	-40	$0.00	(28)	$0.00	-31	$0.00	0.0%	0.0%
63	Major Head Injury3	0	1,540	3,879	105	9,347	1.0%	1.1%	1.0%	1.0%	(57)	$0	$0.00	-197	$0.00	(46)	$0.00	-160	$0.00	-0.1%	0.0%
64	Vertebral Fractures without Spinal Cord Injury	0.161	2,700	5,887	133	14,057	1.3%	1.7%	1.2%	1.8%	342	$300	$410,634.88	109	$131,134.57	277	$332,614.26	88	$106,219.00	0.1%	0.2%
65	Hip Fracture/Dislocation3	0	4,648	11,037	249	23,506	3.1%	3.2%	2.4%	2.6%	707	$0	$0.00	-700	$0.00	573	$0.00	-570	$0.00	-0.1%	0.5%
66	Traumatic Amputation	0.28	8	7	1	28	0.0%	0.0%	0.0%	0.0%	(1)	$182	($1,346.67)	-1	$1,783.81	(1)	($1,096.90)	-1	$1,444.88	0.0%	0.0%
67	Major Complications of Medical Care and Trauma	0.308	9,330	19,780	460	51,001	6.2%	5.3%	4.5%	5.7%	370	$192	$1,375,295.20	615	$1,417,878.29	624	$1,437,385.19	496	$1,148,478.76	0.4%	0.5%
68	Major Organ Transplant Status	0.97	620	1,149	34	4,816	0.4%	0.3%	0.3%	0.5%	(187)	$573	($1,264,186.47)	187	$401,691.38	(158)	($1,048,181.64)	95	$658,504.02	0.3%	-0.1%
69	Artificial Openings for Feeding or Elimination	0.841	4,148	8,731	339	38,654	2.8%	2.8%	3.3%	4.1%	(1,996)	$523	($12,526,477.99)	1611	$3,953,348.20	(1,617)	($10,146,447.17)	752	$5,580,567.74	0.2%	-1.2%
70	Amputation Status: Lower Limb/Amputation Complications	0.26	3,514	6,093	264	28,062	2.3%	1.8%	2.6%	3.1%	385	$162	$747,857.58	832	$1,615,329.90	312	$605,788.94	674	$1,308,412.36	0.6%	0.3%

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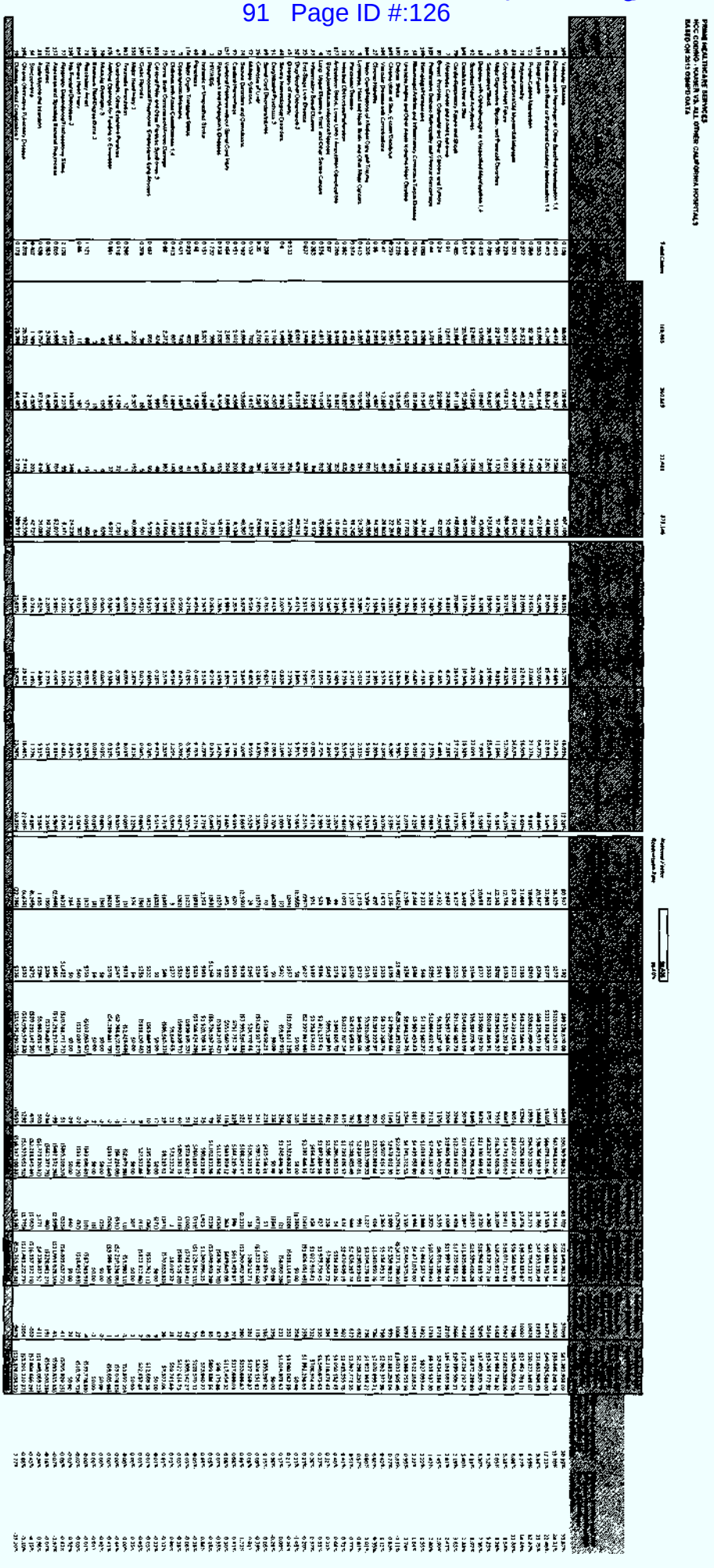

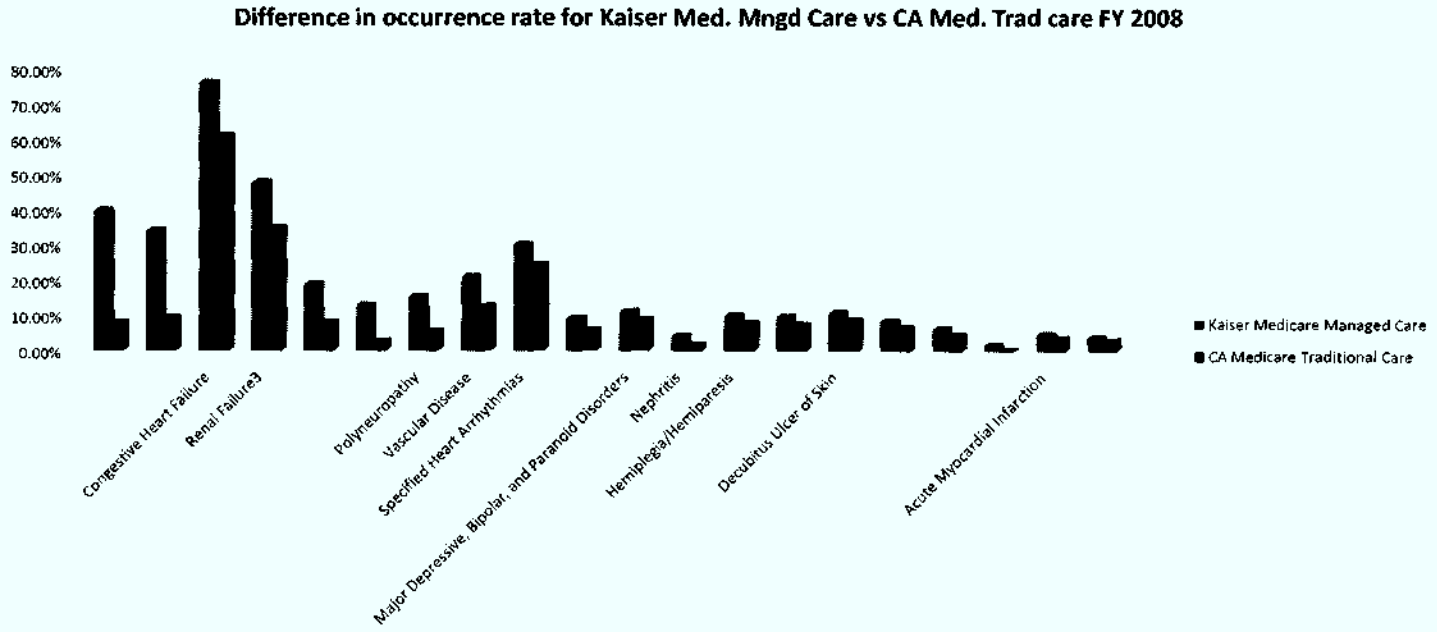

HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Traditional Care
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation	39.64%	7.61%
HCC16	Diabetes with Neurologic orOther Specified Manifestation	34.05%	9.16%
HCC80	Congestive Heart Failure	76.10%	60.74%
HCC131	Renal Failure3	47.77%	34.74%
HCC83	Angina Pectoris/OldMyocardial Infarction	18.75%	7.85%
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation	12.79%	2.40%
HCC71	Polyneuropathy	15.35%	5.22%
HCC105	Vascular Disease	20.81%	12.21%
HCC92	Specified Heart Arrhythmias	30.01%	24.03%
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	9.11%	5.56%
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	11.02%	8.54%
HCC132	Nephritis	4.15%	1.75%
HCC100	Hemiplegia/Hemiparesis	9.99%	7.70%
HCC7	Metastatic Cancer and AcuteLeukemia	9.53%	7.25%
HCC148	Decubitus Ulcer of Skin	10.59%	8.53%
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	8.34%	6.29%
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	6.05%	4.42%
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	1.54%	0.05%
HCC81	Acute Myocardial Infarction	4.61%	3.41%
HCC149	Chronic Ulcer of Skin, ExceptDecubitus	3.74%	2.70%

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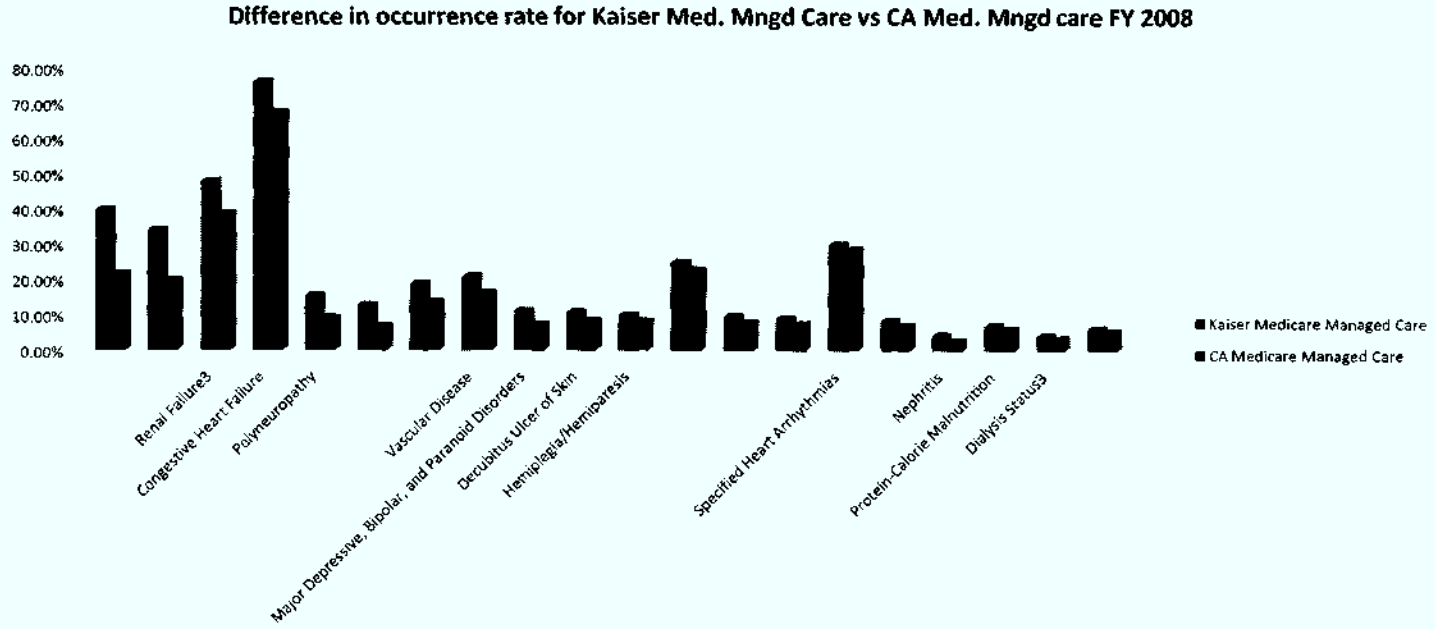
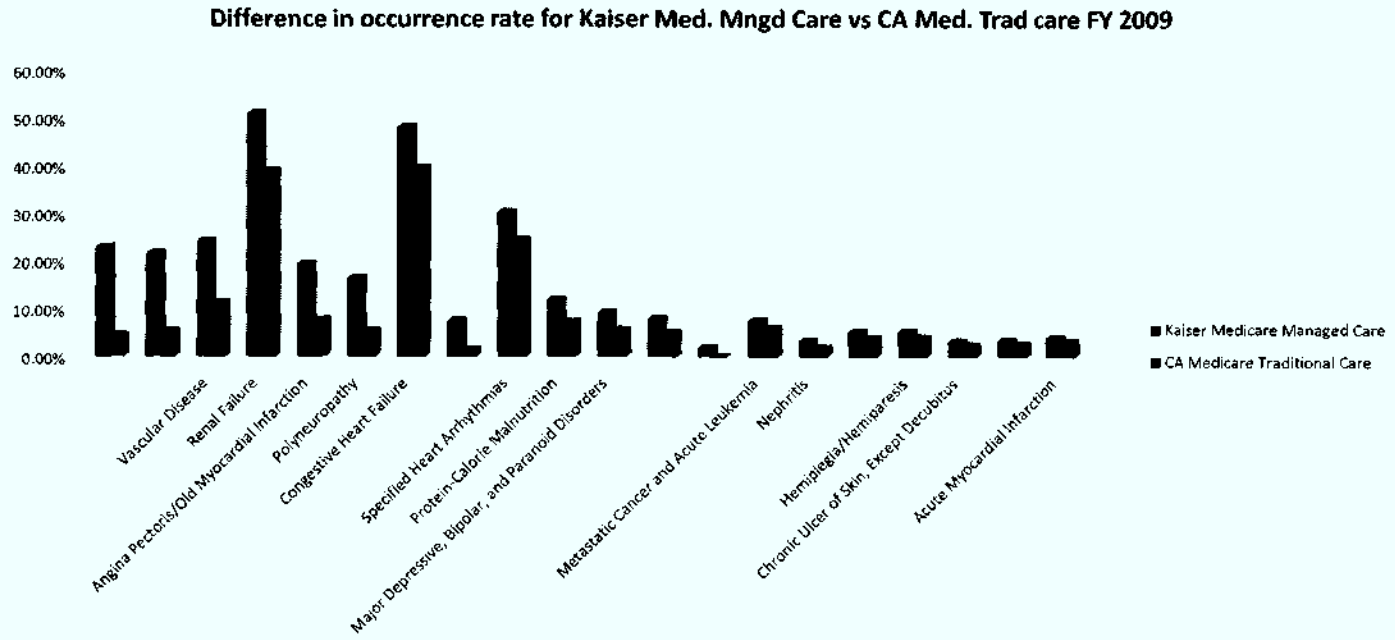
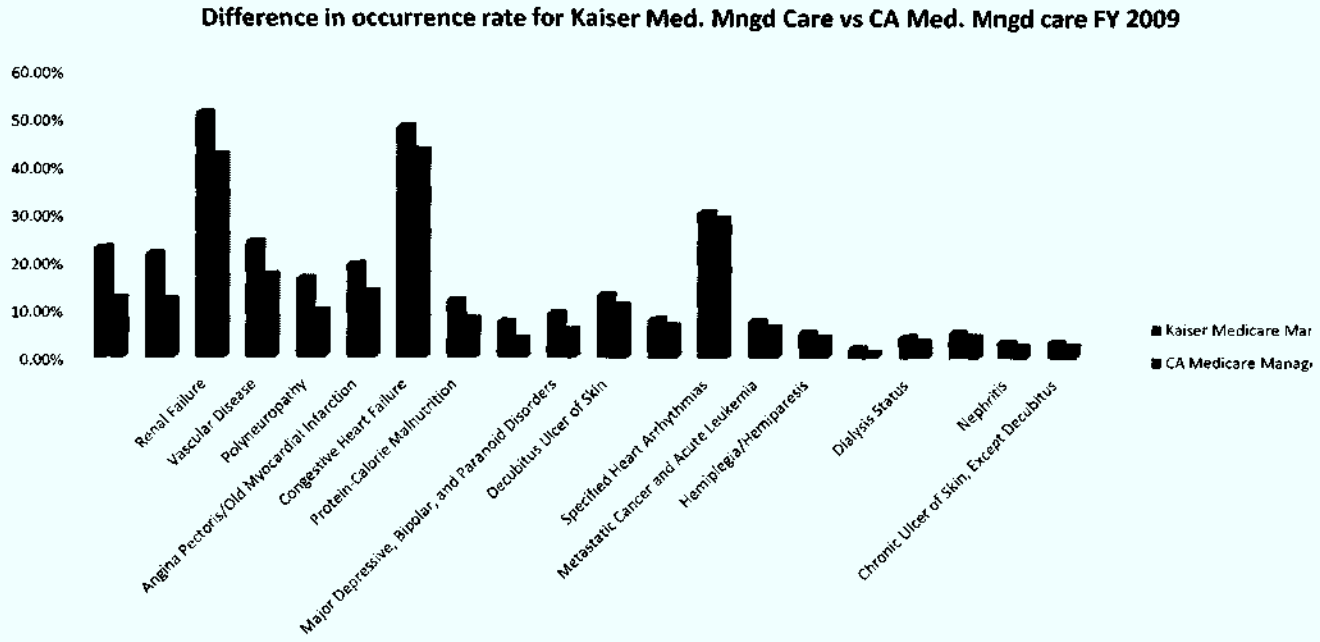


HCC CATEG	HCC Descr	Kaiser Medicare Managed Care	CA Medicare Managed Care
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation	39.64%	21.49%
HCC16	Diabetes with Neurologic orOther Specified Manifestation	34.05%	19.56%
HCC131	Renal Failure3	47.77%	38.49%
HCC80	Congestive Heart Failure	76.10%	67.11%
HCC71	Polyneuropathy	15.35%	9.10%
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation	12.79%	6.59%
HCC83	Angina Pectoris/OldMyocardial Infarction	18.75%	13.47%
HCC105	Vascular Disease	20.81%	16.08%
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	11.02%	7.24%
HCC148	Decubitus Ulcer of Skin	10.59%	8.21%
HCC100	Hemiplegia/Hemiparesis	9.99%	7.96%
HCC108	Chronic ObstructivePulmonary Disease	24.81%	22.79%
HCC7	Metastatic Cancer and AcuteLeukemia	9.53%	7.70%
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	9.11%	7.35%
HCC92	Specified Heart Arrhythmias	30.01%	28.37%
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	8.34%	6.79%
HCC132	Nephritis	4.15%	2.65%
HCC21	Protein-Calorie Malnutrition	6.86%	5.68%
HCC130	Dialysis Status3	4.08%	3.06%
HCC9	Lymphatic, Head and Neck, Brain, and Other Major Cancers	6.05%	5.03%



HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Traditional Care
15	Diabetes with Renal or Peripheral CirculatoryManifestation1	23.02%	4.41%
16	Diabetes with Neurologic or Other SpecifiedManifestation1	21.73%	5.34%
105	Vascular Disease	24.21%	11.40%
131	Renal Failure	51.05%	38.96%
83	Angina Pectoris/Old Myocardial Infarction	19.50%	7.69%
71	Polyneuropathy	16.53%	5.33%
80	Congestive Heart Failure	48.19%	39.49%
18	Diabetes with Ophthalmologic or UnspecifiedManifestation1	7.50%	1.47%
92	Specified Heart Arrhythmias	30.24%	24.45%
21	Protein-Calorie Malnutrition	11.98%	7.26%
55	Major Depressive, Bipolar, and Paranoid Disorders	9.26%	5.58%
10	Breast, Prostate, Colorectal and Other Cancers andTumors	8.07%	4.97%
119	Proliferative Diabetic Retinopathy and VitreousHemorrhage	2.05%	0.05%
7	Metastatic Cancer and Acute Leukemia	7.63%	5.79%
132	Nephritis	3.34%	1.82%
38	Rheumatoid Arthritis and Inflammatory ConnectiveTissue Disease	5.31%	3.81%
100	Hemiplegia/Hemiparesis	5.33%	3.98%
149	Chronic Ulcer of Skin, Except Decubitus	3.25%	2.37%
9	Lymphatic, Head and Neck, Brain, and Other MajorCancers	3.41%	2.55%
81	Acute Myocardial Infarction	3.97%	3.27%



HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Managed Care
15	Diabetes with Renal or Peripheral CirculatoryManifestation1	23.02%	12.36%
16	Diabetes with Neurologic or Other SpecifiedManifestation1	21.73%	11.94%
131	Renal Failure	51.05%	42.34%
105	Vascular Disease	24.21%	17.23%
71	Polyneuropathy	16.53%	9.76%
83	Angina Pectoris/Old Myocardial Infarction	19.50%	13.74%
80	Congestive Heart Failure	48.19%	43.13%
21	Protein-Calorie Malnutrition	11.98%	8.01%
18	Diabetes with Ophthalmologic or UnspecifiedManifestation1	7.50%	3.81%
55	Major Depressive, Bipolar, and Paranoid Disorders	9.26%	5.66%
148	Decubitus Ulcer of Skin	13.09%	10.87%
10	Breast, Prostate, Colorectal and Other Cancers andTumors	8.07%	6.60%
92	Specified Heart Arrhythmias	30.24%	28.88%
7	Metastatic Cancer and Acute Leukemia	7.63%	6.28%
100	Hemiplegia/Hemiparesis	5.33%	4.15%
119	Proliferative Diabetic Retinopathy and VitreousHemorrhage	2.05%	0.90%
130	Dialysis Status	4.40%	3.30%
38	Rheumatoid Arthritis and Inflammatory ConnectiveTissue Disease	5.31%	4.31%
132	Nephritis	3.34%	2.41%
149	Chronic Ulcer of Skin, Except Decubitus	3.25%	2.40%

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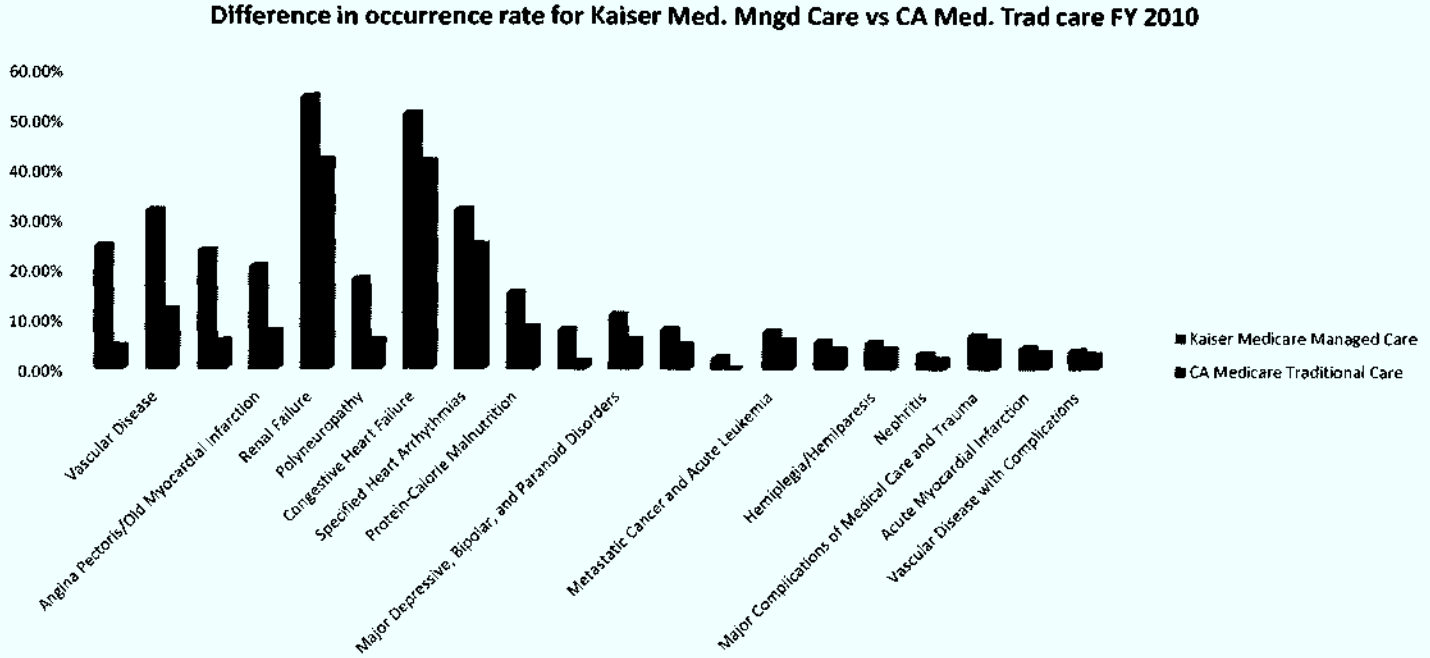
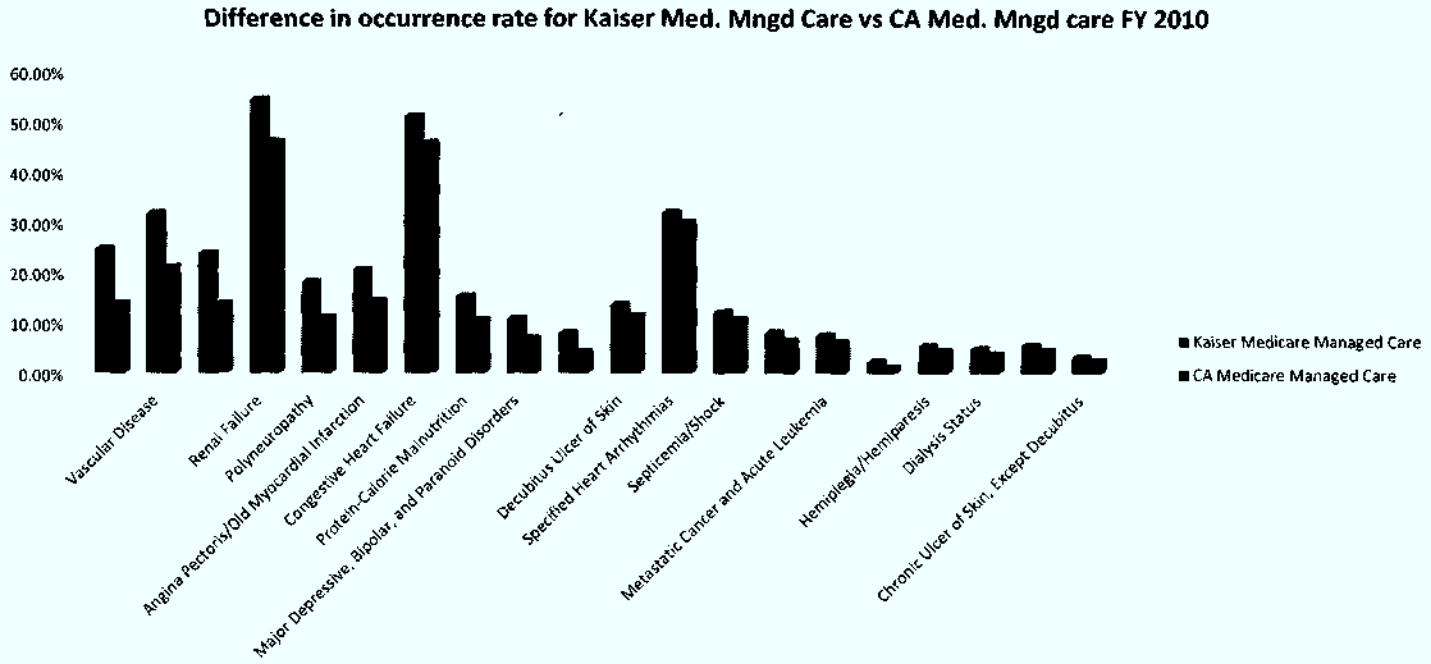
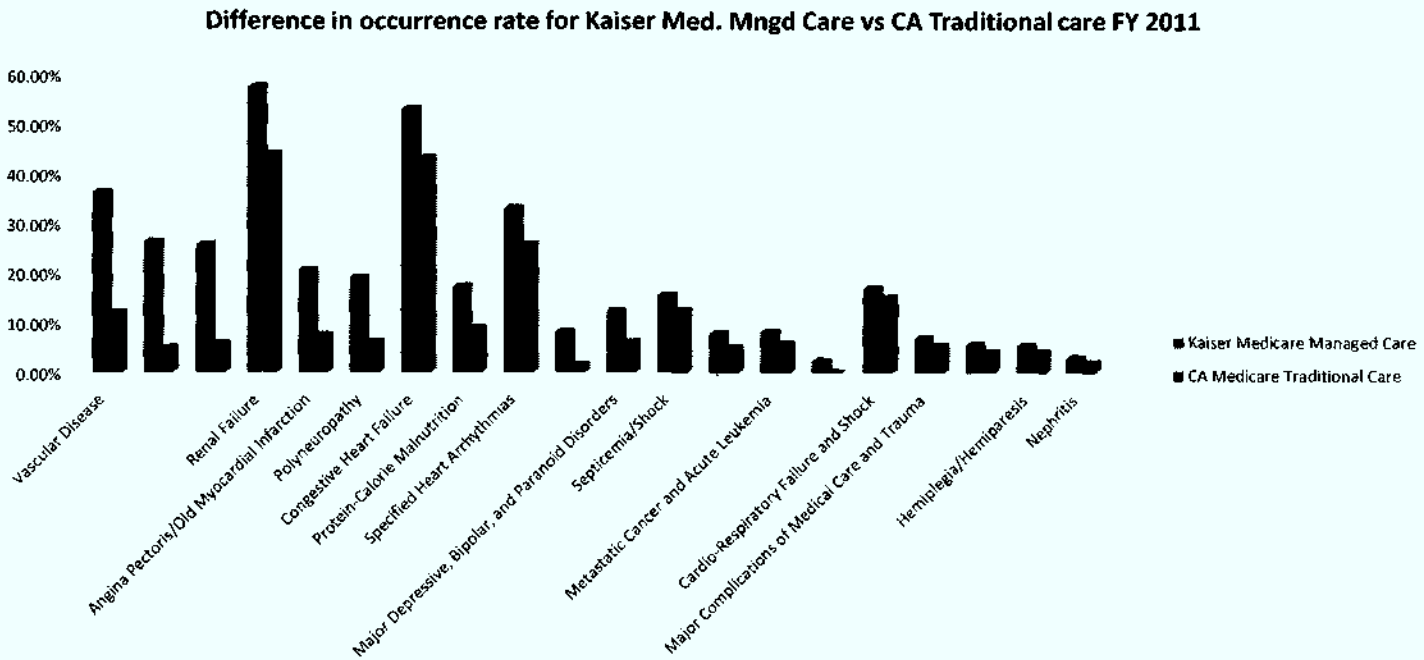


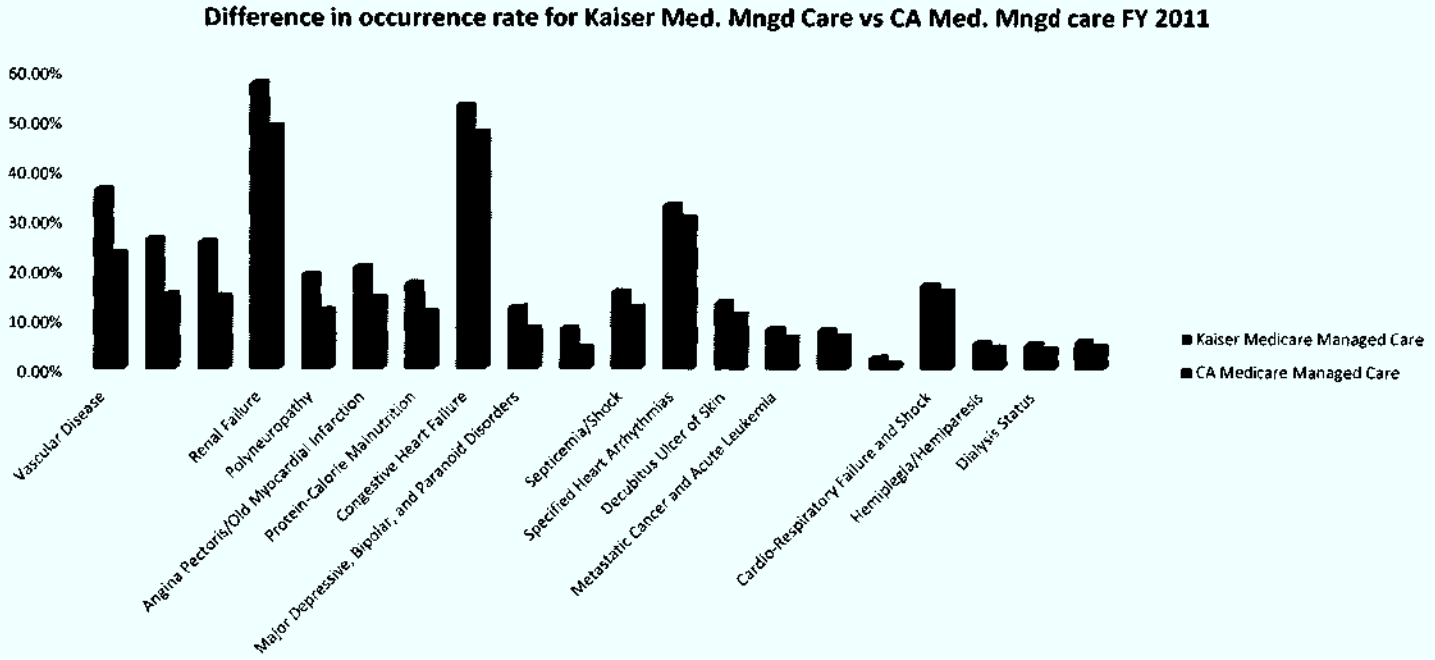
HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Traditional Care
15	Diabetes with Renal or Peripheral CirculatoryManifestation1	24.70%	4.54%
105	Vascular Disease	31.77%	11.79%
16	Diabetes with Neurologic or Other SpecifiedManifestation1	23.80%	5.55%
83	Angina Pectoris/Old Myocardial Infarction	20.51%	7.53%
131	Renal Failure	54.47%	41.77%
71	Polyneuropathy	18.01%	5.71%
80	Congestive Heart Failure	51.14%	41.50%
92	Specified Heart Arrhythmias	31.84%	24.84%
21	Protein-Calorie Malnutrition	15.27%	8.46%
18	Diabetes with Ophthalmologic or UnspecifiedManifestation1	7.87%	1.49%
55	Major Depressive, Bipolar, and Paranoid Disorders	10.87%	5.84%
10	Breast, Prostate, Colorectal and Other Cancers andTumors	7.98%	4.93%
119	Proliferative Diabetic Retinopathy and VitreousHemorrhage	2.34%	0.06%
7	Metastatic Cancer and Acute Leukemia	7.55%	5.78%
38	Rheumatoid Arthritis and Inflammatory ConnectiveTissue Disease	5.55%	3.99%
100	Hemiplegia/Hemiparesis	5.37%	4.00%
132	Nephritis	3.13%	1.92%
164	Major Complications of Medical Care and Trauma	6.75%	5.58%
81	Acute Myocardial Infarction	4.28%	3.34%
104	Vascular Disease with Complications	3.82%	2.94%



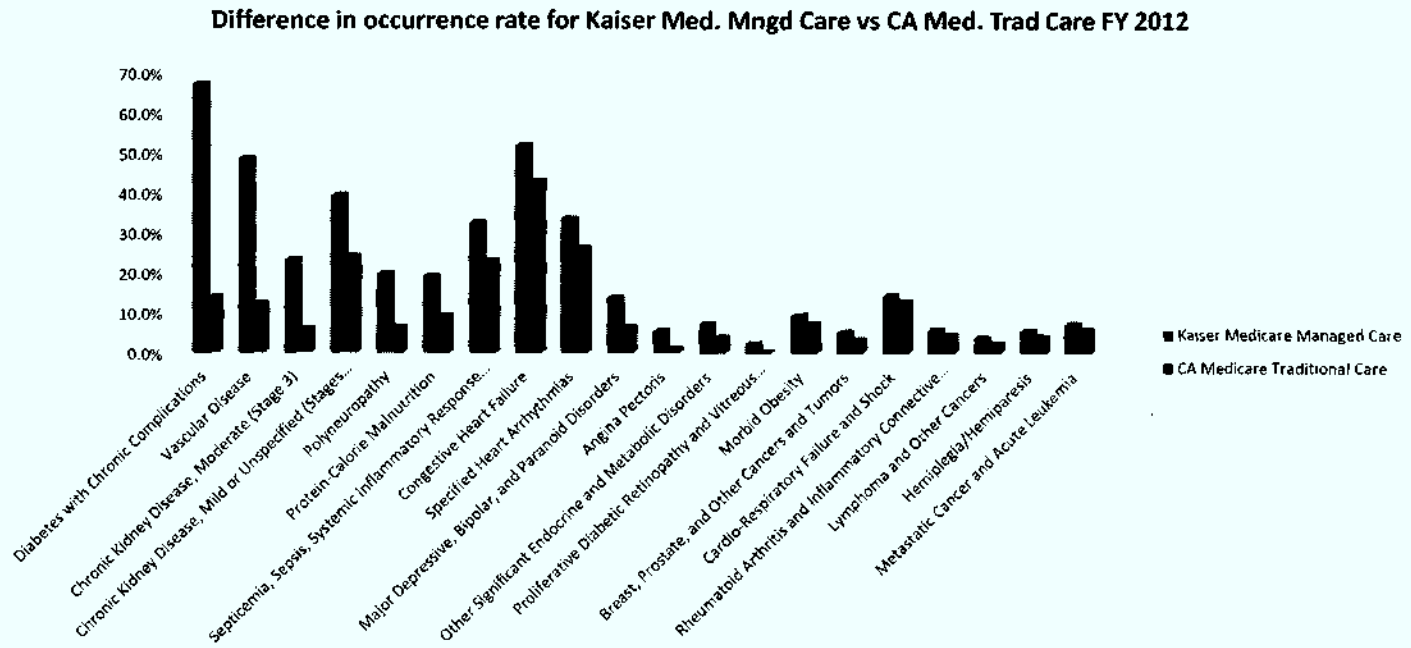
HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Managed Care
15	Diabetes with Renal or Peripheral CirculatoryManifestation1	24.70%	13.93%
105	Vascular Disease	31.77%	21.06%
16	Diabetes with Neurologic or Other SpecifiedManifestation1	23.80%	13.62%
131	Renal Failure	54.47%	46.07%
71	Polyneuropathy	18.01%	10.96%
83	Angina Pectoris/Old Myocardial Infarction	20.51%	14.25%
80	Congestive Heart Failure	51.14%	45.73%
21	Protein-Calorie Malnutrition	15.27%	10.28%
55	Major Depressive, Bipolar, and Paranoid Disorders	10.87%	6.84%
18	Diabetes with Ophthalmologic or UnspecifiedManifestation1	7.87%	4.11%
148	Decubitus Ulcer of Skin	13.49%	11.32%
92	Specified Heart Arrhythmias	31.84%	29.92%
2	Septicemia/Shock	12.13%	10.59%
10	Breast, Prostate, Colorectal and Other Cancers andTumors	7.98%	6.51%
7	Metastatic Cancer and Acute Leukemia	7.55%	6.12%
119	Proliferative Diabetic Retinopathy and VitreousHemorrhage	2.34%	1.06%
100	Hemiplegia/Hemiparesis	5.37%	4.26%
130	Dialysis Status	4.81%	3.76%
38	Rheumatoid Arthritis and Inflammatory ConnectiveTissue Disease	5.55%	4.56%
149	Chronic Ulcer of Skin, Except Decubitus	3.24%	2.44%



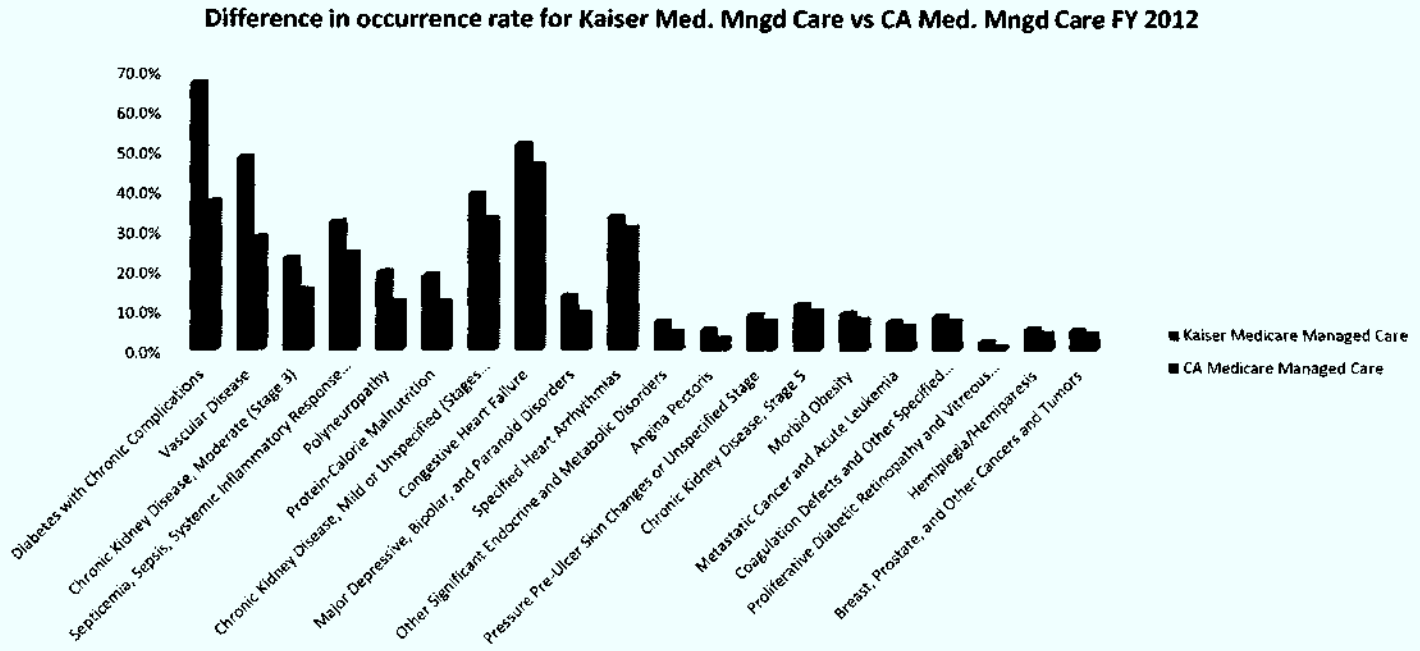
HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Traditional Care
105	Vascular Disease	36.17%	12.03%
15	Diabetes with Renal or Peripheral CirculatoryManifestation1	26.27%	4.79%
16	Diabetes with Neurologic or Other SpecifiedManifestation1	25.60%	5.67%
131	Renal Failure	57.43%	43.89%
83	Angina Pectoris/Old Myocardial Infarction	20.48%	7.44%
71	Polyneuropathy	19.03%	6.03%
80	Congestive Heart Failure	53.07%	43.00%
21	Protein-Calorie Malnutrition	17.16%	8.79%
92	Specified Heart Arrhythmias	32.90%	25.66%
18	Diabetes with Ophthalmologic or UnspecifiedManifestation1	8.06%	1.52%
55	Major Depressive, Bipolar, and Paranoid Disorders	12.42%	6.04%
2	Septicemia/Shock	15.50%	12.38%
10	Breast, Prostate, Colorectal and Other Cancers andTumors	7.83%	4.92%
7	Metastatic Cancer and Acute Leukemia	8.12%	5.78%
119	Proliferative Diabetic Retinopathy and VitreousHemorrhage	2.31%	0.07%
79	Cardio-Respiratory Failure and Shock	16.92%	15.03%
164	Major Complications of Medical Care and Trauma	6.89%	5.32%
38	Rheumatoid Arthritis and Inflammatory ConnectiveTissue Disease	5.58%	4.11%
100	Hemiplegia/Hemiparesis	5.36%	4.04%
132	Nephritis	3.03%	1.96%



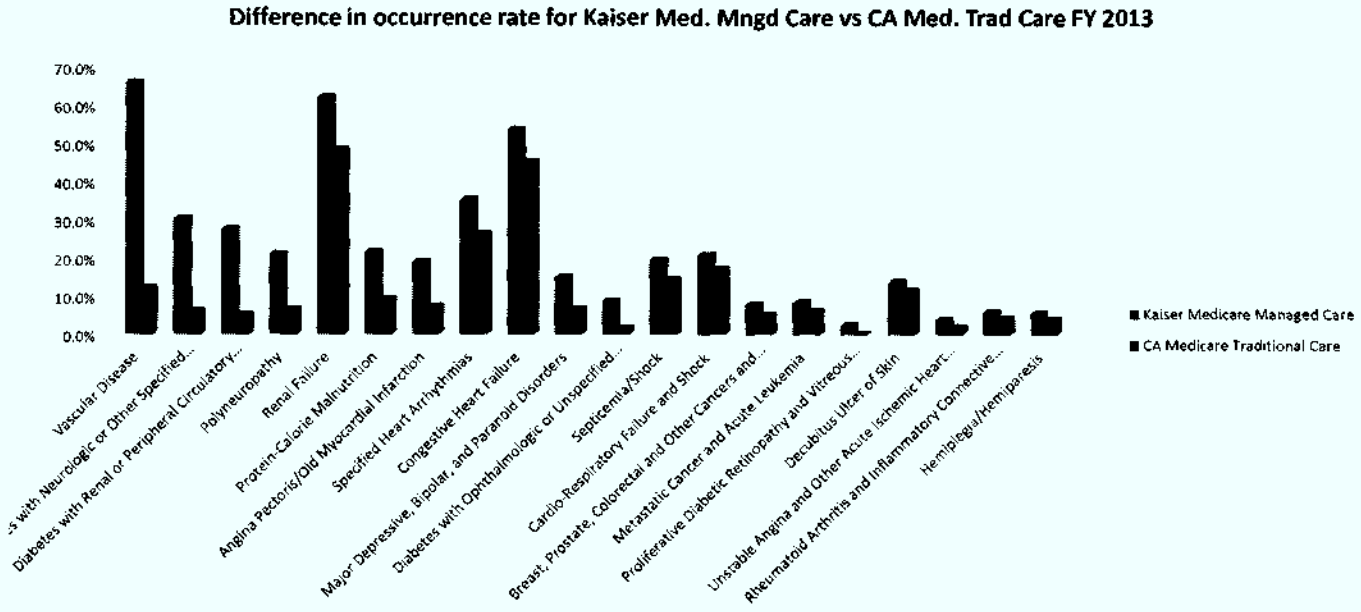
HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Managed Care
105	Vascular Disease	36.17%	23.33%
15	Diabetes with Renal or Peripheral CirculatoryManifestation1	26.27%	14.92%
16	Diabetes with Neurologic or Other SpecifiedManifestation1	25.60%	14.63%
131	Renal Failure	57.43%	48.79%
71	Polyneuropathy	19.03%	11.78%
83	Angina Pectoris/Old Myocardial Infarction	20.48%	14.16%
21	Protein-Calorie Malnutrition	17.16%	11.37%
80	Congestive Heart Failure	53.07%	47.50%
55	Major Depressive, Bipolar, and Paranoid Disorders	12.42%	8.08%
18	Diabetes with Ophthalmologic or UnspecifiedManifestation1	8.06%	4.25%
2	Septicemia/Shock	15.50%	12.33%
92	Specified Heart Arrhythmias	32.90%	30.27%
148	Decubitus Ulcer of Skin	13.43%	10.92%
7	Metastatic Cancer and Acute Leukemia	8.12%	6.40%
10	Breast, Prostate, Colorectal and Other Cancers andTumors	7.83%	6.48%
119	Proliferative Diabetic Retinopathy and VitreousHemorrhage	2.31%	1.05%
79	Cardio-Respiratory Failure and Shock	16.92%	15.67%
100	Hemiplegia/Hemiparesis	5.36%	4.28%
130	Dialysis Status	5.04%	3.98%
38	Rheumatoid Arthritis and Inflammatory ConnectiveTissue Disease	5.58%	4.60%



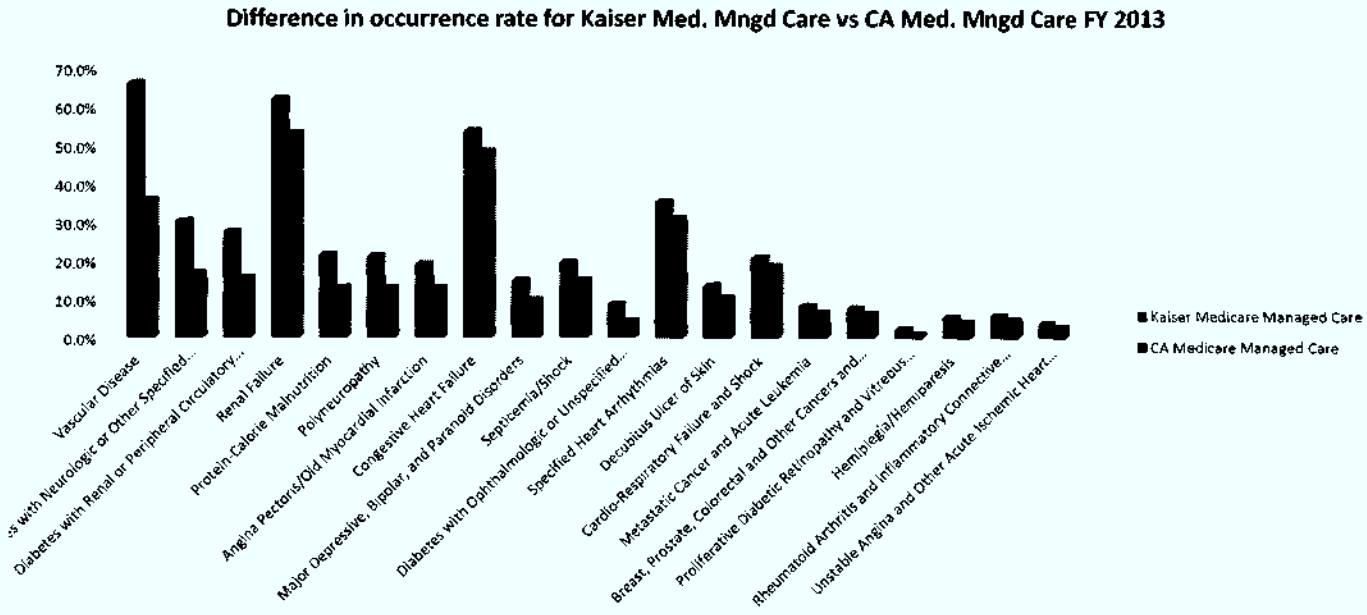
HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Traditional Care
18	Diabetes with Chronic Complications	67.0%	13.6%
108	Vascular Disease	48.4%	12.1%
138	Chronic Kidney Disease, Moderate (Stage 3)	23.1%	5.8%
139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	39.1%	23.8%
75	Polyneuropathy	19.6%	6.3%
21	Protein-Calorie Malnutrition	18.8%	8.9%
2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	32.3%	22.8%
85	Congestive Heart Failure	51.5%	42.7%
96	Specified Heart Arrhythmias	33.3%	26.0%
58	Major Depressive, Bipolar, and Paranoid Disorders	13.6%	6.3%
88	Angina Pectoris	5.3%	0.8%
23	Other Significant Endocrine and Metabolic Disorders	7.2%	3.7%
122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	2.2%	0.1%
22	Morbid Obesity	9.3%	7.2%
12	Breast, Prostate, and Other Cancers and Tumors	5.2%	3.2%
84	Cardio-Respiratory Failure and Shock	14.2%	12.7%
40	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	5.8%	4.3%
10	Lymphoma and Other Cancers	3.7%	2.3%
103	Hemiplegia/Hemiparesis	5.4%	4.0%
8	Metastatic Cancer and Acute Leukemia	7.2%	5.8%



HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Managed Care
18	Diabetes with Chronic Complications	67.0%	37.3%
108	Vascular Disease	48.4%	28.3%
138	Chronic Kidney Disease, Moderate (Stage 3)	23.1%	15.0%
2	Septicemia, Sepsis, Systemic Inflammatory Response Syndrome/Shock	32.3%	24.3%
75	Polyneuropathy	19.6%	12.1%
21	Protein-Calorie Malnutrition	18.8%	12.0%
139	Chronic Kidney Disease, Mild or Unspecified (Stages 1-2 or Unspecified)	39.1%	32.9%
85	Congestive Heart Failure	51.5%	46.3%
58	Major Depressive, Bipolar, and Paranoid Disorders	13.6%	9.1%
96	Specified Heart Arrhythmias	33.3%	30.5%
23	Other Significant Endocrine and Metabolic Disorders	7.2%	4.5%
88	Angina Pectoris	5.3%	2.9%
160	Pressure Pre-Ulcer Skin Changes or Unspecified Stage	9.0%	7.0%
136	Chronic Kidney Disease, Stage 5	11.5%	9.8%
22	Morbid Obesity	9.3%	7.7%
8	Metastatic Cancer and Acute Leukemia	7.2%	5.9%
48	Coagulation Defects and Other Specified Hematological Disorders	8.6%	7.3%
122	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	2.2%	1.0%
103	Hemiplegia/Hemiparesis	5.4%	4.3%
12	Breast, Prostate, and Other Cancers and Tumors	5.2%	4.1%



HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Traditional Care
HCC105	Vascular Disease	66.1%	12.3%
HCC16	Diabetes with Neurologic or Other Specified Manifestation 1,4	30.4%	6.1%
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation 1,4	27.6%	5.1%
HCC71	Polyneuropathy	21.1%	6.6%
HCC131	Renal Failure	62.1%	48.4%
HCC21	Protein-Calorie Malnutrition	21.7%	9.2%
HCC83	Angina Pectoris/Old Myocardial Infarction	19.1%	7.2%
HCC92	Specified Heart Arrhythmias	35.3%	26.4%
HCC80	Congestive Heart Failure	53.7%	45.2%
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	14.9%	6.6%
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation 1,4	8.7%	1.6%
HCC2	Septicemia/Shock	19.5%	14.3%
HCC79	Cardio-Respiratory Failure and Shock	20.8%	17.2%
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	7.8%	4.9%
HCC7	Metastatic Cancer and Acute Leukemia	8.5%	6.0%
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	2.5%	0.1%
HCC148	Decubitus Ulcer of Skin	13.7%	11.4%
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	3.8%	2.0%
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	5.9%	4.2%
HCC100	Hemiplegia/Hemiparesis	5.5%	4.0%



HCC CATEG	HCC Desc	Kaiser Medicare Managed Care	CA Medicare Managed Care
HCC105	Vascular Disease	66.1%	35.8%
HCC16	Diabetes with Neurologic or Other Specified Manifestation 1,4	30.4%	16.7%
HCC15	Diabetes with Renal or Peripheral Circulatory Manifestation 1,4	27.6%	15.5%
HCC131	Renal Failure	62.1%	53.0%
HCC21	Protein-Calorie Malnutrition	21.7%	13.1%
HCC71	Polyneuropathy	21.1%	12.8%
HCC83	Angina Pectoris/Old Myocardial Infarction	19.1%	13.0%
HCC80	Congestive Heart Failure	53.7%	48.3%
HCC55	Major Depressive, Bipolar, and Paranoid Disorders	14.9%	9.8%
HCC2	Septicemia/Shock	19.5%	15.0%
HCC18	Diabetes with Ophthalmologic or Unspecified Manifestation 1,4	8.7%	4.4%
HCC92	Specified Heart Arrhythmias	35.3%	31.2%
HCC148	Decubitus Ulcer of Skin	13.7%	10.3%
HCC79	Cardio-Respiratory Failure and Shock	20.8%	18.6%
HCC7	Metastatic Cancer and Acute Leukemia	8.5%	6.7%
HCC10	Breast, Prostate, Colorectal and Other Cancers and Tumors	7.8%	6.4%
HCC119	Proliferative Diabetic Retinopathy and Vitreous Hemorrhage	2.5%	1.1%
HCC100	Hemiplegia/Hemiparesis	5.5%	4.3%
HCC38	Rheumatoid Arthritis and Inflammatory Connective Tissue Disease	5.9%	4.6%
HCC82	Unstable Angina and Other Acute Ischemic Heart Disease	3.8%	2.9%

EXHIBIT 4

PRIME HEALTHCARE SERVICES
HCC CODING - KAISER VS. ALL OTHER CALIFORNIA HOSPITALS
BASED ON 2013 CMMD DATA

EXHIBIT 5

| Kaiser California | | |

Case 2:15-cv-00201-SMJ ECF No. 148-1 filed 04/12/19 Page 88 of 89 ID#: 2148

United Healthcare of California (UHC of California)						Kaiser		
Year	Title XVIII - Medicare Premiums	Medicare Risk Members	PMPM	% Increase in PMPM	Coding Ajustment Factor Applied	Kaiser PMPM	Kaiser Medicare Risk Members	Excess Payment for Kaiser (Adjusted for the Risk Members)
2007	$3,857,038,000.00	342,173	$939.35	6%		$1,074.14	693,133	$1,121,159,293.92
2008	$3,959,126,000.00	331,644	$994.82	6%		$1,161.02	704,200	$1,404,429,487.33
2009	$4,103,447,000.00	323,873	$1,055.83	6%		$1,179.57	740,173	$1,099,049,733.44
2010	$3,848,251,000.00	303,747	$1,055.77	0%	-3.41%	$1,153.93	782,182	$921,312,571.38
2011	$3,990,628,000.00	307,889	$1,080.10	2%	-3.41%	$1,114.87	825,836	$344,533,588.52
2012	$4,326,863,000.00	326,203	$1,105.36	2%	-3.41%	$1,158.46	894,377	$569,881,724.63
2013	$4,011,753,000.00	330,237	$1,012.34	-8%	-3.41%	$1,175.30	926,127	$1,810,985,066.47
Total								$7,271,351,465.70
Total for 2008 - 2013								$6,150,192,171.78

Inter Valley Health Plan						Kaiser		
Year	Title XVIII - Medicare Premiums	Medicare Risk Members	PMPM	% increase in PMPM	Coding Ajustment Factor	Kaiser PMPM	Kaiser Medicare Risk Members	Excess Payment for Kaiser (Adjusted for the Risk Members)
2007	$131,208,859.00	12,683	$862.10			$1,074.14	693,133	$1,763,646,921.61
2008	$123,870,625.00	12,248	$842.79	-2%		$1,161.02	704,200	$2,689,129,874.84
2009	$130,157,850.00	12,258	$884.85	5%		$1,179.57	740,173	$2,617,684,804.86
2010	$143,336,619.00	14,146	$844.39	-5%	3.41%	$1,153.93	782,182	$2,905,398,147.56
2011	$169,869,477.00	16,558	$854.92	1%	3.41%	$1,114.87	825,836	$2,576,105,845.04
2012	$201,504,134.00	18,341	$915.55	7%	3.41%	$1,158.46	894,377	$2,607,081,126.19
2013	$225,191,470.00	20,237	$927.31	1%	3.41%	$1,175.30	926,127	$2,755,998,195.89
Total								$17,915,044,915.99
Total for 2008 - 2013								$16,151,397,994.38

Aetna Health of California, Inc						Kaiser		
2007	$257,590,453.00	26,199	$819.34			$1,074.14	693,133	$2,119,350,473.56
2008	$315,992,442.00	27,592	$954.36	16%		$1,161.02	704,200	$1,746,359,527.09
2009	$326,103,344.00	27,973	$971.48	2%		$1,179.57	740,173	$1,848,206,016.96
2010	$328,263,418.00	30,548	$895.49	-8%	-3.41%	$1,153.93	782,182	$2,425,793,239.03
2011	$296,552,692.00	23,329	$1,059.31	18%	-3.41%	$1,114.87	825,836	$550,574,447.88
2012	$325,245,507.00	25,049	$1,082.03	2%	-3.41%	$1,158.46	894,377	$820,267,295.93
2013	$306,598,024.00	25,622	$997.18	-8%	-3.41%	$1,175.30	926,127	$1,979,448,372.06
Total								$11,489,999,372.52
Total for 2008 - 2013								$9,370,648,898.96

Blue Cross of California						Kaiser		
2007	$279,339,000.00	27,404	$849.45			$1,074.14	693,133	$1,868,925,691.47
2008	$294,051,000.00	28,202	$868.88	2%		$1,161.02	704,200	$2,468,671,610.81
2009	$301,056,000.00	24,976	$1,004.48	16%		$1,179.57	740,173	$1,555,081,062.78
2010	$231,918,000.00	20,095	$961.76	-4%	-3.41%	$1,153.93	782,182	$1,803,758,064.64
2011	$187,492,000.00	14,236	$1,097.52	14%	-3.41%	$1,114.87	825,836	$171,919,799.66
2012	$154,222,000.00	11,961	$1,074.48	-2%	-3.41%	$1,158.46	894,377	$901,327,305.07
2013	$143,055,000.00	12,223	$975.31	-9%	-3.41%	$1,175.30	926,127	$2,222,507,293.46
Total								$10,992,190,827.90
Total for 2008 - 2013								$9,123,265,136.43

*Healthplans with Title XVIII- Medicare Premiums more than $100,000,000 per year have been used as comparison

UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
CIVIL COVER SHEET

I. (a) PLAINTIFFS (Check box if you are representing yourself ☐)

UNITED STATES OF AMERICA, EX REL, NASER AREFI, AJITH KUMAR, AND PRIME HEALTHCARE SERVICES, INC.

DEFENDANTS (Check box if you are representing yourself ☐)

KASIER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HEALTH PLAN OF COLORADO, KAISER FOUNDATION HEALTH PLAN OF GRORGIA, INC., ET AL

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

County of Residence of First Listed Defendant ALAMEDA
(IN U.S. PLAINTIFF CASES ONLY)

(c) Attorneys (*Firm Name, Address and Telephone Number*) If you are representing yourself, provide the same information.

MARK S. HARDIMAN (SBN 136602), SALVATORE ZIMMITTI (SBN 245678), NELSON HARDIMAN LLP, 11835 WEST OLYMPIC BLVD, SUITE 900, LOS ANGELES CA 90064, TEL: (310) 721-4571,EMAILS: MHARDIMAN@NELSONHARDIMAN.COM, SZIMMITTI@NELSONHARDIMAN.COM

Attorneys (*Firm Name, Address and Telephone Number*) If you are representing yourself, provide the same information.

II. BASIS OF JURISDICTION (Place an X in one box only.)

- ☒ 1. U.S. Government Plaintiff
- ☐ 3. Federal Question (U.S. Government Not a Party)
- ☐ 2. U.S. Government Defendant
- ☐ 4. Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES-For Diversity Cases Only
(Place an X in one box for plaintiff and one for defendant)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated or Principal Place of Business in this State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated and Principal Place of Business in Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. ORIGIN (Place an X in one box only.)

☒ 1. Original Proceeding ☐ 2. Removed from State Court ☐ 3. Remanded from Appellate Court ☐ 4. Reinstated or Reopened ☐ 5. Transferred from Another District (Specify) ☐ 6. Multi-District Litigation

V. REQUESTED IN COMPLAINT: JURY DEMAND: ☒ Yes ☐ No (Check "Yes" only if demanded in complaint.)

CLASS ACTION under F.R.Cv.P. 23: ☐ Yes ☐ No ☒ **MONEY DEMANDED IN COMPLAINT:** $ 14,455,832,951

VI. CAUSE OF ACTION (Cite the U.S. Civil Statute under which you are filing and write a brief statement of cause. Do not cite jurisdictional statutes unless diversity.)

FALSE CLAIMS ACT CASE ON BEHALF OF THE UNITED STATES PURSUANT TO 31 U.S.C. SECTION 3729

VII. NATURE OF SUIT (Place an X in one box only).

OTHER STATUTES
- ☒ 375 False Claims Act
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce/ICC Rates/Etc.
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced & Corrupt Org.
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Info. Act
- ☐ 896 Arbitration
- ☐ 899 Admin. Procedures Act/Review of Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loan (Excl. Vet.)
- ☐ 153 Recovery of Overpayment of Vet. Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment

REAL PROPERTY CONT.
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS: PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Fed. Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury-Med Malpratice
- ☐ 365 Personal Injury-Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

TORTS: PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 American with Disabilities-Employment
- ☐ 446 American with Disabilities-Other
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PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus/Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
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- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Ret. Inc. Security Act

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405 (g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405 (g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS-Third Party 26 USC 7609

FOR OFFICE USE ONLY: Case Number: CV15-07050

ER-1636

UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
CIVIL COVER SHEET

VIII. VENUE: Your answers to the questions below will determine the division of the Court to which this case will be initially assigned. This initial assignment is subject to change, in accordance with the Court's General Orders, upon review by the Court of your Complaint or Notice of Removal.

QUESTION A: Was this case removed from state court? ☐ Yes ☒ No If "no," skip to Question B. If "yes," check the box to the right that applies, enter the corresponding division in response to Question E, below, and continue from there.	STATE CASE WAS PENDING IN THE COUNTY OF:	INITIAL DIVISION IN CACD IS:
	☐ Los Angeles, Ventura, Santa Barbara, or San Luis Obispo	Western
	☐ Orange	Southern
	☐ Riverside or San Bernardino	Eastern

QUESTION B: Is the United States, or one of its agencies or employees, a PLAINTIFF in this action? ☒ Yes ☐ No If "no," skip to Question C. If "yes," answer Question B.1, at right.		
	B.1. Do 50% or more of the defendants who reside in the district reside in Orange Co.? *check one of the boxes to the right* →	☐ YES. Your case will initially be assigned to the Southern Division. Enter "Southern" in response to Question E, below, and continue from there. ☒ NO. Continue to Question B.2.
	B.2. Do 50% or more of the defendants who reside in the district reside in Riverside and/or San Bernardino Counties? (Consider the two counties together.) *check one of the boxes to the right* →	☐ YES. Your case will initially be assigned to the Eastern Division. Enter "Eastern" in response to Question E, below, and continue from there. ☒ NO. Your case will initially be assigned to the Western Division. Enter "Western" in response to Question E, below, and continue from there.

QUESTION C: Is the United States, or one of its agencies or employees, a DEFENDANT in this action? ☐ Yes ☒ No If "no," skip to Question D. If "yes," answer Question C.1, at right.		
	C.1. Do 50% or more of the plaintiffs who reside in the district reside in Orange Co.? *check one of the boxes to the right* →	☐ YES. Your case will initially be assigned to the Southern Division. Enter "Southern" in response to Question E, below, and continue from there. ☐ NO. Continue to Question C.2.
	C.2. Do 50% or more of the plaintiffs who reside in the district reside in Riverside and/or San Bernardino Counties? (Consider the two counties together.) *check one of the boxes to the right* →	☐ YES. Your case will initially be assigned to the Eastern Division. Enter "Eastern" in response to Question E, below, and continue from there. ☐ NO. Your case will initially be assigned to the Western Division. Enter "Western" in response to Question E, below, and continue from there.

QUESTION D: Location of plaintiffs and defendants?	**A.** Orange County	**B.** Riverside or San Bernardino County	**C.** Los Angeles, Ventura, Santa Barbara, or San Luis Obispo County
Indicate the location(s) in which 50% or more of *plaintiffs who reside in this district* reside. (Check up to two boxes, or leave blank if none of these choices apply.)	☐	☐	☐
Indicate the location(s) in which 50% or more of *defendants who reside in this district* reside. (Check up to two boxes, or leave blank if none of these choices apply.)	☐	☐	☐

D.1. Is there at least one answer in Column A? ☐ Yes ☒ No	**D.2. Is there at least one answer in Column B?** ☐ Yes ☒ No
If "yes," your case will initially be assigned to the SOUTHERN DIVISION. Enter "Southern" in response to Question E, below, and continue from there. If "no," go to question D2 to the right. →	If "yes," your case will initially be assigned to the EASTERN DIVISION. Enter "Eastern" in response to Question E, below. If "no," your case will be assigned to the WESTERN DIVISION. Enter "Western" in response to Question E, below. ↓

QUESTION E: Initial Division?	**INITIAL DIVISION IN CACD**
Enter the initial division determined by Question A, B, C, or D above: →	WESTERN DIVISION

QUESTION F: Northern Counties?

Do 50% or more of plaintiffs or defendants in this district reside in Ventura, Santa Barbara, or San Luis Obispo counties? ☐ Yes ☒ No

UNITED STATES DISTRICT COURT, CENTRAL DISTRICT OF CALIFORNIA
CIVIL COVER SHEET

IX(a). IDENTICAL CASES: Has this action been previously filed **in this court**? ☒ NO ☐ YES

If yes, list case number(s): _____

IX(b). RELATED CASES: Is this case related (as defined below) to any civil or criminal case(s) previously filed **in this court**?

☒ NO ☐ YES

If yes, list case number(s): _____

Civil cases are related when they (check all that apply):

☐ A. Arise from the same or a closely related transaction, happening, or event;

☐ B. Call for determination of the same or substantially related or similar questions of law and fact; or

☐ C. For other reasons would entail substantial duplication of labor if heard by different judges.

Note: That cases may involve the same patent, trademark, or copyright is not, in itself, sufficient to deem cases related.

A civil forfeiture case and a criminal case are related when they (check all that apply):

☐ A. Arise from the same or a closely related transaction, happening, or event;

☐ B. Call for determination of the same or substantially related or similar questions of law and fact; or

☐ C. Involve one or more defendants from the criminal case in common and would entail substantial duplication of labor if heard by different judges.

X. SIGNATURE OF ATTORNEY (OR SELF-REPRESENTED LITIGANT): M. HARDIMAN DATE: SEPTEMBER 4, 2015

Notice to Counsel/Parties: The submission of this Civil Cover Sheet is required by Local Rule 3-1. This Form CV-71 and the information contained herein neither replaces nor supplements the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. For more detailed instructions, see separate instruction sheet (CV-071A).

Key to Statistical codes relating to Social Security Cases:

Nature of Suit Code	Abbreviation	Substantive Statement of Cause of Action
861	HIA	All claims for health insurance benefits (Medicare) under Title 18, Part A, of the Social Security Act, as amended. Also, include claims by hospitals, skilled nursing facilities, etc., for certification as providers of services under the program. (42 U.S.C. 1935FF(b))
862	BL	All claims for "Black Lung" benefits under Title 4, Part B, of the Federal Coal Mine Health and Safety Act of 1969. (30 U.S.C. 923)
863	DIWC	All claims filed by insured workers for disability insurance benefits under Title 2 of the Social Security Act, as amended; plus all claims filed for child's insurance benefits based on disability. (42 U.S.C. 405 (g))
863	DIWW	All claims filed for widows or widowers insurance benefits based on disability under Title 2 of the Social Security Act, as amended. (42 U.S.C. 405 (g))
864	SSID	All claims for supplemental security income payments based upon disability filed under Title 16 of the Social Security Act, as amended.
865	RSI	All claims for retirement (old age) and survivors benefits under Title 2 of the Social Security Act, as amended. (42 U.S.C. 405 (g))

TAB 30

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

[UNDER SEAL], Plaintiffs, v. [UNDER SEAL], Defendants.	Case No. 1:14-cv-02889 FIRST AMENDED COMPLAINT **FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)**

DOCUMENT TO BE KEPT UNDER SEAL

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

UNITED STATES OF AMERICA, ex rel. DR. JAMES M. TAYLOR, M.D., Plaintiffs, vs. KAISER PERMANENTE, KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HEALTH PLAN OF COLORADO, KAISER FOUNDATION HEALTH PLAN OF GEORGIA, and KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, Defendants.	Case No. 1:14-cv-02889 FIRST AMENDED COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT [31 U.S.C. §§ 3729 et seq.] **FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)** **JURY TRIAL DEMANDED**

Qui Tam Plaintiff-Relator Dr. James M. Taylor, M.D., through his attorneys, on behalf of the United States of America (the "Government," or the "Federal Government"), for his Complaint against Defendants Kaiser Permanente, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest (collectively "Kaiser" or "the Kaiser Defendants") alleges, based upon personal knowledge, relevant documents, and information and belief, as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States of America arising from false and/or fraudulent records, statements, and claims made and caused to be made by Defendants and/or their agents and employees in violation of the federal False Claims Act, 31 U.S.C. § 3729 *et seq*. This *qui tam* case is brought against Defendants for

knowingly defrauding the federal Government in connection with the Medicare program. As alleged below, since at least 2004 to present, Kaiser has knowingly submitted and caused to be submitted to the Centers for Medicare & Medicaid Services ("CMS") false claims for enhanced "risk adjustment" payments. Likewise, Kaiser has knowingly retained overpayments received from CMS for risk adjustment claims that Kaiser later learned, or in the exercise of reasonable care should have learned, were false.

2. Through the MA program, CMS allows private health insurers to set up managed care plans to cover Medicare beneficiaries. CMS pays a monthly capitation rate for each beneficiary enrolled as a member of a Medicare Advantage ("MA") plan. MA plans must then use that money to pay hospitals, physicians, and other health care providers for the services the plan members receive and to cover the plans' administrative expenses. Certain MA plans are also given money to pay for the plan members' prescription drugs. Under both types of plans, CMS adjusts the capitation rate for each beneficiary to reflect that beneficiary's individual demographics (*e.g.*, age and gender), geographic location, and health status.

3. The adjustment for each member's health status is one of the most significant components of the capitation rate. Individuals with multiple and/or serious health conditions account for more health care costs than healthy members. Accordingly, CMS pays a substantially higher capitation rate for members who have been recently treated for one or more serious, expensive diseases or conditions. These increased payments are known as "risk adjustment" payments. On average, CMS pays MA plans close to $3,000 per year for each condition a member has that requires a risk adjustment payment.

4. To receive these risk adjustment payments, MA plans submit claims to CMS each year for each member for each qualifying disease or condition. MA organizations may only

submit risk adjustment claims if the individual patient has been diagnosed with the condition in question, consistent with established coding standards, and there is documentation in the patient's medical record that: (1) the diagnosis was treated or affected treatment; (2) in a face-to-face visit (except for pathology services performed by a pathologist); (3) with an appropriate provider type; and (4) during the proper time period.

5. Since at least 2004 to present, the Kaiser Defendants have perpetrated a systematic fraud on the Medicare Advantage program. They routinely submit false claims to CMS when they know, or in the exercise of reasonable care should know, that: (1) the patients do not have the diagnoses for which a risk adjustment claim was submitted; and/or (2) the diagnosis: a) was neither treated nor affected the treatment provided; b) in a face-to-face visit; c) with an appropriate provider; d) in the year at issue. In addition, the Kaiser Defendants have refused to correct (and refused to reimburse Medicare for) previously submitted risk adjustment claims when they discover, or in the exercise of reasonable care should discover, that those previously submitted claims were false.

6. Through this scheme, Kaiser has defrauded the United States of tens of millions of dollars.

7. Defendants' conduct alleged herein violates the federal False Claims Act. The federal False Claims Act (the "FCA") was originally enacted during the Civil War. Congress substantially amended the Act in 1986—and, again, in 2009 and 2010—to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. The Act was amended after Congress found that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the amendments would create incentives for

individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf.

8. The FCA prohibits, *inter alia*: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; and (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government. 31 U.S.C. §§ 3729(a)(1)(A)-(B), and (G). Any person who violates the FCA is liable for a civil penalty of up to $11,000 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. § 3729(a)(1).

9. For purposes of the FCA, a person "knows" a claim is false if that person: "(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1). The FCA does not require proof that the defendants specifically intended to commit fraud. *Id*. Unless otherwise indicated, whenever the words "know," "learn," discover," or similar words indicating knowledge are used in this Complaint, they mean knowledge as defined in the FCA.

10. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. The FCA requires that the Complaint be filed under seal for a minimum of 60 days (without service on the defendant during

that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

11. Based on the foregoing laws, *Qui Tam* Plaintiff-Relator Dr. James M. Taylor, M.D. seeks, through this action, to recover damages and civil penalties arising from the false or fraudulent records, statements, and/or claims that the Defendants made or caused to be made in connection with false and/or fraudulent claims for inflated Medicare Advantage payments.

II. PARTIES

12. Relator Dr. James M. Taylor, M.D. ("Relator") is a resident of Broomfield, Colorado and an employee of Colorado Permanente Medical Group ("CPMG"). Dr. Taylor joined Kaiser's Colorado branch in 1995 as a clinician, following eight years in private practice in rural Ohio. In the early 2000s, Dr. Taylor became heavily involved with Kaiser's national Electronic Medical Record ("EMR") and physician coding practices. He is a certified professional coder and AHIMA approved ICD-10 trainer.

13. Dr. Taylor was elected to the Board of Directors of CPMG and served as chair for two years. He is currently Kaiser's national co-chair of the Compliance Committee for ICD-10; a member of Kaiser's national Coding Governance Group (the only delegate representing all physicians for the Regions outside of California); and CPMG's Medical Director of Revenue Cycle/Claims. From 2002 to 2007, he served as CPMG's Physician Director of Coding. He is the only physician to have received Kaiser's National Revenue Cycle "Distinguished Leadership" award.

14. He is a nationally recognized speaker on topics such as EMR documentation, coding, and compliance. He has written articles, created webinars, and presented at national conventions for the American Health Information Association, National Health Care Anti-Fraud

Association, Health Care Compliance Association, National Health Care Auditors and Educators Association, and American Association of Professional Coders.

15. Dr. Taylor has unsuccessfully tried, over the course of his employment at Kaiser, to address internally within Kaiser the issues set forth in this Complaint. As described in greater detail below, as he discovered issues with the submission of false risk adjustment claims associated with specific provider types, diagnoses, or other issues, he repeatedly proposed solutions. At times, Kaiser appeared to be taking steps (either implementing his suggestions or taking other steps) to address the problems. Unfortunately, Relator later learned that Kaiser either did not take the steps it had claimed it was taking, or began implementing corrective actions only to stop them later.

16. Defendant Kaiser Permanente is a non-profit managed care consortium headquartered in Oakland, California. The consortium includes three main groups: (1) the Kaiser Foundation Health Plan, Inc. and its subsidiaries; (2) the Kaiser Foundation Hospitals and their subsidiaries; and (3) the Permanente Medical Groups.

17. Kaiser Permanente is one of the largest managed care organizations in the United States. Opened to public enrollment in 1945, it now boasts almost 9.5 million members throughout California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia.

18. Kaiser has over 174,000 employees (including over 17,000 physicians). In 2013, Kaiser reported more than $53 billion in operating revenue.

19. Kaiser offers Medicare HMO plans, called “Kaiser Permanente Senior Advantage Plans,” in California, Colorado, Georgia, Hawaii, Oregon, and Washington.

20. Some regions, such as California, operate using almost exclusively Kaiser affiliated medical providers. In these regions, Kaiser owns or controls the hospitals and physician offices that provide services to members of Kaiser's insurance plans. In other regions, such as Colorado, Kaiser maintains more limited provider resources. For example, in Colorado, Kaiser's members are seen by physicians in CPMG, a Kaiser affiliate. But because Kaiser has no hospitals in Colorado, when members require inpatient or outpatient care, they are seen by non-Kaiser hospitals with whom Kaiser has contracted to provide care to its members.

21. Defendant Kaiser Foundation Health Plan, Inc. is a non-profit health maintenance organization ("HMO") headquartered in Oakland, California.

22. Defendant Kaiser Foundation Health Plan of Colorado is a non-profit HMO headquartered in Denver, Colorado. It has over 585,000 members, 28 medical offices, and 7,000 staff and physicians. CPMG, a multi-specialty physician group of over 1,000 physicians, contracts with Defendant Kaiser Foundation Health Plan of Colorado to provide medical care to its members.

23. Defendant Kaiser Foundation Health Plan of Georgia is a non-profit health plan headquartered in Atlanta, Georgia. It has over 270,000 members and over 20 affiliated hospitals and medical centers. The Southeast Permanente Medical Group, a multi-specialty physician group of over 450 physicians, contracts with Defendant Kaiser Foundation Health Plan of Georgia to provide care to its members.

24. Defendant Kaiser Foundation Health Plan of the Northwest is a non-profit HMO headquartered in Portland, Oregon. It has over 480,000 members and is affiliated with over 900 physicians at hospitals and medical centers throughout Oregon and Washington.

III. JURISDICTION AND VENUE

25. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

26. Under 31 U.S.C. § 3730(e) there has been no statutorily relevant public disclosure of the "allegations or transactions" in this Complaint. Even if there had been any such public disclosure, Relator is the original source of the allegations herein because he has direct, independent, and material knowledge of the information that forms the basis of this Complaint, and voluntarily disclosed that information to the Government before filing.

27. This Court has personal jurisdiction over the Defendants, pursuant to 31 U.S.C. §3732(a), as one or more Defendants can be found in, reside in, transact business in, and have committed acts related to the allegations in this Complaint in the District of Colorado.

28. Venue is proper, pursuant to 31 U.S.C. § 3732(a), as one or more Defendants can be found in, reside in, and/or transact business in the District of Colorado, and because many of the violations of 31 U.S.C. § 3729 discussed herein occurred within this judicial district.

IV. LEGAL BACKGROUND

A. Medicare

29. Medicare is a federally-funded health insurance program which provides for certain medical expenses for persons who are over 65, who are disabled, or who suffer from End Stage Renal Disease. The Medicare program is administered through the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS").

30. The Medicare program has four parts: Part A, Part B, Part C and Part D. Medicare Part A ("Part A"), the Basic Plan of Hospital Insurance, covers hospital services and

post-hospital nursing facility care. Medicare Part B ("Part B"), the Voluntary Supplemental Insurance Plan, covers services performed by physicians and certain other health care providers, such as services provided to Medicare patients by physicians, laboratories, and diagnostic testing facilities. *See* 42 U.S.C. §§ 1395k, 1395l, 1395x(s). Medicare Part C ("Part C") refers to Medicare's managed care plans. Medicare Part D ("Part D") provides subsidized prescription drug coverage for Medicare beneficiaries.

1. Medicare Managed Care (Parts C and D)

31. Traditionally, Medicare operates on a fee-for-service basis, meaning that Medicare directly pays hospitals, physicians, and other health care providers for each service they provide to a Medicare beneficiary.

32. In 1997, Congress created Medicare Part C, which provides similar benefits to Medicare members, but does so based on a managed care model, rather than the traditional fee-for-service model. Under Part C, rather than pay providers directly, Medicare pays private managed care plans (later named "Medicare Advantage" or "MA" plans) a capitation rate (per member per month) and those plans are responsible for paying providers for the services they provide to members of that specific MA plan.

33. In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act, creating Medicare Part D which provides prescription drug coverage. Although a limited number of Medicare Part D plans are operated under a cost-reimbursement contract, the plans are generally financed under a managed care model. These managed care model plans are provided under both Part D prescription drug plans, which offer only prescription drug coverage, and Part C plans, which integrate the prescription drug coverage with the Part C health care coverage.

34. This Complaint refers, collectively, to Medicare Advantage plans with and without Part D coverage, and stand-alone managed care Medicare Part D Plans as "Medicare Advantage Plans" or "MA Plans."

a. Risk Adjusted Capitation Payments and Claims Submission

35. CMS pays MA plans a monthly capitation rate that reflects, among other things, each member's health status. The process of adjusting the capitation rate to reflect a member's disease states is known as risk adjustment. Risk adjustment is intended to improve the accuracy of the payments CMS makes to these plans. To this end, CMS pays a higher rate for enrollees whom the MA plan represents were treated for certain diseases and conditions in the previous year, based on the expectation that those enrollees will require treatment and/or management for the conditions in the payment year. *See* 2008 Risk Adjustment Training for Medicare Advantage Organizations Participant Guide ("*Participant Guide*"), at 6.4.1 (for purposes of this Complaint, "treatment" is defined as treatment and management within the meaning of the *Participant Guide*).

36. Conversely, CMS pays a lower rate for enrollees who, although they may have certain typically expensive conditions, did not require care, treatment, or management for those conditions in the prior year. For these members, the risk adjustment methodology assumes that because their condition did not require treatment in the prior year, it has improved or otherwise changed so that it is not expected to require treatment in the payment year.

37. The CMS risk adjustment model evaluates enrollee health (and establishes risk adjustment payment rates) using diagnosis classifications set forth in the International Classification of Diseases, 9th Edition, Clinical Modification ("ICD-9") system. The ICD-9 system assigns each diagnosis a specific code, which is "used to describe the clinical reason for a

patient's treatment." *Participant Guide* at 6.2. Under the MA model, these individual diagnosis codes are organized into groups, called Hierarchical Condition Categories ("HCCs"). Medicare Managed Care Manual ("MMCM"), ch. 8, § 50. Every HCC consists of several ICD-9 diagnosis codes that are clinically related and are expected to require a similar level of resources to treat. *Id*. Seemingly similar diagnoses may fall into different HCCs when they are expected to require significantly different levels of treatment.

38. CMS uses the same general model for the Part D portion of risk adjustment. However, because certain diagnoses will be expected to require higher spending for prescription drugs covered under Part D, but not hospital costs and physician fees covered under Part C, and vice versa, a distinct list of Hierarchical Condition Categories ("RxHCCs") with corresponding diagnosis codes was created for Medicare's Part D risk adjustment. *See Participant Guide* at 8.2.5.2. For example, RxHCC 75 represents Attention Deficit Disorder, a condition predicted to increase drug spending. However, because Attention Deficit Disorder is unlikely to result in hospitalization, RxHCC 75 has no corresponding HCC. On the other hand, HCC 77, Respirator Dependence/ Tracheostomy Status, a condition category predictive of Medicare Part C medical costs but not necessarily predictive of Part D drug expenses, has no RxHCC equivalent.

39. Although the HCC and RxHCC systems are not identical, they do have significant overlap. Certain HCCs have equivalent RxHCCs, meaning that the condition categories consist of identical ICD-9 diagnosis codes. For example, HCC 5 (Opportunistic Infections) is equivalent to RxHCC 2 (Opportunistic Infections), and HCC 37 (Bone/Joint/Muscle Infections/Necrosis) is equivalent to RxHCC 39 (Bone/Joint/Muscle Infections/Necrosis). Even where they are not identical, most HCCs overlap with one or more RxHCCs. For example, of the thirty-seven diagnosis codes that fall within HCC 45 (Disorders of Immunity), twenty-seven fall within

RxHCC 52 (Disorders of Immunity), seven fall within RxHCC 51 (Severe Hematological Disorders), and three do not fall within any RxHCCs. Thus, the majority of ICD-9 diagnosis codes that fall into an HCC will also fall into an RxHCC.

40. An individual ICD-9 code included in the HCC system for a particular member corresponds on average to nearly $3,000 in extra revenue for the plan per year.

41. Generally speaking, an MA Plan may only submit a risk adjustment claim for a diagnosis that has been properly coded per ICD-9 standards. *See* 42 C.F.R. § 422.310(d)(1) (risk adjustment data must conform to national standards); *Participant Guide* at 7.1.5 (diagnoses must be "[c]oded in accordance with the ICD-9-CM Guidelines for Coding and Reporting").

42. In addition, a risk adjustment claim may only be submitted if the diagnosis meets four additional requirements. First, the diagnosis must have been treated or affected treatment provided to the patient. *See Participant Guide* at 7-14 ("Code all documented conditions that coexist at time of the encounter/visit, and require or affect patient care treatment or management."); *id*. at 6-4.1 ("Physicians should code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management." (emphasis added)); *id*. at 7-13 ("for hospital inpatient stays . . . diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded").

43. Second, the diagnosis must have been treated (or affected treatment provided) during a face-to-face visit between the provider and the patient (unless the provider is a pathologist). *See Participant Guide* at 7.1.4 ("As a principal risk adjustment rule, risk adjustment diagnoses submitted for enrollees must be supported by medical record documentation and based on a face-to-face encounter."); *id*. at 7.1.5 (Diagnoses must be "based on a face-to-face health service encounter").

44. Third, the provider rendering the service must be a qualified provider type or specialty. *See Participant Guide* at 2.2.1, 3.1.4, 3.2, 4.3, 4.7, 4.11 (risk adjustment diagnoses can come from three broad categories: hospital inpatient facilities, hospital outpatient facilities, and certain physician and physician extender specialties); *see also id.* at 6.1 (MA plans must "[i]mplement procedures to ensure that diagnoses are coming from physician, hospital inpatient, or hospital outpatient provider types."). CMS has enumerated the physician specialties that are an acceptable source of diagnoses for risk adjustment purposes. *See id.* at 3.2.3 ("Only those physician specialties and other clinical specialists identified in Table 3H are acceptable for risk adjustment."). Certain non-physician professionals are also acceptable provider types for risk adjustment, including, *inter alia*, physical therapists, occupational therapists, and physician assistants. *Id* at 3.2.3.

45. Fourth, the service used as the basis for the risk adjustment claim must have occurred during the calendar year preceding the payment year. *See Participant Guide* at 7-11 ("Do not submit medical records for date(s) of service that occurred outside of the data collection period."); *id*. at 7.2.4.1 (Unacceptable medical record documentation includes "documentation for dates of service outside the data collection period"); *id.* at 2.2.1 ("All beneficiary ICD-9-CM diagnosis codes required for the CMS-HCC risk adjustment model must be reported at least once per enrollee in the data collection period."); *id*. at 6.4.1 ("[C]o-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.").

46. CMS has offered specific additional guidance regarding certain practices or diagnoses known to be at particular risk of abuse. For example, clinicians frequently use what are known as "problem lists" to track diagnoses a patient has had in the past or that the treating

provider believes the patient may have. For ease of use, a physician may copy the problem list into the patient chart during an encounter with a patient. This allows the physician to consider whether any issues on the problem list require assessment or treatment or are otherwise clinically relevant. However, in most cases, the fact that a diagnosis appears on a problem list does not in and of itself indicate the physician's judgment that the diagnosis was relevant to the clinical encounter. This is because diagnoses may appear on problem lists for many reasons, including for the purpose of ruling out a diagnosis. For this reason, CMS requires that if a diagnosis from a problem list is submitted for risk adjustment purposes, the list must be comprehensive "and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service." *Id*. at 7-17.

47. However, for chronic conditions such as diabetes, which affect "all but the most minor of medical encounters," as well as chronic conditions such as multiple sclerosis, which "may not impact every minor healthcare episode," the documentation need only reflect that the condition was "part of a general overview of the patient's health when treating co-existing conditions" or was otherwise "evaluated" by the provider. *Id*. at 6.4.1.

48. Another common source of false risk adjustment claims is erroneous application of the rule for coding conditions which were previously treated, but are currently cured, in remission, or otherwise inactive. In such cases, the provider should not code the diagnosis as active when in fact the patient only has a "history of" the diagnosis. For example, a diagnosis of "history of stroke" or "history of cancer," does not risk adjust (*i.e.*, may not be used to support a claim for risk adjustment payments). However, a diagnosis of active cancer or a stroke occurrence will risk adjust. Because of this, CMS requires clinical specificity and that

physicians code "the correct forms and manifestations of diseases and conditions," including whether the patient has an active condition or a history of such. *Id*. at 6.4.3, 6-8.

49. CMS rules also prohibit the submission of risk adjustment claims for diagnoses that are unconfirmed, unless the treating provider was a hospital inpatient department. *Id*. at 6.4.2 ("Physicians and hospital outpatient departments shall not code diagnoses documented as 'probable,' 'suspected,' 'questionable,' 'rule out,' or 'working.'").

50. The risk adjustment claims that the MA Plan submits to CMS must include:

(a) the member's Health Insurance Claim ("HIC") number;

(b) the ICD-9 diagnosis code;

(c) the "service from" date;

(d) the "service through" date; and

(e) the provider type (*e.g.*, hospital inpatient, hospital outpatient, physician).

51. MA plans are responsible for the content of their risk adjustment claims submissions to CMS, regardless of whether they submit the data themselves or through an intermediary. *Participant Guide*, at 3-13. Before submitting data to CMS, MA plans are required to filter the data "to ensure that they submit data from only appropriate data sources." *Id*. at 4-11. For example, filters should include checking that physician data comes from face-to-face encounters with members and ensuring that data does not come from non-covered providers, such as diagnostic radiology services.

52. MA plans are required to correct the risk adjustment data they submit to CMS. When an MA plan learns that information in a risk adjustment claim (*i.e.*, HIC number, diagnosis

code, service dates, or provider type) contains an error, it must submit a "delete record" to CMS for that claim.

53. To test the validity of MA plan risk adjustment data, CMS conducts Risk Adjustment Data Validation ("RADV") audits after the final deadline for submitting risk adjustment data for the payment year. During such audits, CMS "validates" some of the MA plan's HCC scores by reviewing the medical records that the plan contends support the claimed diagnosis codes. *Id*. at 7-1. To facilitate the RADV audits, MA plans are required to submit to CMS medical records and coversheets for each sampled enrollee. Until February 2012, MA plans were required to include the "one best medical record" supporting each HCC. *Id*. at 7-9. Beginning with the CY 2011 RADV audit, CMS began allowing audited MA contracts to submit multiple medical records for each HCC being validated. CMS, *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits*, February 24, 2012.

b. CMS Requires MA Plans To Certify the Validity of Their Bid Rates and Risk Adjustment Data To Prevent Fraud

54. CMS requires MA organizations to submit attestations, each signed by the CEO or CFO (or their authorized, direct subordinate), certifying the accuracy of their risk adjustment submissions. These attestations are a condition that the MA plans must meet to be eligible to receive any capitation payments from CMS.

55. The first attestation, which is submitted annually, requires the MA organization to attest that the risk adjustment data it submits annually to CMS is "accurate, complete, and truthful." The attestation acknowledges that risk adjustment information "directly affects the calculation of CMS payments . . . and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution." The regulations also

provide that if the claims data are generated by a "related entity, contractor, or subcontractor of an MA organization," that entity must similarly certify the "accuracy, completeness, and truthfulness of the data." 42 C.F.R. § 422.504(l)(2).

56. Kaiser Colorado CFO Rick Newsome signs this attestation for Kaiser Colorado. Mr. Newsome typically has his subordinates, such as Relator, sign "sub-attestations" concerning their knowledge of the validity of the data. At times, Relator has signed such attestations, based on his then-belief that Kaiser was taking steps to fix the problems he had identified. However, in approximately 2011, Relator refused to sign the sub-attestation because he learned that Kaiser had not followed through on promised corrective actions. The Kaiser employee responsible for collecting the sub-attestation responded by saying: "I'll just get another person to sign it."

57. In subsequent years, Relator signed the attestations only after assurances that additional corrective actions had been or would be taken. Unfortunately, Relator has come to the conclusion that Kaiser does not intend to correct the problems described in this Complaint, to stop submitting false claims of the type described herein, or to repay the United States for the overpayments that Kaiser knows, or in the exercise of reasonable care would know, it has received due to previously submitted false claims.

58. In addition, the MA organization (and any third-party submitters) must sign an Electronic Data Interchange ("EDI") Enrollment Form prior to submitting risk adjustment data to CMS. The EDI Enrollment Form is a contract between the MA organization and CMS attesting to the accuracy of the data submitted. *Participant Guide* at 4.1. The MA organization attests on the Form "[b]ased on best knowledge, information, and belief," that it will submit risk adjustment data that are accurate, complete, and truthful.

V. ALLEGATIONS

A. Kaiser Has Knowingly Submitted False Claims for Risk Adjustment Payments and Improperly Retained Such Payments

59. The Kaiser Defendants have engaged in a deliberate scheme to defraud the United States by submitting thousands of false claims for risk adjustment payments to CMS. Kaiser has submitted and caused the submission of these claims for risk adjustment payments even though it knew, or in the exercise of reasonable care should have known, that the Medicare patients upon whom the claims were based did not have the claimed diagnoses, had not been treated for those diagnoses in the prior year in a face-to-face visit with an appropriate provider type, or that the claims were otherwise ineligible for risk adjustment payments under CMS rules.

60. As outlined below, Kaiser routinely conducted national, regional, and diagnosis-specific audits to determine the accuracy of its risk adjustment claims submissions. These audits regularly identified categories of claims (often, specific diagnoses) that had high rates of falsity. Notwithstanding this knowledge, Kaiser rarely took even minimal steps to filter its claims to prevent submission of these claims, or to audit prior submissions to find the previously submitted false clams.

61. The limited steps Kaiser did take, when it did so, to filter certain diagnoses further confirmed that physicians often upcoded those diagnoses, leading (absent intervention) to the submission of false claims. Despite this knowledge, Kaiser did not apply this filter to its prior years' submissions for these overcoded diagnoses.

62. This lack of diligence contrasts starkly with Kaiser's considerable efforts and substantial commitment of resources to audit current and past claims to identify new diagnoses that it could use to submit additional risk adjustment claims and thereby increase the amount of the risk adjustment payments it receives from CMS.

63. Kaiser's refusal to take reasonable steps to prevent the submission of false claims, and to make a reasonable inquiry into previously submitted false claims, constitutes reckless disregard as to, and/or deliberate ignorance of, the falsity of those claims.

64. So too, in certain instances, Kaiser had actual knowledge that specific claims it previously submitted to CMS were false. Kaiser's refusal to delete those claims and refund the resulting overpayments to the United States also constitutes a violation of the False Claims Act.

65. Although many of the representative examples detailed below are for Kaiser's Colorado Region, Relator has information and believes, based on reports he has reviewed showing audit results for other regions and Kaiser nationally, his attendance at Regional Reporting Group ("RRG") Meetings, and work with employees in other Kaiser regions, and on that basis alleges, that some or all of Kaiser's other regions knowingly submitted false risk adjustment claims for similar reasons and for similar diagnosis codes as Kaiser Colorado. The Regional Reporting Groups are comprised of representatives from each Kaiser Region who are responsible for conducting audits and other initiatives related to risk adjustment. Relator regularly attended the twice-annual RRG meetings held to discuss risk adjustment issues faced by the various regions. Therefore, Relator has knowledge about the risk adjustment practices and audit results of every Kaiser region.

66. On the basis of reviewing the audit results for other regions and Kaiser nationally, his attendance at RRG Meetings and work with employees in other Kaiser regions, Relator alleges on information and belief that at all times material to this action, i.e., from at least 2004 to present, the fraudulent risk adjustment practices identified herein regarding Colorado were typical of the Kaiser Defendants at some or all of its other regions, including without limitation, Georgia, Hawaii, Oregon and Washington.

67. In addition, although many of the representative examples detailed below cover HCCs rather than RxHCCs, to the extent that Kaiser's audits also covered RxHCCs (which many of them did), they identified similar patterns of knowing submission of false claims for RxHCCs.

68. On this basis, Relator alleges that Kaiser has submitted, and fraudulently refused to delete and repay CMS for, tens of thousands of risk adjustment claims, that it knows, within the meaning of the False Claims Act, are false and/or fraudulent.

1. Kaiser Knows It Is Routinely Submitting False Risk Adjustment Claims to CMS

69. Every year, Kaiser's National Compliance Office ("NCO") conducts a nationwide "Probe" audit to test the accuracy of risk adjustment claims submitted the prior year. The NCO chooses the patients and/or diagnoses to be audited but each region conducts the audit work. Kaiser deliberately designs these audits so that the sample size is too small for the results to be used for statistically significant extrapolation with respect to the error rates for individual HCCs. Instead, it is intended to provide an overall accuracy rate, by region, and to serve as a "flag" or "tripwire" to identify potential problems with individual HCCs.

70. In addition to the annual Probe Audits, Kaiser conducted nationwide audits in anticipation of CMS's Risk Adjustment Data Validation ("RADV") audits. These pre-RADV audits routinely identified similar problems as the Probe Audits.

71. Although these Probe and other audits show an overall trend of increasing accuracy in risk adjustment claims across Kaiser, and for each of its regions, the audits have identified many errors and put Kaiser on notice that it has submitted and continues to submit a substantial number of false risk adjustment claims each year.

72. For the Colorado region, the annual Probe Audits identified the following error rates (including both HCCs and RxHCCs) between 2007 and 2013:

Year	Total HCCs Audited	Errors	Error Rate
2007	207	25	12%
2008	131	19	15%
2009	330	38	12%
2010	428	70	16%
2011	395	55	14%
2012	398	29	7%
2013	238	21	9%

73. Kaiser's audits of other regions, and of national error rates, showed similar results. For example, in both 2006 and 2007, Kaiser conducted pre-RADV audits. Kaiser's audits found an error rate of between 14% and 16% (depending on how strictly certain rules were applied).

74. These Probe, pre-RADV and other ad hoc audits show consistent errors in certain types of risk adjustment claims across the Kaiser system. For example, many of the errors in the 2006 and 2007 national RADV audits were for issues or diagnoses that repeatedly show up as upcoded in subsequent Probe Audits in Colorado and elsewhere, such as coding historical conditions as active, improperly coding based on probable, suspected or rule out diagnoses, and coding for specific diagnoses such as cancer, arrhythmia, stroke, vascular disease, ulcers, vertebral fractures, major depression, and diabetes with complications.

75. In 2010, Kaiser's Northern California Region audited data in its claims systems for care provided to patients in 2009. Of the "Top Ten Failed HCCs by Volume" were several that the Colorado region also found to be routinely problematic, including HCCs for cancer, stroke, arrhythmia, and vascular disease. This audit will be discussed in greater detail below.

76. Examples of risk adjustment claims that the Kaiser audits have identified as routinely false include: (a) false claims submitted based on diagnoses from external providers, (b) high rates of diagnosis specific false claims identified during the Probe Audits; (c) false claims submitted due to other process-based coding violations; and (d) diagnoses that Kaiser identified as upcoded through the use of its "high risk" filter program. These examples (described below) are illustrative of the types of false claims of which Kaiser had knowledge but they do not include each and every false claim.

77. As described in sections V.A.2 and V.A.3. below (paragraphs 162 -183), despite its knowledge that the categories of risk adjustment claims described below are false a significant percentage of the time, Kaiser routinely fails to take reasonable steps to identify which of these claims are false (*i.e.*, Kaiser does not extend its review beyond the discrete audit sample and into previous years' claims submissions), and then to prevent their submission in the first place or to delete them after submission. Instead, Kaiser's reaction to this knowledge on a national and regional level has been (except in isolated instances) to avoid conducting retrospective audits to correct previously submitted false data.

a. False Claims Submitted Based On Diagnoses from External Providers

78. Several of Kaiser's regions rely heavily on external providers (hospitals or other facilities who are not owned by Kaiser) to provide inpatient care to Kaiser's HMO members. These regions include Colorado, Hawaii, and, until recently, Georgia.

79. These external providers submit claims to Kaiser for services provided to Kaiser members. Kaiser then uses the diagnoses from these claims as the basis for risk adjustment claims Kaiser submits to CMS.

80. Kaiser Colorado relies on diagnoses submitted by external providers to support 10% to 13% of its risk adjustment claims.

81. Kaiser's Probe and other audits have identified significant error rates in risk adjustment claims Kaiser submitted to CMS based on diagnoses provided by external providers.

82. For example, for the Colorado region, the error rates for internal providers were as follows:

Year	Internal HCCs Audited	Errors	Error Rate
2007	156	14	9%
2008	119	11	9%
2009	277	29	10%
2010	371	47	13%
2011	341	28	8%
2012	370	18	5%
2013	227	14	6%

83. The error rates for external providers have been up to ten times higher:

Year	External HCCs Audited	Errors	Error Rate
2007	51	11	22%
2008	12	8	67%
2009	53	9	17%
2010	57	23	40%
2011	54	27	50%
2012	28	11	39%
2013	11	7	64%

.

84. The error rates for certain large hospitals in particular are striking. For example, the 2011 Probe Audit found that:

a. Exempla Good Samaritan Medical Center had an error rate of 93% (13 of 14 HCCs reviewed were erroneous);

b. Exempla Lutheran Medical Center had an error rate of 100% (4 of 4 HCCs reviewed were erroneous);

c. Exempla St. Joseph Hospital had an error rate of 67% (24 of 36 HCCs reviewed were erroneous);

d. Pueblo Clinic had an error rate of 92% (11 of 12 HCCs reviewed were erroneous); and

e. Swedish Medical Center had an error rate of 73% (8 of 11 HCCs reviewed were erroneous).

85. In the 2012 Probe Audit, Exempla St. Joseph again showed an elevated error rate of 42% (5 of 12 HCCs were wrong).

86. In the 2010 Probe Audit, Exempla Good Samaritan had an error rate of 40% (4 of 10 HCCs), Exempla St. Joseph had an error rate of 53% (9 of 17 HCCs), and Swedish Medical Center had an error rate of 40% (2 of 5 HCCs).

87. The Exempla chain hospitals are the primary providers of inpatient care for Kaiser patients in Colorado, making their consistently elevated error rates of particular concern. This is not just a problem in the Colorado Region. Because diagnoses submitted by external providers are known to be a significant source of errors across the Kaiser regions, most Kaiser regions subject diagnoses submitted solely by external providers to enhanced scrutiny. The Northern California, Hawaii, and Northwest Regions review all (or nearly all) HCCs that are supported only by a diagnosis from an external provider. The Georgia and Southern California regions conduct targeted samples of some claims provided by certain high volume external providers.

88. Kaiser Colorado's executives are aware that this is a continuing issue. For example, the Kaiser CFO, CPMG Associate Medical Director (Vice President), CPMG CFO, and Executive Director of Revenue Cycle have all been present at meetings where the results of annual Probe Audits were discussed.

89. Moreover, around late 2011, Treska Francis, the leader of the Kaiser Colorado coder group, personally performed an audit of about 100 diagnoses received from Exempla St. Joseph's Hospital and Exempla Good Samaritan Medical Center. She found a 40% to 60% error rate. She reported this to her boss, the Manager of Medicare Risk Business Services, who

ignored the report. Treska then reported the problem to her boss' boss, Tom Rennell, Executive Director of Revenue Cycle for Kaiser Colorado. Mr. Rennell told her to "leave it alone."

90. Later, at Relator's urging, Kaiser Colorado began another audit of external hospitals. The audit was supposed to cover three southern Colorado hospitals. One hospital refused to participate. The initial results from the other two hospitals (18% of the 357 diagnoses audited at St. Thomas More Hospital were invalid; 20% of the 678 diagnoses at Memorial Hospital were invalid) were described in the Kaiser Colorado Medicare Initiative Meeting as "unsettling" and "disturbingly high." Relator does not know if the audit was ever completed, but the final results were never released.

91. Despite knowing of the consistent errors in claims data from external providers, Kaiser Colorado does not conduct any routine targeted audits of claims submitted by external providers. This is particularly egregious because the Colorado region does have a coder review each hospital stay at an external provider to look for additional diagnoses present in the chart but not coded by the treating physician. These coders do not attempt to validate the codes submitted by the hospital. These are simply passed through to CMS for payment.

92. For years, Relator has requested that a filter be created to tag high-risk codes from external providers for review. Instead, Kaiser Colorado created a filter to review codes received from internal providers.

93. Moreover, despite Kaiser Colorado's consistent problems with data from external providers, it has not performed larger audits or instituted a pre-submission review. In fact, Kaiser Colorado's only action appears to have been to attempt to stop reporting error rates associated with data from external providers separately from error rates associated with data from internal providers, so as not to call attention to the problem. The initial version of the 2013

Probe Audit did not identify whether errors were from internal or external providers. Relator insisted that the audit be reopened and amended to add this information.

b. High Rates of False Claims Identified During Probe Audits

94. The following are examples of diagnoses and HCCs identified as frequently upcoded during Kaiser's Probe Audits. Although Relator has the most knowledge about the Probe Audit results from the Colorado Region, he also knows, from his attendance at RRG meetings and work with other Kaiser regions, that these HCCs often were found to be upcoded in other regions as well. Moreover, these are not all of the problematic HCCs that were identified for either the Colorado Region or for other regions; instead, they are representative examples of some of the top problems Relator identified and are illustrative of the types of false claims that, during the times relevant to this action (i.e., from 2004 to present), Kaiser submitted to CMS.

95. **Cancer**: Kaiser's Probe Audits have consistently identified cancer (HCCs 7 – 10) as the most upcoded condition. Improper claims for diagnoses of active cancer have shown up in every single Probe Audit from 2006 to 2013.

96. The most significant and consistent error is that Kaiser providers submit diagnosis codes representing active, current treatment of cancer when, in fact, the patient's cancer is cured, in remission, or otherwise irrelevant to the services provided to the patient.

97. A diagnosis of cancer is permissible under the ICD-9 coding guidelines when there is evidence of active disease. Where a diagnosis of active cancer appears, one would expect to see evidence of treatment (chemotherapy, radiation, surgery, or palliative care) in the patient's medical chart as well.

98. Once there is no evidence of an existing malignancy, the proper diagnosis code is for "history of cancer." "History of cancer" diagnoses fall within the v10 category of HCC codes and do not risk adjust.

99. Colorado is not the only Kaiser region to have significant problems with the submission of false risk adjustment claims for cancer. At RRG meetings attended by Relator, all other Kaiser regions have noted that they also consistently find high error rates in their risk adjustment claims where a patient has a history of cancer improperly coded as active cancer. This is consistently the biggest issue in the annual Probe Audits across the Kaiser organization.

100. The source of these errors is in part historical. Kaiser's physician groups, since 2004, have used an EMR system called HealthConnect. When Kaiser first launched HealthConnect, physicians could not easily enter a diagnosis of "history of cancer" – it simply was not an option in the drop-down menu of diagnoses. Instead, physicians would code a diagnosis of active cancer and note "history of" in the comments field. Although Kaiser has long known this is a problem, when the data from these charts is filtered for submission to CMS, only the diagnosis code of active cancer is submitted and the notation of "history of" is ignored for purposes of data submission to CMS.

101. Although HealthConnect (Kaiser's EMR) now has "history of" codes available, physicians are still accustomed to documenting "history of cancer" in this way (*i.e.*, coding active cancer and noting "history of cancer" in the comments field).

102. In an attempt to identify how big a problem this was, in 2007 Dr. Taylor conducted an audit of over 6,000 risk adjustment claims for Breast or Prostate cancer submitted by CPMG physicians in 2006 and 2007. The audit showed an error rate of 78% for breast cancer and 52% for prostate cancer, resulting in more than $6 million dollars in false claims. Kaiser

deleted the false claims identified in this audit and, accordingly, refunded the overpayments to CMS.

103. Based on these findings, Relator convinced Kaiser Colorado to make changes to its EMR system to try to "prompt" physicians to change their coding behavior. HealthConnect, Kaiser's EMR, was modified so that every time a CPMG physician entered a diagnosis of cancer an alert would pop up, offering a brief explanation of when a diagnosis of active cancer is appropriate and ensuring that was the intended diagnosis as opposed to history of cancer. For example, the breast cancer pop up said:

> "DISEASE MANAGEMENT REMINDER: To use this diagnosis, you must have documented in your note that the cancer is active or exists and/or the current treatment for the cancer.
>
> ACTION: IF NOT ACTIVE, use History of Breast Cancer – enter Hx Breast in the Encounter Diagnosis field to select."

104. The use of this pop-up alert reduced the error rate substantially – to an accuracy rate of 96% for breast cancer and 93% for prostate cancer.

105. Unfortunately, this fix was short-lived. In 2010, Kaiser turned off the alert and replaced it with a limited internal filter. This "filter" program is discussed in greater detail below.

106. With the manual review associated with the filter, the error rate in Kaiser Colorado for improper cancer diagnoses remained below the error rates seen before the alert was implemented. However, in late 2011 or early 2012, Kaiser Colorado decided to turn off the filter to save money and coding resources. As shown by the Probe Audits since, the error rate for

cancer diagnoses has rebounded. Despite the fact that the alert and filter were obviously preventing the submission of false claims, Kaiser has not turned either back on.

107. Moreover, despite the substantial volume of cancer HCC submissions, and increased error rates since the filter was turned off, Kaiser Colorado has not conducted another broad cancer audit such as the one performed in 2007. Instead, Kaiser has responded to the renewed evidence of high cancer error rates with only limited and prospective fixes.

108. For example, Kaiser Colorado's corrective action plan ("CAP") developed after the 2011 Probe Audit called for targeted retrospective audits of diagnoses of active cancer. However, to Relator's knowledge, no such audits were ever performed. The CAP similarly called for Relator and Dr. Teresa Welsh, the CPMG Physician Director of Coding, to visit the CPMG oncologists and discuss the coding accuracy of their cancer diagnoses. Dr. Welsh conducted some follow-up training, but reported back to Relator that, to be effective, such training would have to be done annually given the high turnover rate for oncologists. Kaiser does not conduct this training annually.

109. For years, Relator has recommended a broad retrospective audit of diagnosis codes known to be problematic, including cancer. In 2011, Kaiser Colorado hired an external vendor to conduct such an audit. This was known as the "Peak" project. Relator believes that part of this project was to review past cancer diagnoses submitted for risk adjustment to CMS. Any findings of the Peak audit have been withheld from Relator. However, he was told by Treska Francis, the leader of the Kaiser Colorado coder group, shortly after the audit began that the findings were "not looking good," *i.e.*, that the error rates were substantial.

110. **Stroke**: Kaiser identified problems with claims submitted for HCC 96, Ischemic or Unspecified Stroke, in Probe Audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, and 2011.

111. As with cancer, Kaiser knew stroke was commonly coded as an active event, when, in fact, the patient should have been classified as having a history of stroke. A diagnosis of a cerebrovascular accident (CVA)/stroke (ICD-9 codes 430-437) is appropriate for the initial acute stroke episode.

112. During RRG meetings, Relator learned that CVA/stroke is a diagnosis for which all Kaiser regions show high error rates, especially Kaiser's Northwest Region (Oregon and Washington).

113. Given the clinical profile of acute stroke, it would be particularly easy for Kaiser to audit past claims submissions and/or filter current claims to address this issue before submission. In almost all cases, when a patient is having a stroke she is treated in a hospital. A patient typically is not allowed to leave the hospital until after the stroke is over. Once the acute incident is over, the patient should be diagnosed as either having a history of stroke, or receiving treatment for the late effects of the prior stroke. Thus, in almost all cases, if a physician submits a diagnosis for acute stroke for a patient treated in the physician's office (or any setting other than a hospital), that diagnosis is likely erroneous.

114. Applying this principle, Relator convinced Kaiser to fund a pilot project to have a physician review all of the acute stroke diagnoses made in CPMG physician offices in 2010. Dr. Christina Marchioni, the CPMG physician who performed the review determined that Kaiser had submitted to CMS approximately $3.1 million in false acute stroke claims during the audit period. In fact, she determined that all but two of these claims were false. She also determined

that Kaiser could have submitted replacement claims for treatment of the after effects of stroke for these patients, worth approximately $1.2 million per year.

115. Despite these results, Kaiser did not delete these erroneous codes (and, correspondingly repay CMS), or conduct a similar audit for prior years. Instead, Kaiser simply had the reviewing physician correct the problem list in the patient's chart to reflect that the patient had a "history of stroke" or the "late effects" of stroke to minimize the chance that the error would be repeated in future years.

116. This project temporarily reduced the error rate for risk adjustment claims submitted for stroke in the following year. However, in 2011 Relator's funding for this project was cut and the work stopped. Since then, the error rate for stroke diagnoses has increased again.

117. Relator has recently begun a new program whereby all claims for an acute stroke diagnosis submitted based on an office visit by an internal provider are flagged for further review by Kaiser Colorado coders. If the coders identify errors, they reach out to the internal provider that submitted the diagnosis and ask her to correct the error. Unfortunately, the coders are not authorized to correct the errors themselves to prevent the false claims from being submitted, or to compel the internal providers to correct their errors. Thus, approximately 25% to 30% of the errors the coders identify are ultimately submitted to CMS as risk adjustment claims because the internal provider that submitted the diagnosis ignores the coders' efforts to correct the code.

118. **Vertebral Fractures**: In Probe Audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, and 2011, Kaiser identified problems with claims submitted for HCC 157, Vertebral Fractures without Spinal Cord Injury. This is another diagnosis where Kaiser found

that it often submitted false risk adjustment claims to CMS because physicians improperly coded the condition as active when, in fact, the patient only had a "history of" the condition.

119. **Vascular Disease**: In Probe Audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCCs 104, Vascular Disease with Complications, and/or 105, Vascular Disease.

120. The audit documents and additional research by Kaiser identified at least two causes for these errors. First, some claims erroneously claimed the patient had current vascular disease, when, in fact, they had only a history of the condition.

121. This was particularly true for cases where the patient had a history of pulmonary embolism, a condition when one or more pulmonary arteries in the patient's lungs become blocked. In most cases, pulmonary embolism is caused by blood clots that travel to the lungs from the legs. Patients who have one or more pulmonary emboli are often treated with anti-coagulants to prevent the development of additional emboli. Until a recent rule change, it was improper to classify patients being treated with anti-coagulants to prevent emboli as being treated for pulmonary embolism; they were properly coded as having only a history of pulmonary embolism. Kaiser knew that physicians routinely misapplied this rule, coding patients on anti-coagulants as having pulmonary embolism, thus causing the submission of false claims for HCC 104.

122. Second, certain claims were false because of a "mismapping" problem with HealthConnect, Kaiser's EMR. HealthConnect, used throughout all of its regions, allows physicians to choose a descriptive diagnosis (as opposed to a specific ICD-9 code) when entering clinical information. HealthConnect then "maps" this descriptive diagnosis to a specific ICD-9 diagnosis code, which is then inserted into the medical record documentation. For certain

diagnoses, however, this "diagnosis" file in the past has linked a descriptive term to the wrong ICD-9 diagnosis code.

123. For example, pain in the legs associated with physical activity may be a result of a lack of blood supply to the legs (vascular claudication) or nerve root compression (neurogenic claudication). Relator discovered that when a physician attempted to diagnose a patient with the neurologic condition, it incorrectly mapped to the ICD-9 code for the vascular disorder. For this reason, false claims were submitted for a vascular condition (HCC 104 or 105) when the physician attempted to diagnose a patient with nerve compression (a condition that does not risk adjust).

124. **Chronic Bronchitis**: In Probe Audits conducted in 2007 (the "2006 Wrap-up Report"), 2009, 2010, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCC 108, Chronic Obstructive Pulmonary Disease ("COPD").

125. The probe audits regularly found COPD claims erroneous based on lack of documentation in the record, or because the doctor failed to document the patient's condition with sufficient specificity to determine if the patient actually had COPD.

126. In addition, Kaiser's problematic diagnosis file also affected claims for HCC 108. Because of mismapping, when a physician attempted to diagnose a patient with bronchitis (a diagnosis that does not risk adjust), it was incorrectly mapped to an ICD-9 code for chronic bronchitis, and thus classified as HCC 108 (which does risk adjust). The 2010 Probe Audit specifically flagged this problem, even though it did not affect any risk adjustment claims audited that year.

127. Kaiser's EMR also pressured physicians to use the diagnosis code for chronic bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk adjust). If a

physician chose acute bronchitis as a diagnosis, HealthConnect (Kaiser's EMR) warned them that this could affect their score on certain quality measures. HealthConnect also informed them that if they selected simple bronchitis or chronic bronchitis instead, the quality measure at issue would not be negatively affected.

128. **Metastatic Cancer**: In Probe Audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, 2011, and 2012, Kaiser identified problems with claims submitted for HCC-7, Metastatic Cancer and Acute Leukemia.

129. While some of these errors were caused by improper use of codes for active cancer, when the patient actually had a "history of" cancer, there was at least one other cause. Again, errors in Kaiser's diagnosis file led to the insertion of an incorrect diagnosis code in the file, indicating metastasis in circumstances where the physician selected a non-metastatic descriptive diagnosis. Metastatic cancer is a condition where cancer spreads from one organ to another and results in significant additional risk adjustment payments.

130. **Myocardial Infarction and Old Myocardial Infarction**: In Probe Audits conducted in 2006 (2007 audit of 2005 data), 2010, and 2011, Kaiser identified problems with claims submitted for HCCs 81, Acute Myocardial Infarction ("MI"), and/or 83, Angina Pectoris/Old Myocardial Infarction ("old MI").

131. An MI is a heart attack. Kaiser's Probe Audits identified multiple issues with the claims submitted for HCCs 81 and 83. In some cases, a claim was submitted for an acute MI, when the proper claims should have been for old MI. In other cases, the only support for an old MI diagnosis was a radiology report or other test result, rather than a diagnosis documented by an appropriate provider in a face-to-face visit. In other cases, Kaiser simply concluded that the medical record documentation did not support the diagnosis of an MI or old MI at all.

132. **Malnutrition**: In Probe Audits conducted in 2009 and 2011, Kaiser identified problems with claims submitted for HCC 21, Protein-Calorie Malnutrition.

133. Kaiser identified several causes for these problems. In some cases, the condition was diagnosed as current when the patient actually only had a "history of" the condition.

134. In other cases, the false claim resulted from Kaiser coders and/or computer systems adding a malnutrition diagnosis where the treating physician had not. This often happened when a physician used the term "cachexia" in his or her treatment note. Cachexia can be used as a specific diagnosis, indicating that patient has chronic malnutrition or a specific wasting disease. Alternatively, physicians sometimes use variations of the term cachexia as an adjective to indicate that a patient appears malnourished, even where the patient has not been diagnosed with the disease cachexia (*e.g.*, the patient "looks cachetic"). In the latter case, it is inappropriate for a coder to decide that a patient has cachexia, because only a physician (or other appropriate provider) can determine that a patient has a given condition.

135. **Decubitus Ulcers**: In Probe Audits conducted in 2009 and 2011, Kaiser identified problems with claims submitted for HCC 148, Decubitus Ulcer of Skin.

136. There are two primary ulcer types: (1) decubitus ulcers, due to pressure; and (2) venous stasis ulcers, where the skin breaks down because of prolonged swelling in the extremities due to poor circulation. When properly coded, decubitus ulcers support a risk adjustment claim for HCC 148; venous stasis ulcers do not risk adjust. One reason Kaiser was submitting false claims for HCC 148 is that physician documentation often failed to sufficiently identify the cause of a patient's ulcer. For example, the audit notes for the 2011 Probe Audit report that one claim was found to be false because "record supported skin breakdown due to maceration rather than an ulcer due to pressure."

137. Decubitus ulcers were also improperly claimed when no ulcer was present. For example, another claim from the 2011 Probe Audit invalidated a diagnosis of decubitus ulcer noting that "NCO [Kaiser's National Compliance Office] could find no documentation to support that the patient [had] an ulcer. The physician documented that the SNF nursing staff reported no skin problems."

138. **Sick Sinus Syndrome**: In Probe Audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCC 92, Specified Heart Arrhythmias.

139. Sick sinus syndrome ("SSS") is the name for a group of heart rhythm problems (arrhythmias) in which the sinus node – the heart's natural pacemaker – does not work properly. A person with SSS may have heart rhythms that are too fast, too slow, punctuated by long pauses, or a combination of these rhythm problems. SSS is often treated with the implantation of a pacemaker.

140. Under established coding guidelines, once a patient has received a pacemaker to treat her SSS, it is no longer appropriate to code her condition as acute SSS (assuming the pacemaker is effectively treating the SSS). Instead, her condition should be coded to reflect the presence of the pacemaker.

141. One reason for the number of false claims submitted for HCC 92 is that, as Kaiser knows, physicians routinely submit a diagnosis code for SSS when they only should be submitting the code for the presence of the pacemaker. As Kaiser noted in one record for the 2011 Probe Audit: "The record documents that the patient is on a pacemaker for SSS, and per Coding Clinic guidelines in the situation the SSS may only be coded if … the SSS is addressed or there is a problem with the pacemaker."

142. Kaiser could easily prevent the submission of false claims for Sick Sinus Syndrome by setting up a process in its claims and billing software to flag situations where a claim includes a diagnosis of SSS and the presence of a pacemaker, and delete the diagnosis for SSS. It is notable that Kaiser has chosen not to use such a claims processing rule to fix this problem because Kaiser uses such rules to add new diagnoses if such a change will allow Kaiser to submit additional risk adjustment claims to CMS. For example, in cases where a patient is being treated with a type of drug that typically indicates major depression (a diagnosis that risk adjusts) but the patient has only been diagnosed with standard depression (a diagnosis that does not risk adjust), these claims are flagged for review to potentially code major depression.

143. In a similar way, Kaiser could easily conduct a retrospective audit of previously submitted claims based on a diagnosis of SSS by selecting any such claims that also had a diagnosis code for presence of a pacemaker. Nonetheless, Kaiser has not done so.

144. **Renal Insufficiency**: In Probe Audits conducted in 2009, 2011, and 2013, Kaiser identified problems with claims submitted for HCC 131, Renal Failure.

145. Chronic kidney disease ("CKD") is a condition that is often miscoded, and can have significant impact on risk adjustment scores. Although CKD is classified as Levels I to V, depending on the seriousness of the disease, all five levels of CKD map to the same HCC -- HCC 131.

146. Kaiser knew that patients were often incorrectly diagnosed with low level CKD (Levels I and II), but failed to conduct any targeted audits to test these claims. Such audits would have been particularly straightforward because the diagnosis of CKD Levels I and II is largely driven by two lab test values: (a) the patient's glomerular filtration rate ("GFR") rate; and (b) the presence of protein in the patient's urine.

c. False Claims Submitted Due To Other Coding Violations

147. The Colorado and national Probe Audits also identified consistent problems with the application of basic risk adjustment coding rules. Because these errors were process-based rather than diagnosis specific, it would be more difficult to perform a targeted audit to identify the affected false claims. Notably, though, Kaiser did conduct broad audits to find claims affected by similar process-based issues, as long as those problems led to increased revenue to Kaiser when fixed. Moreover, these process-oriented problems could have been addressed relatively easily using Kaiser's Natural Language Process program (discussed in greater detail below), if Kaiser had chosen to do so.

148. In its Probe Audits, Kaiser found that false claims were routinely submitted to CMS where the diagnosis was listed in medical documentation of a physician or hospital outpatient visit as probable, rule out, or suspected. As discussed above, CMS rules prohibit the use of such a diagnosis for a risk adjustment claim.

149. For example, in the 2011 Colorado Probe Audit, a stroke HCC was deemed invalid because the suspected stroke had been "ruled out by time of discharge but coded as if present." Another claim, for a diagnosis of vascular disease (based on a reported pulmonary embolism), was invalidated because the record specifically stated "P[ulmonary] E[mbolism] ruled out."

150. Again, in the 2013 Colorado Probe Audit, the audit identified a claim submitted for deep vein thrombosis (DVT) where the diagnosis had been "ruled out by work-up."

151. The Probe Audits also found that Kaiser routinely submitted claims where a non-chronic diagnosis was listed on a problem list or elsewhere in the medical record without any

notation or other evidence that the diagnosis was treated or affected the treatment provided. CMS rules prohibit the submission of claims based on such diagnoses.

152. For example, in the 2010 Probe Audit, 7% of all errors were based on a submitted diagnosis for a non-systemic condition where there "was no documentation to support that the condition had been addressed, evaluated, treated, or considered."

153. The Probe Audits also found that Kaiser routinely submitted claims where the only documentation to support the diagnosis was a radiologic or lab test, or other non-face-to-face service. CMS rules prohibit the submission of claims based on such diagnoses.

154. For example, in the 2010 Probe Audit, two of the invalidated HCCs were found to be invalid because they were based on diagnostic radiology reports.

d. Diagnoses Kaiser Identified as Upcoded Through High Risk Filter

155. From approximately 2010 through late 2011 or early 2012, Kaiser's Colorado region used a "filter" program to review certain "high risk" (*i.e.*, often overcoded) diagnoses submitted by internal providers before those diagnoses were submitted to CMS for risk adjustment payments. The filter tagged specified diagnoses for manual review by one of Kaiser Colorado's five coders, every time one of the "high risk" diagnoses was received from a CPMG physician. If the Kaiser coders determined that the diagnosis was invalid, it would be flagged to prevent Kaiser from submitting a risk adjustment claim to CMS on the basis of that diagnosis.

156. The filter was relatively successful in reducing the error rate for some of the diagnoses and internal provider groups it covered. However, for many of the diagnoses, the filter showed that Kaiser continued to have a high error rate.

157. The audits conducted in connection with the filter identified not only specific HCCs that had high error rates, but also the individual diagnosis codes that were problematic.

158. For example, as of July 2011, the filter program reviewed the following HCCs and found the following error rates:

HCC	Description	HCCs Reviewed	Invalid HCCs	Error Rate
8	Lung, Upper Digestive Tract, & Othr Severe Cancers	472	67	14%
9	Lymph, Head & Neck, Brain, & Othr Major Cancers	364	45	12%
10	Breast, Prostate, Colorect & Othr Cancers & Tumors	3,013	509	17%
32	Pancreatic Disease	361	51	14%
44	Severe Hematological Disorders	5	5	100%
92	Specified Heart Arrhythmias	7,113	1,084	15%
96	Ischemic or Unspecified Stroke	460	215	47%
104	Vascular Disease with Complications	582	172	30%
157	Vertebral Fractures without Spinal Cord Injury	320	115	36%
158	Hip Fracture/Dislocation	530	153	29%
164	Major Complications of Medical Care and Trauma	52	19	37%

159. Much to Relator's frustration, though, the filter did not address the category of claims with the highest error rate -- external providers. Nor did Kaiser conduct audits of claims submitted for these "high risk" diagnoses for internal providers in prior years.

160. Further, although Kaiser blocked erroneous diagnoses identified through the filter from being submitted as risk adjustment claims in the year at issue, Kaiser did not correct the problem lists in the EMRs. Because most diagnoses listed on a patient's problem list tend to be included in subsequent claims, by failing to correct the patients' problem lists, there was a high likelihood that the same diagnoses would be submitted to CMS in subsequent years.

161. Even worse, in late 2011 or early 2012, Kaiser Colorado ended the "high risk" filter program itself, even though the audits conducted pursuant to the program continued to show high error rates in the coding for these "high risk" diagnoses. No similar program was adopted to replace the filter program.

2. Kaiser Re-Submits Claims, or Refuses To Delete Claims, for Diagnoses That It Knows Are Invalid

162. In the limited instances where Kaiser conducts a broad retrospective audit to identify previously submitted false claims, it does not always delete those claims or otherwise repay Medicare. For example, as discussed above, during the 2010 stroke pilot project, Kaiser Colorado identified at least $3.1 million in false claims for HCC 96 (Ischemic or Unspecified Stroke). However, Kaiser did not delete those codes, or otherwise repay Medicare for the overpayment it received as a result of these false claims.

163. Further, in the instances where Kaiser does delete previously submitted false codes, it often later re-submits those same claims, thus seeking (and receiving) payment for the diagnoses that it knows to be false.

164. Kaiser Colorado and Kaiser Hawaii do this because of a problem in their claims processing systems. When codes are deleted after an audit, the system for Colorado and Hawaii does not have a flag or other mechanism to indicate that the audit found these diagnoses to be invalid. Nor are the diagnoses removed from the patient's medical record. Thus, when Kaiser conducts "resweeps" – a process designed to re-examine the EMR system to capture diagnoses that were added to patients' medical records after the initial submission of data to Kaiser's risk adjustment claims system – the system picks up the previously deleted diagnoses. Thereafter, Kaiser submits new risk adjustment claims for these diagnoses that Kaiser already determined to

be invalid. Kaiser is aware that the flaw in Colorado and Hawaii's claims processing systems has this effect.

3. Kaiser Acts With Reckless Disregard and/or Deliberate Ignorance As to the Falsity of a Substantial Number of the Risk Adjustment Claims It Submits

165. In addition to the false risk adjustment claims that Kaiser submits (or re-submits) with actual knowledge of their falsity, Kaiser also submits a substantial number of claims that Kaiser knows are false, within the meaning of the False Claims Act, because Kaiser acts with reckless disregard and/or deliberate ignorance as to their truth or falsity.

166. Kaiser is on notice that certain categories of its risk adjustment claims (*e.g.*, as described above, external providers, certain diagnoses) are false a significant percentage of the time. Nonetheless, Kaiser routinely fails to take reasonable steps to identify which of these claims are false, and then to prevent their submission in the first place or to delete them after submission.

167. Despite the fact that Kaiser's Probe and other audits have consistently identified areas where a significant number of the claims Kaiser submits are false, Kaiser's reaction, on a national and regional level, has been to (except in isolated instances) avoid conducting retrospective audits to correct previously submitted false data.

168. Instead, Kaiser's response to these audits focuses primarily on provider coding education that would, at best, only affect future claims. Kaiser's corrective action plans routinely prescribe only the deletion of those specific claims found to be false and some measure of future education. Even worse, in the few instances where a CAP does call for follow up audits, in Relator's experience, these audits are typically not done.

169. Because these Probe Audits routinely identify specific types of claims (either by diagnosis, by provider type, or by other category), in most cases Kaiser could easily do a targeted audit to find erroneous claims in a relatively cost efficient manner. Kaiser refuses to do so.

170. In contrast, Kaiser's response is very different when it learns certain diagnoses are undercoded. Kaiser regularly invests substantial resources in audits to find potential undercoded conditions. Moreover, when Kaiser finds undercoded conditions, it always (or almost always) submits risk adjustment codes for those conditions. For overcoded conditions, on the other hand, Kaiser rarely conducts follow up audits of all claims for that diagnosis submitted in that year, or prior years. Furthermore, in some instances (as with the stroke project discussed above) even where errors are found, Kaiser does not delete the previously submitted erroneous codes.

171. For example, in 2006, Kaiser's Colorado region conducted "Reimbursement Recovery Audits" ("RRA") looking for new diagnosis codes to submit for at least 19 different clinical pathways or diagnoses. None of these audits targeted overcoded claims, even though Kaiser knew that some of the same conditions (*e.g.*, MI) were often overcoded. In 2007, Kaiser Colorado conducted at least 22 such targeted clinical audits.

172. In 2010, Kaiser's Colorado region conducted more than 30 such RRA audits to find new claims. Again, several of the audits targeted diagnoses that Kaiser knew were also routinely overcoded (*e.g.*, breast cancer, prostate cancer, arrhythmia, chronic kidney disease, COPD, MI), yet these audits only looked for new diagnoses to submit, which has the effect of increasing Kaiser's risk adjustment payments from CMS.

173. Relator has learned, through RRG meetings and conversations with other Kaiser employees, that Kaiser's other regions similarly conduct a substantial number of targeted clinical audits designed to find undercoded conditions and thereby increase their Medicare

reimbursement. These audits often cover all, or substantially all, patient charts for a given year that meet certain clinical criteria that suggest a possibility of undercoding. Yet these regions conduct few, if any, similar audits to find overcoding, in which Medicare overpayments would need to be returned.

174. At a September 16, 2008 RRG meeting, Dr. Robert Klein presented the results of Kaiser's Northern California Region's 2008 targeted clinical audits for undercoded claims. The region audited at least 12 different clinical pathways. As with the Colorado region's RRA audits, several of these audits targeted the same diagnoses (*e.g.*, MI, Chronic Kidney Disease) that Kaiser knew were often overcoded as well. No audits were performed to find overcoded claims for these diagnoses. Moreover, Dr. Klein proposed the addition of further retrospective reviews designed to find examples where, *inter alia*, metastatic cancer (HCCs 7 and 10), is undercoded. No similar proposal was made to find examples of overcoded cancer, even though Kaiser knows this is one of the top diagnoses that is overcoded and improperly submitted.

175. Interestingly, in 2010, Kaiser's Northern California Region did take some steps to attempt to remedy overcoded conditions. It audited data in its claims systems for care provided to patients in 2009. This audit appears to have been conducted before these diagnoses were used to submit risk adjustment claims. When the audit found incorrect diagnoses, Kaiser blocked them so that they would not be used as the basis for future risk adjustment claims.

176. Of the 4,566 diagnoses audited, 1,781 (39%) "did not have supporting documentation." Kaiser "blocked" these diagnoses so that no risk adjustment claims were submitted for them. Notably, Kaiser also found an additional 475 diagnoses that should have been included in the claims data.

177. This is exactly the type of due diligence that Kaiser should have been performing across all regions and for all plan years to identify problems with its medical record documentation before those errors led to the submission of false claims. Instead, however it was an anomaly.

178. Moreover, although Kaiser Northern California identified certain diagnoses as routinely incorrectly submitted, it did not conduct an audit of claims submitted for these diagnoses in prior years.

179. One of the most egregious examples of Kaiser's unwillingness to give the search for false claims the same attention as the search for new diagnoses to submit is Kaiser's program designed to "refresh" chronic diagnosis that are submitted one year but not the next. In this process, Kaiser routinely discovers certain patients for whom risk adjustment claims for specific diagnoses submitted in prior years were likely false. Nonetheless, Kaiser refuses to conduct any investigation of those prior year claims.

180. For example, in 2009, Dr. Karl Pregitzer, Associate Medical Director for Physician Business Services at Hawaii Permanente Medical Group, conducted a "diagnosis refresh" audit. He reviewed diagnoses submitted for a patient one year and not the next, where the physician had also removed the diagnosis from the patient's problem list. Dr. Pregitzer queried the treating physicians to determine whether the diagnosis was correctly omitted in the second year. He classified the results into three categories: (1) captured, meaning the diagnosis was incorrectly omitted in the second year; (2) inactivated, meaning the diagnosis was properly omitted in the second year; and (3) pending, meaning it was still unclear whether the diagnosis was properly omitted.

181. In an April 2, 2009 PowerPoint outlining his findings, Dr. Pregitzer raised a concern that the same five diagnoses had the highest number of claims in each of these three categories: (a) HCC 15, Diabetes with Renal or Peripheral Circulatory Manifestation; (b) HCC 16, Diabetes with Neurologic or Other Specified Manifestation; (c) HCC 80, Congestive Heart Failure; (d) HCC 105, Vascular Disease; and (e) HCC 131, Renal Failure. The specific conditions he identified that were causing the problems were all ones that generally do not go away once a patient has them. Thus, Dr. Pregitzer noted that it was unusual to see these conditions showing up in one year, but then a physician determining that they did not exist the following year. His recommendation was that these five diagnoses warranted further data mining, because the results suggested that there was substantial physician confusion about the proper coding rules for these diagnoses.

182. With respect to the second category, inactivated claims, Dr. Pregitzer's findings strongly suggest that the earlier diagnosis was incorrect. Thus, these audit results strongly suggested that for at least one (and likely more) prior years Kaiser had submitted: (a) 104 false claims for HCC 15; (b) 123 false claims for HCC 16; (c) 99 false claims for HCC 80; (d) 205 false claims for HCC 105; and (e) 213 false claims for HCC 131. Nonetheless, Kaiser did not audit the prior years' claims for these patients to determine whether they were accurate.

183. Another area where Kaiser was on clear notice that specific claims were false was with respect to the problems with its diagnosis files. As described above, Kaiser discovered on several occasions that certain diagnoses described in its EMR were incorrectly mapped to ICD-9 diagnosis codes that were eligible for risk adjustment payments. In 2011 Kaiser audited the diagnosis file and found that a substantial number of diagnoses were incorrectly mapped. Relator does not know whether Kaiser fixed these mapping errors. Even worse, to Relator's

knowledge, Kaiser failed to conduct an audit of previously submitted claims affected by these errors, even though it knew that certain errors caused the submission of identifiable risk adjustment claims.

4. Problems with Kaiser's Natural Language Processing Audit Program Caused the Submission of False Claims

184. Beginning in approximately 2009, Kaiser developed a Natural Language Processing ("NLP") audit program to try to find new diagnosis codes to submit. Broadly speaking, the NLP program uses an algorithm to search EMRs to find words that, individually or in combination, indicate that a patient has certain diagnoses. If done properly, NLP analysis can be an effective tool to find diagnoses that were properly documented in the physician treatment notes but not submitted in the claims data.

185. For that matter, a good NLP program can also identify situations where a diagnosis was submitted with the claims data but is not documented in the medical record. Several existing NLP programs on the market provide such functionality. They have a user interface that would permit the user to view all previously reported diagnoses as well as ones added by the software and confirmed by the coders. Further, clicking on any diagnosis would take the reviewer to the corresponding portion of the note.

186. In fact, Kaiser uses such programs (sold by 3M and OptumInsight) to conduct NLP analysis of its hospital radiology and Emergency Department claims for health plans other than its Medicare Advantage plans, *e.g.*, its commercial plans.

187. Some of the problems identified in Kaiser's Probe Audits that, as discussed above, are not necessarily easy to target in a diagnosis-specific audit (*e.g.*, non-chronic conditions that were listed in the record without documentation of treatment; use of radiological

test results as the basis for a claim; coding diagnoses that were listed as possible, probable or rule-out) could readily be targeted through a NLP audit and later corrected/deleted.

188. Rather than use an established NLP program, Kaiser built its own – even though Kaiser uses established NLP products from 3M and OptumInsight for other purposes. Notably, Kaiser's NLP program was built without any function to allow it to audit the validity of previously submitted claims.

189. All face-to-face visits to a physician or hospital by members of Kaiser's MA plans are run through the NLP software to identify new diagnoses that might be appropriate to use for the submission of additional risk adjustment claims. The results are grouped into four categories: (a) True Positive: diagnoses that have been confirmed by two Kaiser coders; (b) More Information Needed: diagnoses that may be present, but further analysis is required to confirm; (c) Problem List Only: diagnoses that show up only on the member's problem list with no documentation of treatment; and (d) False Positives or Found Elsewhere.

190. Kaiser allows the various regions to decide how to use this information. For example, a PowerPoint presented at the Fall 2010 RRG Meeting outlined the results of the "NLP HCC Data Mining Pilot." Three regions had participated in the pilot: (a) Georgia; (b) Hawaii; and (c) Northwest. The Northwest region appears to have simply passed along all of its "True Positive" diagnoses to its risk adjustment claims submission system (which submits the claims to CMS) without further review. The Georgia region passed along most (278 of 294) of the diagnoses to its risk adjustment claims submission system, which submits the claims to CMS. It is unclear from the presentation why some diagnoses were not passed along.

191. The Hawaii region, on the other hand, audited all of the "True Positives" before passing them on. Remarkably it found a 29% error rate in these claims that had supposedly been

confirmed by two Kaiser coders. It now continues to audit all "True Positives." Relator spoke with Terri Keliinoi, Kaiser Hawaii's manager of risk coding, on October 14, 2014. The manager reported that as of the review of the 2014 file, they are still finding a 20% error rate in the "True Positives."

192. This is consistent with Relator's own experience. He personally reviewed over 100 of the supposedly "True Positive" claims for the Colorado Region and found a 10% error rate. In particular, he noted that it appears that the NLP software picks up, and the reviewing coders have validated, diagnoses that appear in problem lists but which lack additional notation of treatment. As described above, a diagnosis may not be submitted for risk adjustment purposes if it just appears in a problem list. There must be further indication that the physician considered or treated the diagnosis.

193. Notwithstanding this high error rate, Kaiser continues to allow its regions to determine whether they will conduct any additional review of the True Positives before submission to CMS. The Colorado region passes the True Positive diagnoses to its claims submission system with no further review, even though Kaiser knows that many of these claims are likely false. Likewise, the Northwest region passes through all True Positive diagnoses with the exception of diagnoses of cachexia (which are known to have very high error rates). The Hawaii region, on the other hand, has both a coder and a physician audit 100% of the "True Positives."

194. By failing to take corrective action to prevent the submission of false diagnosis data, knowing that in the absence of action such data would be submitted, Kaiser knowingly submitted false claims to CMS for risk adjustment payments.

COUNT I

Federal False Claims Act
31 U.S.C. §§ 3729(a)(1)(A)–(B), (G)

195. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 194 of this Complaint.

196. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729, *et seq.*, as amended.

197. By virtue of the acts described above, Defendants, their agents, and employees, knowingly presented or caused to be presented, false or fraudulent claims to the United States Government for payment or approval.

198. By virtue of the acts described above, Defendants, their agents, and employees, knowingly made or used, or caused to be made or used, false or fraudulent records or statements material to false or fraudulent claims.

199. By virtue of the acts described above, Defendants, their agents, and employees, knowingly concealed overpayments from the United States Government and failed to remit such overpayments.

200. The Government, unaware of the falsity of the records, statements and claims made or caused to be made by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' illegal conduct.

201. By reason of Defendants' acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

202. Additionally, the United States is entitled to the maximum penalty of up to $11,000 for each and every violation alleged herein.

PRAYER

WHEREFORE, *Qui Tam* Plaintiff-Relator Dr. James M. Taylor prays for judgment against Defendants as follows:

1. That Defendants cease and desist from violating 31 U.S.C. §§ 3729 *et seq*.

2. That the Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained as a result of Defendants' actions in violation of the Federal False Claims Act, as well as a civil penalty of $11,000 for each violation of 31 U.S.C. § 3729;

3. That Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) of the Federal False Claims Act;

4. That Relator be awarded all costs of this action, including attorneys' fees and expenses; and

5. That the United States and Relator receive all such other relief as the Court deems just and proper.

JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands trial by jury.

DATED: November 3, 2014

Respectfully submitted,

By: /s/ Daniel M. Twetten

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TAB 31

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

[UNDER SEAL], Plaintiffs, v. [UNDER SEAL], Defendants.	Case No. COMPLAINT **FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)**

DOCUMENT TO BE KEPT UNDER SEAL

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UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

UNITED STATES OF AMERICA, ex rel. DR. JAMES M. TAYLOR, M.D., Plaintiffs, vs. KAISER PERMANENTE, KAISER FOUNDATION HEALTH PLAN, INC., KAISER FOUNDATION HEALTH PLAN OF COLORADO, KAISER FOUNDATION HEALTH PLAN OF GEORGIA, and KAISER FOUNDATION HEALTH PLAN OF THE NORTHWEST, Defendants.	Case No. COMPLAINT FOR VIOLATIONS OF THE FEDERAL FALSE CLAIMS ACT [31 U.S.C. §§ 3729 et seq.] **FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)** **JURY TRIAL DEMANDED**

Qui Tam Plaintiff-Relator Dr. James M. Taylor, M.D., through his attorneys, on behalf of the United States of America (the "Government," or the "Federal Government"), for his Complaint against Defendants Kaiser Permanente, Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, and Kaiser Foundation Health Plan of the Northwest (collectively "Kaiser" or "the Kaiser Defendants") alleges, based upon personal knowledge, relevant documents, and information and belief, as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States of America arising from false and/or fraudulent records, statements, and claims made and caused to be made by Defendants and/or their agents and employees in violation of the federal False Claims Act, 31 U.S.C. § 3729 *et seq*. This *qui tam* case is brought against Defendants for

knowingly defrauding the federal Government in connection with the Medicare program. As alleged below, since at least 2004 to present, Kaiser has knowingly submitted and caused to be submitted to the Centers for Medicare & Medicaid Services ("CMS") false claims for enhanced "risk adjustment" payments. Likewise, Kaiser has knowingly retained overpayments received from CMS for risk adjustment claims that Kaiser later learned, or in the exercise of reasonable care should have learned, were false.

2. Through the MA program, CMS allows private health insurers to set up managed care plans to cover Medicare beneficiaries. CMS pays a monthly capitation rate for each beneficiary enrolled as a member of a Medicare Advantage ("MA") plan. MA plans must then use that money to pay hospitals, physicians, and other health care providers for the services the plan members receive and to cover the plans' administrative expenses. Certain MA plans are also given money to pay for the plan members' prescription drugs. Under both types of plans, CMS adjusts the capitation rate for each beneficiary to reflect that beneficiary's individual demographics (*e.g.*, age and gender), geographic location, and health status.

3. The adjustment for each member's health status is one of the most significant components of the capitation rate. Individuals with multiple and/or serious health conditions account for more health care costs than healthy members. Accordingly, CMS pays a substantially higher capitation rate for members who have been recently treated for one or more serious, expensive diseases or conditions. These increased payments are known as "risk adjustment" payments. On average, CMS pays MA plans close to $3,000 per year for each condition a member has that requires a risk adjustment payment.

4. To receive these risk adjustment payments, MA plans submit claims to CMS each year for each member for each qualifying disease or condition. MA organizations may only

submit risk adjustment claims if the individual patient has been diagnosed with the condition in question, consistent with established coding standards, and there is documentation in the patient's medical record that: (1) the diagnosis was treated or affected treatment; (2) in a face-to-face visit (except for pathology services performed by a pathologist); (3) with an appropriate provider type; and (4) during the proper time period.

5. Since at least 2004 to present, the Kaiser Defendants have perpetrated a systematic fraud on the Medicare Advantage program. They routinely submit false claims to CMS when they know, or in the exercise of reasonable care should know, that: (1) the patients do not have the diagnoses for which a risk adjustment claim was submitted; and/or (2) the diagnosis: a) was neither treated nor affected the treatment provided; b) in a face-to-face visit; c) with an appropriate provider; d) in the year at issue. In addition, the Kaiser Defendants have refused to correct (and refused to reimburse Medicare for) previously submitted risk adjustment claims when they discover, or in the exercise of reasonable care should discover, that those previously submitted claims were false.

6. Through this scheme, Kaiser has defrauded the United States of tens of millions of dollars.

7. Defendants' conduct alleged herein violates the federal False Claims Act. The federal False Claims Act (the "FCA") was originally enacted during the Civil War. Congress substantially amended the Act in 1986—and, again, in 2009 and 2010—to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. The Act was amended after Congress found that fraud in federal programs was pervasive and that the Act, which Congress characterized as the primary tool for combating government fraud, was in need of modernization. Congress intended that the amendments would create incentives for

individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf.

8. The FCA prohibits, *inter alia*: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim; and (c) knowingly making, using, or causing to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly concealing or knowingly and improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government. 31 U.S.C. §§ 3729(a)(1)(A)-(B), and (G). Any person who violates the FCA is liable for a civil penalty of up to $11,000 for each violation, plus three times the amount of the damages sustained by the United States. 31 U.S.C. § 3729(a)(1).

9. For purposes of the FCA, a person "knows" a claim is false if that person: "(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1). The FCA does not require proof that the defendants specifically intended to commit fraud. *Id*. Unless otherwise indicated, whenever the words "know," "learn," discover," or similar words indicating knowledge are used in this Complaint, they mean knowledge as defined in the FCA.

10. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. The FCA requires that the Complaint be filed under seal for a minimum of 60 days (without service on the defendant during

that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

11. Based on the foregoing laws, *Qui Tam* Plaintiff-Relator Dr. James M. Taylor, M.D. seeks, through this action, to recover damages and civil penalties arising from the false or fraudulent records, statements, and/or claims that the Defendants made or caused to be made in connection with false and/or fraudulent claims for inflated Medicare Advantage payments.

II. PARTIES

12. Relator Dr. James M. Taylor, M.D. ("Relator") is a resident of Broomfield, Colorado and an employee of Colorado Permanente Medical Group ("CPMG"). Dr. Taylor joined Kaiser's Colorado branch in 1995 as a clinician, following eight years in private practice in rural Ohio. In the early 2000s, Dr. Taylor became heavily involved with Kaiser's national Electronic Medical Record ("EMR") and physician coding practices. He is a certified professional coder and AHIMA approved ICD-10 trainer.

13. Dr. Taylor was elected to the Board of Directors of CPMG and served as chair for two years. He is currently Kaiser's national co-chair of the Compliance Committee for ICD-10; a member of Kaiser's national Coding Governance Group (the only delegate representing all physicians for the Regions outside of California); and CPMG's Medical Director of Revenue Cycle/Claims. From 2002 to 2007, he served as CPMG's Physician Director of Coding. He is the only physician to have received Kaiser's National Revenue Cycle "Distinguished Leadership" award.

14. He is a nationally recognized speaker on topics such as EMR documentation, coding, and compliance. He has written articles, created webinars, and presented at national conventions for the American Health Information Association, National Health Care Anti-Fraud

Association, Health Care Compliance Association, National Health Care Auditors and Educators Association, and American Association of Professional Coders.

15. Dr. Taylor has unsuccessfully tried, over the course of his employment at Kaiser, to address internally within Kaiser the issues set forth in this Complaint. As described in greater detail below, as he discovered issues with the submission of false risk adjustment claims associated with specific provider types, diagnoses, or other issues, he repeatedly proposed solutions. At times, Kaiser appeared to be taking steps (either implementing his suggestions or taking other steps) to address the problems. Unfortunately, Relator later learned that Kaiser either did not take the steps it had claimed it was taking, or began implementing corrective actions only to stop them later.

16. Defendant Kaiser Permanente is a non-profit managed care consortium headquartered in Oakland, California. The consortium includes three main groups: (1) the Kaiser Foundation Health Plan, Inc. and its subsidiaries; (2) the Kaiser Foundation Hospitals and their subsidiaries; and (3) the Permanente Medical Groups.

17. Kaiser Permanente is one of the largest managed care organizations in the United States. Opened to public enrollment in 1945, it now boasts almost 9.5 million members throughout California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, Washington, and the District of Columbia.

18. Kaiser has over 174,000 employees (including over 17,000 physicians). In 2013, Kaiser reported more than $53 billion in operating revenue.

19. Kaiser offers Medicare HMO plans, called "Kaiser Permanente Senior Advantage Plans," in California, Colorado, Georgia, Hawaii, Oregon, and Washington.

20. Some regions, such as California, operate using almost exclusively Kaiser affiliated medical providers. In these regions, Kaiser owns or controls the hospitals and physician offices that provide services to members of Kaiser's insurance plans. In other regions, such as Colorado, Kaiser maintains more limited provider resources. For example, in Colorado, Kaiser's members are seen by physicians in CPMG, a Kaiser affiliate. But because Kaiser has no hospitals in Colorado, when members require inpatient or outpatient care, they are seen by non-Kaiser hospitals with whom Kaiser has contracted to provide care to its members.

21. Defendant Kaiser Foundation Health Plan, Inc. is a non-profit health maintenance organization ("HMO") headquartered in Oakland, California.

22. Defendant Kaiser Foundation Health Plan of Colorado is a non-profit HMO headquartered in Denver, Colorado. It has over 585,000 members, 28 medical offices, and 7,000 staff and physicians. CPMG, a multi-specialty physician group of over 1,000 physicians, contracts with Defendant Kaiser Foundation Health Plan of Colorado to provide medical care to its members.

23. Defendant Kaiser Foundation Health Plan of Georgia is a non-profit health plan headquartered in Atlanta, Georgia. It has over 270,000 members and over 20 affiliated hospitals and medical centers. The Southeast Permanente Medical Group, a multi-specialty physician group of over 450 physicians, contracts with Defendant Kaiser Foundation Health Plan of Georgia to provide care to its members.

24. Defendant Kaiser Foundation Health Plan of the Northwest is a non-profit HMO headquartered in Portland, Oregon. It has over 480,000 members and is affiliated with over 900 physicians at hospitals and medical centers throughout Oregon and Washington.

III. JURISDICTION AND VENUE

25. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on this Court for actions brought under 31 U.S.C. § 3730.

26. Under 31 U.S.C. § 3730(e) there has been no statutorily relevant public disclosure of the "allegations or transactions" in this Complaint. Even if there had been any such public disclosure, Relator is the original source of the allegations herein because he has direct, independent, and material knowledge of the information that forms the basis of this Complaint, and voluntarily disclosed that information to the Government before filing.

27. This Court has personal jurisdiction over the Defendants, pursuant to 31 U.S.C. §3732(a), as one or more Defendants can be found in, reside in, transact business in, and have committed acts related to the allegations in this Complaint in the District of Colorado.

28. Venue is proper, pursuant to 31 U.S.C. § 3732(a), as one or more Defendants can be found in, reside in, and/or transact business in the District of Colorado, and because many of the violations of 31 U.S.C. § 3729 discussed herein occurred within this judicial district.

IV. LEGAL BACKGROUND

A. Medicare

29. Medicare is a federally-funded health insurance program which provides for certain medical expenses for persons who are over 65, who are disabled, or who suffer from End Stage Renal Disease. The Medicare program is administered through the Department of Health and Human Services, Centers for Medicare and Medicaid Services ("CMS").

30. The Medicare program has four parts: Part A, Part B, Part C and Part D. Medicare Part A ("Part A"), the Basic Plan of Hospital Insurance, covers hospital services and

post-hospital nursing facility care. Medicare Part B ("Part B"), the Voluntary Supplemental Insurance Plan, covers services performed by physicians and certain other health care providers, such as services provided to Medicare patients by physicians, laboratories, and diagnostic testing facilities. *See* 42 U.S.C. §§ 1395k, 1395l, 1395x(s). Medicare Part C ("Part C") refers to Medicare's managed care plans. Medicare Part D ("Part D") provides subsidized prescription drug coverage for Medicare beneficiaries.

1. Medicare Managed Care (Parts C and D)

31. Traditionally, Medicare operates on a fee-for-service basis, meaning that Medicare directly pays hospitals, physicians, and other health care providers for each service they provide to a Medicare beneficiary.

32. In 1997, Congress created Medicare Part C, which provides similar benefits to Medicare members, but does so based on a managed care model, rather than the traditional fee-for-service model. Under Part C, rather than pay providers directly, Medicare pays private managed care plans (later named "Medicare Advantage" or "MA" plans) a capitation rate (per member per month) and those plans are responsible for paying providers for the services they provide to members of that specific MA plan.

33. In 2003, Congress passed the Medicare Prescription Drug, Improvement, and Modernization Act, creating Medicare Part D which provides prescription drug coverage. Although a limited number of Medicare Part D plans are operated under a cost-reimbursement contract, the plans are generally financed under a managed care model. These managed care model plans are provided under both Part D prescription drug plans, which offer only prescription drug coverage, and Part C plans, which integrate the prescription drug coverage with the Part C health care coverage.

34. This Complaint refers, collectively, to Medicare Advantage plans with and without Part D coverage, and stand-alone managed care Medicare Part D Plans as "Medicare Advantage Plans" or "MA Plans."

a. Risk Adjusted Capitation Payments and Claims Submission

35. CMS pays MA plans a monthly capitation rate that reflects, among other things, each member's health status. The process of adjusting the capitation rate to reflect a member's disease states is known as risk adjustment. Risk adjustment is intended to improve the accuracy of the payments CMS makes to these plans. To this end, CMS pays a higher rate for enrollees whom the MA plan represents were treated for certain diseases and conditions in the previous year, based on the expectation that those enrollees will require treatment and/or management for the conditions in the payment year. *See* 2008 Risk Adjustment Training for Medicare Advantage Organizations Participant Guide ("*Participant Guide*"), at 6.4.1 (for purposes of this Complaint, "treatment" is defined as treatment and management within the meaning of the *Participant Guide*).

36. Conversely, CMS pays a lower rate for enrollees who, although they may have certain typically expensive conditions, did not require care, treatment, or management for those conditions in the prior year. For these members, the risk adjustment methodology assumes that because their condition did not require treatment in the prior year, it has improved or otherwise changed so that it is not expected to require treatment in the payment year.

37. The CMS risk adjustment model evaluates enrollee health (and establishes risk adjustment payment rates) using diagnosis classifications set forth in the International Classification of Diseases, 9th Edition, Clinical Modification ("ICD-9") system. The ICD-9 system assigns each diagnosis a specific code, which is "used to describe the clinical reason for a

patient's treatment." *Participant Guide* at 6.2. Under the MA model, these individual diagnosis codes are organized into groups, called Hierarchical Condition Categories ("HCCs"). Medicare Managed Care Manual ("MMCM"), ch. 8, § 50. Every HCC consists of several ICD-9 diagnosis codes that are clinically related and are expected to require a similar level of resources to treat. *Id*. Seemingly similar diagnoses may fall into different HCCs when they are expected to require significantly different levels of treatment.

38. CMS uses the same general model for the Part D portion of risk adjustment. However, because certain diagnoses will be expected to require higher spending for prescription drugs covered under Part D, but not hospital costs and physician fees covered under Part C, and vice versa, a distinct list of Hierarchical Condition Categories ("RxHCCs") with corresponding diagnosis codes was created for Medicare's Part D risk adjustment. *See Participant Guide* at 8.2.5.2. For example, RxHCC 75 represents Attention Deficit Disorder, a condition predicted to increase drug spending. However, because Attention Deficit Disorder is unlikely to result in hospitalization, RxHCC 75 has no corresponding HCC. On the other hand, HCC 77, Respirator Dependence/ Tracheostomy Status, a condition category predictive of Medicare Part C medical costs but not necessarily predictive of Part D drug expenses, has no RxHCC equivalent.

39. Although the HCC and RxHCC systems are not identical, they do have significant overlap. Certain HCCs have equivalent RxHCCs, meaning that the condition categories consist of identical ICD-9 diagnosis codes. For example, HCC 5 (Opportunistic Infections) is equivalent to RxHCC 2 (Opportunistic Infections), and HCC 37 (Bone/Joint/Muscle Infections/Necrosis) is equivalent to RxHCC 39 (Bone/Joint/Muscle Infections/Necrosis). Even where they are not identical, most HCCs overlap with one or more RxHCCs. For example, of the thirty-seven diagnosis codes that fall within HCC 45 (Disorders of Immunity), twenty-seven fall within

RxHCC 52 (Disorders of Immunity), seven fall within RxHCC 51 (Severe Hematological Disorders), and three do not fall within any RxHCCs. Thus, the majority of ICD-9 diagnosis codes that fall into an HCC will also fall into an RxHCC.

40. An individual ICD-9 code included in the HCC system for a particular member corresponds on average to nearly $3,000 in extra revenue for the plan per year.

41. Generally speaking, an MA Plan may only submit a risk adjustment claim for a diagnosis that has been properly coded per ICD-9 standards. *See* 42 C.F.R. § 422.310(d)(1) (risk adjustment data must conform to national standards); *Participant Guide* at 7.1.5 (diagnoses must be "[c]oded in accordance with the ICD-9-CM Guidelines for Coding and Reporting").

42. In addition, a risk adjustment claim may only be submitted if the diagnosis meets four additional requirements. First, the diagnosis must have been treated or affected treatment provided to the patient. *See Participant Guide* at 7-14 ("Code all documented conditions that coexist at time of the encounter/visit, and require or affect patient care treatment or management."); *id*. at 6-4.1 ("Physicians should code all documented conditions that co-exist at the time of the encounter/visit, and require or affect patient care treatment or management." (emphasis added)); *id*. at 7-13 ("for hospital inpatient stays . . . diagnoses that relate to an earlier episode which have no bearing on the current hospital stay are to be excluded").

43. Second, the diagnosis must have been treated (or affected treatment provided) during a face-to-face visit between the provider and the patient (unless the provider is a pathologist). *See Participant Guide* at 7.1.4 ("As a principal risk adjustment rule, risk adjustment diagnoses submitted for enrollees must be supported by medical record documentation and based on a face-to-face encounter."); *id*. at 7.1.5 (Diagnoses must be "based on a face-to-face health service encounter").

44. Third, the provider rendering the service must be a qualified provider type or specialty. *See Participant Guide* at 2.2.1, 3.1.4, 3.2, 4.3, 4.7, 4.11 (risk adjustment diagnoses can come from three broad categories: hospital inpatient facilities, hospital outpatient facilities, and certain physician and physician extender specialties); *see also id.* at 6.1 (MA plans must "[i]mplement procedures to ensure that diagnoses are coming from physician, hospital inpatient, or hospital outpatient provider types."). CMS has enumerated the physician specialties that are an acceptable source of diagnoses for risk adjustment purposes. *See id.* at 3.2.3 ("Only those physician specialties and other clinical specialists identified in Table 3H are acceptable for risk adjustment."). Certain non-physician professionals are also acceptable provider types for risk adjustment, including, *inter alia*, physical therapists, occupational therapists, and physician assistants. *Id* at 3.2.3.

45. Fourth, the service used as the basis for the risk adjustment claim must have occurred during the calendar year preceding the payment year. *See Participant Guide* at 7-11 ("Do not submit medical records for date(s) of service that occurred outside of the data collection period."); *id*. at 7.2.4.1 (Unacceptable medical record documentation includes "documentation for dates of service outside the data collection period"); *id.* at 2.2.1 ("All beneficiary ICD-9-CM diagnosis codes required for the CMS-HCC risk adjustment model must be reported at least once per enrollee in the data collection period."); *id*. at 6.4.1 ("[C]o-existing conditions should be documented by one of the allowable provider types at least once within the data reporting period.").

46. CMS has offered specific additional guidance regarding certain practices or diagnoses known to be at particular risk of abuse. For example, clinicians frequently use what are known as "problem lists" to track diagnoses a patient has had in the past or that the treating

provider believes the patient may have. For ease of use, a physician may copy the problem list into the patient chart during an encounter with a patient. This allows the physician to consider whether any issues on the problem list require assessment or treatment or are otherwise clinically relevant. However, in most cases, the fact that a diagnosis appears on a problem list does not in and of itself indicate the physician's judgment that the diagnosis was relevant to the clinical encounter. This is because diagnoses may appear on problem lists for many reasons, including for the purpose of ruling out a diagnosis. For this reason, CMS requires that if a diagnosis from a problem list is submitted for risk adjustment purposes, the list must be comprehensive "and show evaluation and treatment for each condition that relates to an ICD-9 code on the date of service." *Id*. at 7-17.

47. However, for chronic conditions such as diabetes, which affect "all but the most minor of medical encounters," as well as chronic conditions such as multiple sclerosis, which "may not impact every minor healthcare episode," the documentation need only reflect that the condition was "part of a general overview of the patient's health when treating co-existing conditions" or was otherwise "evaluated" by the provider. *Id*. at 6.4.1.

48. Another common source of false risk adjustment claims is erroneous application of the rule for coding conditions which were previously treated, but are currently cured, in remission, or otherwise inactive. In such cases, the provider should not code the diagnosis as active when in fact the patient only has a "history of" the diagnosis. For example, a diagnosis of "history of stroke" or "history of cancer," does not risk adjust (*i.e.*, may not be used to support a claim for risk adjustment payments). However, a diagnosis of active cancer or a stroke occurrence will risk adjust. Because of this, CMS requires clinical specificity and that

physicians code "the correct forms and manifestations of diseases and conditions," including whether the patient has an active condition or a history of such. *Id*. at 6.4.3, 6-8.

49. CMS rules also prohibit the submission of risk adjustment claims for diagnoses that are unconfirmed, unless the treating provider was a hospital inpatient department. *Id*. at 6.4.2 ("Physicians and hospital outpatient departments shall not code diagnoses documented as 'probable,' 'suspected,' 'questionable,' 'rule out,' or 'working.'").

50. The risk adjustment claims that the MA Plan submits to CMS must include:

(a) the member's Health Insurance Claim ("HIC") number;

(b) the ICD-9 diagnosis code;

(c) the "service from" date;

(d) the "service through" date; and

(e) the provider type (*e.g.*, hospital inpatient, hospital outpatient, physician).

51. MA plans are responsible for the content of their risk adjustment claims submissions to CMS, regardless of whether they submit the data themselves or through an intermediary. *Participant Guide*, at 3-13. Before submitting data to CMS, MA plans are required to filter the data "to ensure that they submit data from only appropriate data sources." *Id*. at 4-11. For example, filters should include checking that physician data comes from face-to-face encounters with members and ensuring that data does not come from non-covered providers, such as diagnostic radiology services.

52. MA plans are required to correct the risk adjustment data they submit to CMS. When an MA plan learns that information in a risk adjustment claim (*i.e.*, HIC number, diagnosis

code, service dates, or provider type) contains an error, it must submit a "delete record" to CMS for that claim.

53. To test the validity of MA plan risk adjustment data, CMS conducts Risk Adjustment Data Validation ("RADV") audits after the final deadline for submitting risk adjustment data for the payment year. During such audits, CMS "validates" some of the MA plan's HCC scores by reviewing the medical records that the plan contends support the claimed diagnosis codes. *Id*. at 7-1. To facilitate the RADV audits, MA plans are required to submit to CMS medical records and coversheets for each sampled enrollee. Until February 2012, MA plans were required to include the "one best medical record" supporting each HCC. *Id*. at 7-9. Beginning with the CY 2011 RADV audit, CMS began allowing audited MA contracts to submit multiple medical records for each HCC being validated. CMS, *Notice of Final Payment Error Calculation Methodology for Part C Medicare Advantage Risk Adjustment Data Validation Contract-Level Audits*, February 24, 2012.

b. CMS Requires MA Plans To Certify the Validity of Their Bid Rates and Risk Adjustment Data To Prevent Fraud

54. CMS requires MA organizations to submit attestations, each signed by the CEO or CFO (or their authorized, direct subordinate), certifying the accuracy of their risk adjustment submissions. These attestations are a condition that the MA plans must meet to be eligible to receive any capitation payments from CMS.

55. The first attestation, which is submitted annually, requires the MA organization to attest that the risk adjustment data it submits annually to CMS is "accurate, complete, and truthful." The attestation acknowledges that risk adjustment information "directly affects the calculation of CMS payments . . . and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution." The regulations also

provide that if the claims data are generated by a "related entity, contractor, or subcontractor of an MA organization," that entity must similarly certify the "accuracy, completeness, and truthfulness of the data." 42 C.F.R. § 422.504(l)(2).

56. Kaiser Colorado CFO Rick Newsome signs this attestation for Kaiser Colorado. Mr. Newsome typically has his subordinates, such as Relator, sign "sub-attestations" concerning their knowledge of the validity of the data. At times, Relator has signed such attestations, based on his then-belief that Kaiser was taking steps to fix the problems he had identified. However, in approximately 2011, Relator refused to sign the sub-attestation because he learned that Kaiser had not followed through on promised corrective actions. The Kaiser employee responsible for collecting the sub-attestation responded by saying: "I'll just get another person to sign it."

57. In subsequent years, Relator signed the attestations only after assurances that additional corrective actions had been or would be taken. Unfortunately, Relator has come to the conclusion that Kaiser does not intend to correct the problems described in this Complaint, to stop submitting false claims of the type described herein, or to repay the United States for the overpayments that Kaiser knows, or in the exercise of reasonable care would know, it has received due to previously submitted false claims.

58. In addition, the MA organization (and any third-party submitters) must sign an Electronic Data Interchange ("EDI") Enrollment Form prior to submitting risk adjustment data to CMS. The EDI Enrollment Form is a contract between the MA organization and CMS attesting to the accuracy of the data submitted. *Participant Guide* at 4.1. The MA organization attests on the Form "[b]ased on best knowledge, information, and belief," that it will submit risk adjustment data that are accurate, complete, and truthful.

V. ALLEGATIONS

A. Kaiser Has Knowingly Submitted False Claims for Risk Adjustment Payments and Improperly Retained Such Payments

59. The Kaiser Defendants have engaged in a deliberate scheme to defraud the United States by submitting thousands of false claims for risk adjustment payments to CMS. Kaiser has submitted and caused the submission of these claims for risk adjustment payments even though it knew, or in the exercise of reasonable care should have known, that the Medicare patients upon whom the claims were based did not have the claimed diagnoses, had not been treated for those diagnoses in the prior year in a face-to-face visit with an appropriate provider type, or that the claims were otherwise ineligible for risk adjustment payments under CMS rules.

60. As outlined below, Kaiser routinely conducted national, regional, and diagnosis-specific audits to determine the accuracy of its risk adjustment claims submissions. These audits regularly identified categories of claims (often, specific diagnoses) that had high rates of falsity. Notwithstanding this knowledge, Kaiser rarely took even minimal steps to filter its claims to prevent submission of these claims, or to audit prior submissions to find the previously submitted false clams.

61. The limited steps Kaiser did take, when it did so, to filter certain diagnoses further confirmed that physicians often upcoded those diagnoses, leading (absent intervention) to the submission of false claims. Despite this knowledge, Kaiser did not apply this filter to its prior years' submissions for these overcoded diagnoses.

62. This lack of diligence contrasts starkly with Kaiser's considerable efforts and substantial commitment of resources to audit current and past claims to identify new diagnoses that it could use to submit additional risk adjustment claims and thereby increase the amount of the risk adjustment payments it receives from CMS.

63. Kaiser's refusal to take reasonable steps to prevent the submission of false claims, and to make a reasonable inquiry into previously submitted false claims, constitutes reckless disregard as to, and/or deliberate ignorance of, the falsity of those claims.

64. So too, in certain instances, Kaiser had actual knowledge that specific claims it previously submitted to CMS were false. Kaiser's refusal to delete those claims and refund the resulting overpayments to the United States also constitutes a violation of the False Claims Act.

65. Although many of the representative examples detailed below are for Kaiser's Colorado Region, Relator has information and believes, based on reports he has reviewed showing audit results for other regions and Kaiser nationally, his attendance at Regional Reporting Group ("RRG") Meetings, and work with employees in other Kaiser regions, and on that basis alleges, that some or all of Kaiser's other regions knowingly submitted false risk adjustment claims for similar reasons and for similar diagnosis codes as Kaiser Colorado.

66. On the basis of reviewing the audit results for other regions and Kaiser nationally, his attendance at RRG Meetings and work with employees in other Kaiser regions, Relator alleges on information and belief that at all times material to this action, i.e., from at least 2004 to present, the fraudulent risk adjustment practices identified herein regarding Colorado were typical of the Kaiser Defendants at some or all of its other regions, including without limitation, Georgia, Hawaii, Oregon and Washington.

67. In addition, although many of the representative examples detailed below cover HCCs rather than RxHCCs, to the extent that Kaiser's audits also covered RxHCCs (which many of them did), they identified similar patterns of knowing submission of false claims for RxHCCs.

68. On this basis, Relator alleges that Kaiser has submitted, and fraudulently refused to delete and repay CMS for, tens of thousands of risk adjustment claims, that it knows, within the meaning of the False Claims Act, are false and/or fraudulent.

1. Kaiser Knows It Is Routinely Submitting False Risk Adjustment Claims to CMS

69. Every year, Kaiser's National Compliance Office ("NCO") conducts a nationwide "Probe" audit to test the accuracy of risk adjustment claims submitted the prior year. The NCO chooses the patients and/or diagnoses to be audited but each region conducts the audit work. Kaiser deliberately designs these audits so that the sample size is too small for the results to be used for statistically significant extrapolation with respect to the error rates for individual HCCs. Instead, it is intended to provide an overall accuracy rate, by region, and to serve as a "flag" or "tripwire" to identify potential problems with individual HCCs.

70. In addition to the annual Probe Audits, Kaiser conducted nationwide audits in anticipation of CMS's Risk Adjustment Data Validation ("RADV") audits. These pre-RADV audits routinely identified similar problems as the Probe Audits.

71. Although these Probe and other audits show an overall trend of increasing accuracy in risk adjustment claims across Kaiser, and for each of its regions, the audits have identified many errors and put Kaiser on notice that it has submitted and continues to submit a substantial number of false risk adjustment claims each year.

72. For the Colorado region, the annual Probe Audits identified the following error rates (including both HCCs and RxHCCs) between 2007 and 2013:

Year	Total HCCs Audited	Errors	Error Rate
2007	207	25	12%
2008	131	19	15%
2009	330	38	12%
2010	428	70	16%
2011	395	56	14%
2012	398	29	7%
2013	238	21	9%

73. Kaiser's audits of other regions, and of national error rates, showed similar results. For example, in both 2006 and 2007, Kaiser conducted pre-RADV audits. Kaiser's audits found an error rate of between 14% and 16% (depending on how strictly certain rules were applied).

74. These Probe, pre-RADV and other ad hoc audits show consistent errors in certain types of risk adjustment claims across the Kaiser system. For example, many of the errors in the 2006 and 2007 national RADV audits were for issues or diagnoses that repeatedly show up as upcoded in subsequent Probe Audits in Colorado and elsewhere, such as coding historical conditions as active, improperly coding based on probable, suspected or rule out diagnoses, and coding for specific diagnoses such as cancer, arrhythmia, stroke, vascular disease, ulcers, vertebral fractures, major depression, and diabetes with complications.

75. Similarly, results from a 2008 Probe Audit across all Kaiser regions showed a 15% error rate for HCC risk adjustment claims, and an 11% error rate for RxHCC risk adjustment claims. The results for individual regions ranged from error rates of 5% to 20%.

76. A September 16, 2008 PowerPoint presented at the Fall 2008 Regional Reporting Groups ("RRG") Meeting indicated that the overall error rate across all Kaiser regions was approximately 13% for the 2007 Probe Audit, and 27% for the 2006 Probe Audit. The Regional Reporting Groups are comprised of representatives from each Kaiser Region who are responsible for conducting audits and other initiatives related to risk adjustment. Therefore, by presenting them at the RRG Meeting, these results were distributed widely throughout Kaiser.

77. Similarly, in an April 22, 2008 PowerPoint presented at the RRG Spring Conference, Kaiser personnel identified as "common coding issues" from prior audits several of the diagnoses discussed in greater detail below such as: (a) "Old MI versus acute MI;" (b) "Late effect of [stroke] or history of [stroke] versus acute [stroke];" (c) "History of cancer versus active cancer"; and (d) issues with renal insufficiency coded as chronic kidney disease.

78. The April 22, 2008 PowerPoint also identified coding issues found in the 2006 pre-RADV audit (looking at 2005 risk adjustment claims based on 2004 clinical data). Problems identified included: (a) MI; (b) ulcers; and (c) cancer. Other diagnoses that routinely show up as erroneous in audits of regions other than Colorado include inappropriate linkage of complications to diabetes.

79. The September 16, 2008 PowerPoint discussing the 2006 and 2007 Probe Audit findings observed that some of the problem areas identified by the audits included several of the issues discussed in greater detail below, including: (a) "History of condition vs. current condition" and (b) "Impact of external provider records."

80. In 2010, Kaiser's Northern California Region audited data in its claims systems for care provided to patients in 2009. Of the "Top Ten Failed HCCs by Volume" were several that the Colorado region also found to be routinely problematic, including HCCs for cancer, stroke, arrhythmia, and vascular disease. This audit will be discussed in greater detail below.

81. Examples of risk adjustment claims that the Kaiser audits have identified as routinely false include: (a) false claims submitted based on diagnoses from external providers, (b) high rates of diagnosis specific false claims identified during the Probe Audits; (c) false claims submitted due to other process-based coding violations; and (d) diagnoses that Kaiser identified as upcoded through the use of its "high risk" filter program. These examples (described below) are illustrative of the types of false claims of which Kaiser had knowledge but they do not include each and every false claim.

82. As described in sections V.A.2 and V.A.3. below (paragraphs 169 -190), despite its knowledge that the categories of risk adjustment claims described below are false a significant percentage of the time, Kaiser routinely fails to take reasonable steps to identify which of these claims are false (*i.e.*, Kaiser does not extend its review beyond the discrete audit sample and into previous years' claims submissions), and then to prevent their submission in the first place or to delete them after submission. Instead, Kaiser's reaction to this knowledge on a national and regional level has been (except in isolated instances) to avoid conducting retrospective audits to correct previously submitted false data.

a. False Claims Submitted Based On Diagnoses from External Providers

83. Several of Kaiser's regions rely heavily on external providers (hospitals or other facilities who are not owned by Kaiser) to provide inpatient care to Kaiser's HMO members. These regions include Colorado, Hawaii, and, until recently, Georgia.

84. These external providers submit claims to Kaiser for services provided to Kaiser members. Kaiser then uses the diagnoses from these claims as the basis for risk adjustment claims Kaiser submits to CMS.

85. Kaiser Colorado relies on diagnoses submitted by external providers to support 10% to 13% of its risk adjustment claims.

86. Kaiser's Probe and other audits have identified significant error rates in risk adjustment claims Kaiser submitted to CMS based on diagnoses provided by external providers.

87. For example, for the Colorado region, the error rates for internal providers were as follows:

Year	Internal HCCs Audited	Errors	Error Rate
2007	156	14	9%
2008	119	11	9%
2009	277	29	10%
2010	371	47	13%
2011	340	27	8%
2012	370	18	5%
2013	227	14	6%

88. The error rates for external providers have been up to ten times higher:

Year	External HCCs Audited	Errors	Error Rate
2007	51	11	22%

2008	12	8	67%
2009	53	9	17%
2010	57	23	40%
2011	56	26	46%
2012	28	11	39%
2013	11	7	64%

.

89. The error rates for certain large hospitals in particular are striking. For example, the 2011 Probe Audit found that:

a. Exempla Good Samaritan Medical Center had an error rate of 93% (12 of 14 HCCs reviewed were erroneous);

b. Exempla Lutheran Medical Center had an error rate of 100% (4 of 4 HCCs reviewed were erroneous);

c. Exempla St. Joseph Hospital had an error rate of 67% (32 of 36 HCCs reviewed were erroneous);

d. Pueblo Clinic had an error rate of 92% (11 of 12 HCCs reviewed were erroneous); and

e. Swedish Medical Center had an error rate of 73% (9 of 11 HCCs reviewed were erroneous).

90. In the 2012 Probe Audit, Exempla St. Joseph again showed an elevated error rate of 42% (5 of 12 HCCs were wrong).

91. In the 2010 Probe Audit, Exempla Good Samaritan had an error rate of 40% (4 of 10 HCCs), Exempla St. Joseph had an error rate of 52% (9 of 17 HCCs), and Swedish Medical Center had an error rate of 40% (3 of 5 HCCs).

92. The Exempla chain hospitals are the primary providers of inpatient care for Kaiser patients in Colorado, making their consistently elevated error rates of particular concern.

93. This is not just a problem in the Colorado Region. For example, a September 16, 2008 PowerPoint presented at the Fall 2008 RRG Meeting flagged diagnoses submitted by external providers as one of the top sources for false claims in other regions.

94. For this reason, most Kaiser regions subject diagnoses submitted solely by external providers to enhanced scrutiny. The Northern California, Hawaii, and Northwest Regions review all (or nearly all) HCCs that are supported only by a diagnosis from an external provider. The Georgia and Southern California regions conduct targeted samples of some claims provided by certain high volume external providers.

95. Kaiser Colorado's executives are aware that this is a continuing issue. For example, the Kaiser CFO, CPMG Associate Medical Director (Vice President), CPMG CFO, and Executive Director of Revenue Cycle have all been present at meetings where the results of annual Probe Audits were discussed.

96. Moreover, around late 2011, Treska Francis, the leader of the Kaiser Colorado coder group, personally performed an audit of about 100 diagnoses received from Exempla St. Joseph's Hospital and Exempla Good Samaritan Medical Center. She found a 40% to 60% error rate. She reported this to her boss, the Manager of Medicare Risk Business Services, who ignored the report. Treska then reported the problem to her boss' boss, Tom Rennell, Executive Director of Revenue Cycle for Kaiser Colorado. Mr. Rennell told her to "leave it alone."

97. Later, at Relator's urging, Kaiser Colorado began another audit of external hospitals. The audit was supposed to cover three southern Colorado hospitals. One hospital refused to participate. The initial results from the other two hospitals (18% of the 357 diagnoses audited at St. Thomas More Hospital were invalid; 20% of the 678 diagnoses at Memorial Hospital were invalid) were described in the Kaiser Colorado Medicare Initiative Meeting as "unsettling" and "disturbingly high." Relator does not know if the audit was ever completed, but the final results were never released.

98. Despite knowing of the consistent errors in claims data from external providers, Kaiser Colorado does not conduct any routine targeted audits of claims submitted by external providers. This is particularly egregious because the Colorado region does have a coder review each hospital stay at an external provider to look for additional diagnoses present in the chart but not coded by the treating physician. These coders do not attempt to validate the codes submitted by the hospital. These are simply passed through to CMS for payment.

99. For years, Relator has requested that a filter be created to tag high-risk codes from external providers for review. Instead, Kaiser Colorado created a filter to review codes received from internal providers.

100. Moreover, despite Kaiser Colorado's consistent problems with data from external providers, it has not performed larger audits or instituted a pre-submission review. In fact, Kaiser Colorado's only action appears to have been to attempt to stop reporting error rates associated with data from external providers separately from error rates associated with data from internal providers, so as not to call attention to the problem. The initial version of the 2013 Probe Audit did not identify whether errors were from internal or external providers. Relator insisted that the audit be reopened and amended to add this information.

b. High Rates of False Claims Identified During Probe Audits

101. The following are examples of diagnoses and HCCs identified as frequently upcoded during Kaiser's Probe Audits. Although Relator has the most knowledge about the Probe Audit results from the Colorado Region, he also knows, from his attendance at RRG meetings and work with other Kaiser regions, that these HCCs often were found to be upcoded in other regions as well. Moreover, these are not all of the problematic HCCs that were identified for either the Colorado Region or for other regions; instead, they are representative examples of some of the top problems Relator identified and are illustrative of the types of false claims that, during the times relevant to this action (i.e., from 2004 to present), Kaiser submitted to CMS.

102. **Cancer**: Kaiser's Probe Audits have consistently identified cancer (HCCs 7 – 10) as the most upcoded condition. Improper claims for diagnoses of active cancer have shown up in every single Probe Audit from 2006 to 2013.

103. The most significant and consistent error is that Kaiser providers submit diagnosis codes representing active, current treatment of cancer when, in fact, the patient's cancer is cured, in remission, or otherwise irrelevant to the services provided to the patient.

104. A diagnosis of cancer is permissible under the ICD-9 coding guidelines when there is evidence of active disease. Where a diagnosis of active cancer appears, one would expect to see evidence of treatment (chemotherapy, radiation, surgery, or palliative care) in the patient's medical chart as well.

105. Once there is no evidence of an existing malignancy, the proper diagnosis code is for "history of cancer." "History of cancer" diagnoses fall within the v10 category of HCC codes and do not risk adjust.

106. Colorado is not the only Kaiser region to have significant problems with the submission of false risk adjustment claims for cancer. At RRG meetings attended by Relator, all other Kaiser regions have noted that they also consistently find high error rates in their risk adjustment claims where a patient has a history of cancer improperly coded as active cancer. This is consistently the biggest issue in the annual Probe Audits across the Kaiser organization.

107. The source of these errors is in part historical. Kaiser's physician groups, since 2004, have used an EMR system called HealthConnect. When Kaiser first launched HealthConnect, physicians could not easily enter a diagnosis of "history of cancer" – it simply was not an option in the drop-down menu of diagnoses. Instead, physicians would code a diagnosis of active cancer and note "history of" in the comments field. Although Kaiser has long known this is a problem, when the data from these charts is filtered for submission to CMS, only the diagnosis code of active cancer is submitted and the notation of "history of" is ignored for purposes of data submission to CMS.

108. Although HealthConnect (Kaiser's EMR) now has "history of" codes available, physicians are still accustomed to documenting "history of cancer" in this way (i.e., coding active cancer and noting "history of cancer" in the comments field).

109. In an attempt to identify how big a problem this was, in 2007 Dr. Taylor conducted an audit of over 6,000 risk adjustment claims for Breast or Prostate cancer submitted by CPMG physicians in 2006 and 2007. The audit showed an error rate of 78% for breast cancer and 52% for prostate cancer, resulting in more than $6 million dollars in false claims. Kaiser deleted the false claims identified in this audit and, accordingly, refunded the overpayments to CMS.

110. Based on these findings, Relator convinced Kaiser Colorado to make changes to its EMR system to try to "prompt" physicians to change their coding behavior. HealthConnect, Kaiser's EMR, was modified so that every time a CPMG physician entered a diagnosis of cancer an alert would pop up, offering a brief explanation of when a diagnosis of active cancer is appropriate and ensuring that was the intended diagnosis as opposed to history of cancer. For example, the breast cancer pop up said:

> "DISEASE MANAGEMENT REMINDER: To use this diagnosis, you must have documented in your note that the cancer is active or exists and/or the current treatment for the cancer.
>
> ACTION: IF NOT ACTIVE, use History of Breast Cancer – enter Hx Breast in the Encounter Diagnosis field to select."

111. The use of this pop-up alert reduced the error rate substantially – to an accuracy rate of 96% for breast cancer and 93% for prostate cancer.

112. Unfortunately, this fix was short-lived. In 2010, Kaiser turned off the alert and replaced it with a limited internal filter. This "filter" program is discussed in greater detail below.

113. With the manual review associated with the filter, the error rate in Kaiser Colorado for improper cancer diagnoses remained below the error rates seen before the alert was implemented. However, in late 2011 or early 2012, Kaiser Colorado decided to turn off the filter to save money and coding resources. As shown by the Probe Audits since, the error rate for cancer diagnoses has rebounded. Despite the fact that the alert and filter were obviously preventing the submission of false claims, Kaiser has not turned either back on.

114. Moreover, despite the substantial volume of cancer HCC submissions, and increased error rates since the filter was turned off, Kaiser Colorado has not conducted another broad cancer audit such as the one performed in 2007. Instead, Kaiser has responded to the renewed evidence of high cancer error rates with only limited and prospective fixes.

115. For example, Kaiser Colorado's corrective action plan ("CAP") developed after the 2011 Probe Audit called for targeted retrospective audits of diagnoses of active cancer. However, to Relator's knowledge, no such audits were ever performed. The CAP similarly called for Relator and Dr. Teresa Welsh, the CPMG Physician Director of Coding, to visit the CPMG oncologists and discuss the coding accuracy of their cancer diagnoses. Dr. Welsh conducted some follow-up training, but reported back to Relator that, to be effective, such training would have to be done annually given the high turnover rate for oncologists. Kaiser does not conduct this training annually.

116. For years, Relator has recommended a broad retrospective audit of diagnosis codes known to be problematic, including cancer. In 2011, Kaiser Colorado hired an external vendor to conduct such an audit. This was known as the "Peak" project. Relator believes that part of this project was to review past cancer diagnoses submitted for risk adjustment to CMS. Any findings of the Peak audit have been withheld from Relator. However, he was told by Treska Francis, the leader of the Kaiser Colorado coder group, shortly after the audit began that the findings were "not looking good," *i.e.*, that the error rates were substantial.

117. **Stroke**: Kaiser identified problems with claims submitted for HCC 96, Ischemic or Unspecified Stroke, in Probe Audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, and 2011.

118. As with cancer, Kaiser knew stroke was commonly coded as an active event, when, in fact, the patient should have been classified as having a history of stroke. A diagnosis of a cerebrovascular accident (CVA)/stroke (ICD-9 codes 430-437) is appropriate for the initial acute stroke episode.

119. During RRG meetings, Relator learned that CVA/stroke is a diagnosis for which all Kaiser regions show high error rates, especially Kaiser's Northwest Region (Oregon and Washington).

120. Given the clinical profile of acute stroke, it would be particularly easy for Kaiser to audit past claims submissions and/or filter current claims to address this issue before submission. In almost all cases, when a patient is having a stroke she is treated in a hospital. A patient typically is not allowed to leave the hospital until after the stroke is over. Once the acute incident is over, the patient should be diagnosed as either having a history of stroke, or receiving treatment for the late effects of the prior stroke. Thus, in almost all cases, if a physician submits a diagnosis for acute stroke for a patient treated in the physician's office (or any setting other than a hospital), that diagnosis is likely erroneous.

121. Applying this principle, Relator convinced Kaiser to fund a pilot project to have a physician review all of the acute stroke diagnoses made in CPMG physician offices in 2010. Dr. Christina Marchioni, the CPMG physician who performed the review determined that Kaiser had submitted to CMS approximately $3.1 million in false acute stroke claims during the audit period. In fact, he determined that all but two of these claims were false. He also determined that Kaiser could have submitted replacement claims for treatment of the after effects of stroke for these patients, worth approximately $1.2 million per year.

122. Despite these results, Kaiser did not delete these erroneous codes (and, correspondingly repay CMS), or conduct a similar audit for prior years. Instead, Kaiser simply had the reviewing physician correct the problem list in the patient's chart to reflect that the patient had a "history of stroke" or the "late effects" of stroke to minimize the chance that the error would be repeated in future years.

123. This project temporarily reduced the error rate for risk adjustment claims submitted for stroke in the following year. However, in 2011 Relator's funding for this project was cut and the work stopped. Since then, the error rate for stroke diagnoses has increased again.

124. Relator has recently begun a new program whereby all claims for an acute stroke diagnosis submitted based on an office visit by an internal provider are flagged for further review by Kaiser Colorado coders. If the coders identify errors, they reach out to the internal provider that submitted the diagnosis and ask her to correct the error. Unfortunately, the coders are not authorized to correct the errors themselves to prevent the false claims from being submitted, or to compel the internal providers to correct their errors. Thus, approximately 25% to 30% of the errors the coders identify are ultimately submitted to CMS as risk adjustment claims because the internal provider that submitted the diagnosis ignores the coders' efforts to correct the code.

125. **Vertebral Fractures**: In Probe Audits conducted in 2009, 2010, and 2011, Kaiser identified problems with claims submitted for HCC 157, Vertebral Fractures without Spinal Cord Injury. This is another diagnosis where Kaiser found that it often submitted false risk adjustment claims to CMS because physicians improperly coded the condition as active when, in fact, the patient only had a "history of" the condition.

126. **Vascular Disease**: In Probe Audits conducted in 2007 (from the "2006 Wrap-up Report"), 2009, 2010, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCCs 104, Vascular Disease with Complications, and/or 105, Vascular Disease.

127. The audit documents and additional research by Kaiser identified at least two causes for these errors. First, some claims erroneously claimed the patient had current vascular disease, when, in fact, they had only a history of the condition.

128. This was particularly true for cases where the patient had a history of pulmonary embolism, a condition when one or more pulmonary arteries in the patient's lungs become blocked. In most cases, pulmonary embolism is caused by blood clots that travel to the lungs from the legs. Patients who have one or more pulmonary emboli are often treated with anti-coagulants to prevent the development of additional emboli. Until a recent rule change, it was improper to classify patients being treated with anti-coagulants to prevent emboli as being treated for pulmonary embolism; they were properly coded as having only a history of pulmonary embolism. Kaiser knew that physicians routinely misapplied this rule, coding patients on anti-coagulants as having pulmonary embolism, thus causing the submission of false claims for HCC 104.

129. Second, certain claims were false because of a "mismapping" problem with HealthConnect, Kaiser's EMR. HealthConnect, used throughout all of its regions, allows physicians to choose a descriptive diagnosis (as opposed to a specific ICD-9 code) when entering clinical information. HealthConnect then "maps" this descriptive diagnosis to a specific ICD-9 diagnosis code, which is then inserted into the medical record documentation. For certain diagnoses, however, this "diagnosis" file in the past has linked a descriptive term to the wrong ICD-9 diagnosis code.

130. For example, pain in the legs associated with physical activity may be a result of a lack of blood supply to the legs (vascular claudication) or nerve root compression (neurogenic claudication). Relator discovered that when a physician attempted to diagnose a patient with the neurologic condition, it incorrectly mapped to the ICD-9 code for the vascular disorder. For this reason, false claims were submitted for a vascular condition (HCC 104 or 105) when the physician attempted to diagnose a patient with nerve compression (a condition that does not risk adjust).

131. **Chronic Bronchitis**: In Probe Audits conducted in 2007 (the "2006 Wrap-up Report"), 2009, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCC 108, Chronic Obstructive Pulmonary Disease ("COPD").

132. The probe audits regularly found COPD claims erroneous based on lack of documentation in the record, or because the doctor failed to document the patient's condition with sufficient specificity to determine if the patient actually had COPD.

133. In addition, Kaiser's problematic diagnosis file also affected claims for HCC 108. Because of mismapping, when a physician attempted to diagnose a patient with bronchitis (a diagnosis that does not risk adjust), it was incorrectly mapped to an ICD-9 code for chronic bronchitis, and thus classified as HCC 108 (which does risk adjust). The 2010 Probe Audit specifically flagged this problem, even though it did not affect any risk adjustment claims audited that year.

134. Kaiser's EMR also pressured physicians to use the diagnosis code for chronic bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk adjust). If a physician chose acute bronchitis as a diagnosis, HealthConnect (Kaiser's EMR) warned them that this could affect their score on certain quality measures. HealthConnect also informed them

that if they selected simple bronchitis or chronic bronchitis instead, the quality measure at issue would not be negatively affected.

135. **Metastatic Cancer**: In Probe Audits conducted in 2009, 2010, 2011, and 2012. Kaiser identified problems with claims submitted for HCC-7, Metastatic Cancer and Acute Leukemia.

136. While some of these errors were caused by improper use of codes for active cancer, when the patient actually had a "history of" cancer, there was at least one other cause. Again, errors in Kaiser's diagnosis file led to the insertion of an incorrect diagnosis code in the file, indicating metastasis in circumstances where the physician selected a non-metastatic descriptive diagnosis. Metastatic cancer is a condition where cancer spreads from one organ to another and results in significant additional risk adjustment payments.

137. **Myocardial Infarction and Old Myocardial Infarction**: In Probe Audits conducted in 2006 (2007 audit of 2005 data), 2010, and 2011, Kaiser identified problems with claims submitted for HCCs 81, Acute Myocardial Infarction ("MI"), and/or 83, Angina Pectoris/Old Myocardial Infarction ("old MI").

138. An MI is a heart attack. Kaiser's Probe Audits identified multiple issues with the claims submitted for HCCs 81 and 83. In some cases, a claim was submitted for an acute MI, when the proper claims should have been for old MI. In other cases, the only support for an old MI diagnosis was a radiology report or other test result, rather than a diagnosis documented by an appropriate provider in a face-to-face visit. In other cases, Kaiser simply concluded that the medical record documentation did not support the diagnosis of an MI or old MI at all.

139. **Malnutrition**: In Probe Audits conducted in 2009 and 2011, Kaiser identified problems with claims submitted for HCC 21, Protein-Calorie Malnutrition.

140. Kaiser identified several causes for these problems. In some cases, the condition was diagnosed as current when the patient actually only had a "history of" the condition.

141. In other cases, the false claim resulted from Kaiser coders and/or computer systems adding a malnutrition diagnosis where the treating physician had not. This often happened when a physician used the term "cachexia" in his or her treatment note. Cachexia can be used as a specific diagnosis, indicating that patient has chronic malnutrition or a specific wasting disease. Alternatively, physicians sometimes use variations of the term cachexia as an adjective to indicate that a patient appears malnourished, even where the patient has not been diagnosed with the disease cachexia (*e.g.*, the patient "looks cachetic"). In the latter case, it is inappropriate for a coder to decide that a patient has cachexia, because only a physician (or other appropriate provider) can determine that a patient has a given condition.

142. **Decubitus Ulcers**: In Probe Audits conducted in 2009 and 2011, Kaiser identified problems with claims submitted for HCC 148, Decubitus Ulcer of Skin.

143. There are two primary ulcer types: (1) decubitus ulcers, due to pressure; and (2) venous stasis ulcers, where the skin breaks down because of prolonged swelling in the extremities due to poor circulation. When properly coded, decubitus ulcers support a risk adjustment claim for HCC 148; venous stasis ulcers do not risk adjust. One reason Kaiser was submitting false claims for HCC 148 is that physician documentation often failed to sufficiently identify the cause of a patient's ulcer. For example, the audit notes for the 2011 Probe Audit report that one claim was found to be false because "record supported skin breakdown due to maceration rather than an ulcer due to pressure."

144. Decubitus ulcers were also improperly claimed when no ulcer was present. For example, another claim from the 2011 Probe Audit invalidated a diagnosis of decubitus ulcer

noting that "NCO [Kaiser's National Compliance Office] could find no documentation to support that the patient [had] an ulcer. The physician documented that the SNF nursing staff reported no skin problems."

145. **Sick Sinus Syndrome**: In Probe Audits conducted in 2006 (2007 audit of 2005 data), 2009, 2010, 2011, 2012, and 2013, Kaiser identified problems with claims submitted for HCC 92, Specified Heart Arrhythmias.

146. Sick sinus syndrome ("SSS") is the name for a group of heart rhythm problems (arrhythmias) in which the sinus node – the heart's natural pacemaker – does not work properly. A person with SSS may have heart rhythms that are too fast, too slow, punctuated by long pauses, or a combination of these rhythm problems. SSS is often treated with the implantation of a pacemaker.

147. Under established coding guidelines, once a patient has received a pacemaker to treat her SSS, it is no longer appropriate to code her condition as acute SSS (assuming the pacemaker is effectively treating the SSS). Instead, her condition should be coded to reflect the presence of the pacemaker.

148. One reason for the number of false claims submitted for HCC 92 is that, as Kaiser knows, physicians routinely submit a diagnosis code for SSS when they only should be submitting the code for the presence of the pacemaker. As Kaiser noted in one record for the 2011 Probe Audit: "The record documents that the patient is on a pacemaker for SSS, and per Coding Clinic guidelines in the situation the SSS may only be coded if … the SSS is addressed or there is a problem with the pacemaker."

149. Kaiser could easily prevent the submission of false claims for Sick Sinus Syndrome by setting up a process in its claims and billing software to flag situations where a

claim includes a diagnosis of SSS and the presence of a pacemaker, and delete the diagnosis for SSS. It is notable that Kaiser has chosen not to use such a claims processing rule to fix this problem because Kaiser uses such rules to add new diagnoses if such a change will allow Kaiser to submit additional risk adjustment claims to CMS. For example, in cases where a patient is being treated with a type of drug that typically indicates major depression (a diagnosis that risk adjusts) but the patient has only been diagnosed with standard depression (a diagnosis that does not risk adjust), these claims are flagged for review to potentially code major depression.

150. In a similar way, Kaiser could easily conduct a retrospective audit of previously submitted claims based on a diagnosis of SSS by selecting any such claims that also had a diagnosis code for presence of a pacemaker. Nonetheless, Kaiser has not done so.

151. **Renal Insufficiency**: In Probe Audits conducted in 2009, 2011, and 2013, Kaiser identified problems with claims submitted for HCC 131, Renal Failure.

152. Chronic kidney disease ("CKD") is a condition that is often miscoded, and can have significant impact on risk adjustment scores. Although CKD is classified as Levels I to V, depending on the seriousness of the disease, all five levels of CKD map to the same HCC -- HCC 131.

153. Kaiser knew that patients were often incorrectly diagnosed with low level CKD (Levels I and II), but failed to conduct any targeted audits to test these claims. Such audits would have been particularly straightforward because the diagnosis of CKD Levels I and II is largely driven by two lab test values: (a) the patient's glomerular filtration rate ("GFR") rate; and (b) the presence of protein in the patient's urine.

c. False Claims Submitted Due To Other Coding Violations

154. The Colorado and national Probe Audits also identified consistent problems with the application of basic risk adjustment coding rules. Because these errors were process-based rather than diagnosis specific, it would be more difficult to perform a targeted audit to identify the affected false claims. Notably, though, Kaiser did conduct broad audits to find claims affected by similar process-based issues, as long as those problems led to increased revenue to Kaiser when fixed. Moreover, these process-oriented problems could have been addressed relatively easily using Kaiser's Natural Language Process program (discussed in greater detail below), if Kaiser had chosen to do so.

155. In its Probe Audits, Kaiser found that false claims were routinely submitted to CMS where the diagnosis was listed in medical documentation of a physician or hospital outpatient visit as probable, rule out, or suspected. As discussed above, CMS rules prohibit the use of such a diagnosis for a risk adjustment claim.

156. For example, in the 2011 Colorado Probe Audit, a stroke HCC was deemed invalid because the suspected stroke had been "ruled out by time of discharge but coded as if present." Another claim, for a diagnosis of vascular disease (based on a reported pulmonary embolism), was invalidated because the record specifically stated "P[ulmonary] E[mbolism] ruled out."

157. Again, in the 2013 Colorado Probe Audit, the audit identified a claim submitted for deep vein thrombosis (DVT) where the diagnosis had been "ruled out by work-up."

158. The Probe Audits also found that Kaiser routinely submitted claims where a non-chronic diagnosis was listed on a problem list or elsewhere in the medical record without any

notation or other evidence that the diagnosis was treated or affected the treatment provided. CMS rules prohibit the submission of claims based on such diagnoses.

159. For example, in the 2010 Probe Audit, 7% of all errors were based on a submitted diagnosis for a non-systemic condition where there "was no documentation to support that the condition had been addressed, evaluated, treated, or considered."

160. The Probe Audits also found that Kaiser routinely submitted claims where the only documentation to support the diagnosis was a radiologic or lab test, or other non-face-to-face service. CMS rules prohibit the submission of claims based on such diagnoses.

161. For example, in the 2010 Probe Audit, two of the invalidated HCCs were found to be invalid because they were based on diagnostic radiology reports.

d. Diagnoses Kaiser Identified as Upcoded Through High Risk Filter

162. From approximately 2010 through late 2011 or early 2012, Kaiser's Colorado region used a "filter" program to review certain "high risk" (*i.e.*, often overcoded) diagnoses submitted by internal providers before those diagnoses were submitted to CMS for risk adjustment payments. The filter tagged specified diagnoses for manual review by one of Kaiser Colorado's five coders, every time one of the "high risk" diagnoses was received from a CPMG physician. If the Kaiser coders determined that the diagnosis was invalid, it would be flagged to prevent Kaiser from submitting a risk adjustment claim to CMS on the basis of that diagnosis.

163. The filter was relatively successful in reducing the error rate for some of the diagnoses and internal provider groups it covered. However, for many of the diagnoses, the filter showed that Kaiser continued to have a high error rate.

164. The audits conducted in connection with the filter identified not only specific HCCs that had high error rates, but also the individual diagnosis codes that were problematic.

165. For example, as of July 2011, the filter program reviewed the following HCCs and found the following error rates:

HCC	Description	HCCs Reviewed	Invalid HCCs	Error Rate
8	Lung, Upper Digestive Tract, & Othr Severe Cancers	472	67	14%
9	Lymph, Head & Neck, Brain, & Othr Major Cancers	364	45	12%
10	Breast, Prostate, Colorect & Othr Cancers & Tumors	3,013	509	17%
32	Pancreatic Disease	361	51	14%
44	Severe Hematological Disorders	5	5	100%
92	Specified Heart Arrhythmias	7,113	1,084	15%
96	Ischemic or Unspecified Stroke	460	215	47%
104	Vascular Disease with Complications	582	172	30%
157	Vertebral Fractures without Spinal Cord Injury	320	115	36%
158	Hip Fracture/Dislocation	530	153	29%
164	Major Complications of Medical Care and Trauma	52	19	37%

166. Much to Relator's frustration, though, the filter did not address the category of claims with the highest error rate -- external providers. Nor did Kaiser conduct audits of claims submitted for these "high risk" diagnoses for internal providers in prior years.

167. Further, although Kaiser blocked erroneous diagnoses identified through the filter from being submitted as risk adjustment claims in the year at issue, Kaiser did not correct the problem lists in the EMRs. Because most diagnoses listed on a patient's problem list tend to be included in subsequent claims, by failing to correct the patients' problem lists, there was a high likelihood that the same diagnoses would be submitted to CMS in subsequent years.

168. Even worse, in late 2011 or early 2012, Kaiser Colorado ended the "high risk" filter program itself, even though the audits conducted pursuant to the program continued to show high error rates in the coding for these "high risk" diagnoses. No similar program was adopted to replace the filter program.

2. Kaiser Re-Submits Claims, or Refuses To Delete Claims, for Diagnoses That It Knows Are Invalid

169. In the limited instances where Kaiser conducts a broad retrospective audit to identify previously submitted false claims, it does not always delete those claims or otherwise repay Medicare. For example, as discussed above, during the 2010 stroke pilot project, Kaiser Colorado identified at least $3.1 million in false claims for HCC 96 (Ischemic or Unspecified Stroke). However, Kaiser did not delete those codes, or otherwise repay Medicare for the overpayment it received as a result of these false claims.

170. Further, in the instances where Kaiser does delete previously submitted false codes, it often later re-submits those same claims, thus seeking (and receiving) payment for the diagnoses that it knows to be false.

171. Kaiser Colorado and Kaiser Hawaii do this because of a problem in their claims processing systems. When codes are deleted after an audit, the system for Colorado and Hawaii does not have a flag or other mechanism to indicate that the audit found these diagnoses to be invalid. Nor are the diagnoses removed from the patient's medical record. Thus, when Kaiser conducts "resweeps" – a process designed to re-examine the EMR system to capture diagnoses that were added to patients' medical records after the initial submission of data to Kaiser's risk adjustment claims system – the system picks up the previously deleted diagnoses. Thereafter, Kaiser submits new risk adjustment claims for these diagnoses that Kaiser already determined to

be invalid. Kaiser is aware that the flaw in Colorado and Hawaii's claims processing systems has this effect.

3. Kaiser Acts With Reckless Disregard and/or Deliberate Ignorance As to the Falsity of a Substantial Number of the Risk Adjustment Claims It Submits

172. In addition to the false risk adjustment claims that Kaiser submits (or re-submits) with actual knowledge of their falsity, Kaiser also submits a substantial number of claims that Kaiser knows are false, within the meaning of the False Claims Act, because Kaiser acts with reckless disregard and/or deliberate ignorance as to their truth or falsity.

173. Kaiser is on notice that certain categories of its risk adjustment claims (*e.g.*, as described above, external providers, certain diagnoses) are false a significant percentage of the time. Nonetheless, Kaiser routinely fails to take reasonable steps to identify which of these claims are false, and then to prevent their submission in the first place or to delete them after submission.

174. Despite the fact that Kaiser's Probe and other audits have consistently identified areas where a significant number of the claims Kaiser submits are false, Kaiser's reaction, on a national and regional level, has been to (except in isolated instances) avoid conducting retrospective audits to correct previously submitted false data.

175. Instead, Kaiser's response to these audits focuses primarily on provider coding education that would, at best, only affect future claims. Kaiser's corrective action plans routinely prescribe only the deletion of those specific claims found to be false and some measure of future education. Even worse, in the few instances where a CAP does call for follow up audits, in Relator's experience, these audits are typically not done.

176. Because these Probe Audits routinely identify specific types of claims (either by diagnosis, by provider type, or by other category), in most cases Kaiser could easily do a targeted audit to find erroneous claims in a relatively cost efficient manner. Kaiser refuses to do so.

177. In contrast, Kaiser's response is very different when it learns certain diagnoses are undercoded. Kaiser regularly invests substantial resources in audits to find potential undercoded conditions. Moreover, when Kaiser finds undercoded conditions, it always (or almost always) submits risk adjustment codes for those conditions. For overcoded conditions, on the other hand, Kaiser rarely conducts follow up audits of all claims for that diagnosis submitted in that year, or prior years. Furthermore, in some instances (as with the stroke project discussed above) even where errors are found, Kaiser does not delete the previously submitted erroneous codes.

178. For example, in 2006, Kaiser's Colorado region conducted "Reimbursement Recovery Audits" ("RRA") looking for new diagnosis codes to submit for at least 19 different clinical pathways or diagnoses. None of these audits targeted overcoded claims, even though Kaiser knew that some of the same conditions (*e.g.*, MI) were often overcoded. In 2007, Kaiser Colorado conducted at least 22 such targeted clinical audits.

179. In 2010, Kaiser's Colorado region conducted more than 30 such RRA audits to find new claims. Again, several of the audits targeted diagnoses that Kaiser knew were also routinely overcoded (*e.g.*, breast cancer, prostate cancer, arrhythmia, chronic kidney disease, COPD, MI), yet these audits only looked for new diagnoses to submit, which has the effect of increasing Kaiser's risk adjustment payments from CMS.

180. Relator has learned, through RRG meetings and conversations with other Kaiser employees, that Kaiser's other regions similarly conduct a substantial number of targeted clinical audits designed to find undercoded conditions and thereby increase their Medicare

reimbursement. These audits often cover all, or substantially all, patient charts for a given year that meet certain clinical criteria that suggest a possibility of undercoding. Yet these regions conduct few, if any, similar audits to find overcoding, in which Medicare overpayments would need to be returned.

181. At a September 16, 2008 RRG meeting, Dr. Robert Klein presented the results of Kaiser's Northern California Region's 2008 targeted clinical audits for undercoded claims. The region audited at least 12 different clinical pathways. As with the Colorado region's RRA audits, several of these audits targeted the same diagnoses (*e.g.*, MI, Chronic Kidney Disease) that Kaiser knew were often overcoded as well. No audits were performed to find overcoded claims for these diagnoses. Moreover, Dr. Klein proposed the addition of further retrospective reviews designed to find examples where, *inter alia*, metastatic cancer (HCCs 7 and 10), is undercoded. No similar proposal was made to find examples of overcoded cancer, even though Kaiser knows this is one of the top diagnoses that is overcoded and improperly submitted.

182. Interestingly, in 2010, Kaiser's Northern California Region did take some steps to attempt to remedy overcoded conditions. It audited data in its claims systems for care provided to patients in 2009. This audit appears to have been conducted before these diagnoses were used to submit risk adjustment claims. When the audit found incorrect diagnoses, Kaiser blocked them so that they would not be used as the basis for future risk adjustment claims.

183. Of the 4,566 diagnoses audited, 1,781 (39%) "did not have supporting documentation." Kaiser "blocked" these diagnoses so that no risk adjustment claims were submitted for them. Notably, Kaiser also found an additional 475 diagnoses that should have been included in the claims data.

184. This is exactly the type of due diligence that Kaiser should have been performing across all regions and for all plan years to identify problems with its medical record documentation before those errors led to the submission of false claims. Instead, however it was an anomaly.

185. Moreover, although Kaiser Northern California identified certain diagnoses as routinely incorrectly submitted, it did not conduct an audit of claims submitted for these diagnoses in prior years.

186. One of the most egregious examples of Kaiser's unwillingness to give the search for false claims the same attention as the search for new diagnoses to submit is Kaiser's program designed to "refresh" chronic diagnosis that are submitted one year but not the next. In this process, Kaiser routinely discovers certain patients for whom risk adjustment claims for specific diagnoses submitted in prior years were likely false. Nonetheless, Kaiser refuses to conduct any investigation of those prior year claims.

187. For example, in 2009, Dr. Karl Pregitzer, Associate Medical Director for Physician Business Services at Hawaii Permanente Medical Group, conducted a "diagnosis refresh" audit. He reviewed diagnoses submitted for a patient one year and not the next, where the physician had also removed the diagnosis from the patient's problem list. Dr. Pregitzer queried the treating physicians to determine whether the diagnosis was correctly omitted in the second year. He classified the results into three categories: (1) captured, meaning the diagnosis was incorrectly omitted in the second year; (2) inactivated, meaning the diagnosis was properly omitted in the second year; and (3) pending, meaning it was still unclear whether the diagnosis was properly omitted.

188. In an April 2, 2009 PowerPoint outlining his findings, Dr. Pregitzer raised a concern that the same five diagnoses had the highest number of claims in each of these three categories: (a) HCC 15, Diabetes with Renal or Peripheral Circulatory Manifestation; (b) HCC 16, Diabetes with Neurologic or Other Specified Manifestation; (c) HCC 80, Congestive Heart Failure; (d) HCC 105, Vascular Disease; and (e) HCC 131, Renal Failure. The specific conditions he identified that were causing the problems were all ones that generally do not go away once a patient has them. Thus, Dr. Pregitzer noted that it was unusual to see these conditions showing up in one year, but then a physician determining that they did not exist the following year. His recommendation was that these five diagnoses warranted further data mining, because the results suggested that there was substantial physician confusion about the proper coding rules for these diagnoses.

189. With respect to the second category, inactivated claims, Dr. Pregitzer's findings strongly suggest that the earlier diagnosis was incorrect. Thus, these audit results strongly suggested that for at least one (and likely more) prior years Kaiser had submitted: (a) 104 false claims for HCC 15; (b) 123 false claims for HCC 16; (c) 99 false claims for HCC 80; (d) 205 false claims for HCC 105; and (e) 213 false claims for HCC 131. Nonetheless, Kaiser did not audit the prior years' claims for these patients to determine whether they were accurate.

190. Another area where Kaiser was on clear notice that specific claims were false was with respect to the problems with its diagnosis files. As described above, Kaiser discovered on several occasions that certain diagnoses described in its EMR were incorrectly mapped to ICD-9 diagnosis codes that were eligible for risk adjustment payments. In 2011 Kaiser audited the diagnosis file and found that a substantial number of diagnoses were incorrectly mapped. Relator does not know whether Kaiser fixed these mapping errors. Even worse, to Relator's

knowledge, Kaiser failed to conduct an audit of previously submitted claims affected by these errors, even though it knew that certain errors caused the submission of identifiable risk adjustment claims.

4. Problems with Kaiser's Natural Language Processing Audit Program Caused the Submission of False Claims

191. Beginning in approximately 2009, Kaiser developed a Natural Language Processing ("NLP") audit program to try to find new diagnosis codes to submit. Broadly speaking, the NLP program uses an algorithm to search EMRs to find words that, individually or in combination, indicate that a patient has certain diagnoses. If done properly, NLP analysis can be an effective tool to find diagnoses that were properly documented in the physician treatment notes but not submitted in the claims data.

192. For that matter, a good NLP program can also identify situations where a diagnosis was submitted with the claims data but is not documented in the medical record. Several existing NLP programs on the market provide such functionality. They have a user interface that would permit the user to view all previously reported diagnoses as well as ones added by the software and confirmed by the coders. Further, clicking on any diagnosis would take the reviewer to the corresponding portion of the note.

193. In fact, Kaiser uses such programs (sold by 3M and OptumInsight) to conduct NLP analysis of its hospital radiology and Emergency Department claims for health plans other than its Medicare Advantage plans, *e.g.*, its commercial plans.

194. Some of the problems identified in Kaiser's Probe Audits that, as discussed above, are not necessarily easy to target in a diagnosis-specific audit (*e.g.*, non-chronic conditions that were listed in the record without documentation of treatment; use of radiological

test results as the basis for a claim; coding diagnoses that were listed as possible, probable or rule-out) could readily be targeted through a NLP audit and later corrected/deleted.

195. Rather than use an established NLP program, Kaiser built its own – even though Kaiser uses established NLP products from 3M and OptumInsight for other purposes. Notably, Kaiser's NLP program was built without any function to allow it to audit the validity of previously submitted claims.

196. All face-to-face visits to a physician or hospital by members of Kaiser's MA plans are run through the NLP software to identify new diagnoses that might be appropriate to use for the submission of additional risk adjustment claims. The results are grouped into four categories: (a) True Positive: diagnoses that have been confirmed by two Kaiser coders; (b) More Information Needed: diagnoses that may be present, but further analysis is required to confirm; (c) Problem List Only: diagnoses that show up only on the member's problem list with no documentation of treatment; and (d) False Positives or Found Elsewhere.

197. Kaiser allows the various regions to decide how to use this information. For example, a PowerPoint presented at the Fall 2010 RRG Meeting outlined the results of the "NLP HCC Data Mining Pilot." Three regions had participated in the pilot: (a) Georgia; (b) Hawaii; and (c) Northwest. The Northwest region appears to have simply passed along all of its "True Positive" diagnoses to its risk adjustment claims submission system (which submits the claims to CMS) without further review. The Georgia region passed along most (278 of 294) of the diagnoses to its risk adjustment claims submission system, which submits the claims to CMS. It is unclear from the presentation why some diagnoses were not passed along.

198. The Hawaii region, on the other hand, audited all of the "True Positives" before passing them on. Remarkably it found a 29% error rate in these claims that had supposedly been

confirmed by two Kaiser coders. It now continues to audit all "True Positives." Relator spoke with Terri Keliinoi, Kaiser Hawaii's manager of risk coding, on October 14, 2014. The manager reported that as of the review of the 2014 file, they are still finding a 20% error rate in the "True Positives."

199. This is consistent with Relator's own experience. He personally reviewed over 100 of the supposedly "True Positive" claims for the Colorado Region and found a 10% error rate. In particular, he noted that it appears that the NLP software picks up, and the reviewing coders have validated, diagnoses that appear in problem lists but which lack additional notation of treatment. As described above, a diagnosis may not be submitted for risk adjustment purposes if it just appears in a problem list. There must be further indication that the physician considered or treated the diagnosis.

200. Notwithstanding this high error rate, Kaiser continues to allow its regions to determine whether they will conduct any additional review of the True Positives before submission to CMS. The Colorado region passes the True Positive diagnoses to its claims submission system with no further review, even though Kaiser knows that many of these claims are likely false. Likewise, the Northwest region passes through all True Positive diagnoses with the exception of diagnoses of cachexia (which are known to have very high error rates). The Hawaii region, on the other hand, has both a coder and a physician audit 100% of the "True Positives."

201. By failing to take corrective action to prevent the submission of false diagnosis data, knowing that in the absence of action such data would be submitted, Kaiser knowingly submitted false claims to CMS for risk adjustment payments.

COUNT I

Federal False Claims Act
31 U.S.C. §§ 3729(a)(1)(A)–(B), (G)

202. Relator realleges and incorporates by reference the allegations made in Paragraphs 1 through 201 of this Complaint.

203. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729, *et seq.*, as amended.

204. By virtue of the acts described above, Defendants, their agents, and employees, knowingly presented or caused to be presented, false or fraudulent claims to the United States Government for payment or approval.

205. By virtue of the acts described above, Defendants, their agents, and employees, knowingly made or used, or caused to be made or used, false or fraudulent records or statements material to false or fraudulent claims.

206. By virtue of the acts described above, Defendants, their agents, and employees, knowingly concealed overpayments from the United States Government and failed to remit such overpayments.

207. The Government, unaware of the falsity of the records, statements and claims made or caused to be made by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' illegal conduct.

208. By reason of Defendants' acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

209. Additionally, the United States is entitled to the maximum penalty of up to $11,000 for each and every violation alleged herein.

PRAYER

WHEREFORE, *Qui Tam* Plaintiff-Relator Dr. James M. Taylor prays for judgment against Defendants as follows:

1. That Defendants cease and desist from violating 31 U.S.C. §§ 3729 *et seq*.

2. That the Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained as a result of Defendants' actions in violation of the Federal False Claims Act, as well as a civil penalty of $11,000 for each violation of 31 U.S.C. § 3729;

3. That Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) of the Federal False Claims Act;

4. That Relator be awarded all costs of this action, including attorneys' fees and expenses; and

5. That the United States and Relator receive all such other relief as the Court deems just and proper.

JURY DEMAND

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands trial by jury.

DATED: October 22, 2014

Respectfully submitted,

By: /s/ Daniel M. Twetten

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UNDER SEAL

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

JCS

UNITED STATES OF AMERICA *ex rel.* [FILED UNDER SEAL] Plaintiff, v. [FILED UNDER SEAL] Defendant.	Case No. CV 13 3891 **COMPLAINT FOR MONEY DAMAGES AND CIVIL PENALTIES FOR VIOLATIONS OF THE FALSE CLAIMS ACT** **DEMAND FOR JURY TRIAL**

NATURE OF THE ACTION

1. This is a civil action brought by Relator Ronda Osinek on her own behalf and on behalf of the United States of America against Kaiser Permanente ("Kaiser") under the False Claims Act, 31 U.S.C. § 3729, *et seq.*, to recover damages, civil penalties, and other relief owed to the United States and Relator.

2. Defendant Kaiser is a private provider of Medicare Advantage insurance under Medicare Part C. Kaiser defrauded the United States through a sophisticated scheme to upcode diagnoses to ensure Medicare payments for reimbursable, high-value conditions. Kaiser effectuated its scheme through data mining and pressuring physicians and staff to retroactively change patient medical records.

3. Kaiser's upcoding scheme is a direct violation of the Federal requirements for Medicare beneficiary reimbursement, leads to the submission of false and fraudulent claims to the United States, and results in Kaiser receiving excess Medicare payments.

PARTIES

4. Plaintiff is the United States of America by and through Relator, Ronda Osinek. Relator is a resident of the State of California. Plaintiff brings this action on behalf of the United States Department of Health and Human Services and its component, the Centers for Medicare & Medicaid Services.

5. Relator Ronda Osinek has been employed by The Permanente Medical Group of Kaiser Permanente, as a Data Quality Trainer since June 2006. Internal, non-public information known to Relator serves as the basis for this action. Relator has direct knowledge of methods used by Defendant to submit false or fraudulent data to CMS for reimbursement.

6. Defendant, Kaiser Permanente is a California corporation with its principal place of business at One Kaiser Plaza, Oakland, California 94612. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage plans than any other organization in California. At all times relevant, Kaiser conducted business in California, including but not limited to providing healthcare services through Medicare Advantage plans and to the general public in California.

JURISDICTION AND VENUE

7. This Court has subject matter jurisdiction under 28 U.S.C. §1345. This Court has subject matter jurisdiction over the claims alleged in this Complaint under 28 U.S.C. §§ 1331 (Federal question), 1345 (United States as plaintiff), and 31 U.S.C. § 3732(a) (False Claims Act).

8. This Court has personal jurisdiction over Defendant pursuant to 31 U.S.C. § 3732(a) because Defendant can be found, resides, and transacts business in the Northern District of California and because an act proscribed by 31 U.S.C. § 3729 occurred within this District.

9. This Complaint is not based on the facts underlying any pending action, within the meaning of the False Claims Act's first to file rule, 31 U.S.C. § 3730(b)(5).

10. This action is not precluded by any provisions of the False Claims Act's jurisdiction bar. 31 U.S.C. § 3730(e) *et seq*.

a. This Complaint is not based upon allegations or transactions that are the subject of a civil suit or an administrative civil money penalty proceeding in which the United States is already a party. 31 U.S.C. §3730(e)(3).

b. There has been no "public disclosure" of the matters alleged herein and this action is not "based upon" any such disclosure, within the meaning of 31 U.S.C. §3730(e)(4)(A). Notwithstanding the foregoing, Relator is an "original source" of this information as defined by 31 U.S.C. §3730(e)(4)(B) of the False Claims Act, and as such, she is expressly excepted from its public disclosure bar.

11. Venue is proper in the San Francisco or Oakland Divisions of the Northern District of California under 31 U.S.C. § 3732(a), 28 U.S.C. § 1391(b), and Civil Local Rule 3-2(d) because Defendant can be found in and transacts business within this District.

THE FEDERAL FALSE CLAIMS ACT

12. The False Claims Act was originally enacted in 1863, and was substantially amended in 1986. Congress enacted the 1986 amendments to enhance and modernize the government's tools for recovering losses sustained by frauds against it after finding that federal program fraud was pervasive. The amendments were intended to create incentives for individuals with knowledge of government

frauds to disclose the information without fear of reprisals or government inaction, and to encourage the private bar to commit resources to prosecuting fraud on the government's behalf.

13. The False Claims Act provides that any person who presents, or causes to be presented, false or fraudulent claims for payment or approval to the United States Government, or knowingly makes, uses, or causes to be made or used false records and statements to induce the government to pay or approve false and fraudulent claims, is liable for a civil penalty ranging from $5,500 up to $11,000 for each such claim, plus three times the amount of the damages sustained by the federal government. No proof of specific intent to defraud is required under the Act.

14. The Act also allows any person having information about false or fraudulent claims to bring an action for himself or herself and the government, and to share in any recovery. Based on these provisions, Relator seeks through this action to recover all available damages, civil penalties, and other relief for state and federal violations alleged. Although the precise amount of the loss from Kaiser's misconduct alleged in this action cannot presently be determined, it is estimated that the damages and civil penalties amount to millions of dollars.

BACKGROUND

15. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare program. Medicare is a federally-funded health insurance program for people who are over the age of 65, under age 65 with certain disabilities, and for people of all ages with End-Stage Renal Disease. As of 2012, Medicare provided insurance to approximately 50.7 million people.

16. The Centers for Medicare & Medication Services ("CMS") is the division of the Department of Health and Human Services that is responsible for the reimbursement, administration, and supervision of the Medicare program. Medicare includes the following categories of benefits: hospital insurance for inpatient hospital care (Part A), medical insurance for doctors' services and outpatient care (Part B), and prescription drug coverage to offset the cost of medications (Part D). Medicare beneficiaries may opt out of the traditional program and receive benefits through Medicare Part C, also known as "Medicare Advantage." Medicare Advantage plans are federally funded privately-run insurance plans. For a monthly fee established by Medicare that is determined per

enrollee, Medicare Advantage organizations, such as Kaiser, provide the services available through Medicare Parts A and B (inpatient and outpatient services).

17. The per-enrollee monthly fee is derived by a formula that is primarily based on two main factors. The first factor, the base rate, is the standard cost of providing Medicare Parts A and B benefits to an average beneficiary. The second factor is a risk score that takes into consideration the enrollee's actual health risks based on disease conditions and his or her demographics, such as age and gender. The risk score is calculated using a complex statistical model called the CMS-HCC Risk Adjustment Model. The result is that enrollees with more severe health risks derive a higher monthly payment because Medicare expects that they will require more expensive care. In other words, the higher the risk score, the more money Medicare pays the Medicare Advantage organization (such as Kaiser) each month.

18. CMS requires Medicare enrollees' disease conditions to be diagnosed and memorialized by a physician as a result of a face-to-face encounter according to the *International Classification of Disease, Ninth Revision, Clinical Modification* ("ICD-9"), which is the official system of assigning codes to diagnoses associated with health care in the United States. The ICD-9 codes are mapped to disease groups known as hierarchical condition categories or HCCs. The HCC categories are, in turn, used under the risk adjustment model to reflect the enrollee's health risks, and thus directly correlate to the amount of payments the Government is to pay the Medicare Advantage organization each month.

FEDERAL REQUIREMENTS FOR MEDICARE ADVANTAGE PAYMENTS

19. Medicare Advantage plans such as Kaiser are legally obligated to accurately and properly submit data to CMS to receive payment for Medicare beneficiaries. The Medicare Advantage plan must have documentation from provider encounters (rather than prescriptions or test results) supporting associated ICD-9 diagnoses. Any causal link between a disease and a resulting complication must be established and supported during the doctor-patient visit. According to the ICD-9 Official Guidelines:

> The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved. The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.

> The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.

20. All relevant documentation is entered into a medical record at the time of service. CMS recognizes, however, there may be times that a provider will need to amend, correct, or enter documentation related to an encounter. CMS expects supplemental documentation to be occasional, and that delayed or amended entries will be entered within a reasonable time frame. *See* Medicare Program Integrity Manual, Pub. 100-08, ¶3.3.2.5 (Rev. 442, Implementation Jan. 8, 2013). CMS will consider delayed or amended explanations for diagnoses so long as the explanations are for clarification and not for substantiating retroactive diagnoses. According to the leading organization that trains and certifies individuals on physician-based medical coding, the American Association of Professional Coders or AAPC, Medicare understands a reasonable time frame to be 24 to 48 hours because it is not reasonable for a provider to recall a visit two weeks (or more) after it occurred. Similarly, according to AAPC, addenda to medical records should not be a normal practice, but an exception to CMS' general rule in which a provider fully documents a visit at the time of the encounter or shortly thereafter.

21. CMS also requires that all documentation in a medical record be specific to a given patient's situation at the time of the documented visit, which means medical records documentation language should not be the same (i.e., cloned or boilerplate) from patient to patient or provider to provider.

KAISER VIOLATED THE FALSE CLAIMS ACT

22. Prior to 2004, Medicare Advantage organizations such as Kaiser were paid by CMS only based on an enrollee's demographic information. For instance, prior to 2004, Kaiser was paid the same for all 77-year-old women in a community regardless of their actual disease conditions. When Congress passed the Medicare Modernization Act of 2003, CMS phased in the CMS-HCC Risk Adjustment Model between 2004 and 2007. Beginning in 2007, Medicare Advantage plans received payments based entirely on the CMS-HCC Risk Adjustment Model, which, as described above, considers an enrollee's actual health risk.

23. In response to the phase-in of the Risk Adjustment Model, Kaiser established the Encounter Information Operations department. The department is managed by The Permanente Medical Group, Inc., in Oakland, California, and tasked with overseeing Medicare coding and ensuring document standards are met. The Encounter Information Operations department includes Data Quality Trainers, Data Quality Auditors, CMS project managers, and CMS lead physician(s) who are assigned to, and work out of, each of Kaiser's Northern California facilities. Relator, a trained and certified medical coder, was recruited and hired by The Permanente Medical Group as the Data Quality Trainer and Audit Manager for the San Rafael Kaiser facility in 2006. Relator trained physicians on coding guidelines. If the facility's auditor found discrepancies between coding and documentation in progress or visit notes, Relator was sent to meet with the physicians to remediate the discrepancies and re-train them on proper coding practices.

24. In or about 2007, there was a shift in the interactions with doctors and the management of the Encounter Information Operations department at Kaiser. Kaiser's Encounter Information Operations department began using a system to capture "missed opportunities," which are brought to the attention of physicians to ensure that all possible Medicare billing opportunities are captured, a process some Kaiser physicians refer to as "diagnosis chasing." By moving away from its focus on data quality and auditing physician coding to what Kaiser terms "refreshing" and "data mining," Kaiser was able to increase its billings for high value hierarchical condition categories or HCCs.

25. Kaiser focuses its data mining on high value disease conditions for which Kaiser can maximize its reimbursement from Medicare and increase its revenue. Put another way, Kaiser identified the higher value HCCs and then determined the diagnoses its doctors would need to make to support the HCCs Kaiser wanted to submit for Medicare reimbursement. As of 2012, the Encounter Information Operations department used a variety of algorithms to identify the following disease conditions for data mining, which leads to upcoding (changes made over time in the diagnosis codes that make their enrollees appear less healthy than they actually are):

a. Chronic kidney disease

b. Diabetes mellitus with diabetic chronic kidney disease

c. Diabetes mellitus with diabetic nephropathy

d. Congestive heart failure

e. Depression

f. Amputations

g. Ostomy

h. Tracheostomies

i. Stable angina

j. Peripheral vascular disease

k. Diabetic peripheral vascular disease

l. Diabetes with diabetic dyslipidemia

m. Diabetes with diabetic erectile dysfunction

n. Chronic respiratory failure

o. Cachexia/Protein Calorie Malnutrition

p. Severe obesity

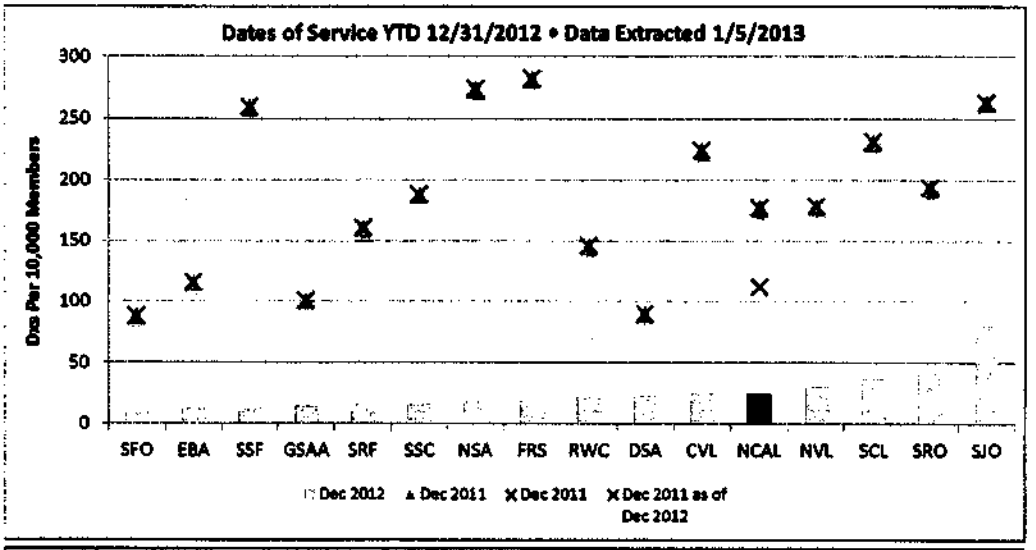
q. Dementia

r. Seizure

s. Chronic pancreatitis

26. The consequence of Kaiser's focus on refreshing and data mining for missed opportunities is that physicians take into consideration HCCs and the Medicare payment system when coding and recording patient encounters. For example, Kaiser told its physicians to diagnose chronic kidney disease instead of the lower value nephritis or nephropathy. From 2010 to 2012, Kaiser shifted diagnoses from the lower risk nephropathy to the higher health risk (and higher-paying) chronic kidney disease. The charts below demonstrate Kaiser's success in bringing up its chronic kidney disease diagnoses while shifting away from the lower-paying nephropathy. HCC 132 (nephropathy) dropped by 200 diagnoses per 10,000 members from 2010 to 2012. HCC 131 (chronic kidney disease), which has a higher risk and is reimbursable at a higher rate than HCC 132, increased by more than 400 diagnoses per 10,000 members during the same time period.

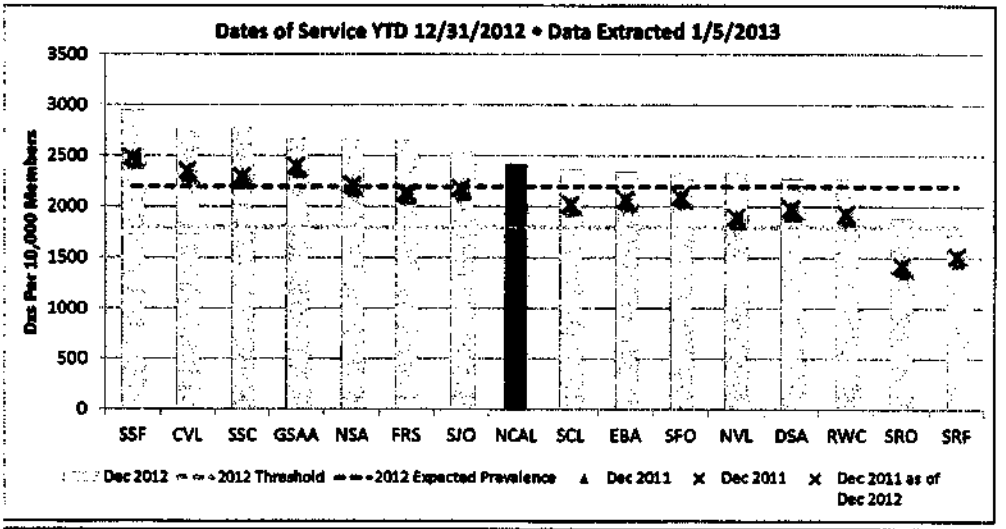
HCC 132: Nephropathy



	SFO	EBA	SSF	GSAA	SRF	SSC	NSA	FRS	RWC	DSA	CVL	NCAL	NVL	SCL	SRO	SJO
Dec 2012	9	12	13	14	15	16	17	18	21	23	25	25	30	37	41	80
Dec 2011	88	115	259	101	161	188	274	282	146	90	225	177	178	232	194	263
Dec 2010	253	215	246	245	171	320	259	268	136	204	217	225	184	253	198	282

19 KAISER PERMANENTE

HCC 131: Chronic Kidney Disease



	SSF	CVL	SSC	GSAA	NSA	FRS	SJO	NCAL	SCL	EBA	SFO	NVL	DSA	RWC	SRO	SRF
Dec 2012	2,944	2,768	2,767	2,668	2,655	2,652	2,535	2,412	2,369	2,339	2,332	2,331	2,271	2,269	1,887	1,816
Dec 2011	2,491	2,353	2,295	2,403	2,212	2,134	2,179	2,045	2,020	2,071	2,095	1,898	1,981	1,931	1,422	1,515
Dec 2010	2,364	2,261	2,044	2,187	2,169	2,069	2,122	1,926	1,976	1,914	1,884	1,796	1,741	1,900	1,421	1,462

18 KAISER PERMANENTE

27. Likewise, when CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser tells its physicians to change coding practices to reflect new reimbursable codes. CMS is "concerned about the high rate of coding of other HCCs by M[edicare] A[dvantage] organizations, [Fee for Service or] FFS providers, given that the coefficients are calibrated on FFS data." Therefore, CMS "made changes to . . . HCCs to address M[edicare] A[dvantage] coding intensity." For example, "[s]ince the clinically-revised model allowed [CMS] to better estimate marginal costs for a wider range of renal disease (specifically, the current HCC131 renal failure is split among a range of acute and chronic kidney conditions), we removed the lower-severity kidney disease HCCs, including Chronic Kidney Disease (CKD) stage 3, CKD stages 1-2, or unspecified; unspecified renal failure; and nephritis." In other words, to address upcoding, CMS notified Medicare Advantage providers that starting in 2014, the HCCs for chronic kidney disease stages 1 through 3 would be eliminated, meaning that Kaiser would no longer receive reimbursement for patients submitted with HCC 131. In response to CMS's notification that HCC 131 will be eliminated, Kaiser promptly sent materials to its staff to begin prompting physicians to code diagnoses for acute kidney injury instead of chronic kidney disease stage 1, 2, or 3, which will be included in the 2014 HCC list and reimbursable by Medicare.

28. To support the HCCs submitted to Medicare, Kaiser needs its physicians to amend patient files. Under CMS guidelines, physicians must verify that they considered a diagnosis or treated a diagnosis during the physician encounter, which means a physician must address what was contemporaneously considered if he or she addends a diagnosis. Kaiser's Medicare enrollee medical records include addenda with supporting statements or documentation that were not addressed at the time of an encounter. Kaiser should be training physicians to follow Medicare best practices and guidelines to contemporaneously document and code disease conditions during or immediately after face-to-face visits. Instead, Kaiser has its physicians systematically addend patient records retroactively—often many months after visits—with cloned or boilerplate language to make the patient record appear to comply with CMS instructions.

29. After an encounter, Kaiser tells physicians to go back to see what a member's previous test results showed to make diagnoses, which is not an appropriate data source for coding a diagnosis

under CMS guidelines nor does it comply with CMS best practices for contemporaneous documentation and coding. In the specific example below, a patient was seen for a knee and sleep problem. Two months after the visit, the physician addended the progress note to say the patient has diabetes with chronic kidney disease (DM2 W DIABETIC CKD STAGE 1) based on laboratory tests, with no indication that the diabetes or chronic kidney disease was addressed at the visit:

Reason For Visit History

User	Date & Time
Sitchler, Christi A	**7/6/2012 2:26 PM**

Reason For Visit
KNEE PROBLEM
Comment : RT x 2 days
SLEEP PROBLEM

User	Date & Time
Sitchler, Christi A	**7/6/2012 2:25 PM**

Reason For Visit
KNEE PROBLEM
Comment : RT x 2 days

User	Date & Time
Sitchler, Christi A	**7/6/2012 2:25 PM**

Reason For Visit
KNEE PROBLEM

Diagnoses

SPRAIN TIBIOFIBULA, SUPERIOR - Primary	844.3
MAJOR DEPRESSION, RECURRENT	296.30
DYSSOMNIA	780.56
DM 2 W DIABETIC CKD STAGE 1 (GFR >= 90)	250.40, 585.1

After Visit Summary

After Visit Summary

Progress Notes

Lewis, Anna Klaartje (M.D.) 9/19/2012 7:50 PM Signed
After review of my note for this visit encounter, I recall this encounter and am addending this note to state that this patient has diagnosis of:

DM 2 W DIABETIC CKD STAGE 1 (GFR >= 90)
Note: GLOMERULAR FILTRATION RATE - AFRICAN AMERICAN >60 07/06/2012
GLOMERULAR FILTRATION RATE - AFRICAN AMERICAN >60 04/03/2012
GLOMERULAR FILTRATION RATE - AFRICAN AMERICAN >60 06/21/2011
GLOMERULAR FILTRATION RATE, NONAFRICAN AMERICAN >60 07/06/2012
GLOMERULAR FILTRATION RATE, NONAFRICAN AMERICAN >60 04/03/2012
GLOMERULAR FILTRATION RATE - NONAFRICAN AMERICAN >60 06/21/2011
GLOMERULAR FILTRATION RATE - NONAFRICAN AMERICAN >60 11/04/2010
GLOMERULAR FILTRATION RATE - NONAFRICAN AMERICAN >60 03/18/2010
CREATININE 0.78 07/06/2012
ALBUMIN/CREATININE RATIO, UR 54.5 07/06/2012
GFR is stable, but patient has microalbuminuria. Will follow. Control DM, HTN

30. In addition, Kaiser tells its doctors to change diagnoses to upcode to higher value and more complicated forms of diseases. For example, Kaiser prompted physicians to addend diabetes diagnoses to include hyperlipidemia as a complication where tests or records reflected hyperlipidemia regardless of whether the hyperlipidemia was actually *due to* diabetes. Likewise, changed diagnoses to add complications are addended long after patient encounters. Dr. Pont, in the example below, addended her progress note seven months after the initial patient visit to change a diagnosis from

diabetes without complications (ICD-9 250.00) to diabetes with mixed hyperlipidemia (250.80, 272.2), which maps to a higher reimbursement HCC:

Visit and Patient Information

Encounter Date
[redacted]

Reason For Visit History

User	Date & Time
Griffin, Kristine G (M.A.)	2/3/2012 10:51 AM

Reason For Visit
PHYSICAL EXAMINATION

Diagnoses

ACTINIC KERATOSIS - Primary	702.0
PHASE POPULATION MANAGEMENT PROGRAM.	V49.89
DM, WO RETINOPATHY	250.00
DM 2	250.00
HYPERLIPIDEMIA	272.4
HTN	401.9
GOUT	274.9
SCREENING FOR CA, COLON	V76.51
ELEVATED PROSTATE SPECIFIC ANTIGEN MEASUREMENT	790.93
HYPERPARATHYROIDISM, PRIMARY	252.01
DM 2 W DIABETIC HYPERLIPIDEMIA, MIXED	250.80, 272.2

After Visit Summary

After Visit Summary

Progress Notes

Pont, Joan Turner (M.D.) 9/20/2012 6:57 PM Signed
Addendum to previous chart entry on 2-3-12
After reviewing the notes from the aforementioned visit, I recall the visit. The previous note reflects that I evaluated the patient who has the diagnosis of dm2 with mixed hyperlipidemia as evidence by tg 210 on 11-8-05, ldl 134 on 6-5-01.

Pont, Joan Turner (M.D.) 2/3/2012 11:30 AM Signed
Clinical Progress Note:
Patient presents with a chief complaint of PHYSICAL EXAMINATION

HPI: completed cataract surgery and whiter and brighter vision! Left still needs to be done

I have reviewed
medical history with no changes 2/3/2012, social history with no changes 2/3/2012 and family history with no changes 2/3/2012

31. Kaiser also addended and submitted diagnostic codes for complex conditions without proper support (i.e., not a true causal connection). In 2009, providers were told to capture diagnoses of Peripheral Vascular Disease ("PVD") and Diabetic Peripheral Vascular Disease ("DPVD") using Carotid Artery Stenosis as evidence.

a. Dr. Lori Selleck saw a patient on April 10, 2009 at 4:31 PM. There is no mention of PVD, however, four months later, on December 30, 2009, there is an addendum stating, "PVD = carotid a stenosis." Not only is the code assigned long after the patient encounter, but there is no evidence or documentation showing that the condition was present during the physician encounter. Furthermore, PVD and Carotid Artery Stenosis have no causal link:

Office Visit

Visit and Patient Information

Encounter Date

Reason For Visit History

User	Date & Time
Steenburgh, Tyrone N (M.A.)	4/16/2000 4:31 PM

Reason For Visit
PHYSICAL EXAMINATION

Diagnoses

HEALTH CHECK UP, ADULT - Primary	V70.0
HYPERTENSION	401.9
GIANT CELL ARTERITIS	446.5
HYPERLIPIDEMIA	272.4
CAROTID ARTERY STENOSIS, ASYMPTOMATIC	433.10
PERIPHERAL VASCULAR DISEASE	443.9

After Visit Summary

Progress Notes

Selleck, Lori Z. (M.D.) 12/30/2000 12:28 PM Addendum
PVD = carotid a stenosis

b. Dr. David Conant met with a patient on June 28, 2011. Almost one year later, on May 28, 2012, at 8:44 AM he addended his progress note to replace nephropathy with chronic kidney disease, just as Kaiser encouraged to ensure the higher value HCC would be captured when Medicare paid for this enrollee:

Visit and Patient Information

Encounter Date

Reason For Visit History

User	Date & Time
Jones, Marlene J. (M.A.)	6/28/2011 8:56 AM

Reason For Visit
HEALTH MAINTENANCE

Diagnoses

HEALTH CHECK UP, ADULT - Primary	V70.0
DM 2 W LOW HDL AND HIGH TRIGLYCERIDE DUE TO DM (DIABETIC DYSLIPIDEMIA)	250.80, 272.4
HYPERLIPIDEMIA	272.4
HTN	401.9
DM 2 W DIABETIC CHRONIC KIDNEY DISEASE, STAGE 1	250.40, 585.1

After Visit Summary

Progress Notes

Conant, David Loring (M.D.) 5/17/2012 8:44 AM Addendum
Diagnosis of DM2 with diabetic nephropathy microalbuminuria was replaced with DM2 with diabetic chronic kidney disease stage 1 because the latter is more appropriate for his condition.

Conant, David Loring (M.D.) 6/28/2011 9:26 AM Signed
Chief Complaint
Member presents with Patient presents with:
HEALTH MAINTENANCE

HPI: Accompanied by mother and sister. Generally doing well. Attending day program, using stationary bike 45 minutes on most days.

At todey's visit I reviewed the patient's problem list, past medical and surgical history, social history and relevant family history.

32. Kaiser also provides boilerplate phrases to help its physicians justify addenda. Kaiser's boilerplate addendum phrases can be automatically inserted through a combination of key strokes and physicians are expected to use these phrases rather than their own language and discretion based on what they recall from visits. The language Kaiser physicians use is intended to give CMS the impression that the doctor thought about the addenda and wants to comply with Medicare instructions for amendments and corrections. Encounter Information Operations staff send emails to physicians recommending the use of macros such as ".DXUPDATE" for addendum phrases, leading the physicians to state exactly what Kaiser needs records to say to amend records for coding. For example, when a physician enters ".DXUPDATE," the following phrases will populate the medical record: "After review of my note for this encounter, I recall this visit and am addending this note to state that this patient has a more specific diagnosis of: @diag@."

a. Dr. Rukiye Yoltar met with a patient on September 5, 2012. At 5:53 PM on October 9, 2012, a month later she writes: "After review of my note for this encounter, I recall this visit and am addending this note to state that this patient has a more specific diagnosis of: DM 2 W DIABETIC MIXED HYPERLIPIDEMIA (primary encounter diagnosis)."

b. Dr. Charles E. Metzger met with a patient on January 19, 2012 at 11:13 AM. Nearly nine months later on October 9, 2012, at 6:34 PM he used nearly identical language as Dr. Yoltar on the same day: "After review of my note for this encounter, I recall this visit and am addending this note to state that this patient has a more specific diagnosis of: DM2 W DIABETIC MIXED HYPERLIPIDEMIA."

c. Another example of boilerplate language was sent through email for use with upcoding to diabetes with diabetic chronic kidney disease:

FROM EMAIL SENT BY KAREN GRAHAM TO DOC CODING LEADS

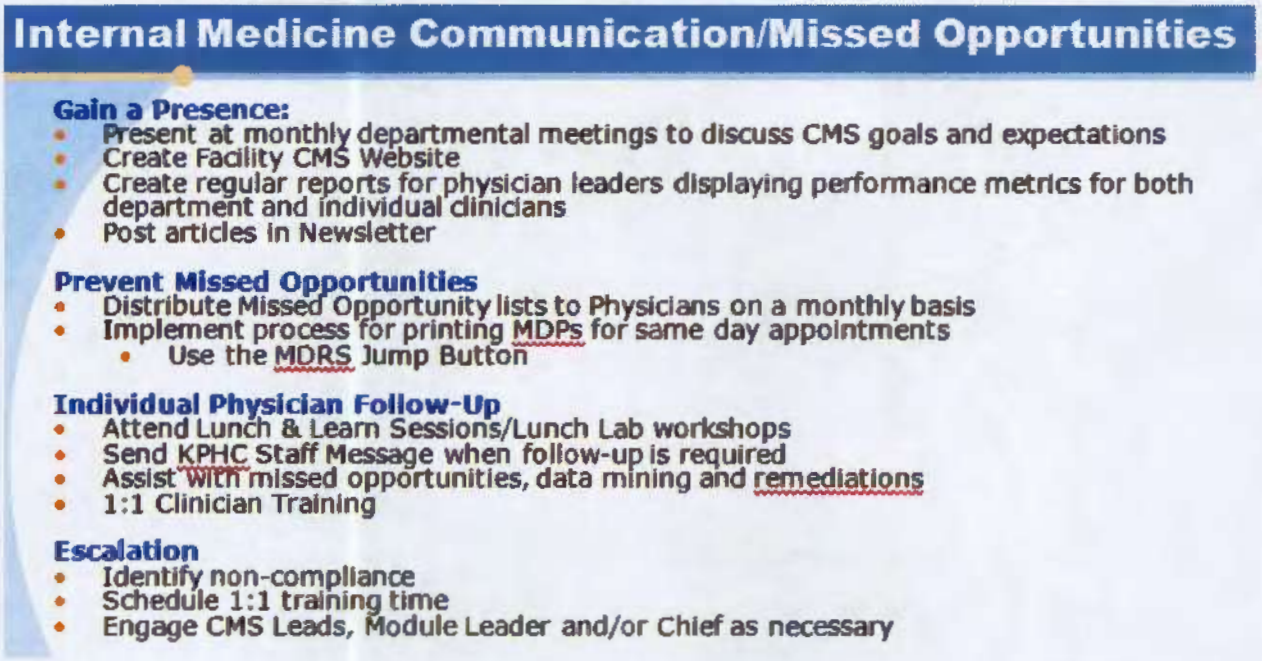
Karen Graham/CA/KAIPERM
11/08/2011 11:34 PM

To Doc Coding Leads-KPNC
cc
Subject EBA-SmartPhrase for Addendum to capture DM w/DCKD

As a follow up to the Doc & Coding Leads conf call, East Bay provided the following Smartphrase which Dr. David Law created to use in an Addendum for DM w/DCKD:

"After reviewing my visit note, I recall this encounter. The visit note reflects that I evaluated the patient, who has the diagnosis of diabetic CKD, stage 1. Plan is to optimize control of blood pressure and diabetes, and recheck urine protein"

33. Although physicians should be using their own discretion for diagnosing, if doctors disagree with the prompt to review and addend records, they must explain their refusal to the regional Encounter Information Operations auditors. To ensure there are almost no "missed opportunities" to capture data mined and refreshed diagnoses, Kaiser pressures its physicians to addend diagnoses and capture the high value HCCs, with the assistance of staff, including Relator. For example, to ensure capturing of HCCs, Kaiser instituted an escalation process for physicians who do not agree with the data mining prompts. Physicians will have to meet one-on-one with Data Quality Trainers if they refuse to make diagnoses changes that are presented by data mining. The physicians must explain why they disagree, resulting in The Permanente Medical Group's management engaging with these physicians directly until there is resolution. Physicians often give in and use the diagnoses that management asks for rather than using their own, original judgment in coding diagnoses. The following slide from the Encounter Information Operations department describes the escalation process, including meeting with management such as Lead Physician Jill Dunton.



34. In addition to the escalation process the physicians face if they refuse to comply with the prompts to refresh or retroactively change diagnoses, physicians have personal report cards based on how they perform in certain areas, which are tied to their compensation. After the Encounter Information Operations shifted to emphasizing the importance of HCC and their matching diagnostic codes, the physician report cards included how they respond to refreshing and data mining prompts. In other words, bonuses for doctors now become, at least in part, tied to diagnosis chasing.

35. Kaiser also pressures providers into approving retroactive diagnoses, which increase revenue, but does not ensure quality of care. Kaiser has mandatory meetings called "coding parties," where physicians are gathered in a single room with computers and asked to review past progress notes for addenda related to revised medical diagnoses. Coding parties occur on at least a yearly basis. There are new diagnoses to focus on every year and physicians are expected to addend 30 to 40 progress notes over a 3-hour period. Addenda made in September and October of 2012, demonstrate there were "coding parties" where, for example, the following physicians amended medical records, including for diagnoses of diabetes with mixed hyperlipidemia, as described above:

a. On September 19, 2012:

- Dr. Irina Sophie Cons Defischer addended at 6:15 PM; and

- Dr. Patrick Flynn Roland addended at 6:38 PM; and
- Dr. Anna Klaertje Lewis addended at 7:11, 7:22; 7:25, and 7:50 PM.

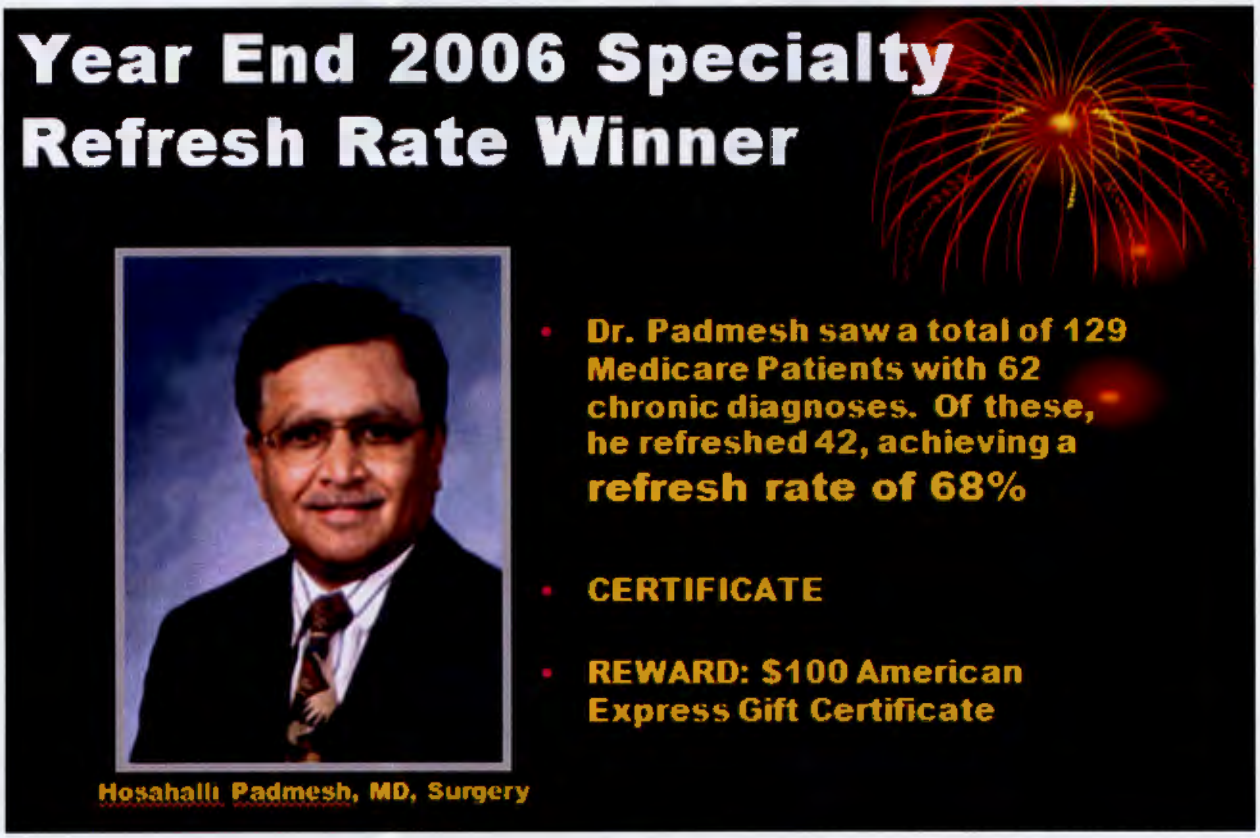
b. On September 20, 2012:

- Dr. Raymund Mafnus Damian addended at 6:14 PM;
- Dr. Carolyn Mar addended at 6:37 PM;
- Dr. Jill Dunton addended at 6:40 PM and 7:10 PM;
- Dr. John David Culbertson addended at 6:42 PM;
- Dr. Roberto Gonzalez addended at 6:46 PM;
- Dr. Ryan Scott Lum addended at 6:47 PM;
- Dr. Joan Turner Pont addended at 6:47 and 6:57 PM;
- Dr. John David Culbertson addended at 6:56 PM;
- Dr. Alan Kneital addended at 6:56, 6:59, 7:01, 7:06, and 7:10 PM; and.
- Dr. Lori Selleck addended at 7:04 PM.

c. On October 9, 2012:

- Dr. Rukiye Yoltar addended at 5:53 and 6:20 PM;
- Dr. Daniel Gerard White addended at 6:16 PM; and
- Dr. Charles Metzger addended at 6:33 and 6:34 PM.

36. Kaiser also pressures physicians to diagnose Medicare patients through incentive programs, such as this doctor's $100 reward:



37. Kaiser tracks and rewards physicians based on the percentage of chronic conditions they are able to capture and refresh. Additionally, Kaiser positioned the Southern California Region against Northern California in competition for the highest risk scores and physician approval rates. The following demonstrates the competition from the CMS Leads Meetings in 2008:

HCC Hierarchy	NCal		SCal			Potential Increase
	Higher HCCs	Low HCCs	High HCCs	Low HCCs		
Diabetes HCC 15-19	56%	44%	73%	27%		$53M
Cancer HCC 7-10	16%	84%	20%	80%		$17M
Renal Failure HCC 131-132	83%	17%	99%	1%		$10M
Depression	569 / 10k		852 / 10k			$20M
Protein Calorie Malnutrition	37 / 10k		157 / 10k			$33M
Totals						$133M

"Highest Specificity" Documentation (It's more than 'See & Capture' now)

ISSUE:

In five HCCs categories, SCal appears to document more conditions in higher diagnostic categories of the same hierarchy, which could result in:

- enhanced patient care tracking
- improved disease monitoring
- appropriate reimbursement for illness burden
- significant financial impact, estimated at an estimated $80M variance for capture within the 5 categories

Regional Focus Audit Verification

- 7% of Cancer HCC7 indicated metastatic disease was implicitly or explicitly documented but not captured
- 25% of Diabetes complications – not captured

38. The competitive pressure is not only exerted between regions, but within the region. An email from Aaron Smith regarding the San Rafael Kaiser facility on May 17, 2013, describes the ranking of facilities on documentation and coding "missed opportunities" for April 2013. Mr. Smith states:

> Refresh: We are at 70.9%, 6th in the Region (down from 5th last month), above where we were in 2012 (69%), above the tracking goal of 64%, as well as the Region average of 67.3 percent.
>
> With the change in payment structure for 2013 (60% for Data Mining, 40% for Refresh), I believe passing the April benchmark brings our performance payment for the year to $143,114.

We currently have just under 1600 outstanding missed opportunities out to PCP's. Granted many of those are data mining prompts, which are not in our refresh denominator, but are in the addressed data mining denominator (which is actually worth more locally than standard refresh). So we certainly could and should be doing better than our 70.9% rate if that number could be significantly reduced through one-on-one sit-down with those PCP's who have a large number of dx that we have not hard [sic] back on."

Seeing Pts: We are at 78.1%, 3rd in the Region, above where we were at this point in 2012 (76.7%) and the Region average (75.6%).

The caller and PCP/MA's are currently calling those members who were unable to reach when they were originally on a call list and were due for an appointment in the first half of the year. With such an elevated Seeing Patients percentage, it's a bit disappointing that hasn't translated to a higher overall refresh percentage and data mining addressed rate which are two [of] the benchmarks that **we are financially incentivized on** [emphasis added].

...

Data Mining: We are below the Region average in terms of coding (88.8% vs. 91.9%) and have gone through a lower percentage of overall prompts than the NCAL [Kaiser Northern California] average to date (43.5% vs. 48.2%). This places us 13th in NCAL, which is staggeringly low considering where we are at with Patients Seen and Refresh. The percentage of prompts required to either be stopped or coded for by the end of the year is 90 percent. Doing that will lead to receiving the remaining 60% of the annual allocation not tied in with refresh.

Part of the gap between the 43.5 and 48.2 numbers could be made up by that overwhelming number of PCP missed opportunities mentioned above, which includes a large number of data mining prompts that even if we can't addend for or stop could at least be put on the Problems List to alert the clinician the next time they see the member. That will be of utmost importance as this is a category that the denominator can continue to grow through October 31, which is the deadline for Region in releasing prompts that need to be addressed or stopped by December 31, 2013.

39. Kaiser ties funding allocations to a facility's refresh and data mining rates such that a facility will lose an allocation if goals are not met. For example, in 2012, Kaiser's goal for refreshing chronic diagnoses was 99%, which was 60% of a facility's total allocation. The 2012 goal for addressing data mining conditions was 90%, which was 40% of the total allocation. In other words, if the providers do not address at least 90% of the data mined conditions, 40% of the allocation was unavailable the next year.

2012 REFRESH GOAL

Maintaining Diagnoses = 99%

This represents 60% of Performance Allocation

2012 'New' Focus: Capture Key Conditions

Expected Prevalence Rates

- **Protein Calorie Malnutrition – 250 / 10k**
- **Diabetes w/ Neurologic Manifestations – 600 / 10k**
- **Vascular Disease / Aortic Atherosclerosis – 1,200/ 10k**
- **Renal Failure – 2,200 / 10k**

This represents 40% of Performance Allocation

40. In 2013, Kaiser's goal for refreshing chronic diagnoses is 99%, which is 40% of a facility's total allocation. The 2013 goal for addressing data mining conditions is still 90%, but it is now 60% of the total allocation. Data mining is a key factor for Kaiser's facility allocations. The Data Quality Trainers, such as Relator, are managed by the regional office in Oakland, so the pressure is primarily on the physicians to make sure they address all the refreshing and data mining for own their facilities.

41. The focus since 2007 on data mining and high value HCCs has ensured increased billings from Kaiser to Medicare. For example in 2009 alone, high value HCCs resulted in $51 million dollars in CMS payments to Kaiser's Northern California region:

Data-Mining Condition	Volume	Reimbursement
HF	62	$ 52,500.00
CKD	3434	$ 7,237,327.00
DEP	4927	$ 9,470,285.00
DM w/ PN	7499	$ 7,762,590.00
Protein Calorie Malnutrition	435	$ 1,048,829.00
AMP, OST-STOMA, Trach	142	$ 440,911.00
DM w/ PVD	188	$ 392,679.00
DM w/ CKD	1785	$ 6,018,734.00
MDD	1318	$ 3,101,175.00
CAD	6983	$ 4,639,435.00
PVD	439	$ 755,458.00
DM w/ DYS	2965	$ 6,133,814.00
DM w/ ED	1791	$ 3,705,113.00
Totals	31968	$51M

42. Kaiser failed to, and continues to fail to, comply with CMS guidelines and instructions. With the addition of more data mining prompts each year, despite CMS' efforts to rein in payments to Medicare Advantage organizations, Kaiser's reimbursement continues to grow, violating the False Claims Act.

COUNT I

False Claims Act Violations – Presentation of False Claims

(31 U.S.C. § 3729(a)(1)(A))

43. Relator re-alleges and incorporates all paragraphs alleged herein.

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

45. By reason of these payments, the United States has been damaged, and continues to be damaged, by a substantial amount.

COUNT II

False Claims Act Violations – False Records or Statements

(31 U.S.C. § 3729(a)(1)(B))

46. Relator re-alleges and incorporates all paragraphs alleged herein.

47. By virtue of the acts described above, Defendant knowingly made, used, or caused to be made or used, false records or statements material to false or fraudulent claims paid or approved by the United States Government in violation of 31 U.S.C. § 3729(a)(1)(B).

48. By reason of these payments, the United States has been damaged, and continues to be damaged, by a substantial amount.

PRAYER FOR RELIEF

WHEREFORE, Relator Ronda Osinek requests that judgment be entered against Defendant, ordering that:

49. Defendant pays not less than $5,500 and not more than $11,000 for each violation of 31 U.S.C. § 3729(a) plus three times the amount of damages the United States has sustained because of Defendant's actions;

50. Relator be awarded the maximum amount allowed pursuant to 31 U.S.C. § 3730(d);

51. Relator be awarded all costs of this action, including attorneys' fees and costs pursuant to 31 U.S.C. § 3730(d); and

52. The United States and Relator recover such other relief as the Court deems just and proper.

JURY TRIAL

Pursuant to Federal Rule of Civil Procedure 38, Plaintiff demands a trial by jury.

Dated: August 20, 2013

Respectfully Submitted

GIRARD GIBBS LLP

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Attorneys for Plaintiff

No. 22-15862

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Marcia Stein and Rodolfo Bone, Relators,
Plaintiffs and Appellants,

and

United States of America, ex rel.,
Plaintiff,

vs.

Kaiser Foundation Health Plan, Inc., et al.,
Defendants and Appellees.

On Appeal from the United States District Court
for the Northern District of California
Case Nos. 3:16-cv-05337-EMC c/w 3:13-cv-03891-EMC
The Honorable Edward M. Chen

APPELLANTS' EXCERPTS OF RECORD
VOLUME 9 of 9

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TAB 33

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* MARCIA STEIN and RODOLFO BONE, Plaintiffs, v. KAISER FOUNDATION HEALTH PLAN, INC., et al., Defendants.	CASE NO. 16-cv-05337-EMC CONSOLIDATED WITH: CASE NO. 13-cv-03891-EMC (Lead Case) CASE NO. 16-cv-01558-EMC CASE NO. 16-cv-05337-EMC CASE NO. 18-cv-01347-EMC CASE NO. 21-cv-03124-EMC CASE NO. 21-cv-03894-EMC **NOTICE OF APPEAL**

Notice is hereby given that Plaintiffs and Relators Marcia Stein and Rodolfo Bone hereby appeal to the United States Court of Appeals for the Ninth Circuit from an order entered on May 5, 2022, a copy of which is attached as Exhibit 1. Appellants' Representation Statement is attached as Exhibit 2.

THE ZINBERG LAW FIRM, A.P.C.

HANAGAMI LAW, A.P.C.

Dated: June 3, 2022

By: */s/William K. Hanagami*
William K. Hanagami
Attorneys for Plaintiffs and *Qui Tam* Relators, Marcia Stein and Rodolfo Bone

EXHIBIT 1

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC, et al.,

Defendants.

Case No. 13-cv-03891-EMC

CONSOLIDATED MEMBER CASES

Case No. 16-cv-01558-EMC
Case No. 16-cv-05337-EMC
Case No. 18-cv-01347-EMC
Case No. 21-cv-03124-EMC
Case No. 21-cv-03894-EMC

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION TO DISMISS

Docket No. 141

The above cases are all predicated on allegations that various Kaiser entities[1] submitted false claims for payment to the federal government as part of the Medicare Part C program, which is also called Medicare Advantage. *Osinek* was the first-filed case and was followed by five other cases: *Taylor*, *Arefi*, *Stein*, *Bryant*, and *Bicocca*.[2] The cases were consolidated in June 2021. *See Osinek*, Docket No. 61 (order). In July 2021, the United States filed a notice that it was

[1] The Kaiser entities are, generally speaking, various Health Plans, Hospitals, and Medical Groups. These entities "publicly hold themselves out and do business collectively as an integrated healthcare provider called "Kaiser Permanente." U.S. Compl. ¶ 28.

[2] *Taylor* was initially filed in the District of Colorado in 2014; *Arefi* in the Central District of California in 2015; *Stein* in the Central District of California in 2016; *Bryant* in the Northern District of California in 2016; and *Bicocca* in the Eastern District of California in 2020.

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intervening in part and declining to intervene in part.[3] *See Osinek*, Docket No. 64 (notice of election).

Currently pending before the Court is Defendants' motion to dismiss based on the first-to-file bar in the False Claims Act ("FCA"). The relevant FCA provision states as follows: "When a person brings an action under this subsection, no person other than the Government may intervene or *bring a related action based on the facts underlying the pending action*." 31 U.S.C. § 3730(b)(5) (emphasis added). The purpose of the first-to-file bar is twofold: (1) "to promote incentives for whistle-blowing insiders" and (2) "[to] prevent opportunistic successive plaintiffs." *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1187 (9th Cir. 2001). Defendants argue that, with limited exceptions, the claims presented by the cases that follow *Osinek* are barred. The *Arefi* plaintiffs have filed a statement of nonopposition with respect to the motion to dismiss their case. *See* Docket No. 143 (nonopposition). The plaintiffs in all other cases have opposed dismissal.

Having considered the parties' briefs, as well as the oral argument of counsel, the Court hereby **GRANTS** in part and **DENIES** in part Defendants' motion.

I. FACTUAL & PROCEDURAL BACKGROUND

A. United States' Complaint-in-Intervention

Although the United States' Complaint-in-Intervention is not at issue in the pending motion, the Court begins with this pleading as it provides a good overview of the Medicare background.

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[3] The notice stated as follows:

> Specifically, the United States intervenes on the allegations that defendants Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group, Inc.; and Colorado Permanente Medical Group, P.C.; submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda under Medicare Part C from the years 2009 until present. The United States declines to intervene on all other allegations.

Osinek, Docket No. 64 (notice).

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"Medicare is a federally operated health insurance program." U.S. Compl. ¶ 52. It has four parts:

- Part A covers inpatient and institutional care.
- Part B covers outpatient care.
- Part C is the Medicare Advantage program at issue in this case.
- Part D covers prescription drugs.

See U.S. Compl. ¶ 52.

Parts A and B are "traditional" Medicare.

> [T]he Government reimburses healthcare providers using a fee-for-service system, in which providers submit claims to CMS [Centers for Medicare and Medicaid Services] for healthcare services actually rendered, such as a provider officer visit or hospital stay. CMS then pays the providers directly for each service based on payment rates predetermined by the Government.

U.S. Compl. ¶ 53.

A Medicare beneficiary can opt out of traditional Medicare and enroll instead in a Medicare Advantage plan managed by a Medicare Advantage Organization ("MAO"). *See* U.S. Compl. ¶ 54. "CMS reimburses [Medicare Advantage] plans differently than traditional Medicare." U.S. Compl. ¶ 58. Specifically, Medicare Advantage uses a "'capitation' payment system." *United States ex rel. Silingo v. Wellpoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under that system, "private health insurance organizations provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program – regardless of actual healthcare usage." *Id.* The fixed monthly fee for an enrollee is set as follows. First, there is a predetermined base payment for each enrollee in a Medicare Advantage plan. *See* U.S. Compl. ¶ 57. Second, the base payment is then adjusted "to account for (1) demographic factors such as age and gender (among others) and (2) health status. This is known as risk adjustment." U.S. Compl. ¶ 58.

Risk adjustment is accomplished by assigning each beneficiary a risk score, which "acts as a multiplier that is applied to the [Medicare Advantage] plan's base rate to determine the overall monthly payment for the beneficiary." U.S. Compl. ¶ 58. A beneficiary's risk score is determined through a model called the CMS Hierarchical Conditions Category ("CMS-HCC") model, which,

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as indicated above, is based on the patient's demographic factors and health status. *See* U.S. Compl. ¶ 59. With respect to health status, the model relies on diagnosis codes from the International Classification of Diseases ("ICD"). *See* U.S. Compl. ¶ 60. "ICD diagnosis codes are alphanumeric codes used by healthcare providers, insurance companies, and public health agencies to represent medical conditions; every disease, injury, infection, and symptom has its own code." U.S. Compl. ¶ 62.

> The ICD diagnosis codes included in the CMS-HCC model are grouped into categories of clinically related medical diagnoses that comprise the HCCs (i.e., the categories). For example, various cancer diagnosis codes are grouped together (e.g., colorectal and bladder cancers). The CMS-HCC model organizes related conditions into hierarchies based on disease severity and expected cost. For example, various cancer HCCs are in the same hierarchy, with the HCC associated with metastatic cancer diagnosis codes as the most severe. If a patient is diagnosed with conditions (diagnosis codes) that correspond to more than one HCC in a hierarchy, only the most severe HCC is kept and any lower-ranking HCCs are dropped.

U.S. Compl. ¶ 63.

> Each HCC is assigned a coefficient. CMS calculates a beneficiary's risk score by adding the coefficients associated with each of the beneficiary's applicable demographic characteristics (such as age and gender) and the applicable HCCs, if any, that apply to the beneficiary. A risk score of 1.0 reflects the average expected Medicare-incurred expenses. A risk score of 0.75 reflects expected costs for a particular beneficiary that are 25% less than the estimated average costs for enrollees in the MA plan, and a risk score of 1.25 reflects expected costs that are 25% greater than the estimated average costs for enrollees in the MA plan.

U.S. Compl. ¶ 65.

The CMS-HCC model is prospective in the sense that it uses diagnoses made in a base year (the 'service year'), along with demographic information (such as age and gender, among others), to predict costs for Medicare benefits and adjust payments for the following year (the 'payment year')." U.S. Compl. ¶ 60.

"To combat the 'incentive for [Medicare Advantage] organizations to potentially over-report diagnoses,' Medicare regulations require risk adjustment data to be produced according to certain best practices." *Silingo*, 904 F.3d at 673. For example,

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> the diagnosis codes that MA Organizations submit to CMS for risk-adjustment purposes must be:
>
> a. established by a qualified physician;
>
> b. based on a face-to-face medical visit between the patient and physician[4];
>
> c. documented in the medical record; and
>
> d. coded in compliance with the ICD [Official Guidelines for Coding and Reporting], including the limitation that the condition must have required or affected patient care, treatment, or management for the visit.[5]

U.S. Compl. ¶ 87 (emphasis added); *see also Silingo*, 904 F.3d at 673 (also noting best practices).

"[I]t is an express condition of payment that a Medicare Advantage organization 'certify (based on best knowledge, information, and belief) that the [risk adjustment] data it submits . . . are accurate, complete, and truthful.'" *Id.* (quoting 42 C.F.R. § 422.504(l)(2)).

B. Osinek Complaint

The Court turns next to the Osinek Complaint as it provides the baseline for the Court – *i.e.*, the Court will have to compare the Osinek Complaint with the complaints in the other cases to determine whether the cases are related. *See* 31 U.S.C. § 3730(b)(5) (providing that, "[w]hen a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action").[6]

The allegations below all come from Ms. Osinek's original complaint filed in 2013. (Ms.

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[4] For example,

> even if an MA organization knows that a patient was diagnosed in a prior year with a chronic condition that tends not to go away, the MA organization may not submit the diagnosis for payment for the current year unless the physician has a face-to-face visit with the patient in the current year and the chronic condition required or affected care, management, or treatment during that patient visit.

U.S. Compl. ¶ 85.

[5] "In other words, only those conditions that specifically mattered to the patient care, treatment, or management that the physician actually provided at the visit could be submitted to CMS for payment." U.S. Compl. ¶ 5.

[6] Similarly, later-filed complaints must be compared with all preceding complaints.

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Osinek filed an amended complaint in 2021. For the reasons discussed below, it is Ms. Osinek's original complaint that matters for purposes of the pending motion.)

Ms. Osinek has sued "Kaiser Permanente," "a private provider of Medicare Advantage insurance under Medicare Part C." Osinek Compl. ¶ 2. Ms. Osinek describes "Kaiser Permanente" as follows:

> Kaiser Permanente is a California corporation with its principal place of business [in] Oakland, California 94612. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage Plans than any other organization in California. At all times relevant, Kaiser conducted business in California, including but not limited to providing healthcare services through Medicare Advantage plans and to the general public in California.

Osinek Compl. ¶ 6.

According to the complaint, starting around 2007, Kaiser Permanente began a "scheme to upcode diagnoses to ensure Medicare payments for reimbursable, high-value conditions." Osinek Compl. ¶ 2. Not surprisingly, Kaiser Permanente "focuses . . . on high value conditions" so that it "can maximize its reimbursement from Medicare." Osinek Compl. ¶ 25. High-value disease conditions included, *e.g.*, chronic kidney disease, congestive heart failure, depression, chronic respiratory failure, cachexia/protein calories malnutrition, severe obesity, and seizure. *See* Osinek Compl. ¶ 25.

Kaiser Permanente effectuated its upcoding scheme in various ways. For example:

- Data mining. Kaiser Permanente used "algorithms to identify [high-value] disease conditions for data mining." Osinek Compl. ¶ 25. "Kaiser identified the higher value HCCs and then determined the diagnoses its doctors would need to make to support the HCCs Kaiser wanted to submit for Medicare reimbursement." Osinek Compl. ¶ 25.
- Refreshing. Although not clearly described in the complaint, refreshing appears to be a process related to chronic conditions. *See* Osinek Compl. ¶ 37 (alleging that "Kaiser tracks and rewards physicians based on the percentage of chronic conditions they are able to capture and refresh"). As indicated above, Medicare

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Advantage plans are compensated based on medical conditions diagnosed in the previous payment year. Therefore, if a patient has a chronic condition, then that condition must be rediagnosed each year – *i.e.*, refreshed. Presumably, Kaiser Permanente used refreshing "to increase its billings for high value . . . HCCs," Osinek Compl. ¶ 24, because a doctor would be told to include the chronic condition as a diagnosis for a visit even if that condition was not at issue in the patient visit.[7]

- Guidance and policies. Kaiser Permanente provided guidance or policies that supported upcoding. For example, "Kaiser told its physicians to diagnose chronic kidney disease instead of the lower value nephritis or nephropathy." Osinek Compl. ¶ 26. As another example, "when CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser tells its physicians to change coding practices to reflect new reimbursable codes. . . . In response to CMS's notification that HC 131 will be eliminated, Kaiser promptly sent materials to its staff to begin prompting physicians to code diagnoses for acute kidney injury instead of chronic kidney disease stage 1, 2, or 3, which will be included in the 2014 HCC list and reimbursable by Medicare." Osinek Compl. ¶ 27.
- Addenda. In theory, "[a]ll relevant documentation is entered into a medical record at the time of service," but CMS recognizes "there may be times that a provider will need to amend, correct, or enter documentation related to an encounter. CMS

[7] The United States' Complaint provides further context on refreshing. *See, e.g.*, U.S. Compl. ¶ 7 ("Kaiser also employed a related data-mining program called 'refresh,' where Kaiser would mine patient medical files to find old diagnoses that had not yet been diagnosed in the current service year. If a physician failed to address any of these old diagnoses at a patient visit, the physician would be provided a list of these 'missed opportunities' – i.e., opportunities for risk-adjustment payment – to create an addendum to retrospectively add these diagnoses to the medical record."); U.S. Compl. ¶ 151 ("Another category of Kaiser's data-mining efforts focused on capturing diagnoses that had been made in a prior year. Kaiser referred to this program as 'refresh' and to conditions that needed to be captured as 'unrefreshed diagnoses.' Kaiser created algorithms that mined patients' electronic medical records for any diagnoses that had been made in any setting during the past several (typically three) years. As detailed below, Kaiser meticulously monitored and tracked these diagnoses, and if a physician failed to re-diagnose these conditions at a patient visit, Kaiser would systematically pressure the physician to add the diagnoses via addenda, as it did with its other data-mining efforts.").

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expects supplemental documentation to be occasional and that delayed or amended entries will be entered within a reasonable time frame. CMS will consider delayed or amended explanations for diagnoses so long as the explanations are for clarification and *not* for substantiating retroactive diagnoses." Osinek Compl. ¶ 20 (emphasis added). Kaiser Permanente had its doctors use addenda to retroactively diagnose – *e.g.*, long after a patient visit, for a condition for which the patient was not treated at the time of the face-to-face visit, based on tests run after the face-to-face visit, to change a diagnosis to a higher value and more complicated form of disease, without proper support/documentation, and/or using boilerplate language. *See, e.g.*, Osinek Compl. ¶¶ 28-32.

- Pressuring doctors. "Kaiser pressures its physicians to addend diagnoses and capture the high value HCCs" – *e.g.*, there is "an escalation process for physicians who do not agree with the data mining prompts"; "[p]hysicians will have to meet one-on-one with Data Quality Trainers if they refused to make diagnoses changes that are presented by data mining"; "physicians have personal report cards based on how they perform in certain areas [including response to refreshing and data mining prompts], which are tied to their compensation"; and there are "mandatory meetings called 'coding parties,' where physicians are gathered in a single room with computers and asked to review past progress notes for addenda related to revised medical diagnoses." Osinek Compl. ¶¶ 33-35.

II. LEGAL ISSUES

Before the Court compares *Osinek* and the later-filed cases, it first takes into consideration four legal issues related to the first-to-file bar, each of which will have an impact on the Court's comparison of the cases.

(1) Is the first-to-file bar jurisdictional in nature?

(2) In comparing the first-filed and later-filed actions, should a court look at the original complaints or any amended complaints instead (assuming amended complaints have been filed)?

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(3) In comparing the first-filed and later-filed actions, must the facts in the actions be identical in order for a court to apply the first-to-file bar?

(4) In comparing the first-filed and later-filed actions, how should a court proceed where there are different defendants?

A. Jurisdiction

Although not all courts agree, the Ninth Circuit has expressly held that the first-to-file provision (§ 3730(b)(5)) is jurisdictional in nature. *See, e.g., United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir. 2015) (stating that "[w]e treat the first-to-file bar as jurisdictional"); *see also United States ex rel. Marshall v. Univ. of TN Med. Ctr. Home Care Servs., LLC*, No. 3:17-CV-96, 2021 U.S. Dist. LEXIS 159167, at *41 & n.4 (E.D. Tenn. Aug. 23, 2021) (noting that the Fourth, Fifth, Sixth, Ninth, and Tenth Circuits have held that § 3730(b)(5) is jurisdictional but that the D.C., First, Second, and Third Circuits have held that it is not; citing cases).

The Ninth Circuit's view of § 3730(b)(5) as jurisdictional is important because it impacts which complaints should be considered when a court compares the first-filed and later-filed actions. *See* Reply at 4 (making this same point). That issue is addressed below.

In their papers, the *Stein* plaintiffs argue that the first-to-file bar is not jurisdictional. In support, they rely on *Gonzalez v. Thaler*, 565 U.S. 134 (2012), where the Supreme Court stated as follows: "A rule is jurisdictional '[i]f the Legislature clearly states that a threshold limitation on a statute's scope shall count as jurisdictional.'" *Id.* at 141. The problem for the *Stein* plaintiffs is that, post-*Gonzalez*, the Ninth Circuit issued *Hartpence* which clearly held that the first-to-file bar is jurisdictional. *See Hartpence*, 792 F.3d at 1130. The *Stein* plaintiffs acknowledge *Hartpence* but contend that the decision should not be given any weight as it relied solely on *Lujan*, 243 F.3d at 1181, a pre-*Gonzalez* decision. The Court rejects the *Stein* Plaintiffs' attempt to avoid *Hartpence*. *Hartpence* is binding authority that is clearly on point and was issued post-*Gonzalez*. It is not up to this Court to decide whether *Hartpence* was wrongly decided because the Ninth Circuit did not explicitly address *Gonzalez*.

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B. Original v. Amended Complaint

The next issue for the Court to consider is which complaints should be evaluated in determining whether the first-filed and later-filed actions are related: the original complaints or the amended complaints? All of the cases before the Court – including *Osinek* – have amended complaints except for *Arefi*. (As noted above, the *Arefi* plaintiffs do not oppose Defendants' motion to dismiss their suit.) Below is a timeline with respect to the filing of the complaints.

Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
8/22/2013 (original complaint)					
	10/22/2014 (original complaint)				
	11/3/2014 (FAC)				
		9/4/2015			
			5/16/2016 (original complaint)		
			11/3/2016 (FAC)		
				3/1/2018 (original complaint)	
					2/10/2020 (original complaint)
					10/9/2020 (FAC)
7/27/2021 – U.S. notice of election to intervene in part					
7/29/2021 – Court order granting U.S. request to unseal complaints					
10/7/2021 (FAC)					
10/25/2021 – U.S. complaint in intervention					
			11/12/2021 (SAC)		
	11/15/2021 (SAC)			11/15/2021 (FAC)	

A number of courts have held that a court should compare (1) the original complaint in the later-filed action with (2) whatever was the operative complaint in the first-filed action at the time the later-filed action was filed (which in this case would be the original complaint in *Osinek*). *See, e.g.*:

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- *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1279 (10th Cir. 2004) (stating that "[w]e judge whether § 3730(b)(5) barred Grynberg's [later-filed] qui tam action by looking at the facts as they existed at the time the action was brought"; at the time the Grynberg suit was filed, "Precision's 1992 amended complaint [in the first-filed case] was pending in federal district court").
- *U.S. ex rel. Branch Consultants, L.L.C. v. Allstate Ins. Co.*, 782 F. Supp. 2d 248, 259 (E.D. La. 2011) (hereinafter "*Branch II*") (indicating that "the Court should look to the jurisdictional facts that existed at the time the action was filed, as opposed to facts that existed when the relator later filed an amended complaint").
- *United States ex rel. Cestra v. Cephalon, Inc.*, No. 14-01842, 2014 U.S. Dist. LEXIS 143745, at *7-8 (E.D. Pa. Oct. 9, 2014) (agreeing with *Grynberg* and *Branch*).
- *United States ex rel. Carter v. Halliburton*, No. 1:11cv602 (JCC/JFA), 144 F. Supp. 3d 869, 881 (E.D. Va. 2015) (noting, *inter alia*, that "[i]t is consistent with the jurisdictional limitation to apply the first-to-file bar at the time the initial complaint is filed, rather than when the complaint is amended").
- *United States ex rel. Marshall v. Univ. of TN Med. Ctr. Home Care Servs., LLC*, No. 3:17-CV-96, 2021 U.S. Dist. LEXIS 159167, at *24 (E.D. Tenn. Aug. 23, 2021) (also agreeing with *Grynberg* and *Branch*).

In the case at bar, Defendants advocate for this approach, and most of the plaintiffs agree – but not all. *See, e.g.*, Stein Opp'n at 3 n.2 (arguing that the Court should consider the SAC which was filed in November 2021); Bicocca Opp'n at 5 (arguing that the Court should consider the FAC which was filed in October 2020).

The district court in *Branch II* has provided the most extensive analysis as to why the above approach should be followed. *Branch II* was the later-filed action. The first-filed action was known as *Rigsby*. After Branch filed its original complaint in August 2006, it filed two different amended complaints. The court gave several reasons why – for purposes of § 3730(b)(5) – the original complaint in *Branch II* (and not any amended complaint) should be compared with

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the complaint in *Rigsby*.

First, the text of § 3730(b)(5) supports this approach.

> The first-to-file bar [in § 3730(b)(5)] and the original source exception to the public disclosure bar [in § 3730(e)(4)] refer specifically to jurisdictional facts that must exist when an "action," not a complaint, is filed. Under 31 U.S.C. § 3730(b)(5), *a qui tam* plaintiff may not "bring a related action based on the facts underlying the pending action." As the Seventh Circuit has noted, "[*o*]*ne 'brings' an action by commencing suit*." *United States ex rel. Chovanec v. Apria Healthcare Group Inc.*, 606 F.3d 361, 362 (7th Cir. 2010). Further, in order to be an original source under 31 U.S.C. § 3730(e)(4)(B), a relator must provide the information on which the allegations are based to the government "before filing an action under this section which is based on the information." Both provisions appear to contemplate that certain requirements must be met at the time a qui tam action is filed. The use of the term "action" in both provisions indicates that the Court should look to the jurisdictional facts that existed at the time the action was filed, as opposed to facts that existed when the relator later filed an amended complaint.
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> As the Third Circuit has noted, however the FCA is based on the model of a single-count complaint, and it sometimes uses the term "action" when it likely means "claim." *United States ex rel. Merena v. SmithKline Beecham Corp.*, 205 F.3d 97, 101-02 (3d Cir. 2000). For example, under § 3730(b)(2) and (4), the government may choose to "proceed with the action" or may "decline to take over the action," yet it is commonplace for the government to proceed with only certain claims and not with others. *Id.* at 102. But even if "action" can mean "claim" in some contexts, it is perfectly natural to read the first-to-file bar and the original source provision as imposing certain requirements that must be met at the time the suit begins.

Branch II, 782 F. Supp. 2d at 259-60 (emphasis added).

Second, general jurisdictional principles also support the approach.

> The notion that a court cannot proceed if it lacked jurisdiction at the time the original complaint was filed is consistent with the "time-of-filing rule," under which "the jurisdiction of the Court depends upon *the state of things at the time of the action brought*[.]" *Mollan v. Torrance*, 22 U.S. 537, 539 (1824) (diversity jurisdiction exists if the parties are diverse when the action was brought, even if diversity is not maintained throughout the litigation) . . . .

Id. at 260 (emphasis added).

Third, the Supreme Court's decision in *Rockwell International Corp. v. United States*, 549 U.S. 457 (2007), does not conflict with the above approach.

> While the ruling [in *Rockwell*] focused on the original source

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> provision [rather than the first-to-file provision], it also made broader jurisdictional statements that are relevant to the FCA as a whole. In *Rockwell*, the relator brought a *qui tam* action relating to toxic waste disposal at a nuclear weapons plant. The Supreme Court held that the relator was not an original source of new allegations in the amended complaint just because he was an original source of the allegations in the original complaint. *Id.* at 473-74. The Court concluded that the relator, "at a minimum," must be an original source of the claims in the amended complaint. *Id.* at 473. But the Court did not suggest that the original complaint becomes irrelevant for jurisdictional purposes once an amended complaint is filed. To the contrary, the Court stated that its holding was consistent with "[t]he rule that subject-matter jurisdiction 'depends on the state of things at the time of the action brought.'" *Id.* (quoting *Mollan v. Torrance*, 22 U.S. 537, 539 (1824)). . . . [Cases cited in *Rockwell*] indicate that a court cannot proceed if it lacked jurisdiction at the time the initial complaint was filed.
>
> *Rockwell* goes on to state that jurisdiction is also defeated if a plaintiff amends the complaint to withdraw the allegations upon which the court's jurisdiction is based, "unless they are replaced by others that establish jurisdiction." . . . But *Rockwell* does not suggest that a plaintiff can establish jurisdiction by amendment when jurisdiction did not previously exist. Indeed, such a conclusion would be directly contrary to the Court's statement that "demonstration that the original allegations were false will defeat jurisdiction."

Id. at 261-62.

Finally, there are several practical/policy reasons to support the approach. For example,

> the pre-filing disclosure requirement of § 3730(e)(4)(B) could not function if a court could acquire jurisdiction over a *qui tam* complaint through amendment. If a court could gain jurisdiction over a *qui tam* action by amendment, then a relator could neglect to inform the government of the information upon which the allegations are based before filing his or her action. Instead, the relator could provide that information to the government at a later time, and then amend the complaint, even in a trivial fashion, to ensure jurisdiction. Such a procedure would make the statutory language requiring disclosure to the government "before filing an action" meaningless.

Id. at 263.

In addition,

> while the first-to-file bar of 31 U.S.C. § 3730(b)(5) encourages relators to quickly report fraud about which they become aware, problems arise when a relator files without yet having direct and independent knowledge of the information underlying the allegations. As discussed *infra*, the Fifth Circuit has held that even skeletal allegations can bar other actions under the first-to-file bar in at least some circumstances. *See United States ex rel. Branch*

> *Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 379 (5th Cir. 2009). It would be anomalous if a relator could secure a place in the jurisdictional queue with merely skeletal allegations, only to then file an amended complaint after actually becoming an original source, and thereby trump any meritorious, related actions that were filed in the meantime. *Cf. United States ex rel. Ortega v. Columbia Healthcare, Inc.*, 240 F. Supp.2d 8, 14 (D.D.C. 2003) (amended complaint could not "relate back" to the date the original complaint was filed in order to jump ahead in line). Such an approach would shut out deserving relators while rewarding those who bring actions without having direct and independent knowledge of their publicly disclosed allegations. A relator, under this scenario, could secure first-to-file status before actually conducting the investigation that uncovers direct and independent information about the fraud. Requiring jurisdiction at the time the original complaint was filed allows a court to dismiss such an attempt, regardless of later amendments.

Id. at 264.[8]

> Finally, the time-of-filing rule has the advantage of simplicity. The benefits of a clear-cut rule are apparent in this case, which involves multiple claims, complaints, and defendants, as well as other relators whose complaints have themselves been amended and involve multiple defendants. *See United States ex rel Rigsby v. State Farm Ins. Co.*, No. 06-433, 2006 U.S. Dist. LEXIS 98179 (S.D. Miss. 2006) (discussed *infra*); *United States ex rel Denenea v. Allstate Ins. Co.*, No. 07-2795, 2011 U.S. Dist. LEXIS 6419 (E.D. La.); *United States ex rel Sonnier v. Allstate Ins. Co.*, No. 09-1038 (M.D. La.). The Court's jurisdiction may expand or shrink as amendments are made to the complaint, but that jurisdiction must rest upon a solid foundation.

Id.

The analysis in *Branch II* is sound and persuasive. Furthermore, the analysis in *Branch II* does not conflict with Ninth Circuit law, including *Hartpence*. Admittedly, in *Hartpence*, the Ninth Circuit made the following comment in a footnote: "For purposes of determining jurisdiction, we look to the allegations in the amended complaints. *Rockwell Int'l Corp. v. United States*, 549 U.S. 457, 473-74 (2007)." *Hartpence*, 792 F.3d at 1125 n.2. But this footnote in *Hartpence* does not mean that, for purposes of the first-to-file bar, that a court should look to an amended pleading in a later-filed case.

[8] Relatedly, if the rule were that an amended complaint in the later-filed action should be considered (and not the original), that would give the relator in the later-filed action an incentive to amend its complaint once the first-filed action becomes public – *i.e.*, so as to try to distinguish the later-filed action from the first-filed action.

First, *Hartpence* referred to two different FCA provisions, not only the first-to-file bar (in § 3730(b)(5)) but also the public disclosure bar (in § 3730(e)(4)). *Hartpence*'s reference to *Rockwell* in footnote 2 may well have related to the public disclosure bar, which would make sense since *Rockwell* was a public disclosure case and not a first-to-file case

Second, as the *Branch II* court pointed out, *Rockwell* (the case that *Hartpence* cited) acknowledged the "rule that subject-matter jurisdiction 'depends on the state of things at the time of the action brought.'" *Rockwell*, 549 U.S. at 473.

Third, *Rockwell*'s statement that "courts look to the amended complaint" must be evaluated in context. The *Rockwell* Court noted that, if "original allegations [related to jurisdiction] were false," then jurisdiction is defeated. *Id.* "So also will the withdrawal of those allegations unless they are replaced by others that establish jurisdiction. Thus, when a plaintiff files a complaint in federal court and then voluntarily amends the complaint, courts look to the amended complaint to determine jurisdiction." *Id.* at 473-74. As indicated by the above text, the *Rockwell* Court made the last statement in the context of a plaintiff *withdrawing* allegations that gave rise to jurisdiction and pleading new allegations.

Finally, courts have recognized the context in which the *Rockwell* statement above was made and thus taken note of the limits of *Rockwell*. For instance, the Fifth Circuit has stated:

> The [*Rockwell*] Court did not hold . . . that the original complaint is irrelevant to jurisdiction or that a relator need not establish jurisdiction from the moment he first files his action. Indeed, *Rockwell* did not speak to the question whether a relator can use an amended complaint to establish jurisdiction when the original complaint is lacking. Consequently, we fall back on the longstanding rule that the amendment process cannot "be used to create jurisdiction retroactively where it did not previously exist." If [the relator's] complaint did not establish jurisdiction, it should have been dismissed; his amendments cannot save it.

U.S. ex rel. Jamison v. McKesson Corp., 649 F.3d 322, 328 (5th Cir. 2011). Similarly, in *Strudley v. Santa Cruz County Bank*, 747 F. App'x 617 (9th Cir. 2019), the Ninth Circuit held that the plaintiffs could not amend as a matter of right to cure a jurisdictional defect in the original complaint. "In line with Supreme Court precedent, this Circuit has adhered to the time-of-filing rule, which provides that '[s]ubject matter jurisdiction must exist as of the time the action is

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commenced.'" *Id.* at 618. The court went on to reject the plaintiffs' reliance on *Rockwell*.

> *Rockwell* stands for the proposition that a plaintiff may voluntarily amend its original complaint to *remove* federal jurisdiction (except when a case has been removed to federal court). Plaintiffs amended their complaint for the exact opposite purpose in this case [*i.e.*, in the attempt to create jurisdiction]. Therefore, the district court correctly looked to the original complaint in concluding that it lacked subject matter jurisdiction over this case.

Id.; *see also Black Hills Media, LLC v. Pioneer Corp.*, No. CV 13-05980 SJO (PJWx), 2014 U.S. Dist. LEXIS 132030, at *9 (C.D. Cal. Jan. 14, 2014) ("The court in *Rockwell* had jurisdiction over the original complaint when it was first filed, and the issue before the Supreme Court was whether the amended complaint *divested* the court of that existing jurisdiction. The Supreme Court determined that it did so. The opposite was true in [a Federal Circuit case], where the court had no jurisdiction over the original complaint, and the amended complaint would therefore grant the court jurisdiction that would not otherwise exist.") (emphasis added).

Accordingly, the Court shall compare the original complaint in *Osinek* (*i.e.*, the operative complaint in the first-filed action at the time the later-filed action was filed) with the original complaints in the later-filed actions.

C. "Identical Facts" Test v. "Material Facts" Test

Turning to the heart of the matter, the Court considers next what is the legal standard for determining whether a first-filed suit and a later-filed suit are related for purposes of § 3730(b)(5). Like other circuit courts, the Ninth Circuit has rejected the position that the first-filed and later-filed actions must be based on "identical facts" in order to be deemed related. Instead of an "identical facts" test, the Ninth Circuit applies a "material facts" test.

> Most of the few courts that have addressed § 3730(b)(5) have rejected an identical facts test. The cases' common principle is that "section 3730(b)(5) precludes a subsequent relator's claim that alleges the defendant engaged in the same type of wrongdoing as that claimed in a prior action even if the allegations cover a different time period or location within a company." *United States ex rel. Capella v. United Technologies Corp.*, 1999 U.S. Dist. LEXIS 10520, 1999 WL 464536, at *9 (D. Conn. June 3, 1999) (summarizing the tests used by other courts). The Third Circuit, the only appellate court to discuss and apply § 3730(b)(5), rejected an identical facts test. *See LaCorte*, 149 F.3d at 233-34. We find the Third Circuit's reasoning persuasive.

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> Section 3730(b)(5)'s plain language refers to "related" not "identical" actions. Therefore, we need not review the legislative history. *See Hockings*, 129 F.3d at 1071. Even if the language were considered ambiguous, the single sentence from the legislative history does not compel a different result. Furthermore, an identical facts test would defeat the congressional objectives for the 1986 amendments: "adequate incentives for whistle-blowing insiders with genuinely valuable information and discouragement of opportunistic plaintiffs who have no significant information to contribute of their own." *United States ex rel. Springfield Terminal Ry. v. Quin*n, 304 U.S. App. D.C. 347, 14 F.3d 645, 649 (D.C. Cir. 1994). Limiting § 3730(b)(5) to only bar actions with identical facts would be contrary to the plain language and legislative intent: (1) using a narrow jurisdictional bar, such as an identical facts test, would decrease incentives to promptly bring qui tam actions; (2) multiple relators would expect a recovery for the same conduct, thereby decreasing the total amount each relator would potentially receive and incentives to bring the suit; and (3) a narrow identical facts bar would encourage piggyback claims, which would have no additional benefit for the government," since once the government knows the essential facts of a fraudulent scheme, it has enough information to discover related frauds." *LaCorte*, 149 F.3d at 234.
>
> Therefore, we hold that § 3730(b)(5) bars later-filed actions alleging the same material elements of fraud described in an earlier suit, regardless of whether the allegations incorporate somewhat different details.

Lujan, 243 F.3d at 1188-89; *see also United States ex rel. St. John LaCorte v. SmithKline Beecham Clinical Labs., Inc.*, 149 F.3d 227, 234 (3d Cir. 1998) (stating that, "once the government knows the essential facts of a fraudulent scheme, it has enough information to discover related frauds").

As a practical matter, the material facts test often has a court consider "whether the [later-filed] Complaint alleges a fraudulent scheme the government already would be equipped to investigate based on the [first-filed] Complaint." *United States ex rel. Batiste v. SLM Corp.*, 659 F.3d 1204, 1209 (D.C. Cir. 2011) (noting, for example, "[i]f the government investigated the facts alleged in [first-filed] complaint on a nationwide basis, it would discover continuing fraud in the New Jersey offices [which was the focus of the later-filed complaint"); *see also id.* at 1210 (stating that "[s]ection 3730(b) is designed to allow recovery when a *qui tam* relator puts the government on notice of potential fraud being worked against the government, but to bar copycat actions that provide no additional material information"); *Hartpence*, 792 F.3d at 1125, 1131-32 ("disagree[ing] that [the later-filed] action provided no additional benefit to the government"; the

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plaintiff in the later-filed suit "provided information about a different form of fraud, and without that information the government might not have investigated beyond [defendant's] fraudulent coding practices").[9]

As a frame of reference, below is a brief discussion of some cases where the material facts test was not met and where the material facts test was met.

1. Material Facts Test Not Satisfied

In *Hartpence*, the Ninth Circuit held that the material facts test was not satisfied. The defendant in *Hartpence* was KCI, a company that manufactured medical devices that speeded the healing of wounds. One such device was a V.A.C. (vacuum assisted closure) device. *See id.* at 1124. "V.A.C. devices perform negative pressure wound therapy ('NPWT')," and Medicare has covered NPWT devices as durable medical equipment. *Id.*

In the first-filed suit, the plaintiff Hartpence alleged that KCI had engaged in fraudulent conduct by submitting claims to Medicare related to the V.A.C. devices. Specifically, Hartpence asserted that KCI had submitted claims with a certain billing code, which indicated compliance with certain requirements even though those requirements had not, in fact, been met in various ways. *See, e.g., id.* at 1125 (noting that "Hartpence alleges that KCI improperly submitted claims with the KX modifier [*i.e.*, billing code]: (1) when there was no wound improvement in the

[9] Dr. Taylor contends that this notice standard is no longer applicable after *Kellogg Brown & Root Servs. v. United States ex rel. Carter*, 575 U.S. 650 (2015). *See* Taylor Opp'n at 21-22 n.23. In support, he cites an opinion from a Washington district court, *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, No. 4:14-cv-5002-EFS, 2015 U.S. Dist. LEXIS 137979 (E.D. Wash. Oct. 1, 2015). There, the court stated: "The Supreme Court's ruling in *Brown* inherently limits this 'notice' analysis. Applying a broad 'notice' test does not serve the FCA's purpose of providing private parties the opportunity to pursue actions alleging fraud against the government *once the first-to-file bar lifts following the dismissal of the earlier action*." *Id.* at *22 (emphasis added).

As indicated by the language italicized above, *Savage* has no application here because the first-filed action – *Osinek* – has not been dismissed and therefore the first-to-file bar cannot have not been lifted. *See also Brown*, 575 U.S. at 662 (indicating that "an earlier suit bars a later suit while the earlier suit remains undecided but ceases to bar that suit once it is dismissed"; rejecting the argument that the first-filed action remains pending even after it has been dismissed).

Moreover, the Ninth Circuit's decision in *Hartpence* – which applied the notice standard above – was issued *after* the Supreme Court's decision in *Brown*. *Brown* was decided in May 2015, and *Hartpence* in July 2015.

previous month; (2) for the treatment of wounds for which V.A.C. therapy was neither reasonable nor necessary; (3) when the required wound measurement documentation was absent; [etc.]").

In the later-filed suit, the plaintiff Godecke also claimed that KCI had improperly used the same billing code – albeit for a different reason. *See id.* (taking note of allegation that "KCI violated the FCA by knowingly misusing the KX modifier in submitting claims for a full month of V.A.C. therapy, even when the therapy . . . had been stopped and restarted within the same month"). In addition, Godecke claimed that there was a FCA violation related to DWOs (detailed written orders). Suppliers of durable medical requirement were required to obtain DWOs from a patient's treating physician before dispensing the supplied for which they sought reimbursement from Medicare. *See id.* at 1125 n.4. According to Godecke, "KCI ignored the requirement to receive correct and completed [DWOs] before delivering supplies and beginning therapy." *Id.* at 1125.

The Ninth Circuit effectively acknowledged the similarity of the Hartpence and Godecke complaints in that both implicated improper use of the same billing code (even though there were different reasons why the billing code was not properly used). However,

> Godecke's second claim involves different underlying facts. Whereas Hartpence's claims all allege knowing misuse of the KX modifier [*i.e.*, billing code], Godecke's second claim is based on facts which show KCI's violation of a *different Medicare program requirement* – the requirement that a provider receive Detailed Written Orders for the V.A.C. device before beginning to treat patients with the device. . . . [T]he claims are based on different material facts. The rules governing use of KX modifiers and DWOs were disseminated at different times, in different publications, and are plainly treated as separate regulations under the program.
>
> We further disagree that Godecke's action provided no additional benefit to the government. Unaided by Godecke's complaint, the government may have never discovered that KCI, in addition allegedly to misusing the KX coding system, was allegedly submitting V.A.C. claims before receiving DWOs. The two alleged frauds are materially different: the KX fraud allegations are based on *government payment for devices which were used, but unnecessary for treatment*, while the DWOs fraud allegations are based on the *government paying for devices that were never used at all*. The alleged frauds, in short, exist completely independent of one another.

Id. at 1131 (emphasis added).

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2. Material Facts Test Satisfied

In *United States ex rel. Hampton v. Columbia/Hca Healthcare Corp.*, 318 F.3d 214 (D.C. Cir. 2003), the D.C. Circuit concluded that the material facts test was satisfied. The plaintiff Hampton's suit was the later-filed suit. The first-filed suit was brought by Boston. According to Hampton, the defendant companies and several employees had improperly billed the government under the Medicare program for home health services – *e.g.*,

> the companies billed for services that were miscoded; already paid for; performed by others; never administered; or supposedly administered to Hampton's mother after she died in 1996. Hampton also claimed that [the companies] submitted bills for supplies and medications that were unnecessary or never received; and that they billed for services to patients who did not qualify under the Medicare guidelines, did not need treatment, or were not charged required copayments. The companies submitted false or inaccurate documentation to the government and, so she alleged, shredded documents in order to destroy evidence of the fraud.
>
> [The D.C. Circuit held that Hampton's case and Boston's case were related because] Boston's allegations were along very much the same lines. He asserted that HCA home health subsidiaries billed the government for services that did not meet the Medicare eligibility criteria, for undocumented services, and for services not medically necessary. He also alleged that they submitted false or inaccurate Medicare documentation and destroyed documents.

Id. at 219.

Likewise, in *Batiste*, the D.C. Circuit also found the first- and later-filed cases related. The plaintiff Batiste filed the later action. Zahara filed the earlier action. The court found that "[a] side-by-side comparison has persuaded us that, although the complaints allege somewhat different facts, Zahara's complaint suffices to put the U.S. government on notice of allegedly fraudulent forbearance practices at [Sallie Mae] and its subsidiaries, and Batiste's complaint alleges the same material elements of the same fraud." *Id.* at 1209. In particular,

> Zahara and Batiste broadly allege that the same fraudulent activities occurred at each of their offices, for the same reasons, and that similar SLM corporate policies promoted the fraudulent behavior. They both allege SLM fraudulently increased its profits and promoted its standing with the Department of Education by falsifying forbearances. And both allege that SLM's corporate culture promoted increasing the dispensation of forbearances through quotas and a team bonus system. Though Zahara focused on the fabrication of oral forbearance requests, and Batiste focused

> on the offering of forbearances to unqualified borrowers, the allegations of the first complaint give the government grounds to investigate all that is in the second.
>
> Under the . . . material facts test, these complaints allege essentially the same corporation-wide scheme. The Zahara Complaint would suffice to equip the government to investigate SLM's allegedly fraudulent forbearance practices nationwide. Batiste's additional details would not give rise to a different investigation or recovery.

Id. at 1209-10.

D. Different Defendants

Finally, the Court must consider whether it makes a difference in "material facts" when different defendants are sued in the first-filed and later-filed actions. In *Osinek*, the original complaint named only one defendant – Kaiser Permanente – which Ms. Osinek described as "a private provider of Medicare Advantage insurance under Medicare Part C." Osinek Compl. ¶ 2.

> Kaiser Permanente is a California corporation with its principal place of business [in] Oakland, California 94612. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage Plans than any other organization in California. At all times relevant, Kaiser conducted business in California, including but not limited to providing healthcare services through Medicare Advantage plans and to the general public in California.

Osinek Compl. ¶ 6. The later-filed actions named a variety of different Kaiser entities, including but not limited to Kaiser Permanente.

COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
Kaiser Permanente	Kaiser Permanente		Kaiser Permanente	Kaiser Permanente	
	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	
	Kaiser Foundation Health Plan of Colorado	Kaiser Foundation Health Plan of Colorado	Kaiser Foundation Health Plan of Colorado		

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COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
	Kaiser Foundation Health Plan of Georgia	Kaiser Foundation Health Plan of Georgia, Inc.	Kaiser Foundation Health Plan of Georgia, Inc.		
	Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest		
		Kaiser Foundation Hospitals	Kaiser Foundation Hospitals	Kaiser Foundation Hospitals	
		Southern California Permanente Medical Group	Southern California Permanente Medical Group	Southern California Permanente Medical Group	Southern California Permanente Medical Group, Inc.
		The Permanente Medical Group	The Permanente Medical Group	The Permanente Medical Group	Permanente Medical Group, Inc.
		Colorado Permanente Medical Group, P.C.	Colorado Permanente Medical Group	Colorado Permanente Medical Group P.C.	
		The Southeast Permanente Medical Group	The Southeast Permanente Medical Group	Southeast Permanente Medical Group	
		Hawaii Permanente Medical Group	Hawaii Permanente Medical Group	Hawaii Permanente Medical Group	
		Northwest Permanente, P.C.	Northwest Permanente, P.C.		
			Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.		
			Kaiser Foundation Health Plan of Washington		

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COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
			Mid-Atlantic Permanente Medical Group	Mid-Atlantic Permanente Medical Group, PC	
			Group Health Permanente		
				The Permanente Federation, LLC	The Permanente Federation, LLC
				Northwest Permanente Physicians & Surgeons, P.C.	
				Washington Permanente Medical Group	

The Ninth Circuit has not expressly addressed the issue of different defendants, but other circuit courts have. Most have indicated that "adding a new defendant to the mix does not *necessarily* allow a later-filed action to evade the first-to-file bar." *Cho v. Surgery Partners, Inc.*, No. 20-14109, 2022 U.S. App. LEXIS 8774, at *15 (11th Cir. Apr. 1, 2022) (emphasis in original). This is particularly true where the new defendant(s) named in the later-filed action is a subsidiary or affiliate of the defendant(s) named in the first-filed action. *See Branch I*, 560 F.3d at 379 (noting that "allegations of fraud against a corporation may bar subsequent allegations of fraud against the corporation's subsidiaries").

That being said, the fact that the new defendant(s) in the later-filed action is a subsidiary or affiliate of the defendant(s) in the first-filed action does not automatically mean that the first-filed and later-filed actions are related either. Ultimately, resolution depends on how the first-filed action defines the scope of the misconduct. If there are, *e.g.*, allegations in the first-filed suit that there was a nationwide problem or a corporate-wide problem, then, most likely, the fact that new subsidiaries or affiliates are named in the later-filed action will not make that action unrelated for purposes of § 3730(b)(5). *Cf. Batiste*, 659 F.3d at 1210 (related complaints "essentially alleged

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same corporate-wide scheme"). On the other hand, if the first-filed action focuses on a local problem, then, most likely, a broader-in-scope later-filed action will not be related, even if the new defendant(s) in the latter action is an affiliate of the defendant named in the earlier action. *Cf. United States ex rel. Chovanec v. Apria Healthcare Group, Inc.*, 606 F.3d 361, 364 (7th Cir. 2010) (stating that, "to understand whether the suits materially overlap we must know whether the initial suits alleged frauds by rogue personnel at scattered offices or instead alleged a scheme orchestrated by Apria's national management").

"Two cases from the D.C. Circuit, *Hampton* and *Heath*, serve as useful bookends for this analysis." *Cho*, 2022 U.S. App. LEXIS 8774, at *15. *Hampton* found the first- and later-filed actions at issue related; *Heath* found the first- and later-filed actions at issue unrelated.

1. *Hampton*

In *Hampton*, the plaintiff Hampton named the following defendants in her later-filed action: HCA; Clinical Arts (Georgia subsidiary of HCA); and several Clinical Arts employees. She alleged that the defendants "had improperly billed the government under the Medicare program for home health services." *Hampton*, 318 F.3d at 218. The court was asked to decide whether Hampton's action was barred by an earlier lawsuit, filed by Boston. The D.C. Circuit noted that

> Hampton thinks her complaint differs significantly from Boston's because it named different defendants. Boston sued only HCA. Hampton sued not only HCA but also HCA's subsidiary Clinical Arts and several Clinical Arts employees. As Hampton sees it, Boston's complaint cannot possibly have covered fraud by Clinical Arts and its employees because it (1) fails to name Clinical Arts or its employees as defendants and (2) specifically mentions fraud at HCA home health care subsidiaries in six states that do not include Georgia.

Id. The court, however, found that

> these are not differences in the material elements of the fraud. Boston was a senior manager in HCA's home care group. *He alleged a corporate-wide problem*, revealed through internal audits, in which HCA perpetrated fraud in providing home health care services *through numerous subsidiaries*. It is true that Boston's complaint mentioned instances of fraud at particular home health agencies in only six specific states, not including Georgia. But Boston's complaint described these as *"examples" and "samplings"* of "a huge number of illegal payments from Medicare . . . received

> by Columbia/HCA's 550 home health locations *in 37 states*." Given Boston's broad allegations based on his position as an HCA insider, Hampton's naming Clinical Arts – a specific HCA subsidiary – and naming individual employees of Clinical Arts were merely variations on the fraud Boston's complaint described.

Id. (emphasis added); *see also Batiste*, 659 F.3d at 1209 (acknowledging that plaintiff in first-filed suit "discusses activities at [a Sallie Mae] subsidiary office in Nevada, but [still] alleges a nationwide scheme attributable not only to the subsidiary, but also to [Sallie Mae]"; thus, "[i]f the government investigated the facts alleged in [that plaintiff's] complaint on a nationwide basis, it would discover continuing fraud in the New Jersey offices"); *Chovanec*, 606 F.3d at 364 (taking note of allegations that fraud was enabled by changes made to a computer system used in all of a company's offices; also taking note of allegations that national headquarters provided guidance that enabled fraud); *United States ex rel. Marion v. Heald Coll., LLC*, No. 5:12-cv-02067-PSG, 2015 U.S. Dist. LEXIS 97767, at *11 (N.D. Cal. July 24, 2015) (stating that "[a]llowing plaintiffs to escape the first-to-file bar by naming specific employees who carried out a previously-alleged corporate fraud contravenes the purpose of Section 3730(b)(5) – to prevent piggyback claims[;] [h]ere, the previously-filed complaints against Corinthian [Colleges] allege that fraudulent conduct extended far beyond individual campuses and pervaded the entire company").

2. *Heath*

In *United States ex rel. Todd Heath v. AT&T, Inc.*, 791 F.3d 112 (D.C. Cir. 2015), the plaintiff Heath filed the later-filed action against AT&T and nineteen of its subsidiaries. The lawsuit was related to a federal program known as the Universal Service Fund. *See id.* at 117. Under federal law, "every interstate telecommunications carrier must contribute a portion of its quarterly interstate and international telecommunications revenue to the . . . Fund." *Id.* at 116. One of the programs administered through the Fund is "E-Rate," which "entitles qualifying schools and libraries to receive Internet and telephone services at discounted rates." *Id.* at 116-17. According to Heath,

> AT&T orchestrated and implemented through its subsidiaries a corporate-wide scheme to have false claims submitted to the Universal Service Fund by depriving schools and libraries in the E-Rate program of the lowest corresponding price for services. Schools and libraries, unaware of those overcharges, then passed

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> those inflated costs on to the federal government for reimbursement through the Universal Service Fund.

Id. at 117. Of particular note, Heath asserted that AT&T deliberately or recklessly chose not to train its employees in the lowest-corresponding-price requirement. *See id.* (taking note of allegation that AT&T was a recidivist violator of the E-Rate Program).

Heath had also filed an earlier lawsuit but only against Wisconsin Bell, which was a wholly owned subsidiary of AT&T. *See id.* at 118. In this suit, Heath asserted that "Wisconsin Bell charged some E-Rate eligible schools more than others, and that Wisconsin Bell generally failed to provide school districts with the benefit of the favorable pricing it offered to state departments, agencies, and universities." *Id.* Furthermore, "[w]hen informed of this pricing discrepancy, Wisconsin Bell's sales representatives 'regularly denied the existence of the agreements' between Wisconsin Bell and other Wisconsin agencies." *Id.*

One issue before the D.C. Circuit was whether Heath's first-filed suit was a bar to his later-filed action. The court held that the first-filed suit was not a bar because the

> two complaints target factually distinct types of frauds. The Wisconsin Bell Complaint alerted the federal government only to a limited scheme by Wisconsin Bell to defraud the E-Rate program within Wisconsin. That alleged fraud was accomplished, in part, through affirmative misrepresentations by Wisconsin Bell employees to schools and libraries within Wisconsin, in which those employees openly denied the existence of a state contract with a lower corresponding price.
>
> In contrast, the AT&T Nationwide Complaint alleges a different and more far-reaching scheme to defraud the federal government through service contracts entered into across the Nation, and then to cover up that fraud. Critically, the alleged fraud was accomplished not through affirmative misrepresentations about the lowest corresponding price, but through institutionalized disregard of the lowest-corresponding-price requirement altogether in AT&T's employee-training and billing procedures. According to the AT&T Nationwide Complaint, AT&T and its subsidiaries deliberately failed to enforce that lowest-price mandate by refusing to train or even tell employees about that limitation on charges, and by failing to incorporate that limitation into its billing practices.

Id. at 121.

The court continued:

> On its face, the Wisconsin Bell complaint discloses nothing more than the rogue actions of individuals within a single AT&T subsidiary and their specific, overt misrepresentations. Nothing in

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> the complaint would have alerted the United States government to a nationwide scheme centered in AT&T's corporate headquarters of mischarging the E-Rate program and subsequently concealing those overpayments. Nor, given the affirmative misrepresentations at issue, would the Wisconsin Bell Complaint have pointed the federal government to AT&T's systematic refusal to institutionalize compliance by employees with the lowest-corresponding-price requirement.
>
> The fraud thus manifested itself in sufficiently distinct ways in the two cases that the material elements of the fraud differ. As the Seventh Circuit has recognized, "to understand whether the suits materially overlap we must know whether the initial suit[] alleged frauds by rogue personnel at scattered offices or instead alleged a scheme orchestrated by * * * national management." Because the Wisconsin Bell Complaint alleged only the former, it did not disclose the nationwide fraud grounded in institutionalized training and enforcement failures, and compounded by efforts at concealment, that is the focus of Heath's later complaint.

Id. at 121-22 (citation omitted). The D.C. Circuit distinguished, *inter alia*, *Hampton* because, there, "the first complaint alleged a broad fraudulent scheme orchestrated by a national or parent company, and the second complaint merely added additional facts or widened the circle of victims of the same fraudulent conduct." *Id.*

> Those cases stand for the simple proposition that the greater fraud often includes the lesser. The problem for AT&T is that the lesser fraud does not, without more, include the greater. The Wisconsin Bell Complaint did not allege that AT&T encouraged Wisconsin Bell's fraud or affirmative misrepresentations, or even knew anything about them. Nor did the Wisconsin Bell Complaint suggest that AT&T and its subsidiaries engaged in "uniform billing practices" across the United States. There simply is no hint in the Wisconsin Bell Complaint of a country-wide, institutionalized corporate practice of disregarding the lowest-price requirement or of a calculated refusal to educate or train employees.

Id. at 122-23.

The court acknowledged AT&T's point that the E-Rate program is a national program but, it pointed out, so too "is virtually every law policed by the *federal* False Claims Act." *Id.* at 123 (emphasis in original). The first-to-file bar could not be triggered "every time an initial complaint alleges that a subsidiary of a national company violated a national law" or "a broad swath of False Claims Act coverage" would be "erase[d]." *Id.* The court underscored that the purpose of the first-to-file bar was "to prevent copycat litigation, which tells the government nothing it does not already know" but, here, "Heath's complaints go after two materially distinct fraud schemes." *Id.*;

see also United States ex rel. Branch Consultants v. Allstate Ins. Co., 560 F.3d 371, 379 (5th Cir. 2009) (stating that the first-filed action "*Rigsby* does not allege a true industry-wide fraud or concerted action among a narrow group of participants[;] [r]ather, looking only at the facts pleaded . . . , *Rigsby* implicates, at most, four specific [write-your-own] insurers among the approximately ninety-five WYI insurers conducting business in the Louisiana and Mississippi areas during Hurricane Katrina," and, therefore, "*Rigsby* tells the government nothing about which of the ninety-one other WYO insurers . . . , if any, actually engaged in any fraud").

III. COMPARING RELATOR ACTIONS

Having reviewed the major legal issues, the Court may now turn to a comparison of the first-filed action, *Osinek*, with the various later-filed actions. The Court makes the comparisons in the order listed below because, *e.g.*, if there are material differences between *Osinek* and *Taylor*, that would effectively make *Taylor* the first-filed action for the new material facts. In other words, the remaining cases would then need to be compared to both *Osinek* and *Taylor*.

- Case No. C-21-3894 EMC *Taylor* (filed in the District of Colorado in 2014 and transferred to this District in 2021).
- Case No. C-16-1558 EMC *Arefi* (filed in the Central District of California in 2015 and transferred to this District in 2016).
- Case No. C-16-5337 EMC *Stein* (filed in the Central District of California in 2016 and transferred this District in 2016).
- Case No. C-18-1347 EMC *Bryant*.
- Case No. C-21-3124 EMC *Bicocca* (filed in the Eastern District of California in 2020 and transferred to this District in 2021).

A. *Osinek* and *Taylor*[10]

Dr. Taylor argues that his case is materially different from *Osinek* in two ways: (1) different defendants were sued in each case and (2) different frauds were implicated in each case.

[10] Dr. Taylor argues his FAC is the operative complaint for purposes of comparing his case to cases filed after his. *See* Taylor Opp'n at 6 n.4. But for purposes of comparing *Osinek* and *Taylor*, the Court compares the *Osinek* complaint to Dr. Taylor's original complaint. At the time Dr. Taylor brought his case, there was only the original complaint in *Osinek* on file.

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1. Different Defendants

Ms. Osinek sued only one entity: Kaiser Permanente. In contrast, Dr. Taylor sued multiple Kaiser entities: Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; Kaiser Foundation Health Plan of Georgia; and Kaiser Foundation Health Plan of the Northwest.

Dr. Taylor argues that the difference in defendants is meaningful. Defendants argue to the contrary. They take the position that, by suing "Kaiser Permanente," Ms. Osinek implicitly sued a national defendant which therefore covered all regional or local subsidiaries or affiliates. Defendants further argue that allegations made in the Osinek Complaint show that Ms. Osinek was implicating a nationwide fraud. *See* Mot. at 20. The Court finds that the Osinek complaint does not allege a nationwide fraud.

As a starting point, the Court takes note that there does not appear to be any legal entity with the name "Kaiser Permanente." Rather, "Kaiser Permanente" seems to be a trade name used by various Kaiser entities. *See* Mot. at 1 (asserting that there are "various healthcare organizations operating under the Kaiser Permanente trade name"); *cf.* U.S. Compl. ¶ 28 (noting Kaiser's Health Plans, Permanente Medical Groups, and hospitals publicly hold themselves out and do business collectively as an integrated healthcare providers called 'Kaiser Permanente'"); Taylor Compl. ¶ 16 (alleging that "Kaiser Permanente is a non-profit care consortium" that "includes three main groups: (1) the Kaiser Foundation Health Plan, Inc. and its subsidiaries; (2) the Kaiser Foundation Hospitals and their subsidiaries; and (3) the Permanente Medical Groups"). Thus, the fact that Ms. Osinek (not to mention Dr. Taylor and others) sued "Kaiser Permanente" is not particularly telling one way or the other.

What is more significant are the allegations in Ms. Osinek's complaint – specifically, the geographic scope of the allegations. The complaint implicates California only. For example, Ms. Osinek describes "Kaiser Permanente" as follows:

> a California corporation with its principal place of business *[in] Oakland* . . . . Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage plans than any other organization *in California*. At all times relevant, Kaiser conducted business *in California*, including

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> but not limited to providing healthcare services through Medicare Advantage plans and to the general public *in California*.

Osinek Compl. ¶ 6 (emphasis added).

One might argue that the above paragraph is California-centric because Ms. Osinek was simply trying to establish that jurisdiction in California is proper. However, nowhere in the complaint does Ms. Osinek allege that there is a problem outside of California. She does not mention any other state. She does not allege a "corporate-wide problem" as in *Hampton*, 318 F.3d at 218. She never even uses the term "nationwide" or "corporate-wide" or otherwise suggest a "'scheme orchestrated by . . . national management.'" *Heath*, 791 F.3d at 122 (quoting *Chovanec*, 606 F.3d at 364). Nor is it not clear that any practice identified by Ms. Osinek was necessarily nationwide or corporate-wide in nature – *e.g.*, there is no suggestion that data mining through the use of algorithms was implemented through a nationwide computer system.

Defendants contend that just because the Osinek Complaint gave California examples does not mean that the pleading is limited in scope to California. In principle, this is true. But there must be some indication in the pleading that the problem extends outside of California.[11] *Compare Hampton*, 318 F.3d at 218 ("It is true that Boston's complaint mentioned instances of fraud at particular home health agencies in only six specific states, not including Georgia. But Boston's complaint described these as 'examples' and 'samplings' of 'a huge number of illegal payments from Medicare . . . received by Columbia/HCA's 550 home health locations in 37 states.'"). Indeed, if the rule were to the contrary, then there would seem to be serious policy concerns. The mere fact that a defendant company is part of a larger network of affiliated companies would be enough to deem the government on notice of a nationwide or corporate-wide problem – which would then, under the first-to-file bar, cut off all other actions. But if the government declined to investigate on a nationwide or corporate-wide scale (*e.g.*, because of limited resources), and the first filer stayed within the limited scope of its complaint as pled, then no one else would be able to bring a FCA claim to address a potentially broader problem. This

[11] Notably, where the Osinek Complaint does at one point refer to different regions, both of the regions identified are still based in California. *See* Mot. at 20 (citing Osinek Compl. ¶ 37); Osinek Compl. ¶ 37 (alleging that "Kaiser positioned the Southern California Region against Northern California in competition for the highest risk scores and physician approval rates").

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would run counter to the FCA which is meant to encourage the uncovering of fraud against the government. The first-to-file bar would not only "prevent copycat litigation," *Heath*, 791 F.3d at 123, but also a wide swath of litigation far broader than the first-filed suit. Here, *Taylor* is not simply an "opportunistic successive suit," *Lujan*, 243, F.3d at 1187; *Taylor* cannot be said to have "provided no additional benefit to the government." *Hartpence*, 792 F.3d at 1131.

Confronted with this obstacle, Defendants invoke the practical aspect of the material facts test, which asks whether "[t]he first-filed claim provides the government notice of the essential facts of an alleged fraud." *Lujan*, 243 F.3d at 1187. Defendants note that, a few months after the *Osinek* complaint was filed in 2013, the government issued four subpoenas to (1) the Kaiser Foundation Health Plan; (2) the Permanente Medical Group; (3) Southern California Permanente Medical Group; and (4) Kaiser Foundational Hospitals. The subpoenas covered not only the named entities but also *all subsidiaries and affiliates*.[12] *See* RJN, Exs. A-D (subpoenas). Thus, Defendants argue, the government implicitly understood that *Osinek* pointed to a nationwide or corporate-wide problem. Defendants add that, in 2017, the government sent a letter to Defendants seeking the production of documents from the Colorado regions specifically – and cited to the 2013 subpoenas in support of that request. *See* RJN, Ex. E.

Defendants' contention is not convincing for several reasons. First, Dr. Taylor raises a legitimate argument that only the complaints should be considered in determining whether the first-to-file bar applies – not evidence outside of the complaints. *Cf. In re Natural Gas Royalties ex rel. United States*, 562 F.3d 1023, 1031 (10th Cir. 2009) (stating that "[t]he first-to-file bar is designed to be quickly and easily determinable, simply requiring a side-by-side comparison of the complaints"); *Batiste*, 659 F.3d at 1209 (making a "side-by-side comparison" of the complaints in the first-filed and later-filed suits). Dr. Taylor has not been privy to all of the communications

[12] *See, e.g.*, RJN, Ex. A (Subpoena at 2) ("The term 'KAISER FOUNDATION HEALTH PLAN, INC.' refers to the person or entity with its primary offices located at One Kaiser Plaza, Oakland, California, and also includes all current and former: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, *subsidiaries*, regions, segments, branches, groups, *affiliates*, and divisions; and joint ventures of which it is a part.") (emphasis added).

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between the United States and Defendants. It is entirely possible that some communications might support his position here rather than Defendants.[13] And if the Court were to permit Dr. Taylor to, in effect, conduct discovery into the government's communications – or more generally, into the government's understanding of the *Osinek* complaint – then there would effectively be a mini trial on a secondary matter that would only delay the process of moving forward with the case. The task before the Court at this juncture is to compare the complaints, not conduct a mini-trial based on facts.

Accordingly, the Court does not dismiss *Taylor* based on the first-to-file bar because *Taylor* is broader in scope than *Osinek* in terms of defendants. *See Heath*, 791 F.3d at 122 ("Those cases [such as *Hampton*] stand for the simple proposition that the greater fraud often includes the lesser. The problem for AT&T is that the lesser fraud does not, without more, include the greater.").

2. Different Frauds

The closer question is whether *Taylor* implicates different frauds than does *Osinek*.

As noted above, *Osinek* is about mining records to look for places to upcode, particularly for high-value conditions. Upcoding was ultimately improper because it was based on, *e.g.*, exaggerating a patient's condition, diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a condition for which the patient was not treated, diagnosing without the proper support/documentation, and the like.

Taylor is essentially the flip side. It asserts the theory that, as a result of regular internal audits, Kaiser knew there were high error rates in risk adjustment claims in certain areas but *failed* to take action to find the false claims retroactively – and thus improperly retained the

[13] Even if the Court were to consider the 2013 subpoenas issued by the government and its 2017 letter to Defendants, Defendants do not fare any better. Although the subpoenas did refer to subsidiaries and affiliates, that language is boilerplate in nature. And fact that the government only issued subpoenas to four specific Kaiser entities (all of which appear to be based in California) points to a more limited scope of inquiry. As for the letter, the fact that the government relied on the 2013 subpoenas to justify an inquiry into Colorado in 2017 largely seems a litigation tactic. Notably, by 2017, the *Taylor* complaint – which expressly implicated the Colorado region – had been filed. (The original complaint in *Taylor* was filed in October 2014.)

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government's overpayment for those false claims (essentially, a reverse false claim theory).[14] *See, e.g.*, Taylor Compl. ¶¶ 81-82 (citing "[e]xamples of risk adjustment claims that the Kaiser audits have identified as routinely false" and alleging that, "despite its knowledge that the categories of risk adjustment claims . . . are false a significant percentage of the time, Kaiser routinely fails to take reasonable steps to identify which of these claims are false . . . and then to prevent their submission in the first place or to delete them after submission"). *Taylor* contrasts the lack of effort by the Kaiser entities to take action to address the errors with their zealous pursuit of reviewing records to find instances where diagnoses could be added (*i.e.*, upcoding). *See* Taylor Compl. ¶ 62 (alleging that Kaiser's "lack of diligence contrasts starkly with [its] considerable efforts and substantial commitment of resources to audit current and past claims to identify new diagnoses that it could use to submit additional risk adjustment claims and thereby increase the amount of the risk adjustment payments it receives from CMS.").

Dr. Taylor argues that the flip side makes his case materially different from *Osinek*. Specifically, he argues that his case, unlike *Osinek*, focuses on (1) Kaiser's failure to act even after audits revealed high error rates for certain HCCs or diagnoses; (2) Kaiser's failure to act even after audits revealed high error rates for diagnoses made by external providers; and (3) Kaiser's failure to act even after audits revealed high error rates for "True Positive" results associated with Kaiser's Natural Language Processing program. Each of these claimed differences is discussed below.

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[14] In their papers, Defendants suggest that Dr. Taylor does not have a viable claim here: "Taylor's allegations about error rates identified in audits of diagnosis-code data do not identify a unique fraud scheme. Rather they purport to show that Defendants had *knowledge* of the upcoding scheme that Osinek already alleged." Reply at 3 (emphasis added). Defendants likely make this argument because, in its complaint, the United States alleges that "Kaiser's internal audits put [it] on . . . notice of fraudulent diagnoses." U.S. Compl. at 68; *see also* U.S. Compl. ¶ 304 (alleging that "[a] variety of internal audits provided further notice that Kaiser's addenda and query practices were resulting in false claims to CMS").

Although Defendants fairly argue that the audits are relevant to Kaiser's knowledge, it is not clear why Dr. Taylor would not also have a viable claim based on the theory that Kaiser failed to take corrective action which resulted in its being able to keep government overpayments for false claims in violation of the FCA. *Cf. United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1173 (9th Cir. 2016) (indicating that plaintiff had a viable theory based on allegations that, in the face of audit error rates in excess of 20%, defendants conceived and directed retrospective reviews that were "designed to identify only favorable reporting errors").

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a. High Error Rates for Certain HCCs or Diagnoses

Dr. Taylor first claims a violation of the FCA because Kaiser failed to act even after audits revealed high error rates in risk adjustment claims for certain HCCs or diagnoses. For example, Dr. Taylor alleges as follows with respect to cancer:

- "Every year, Kaiser's National Compliance Office ('NCO') conducts a nationwide 'Probe' audit to test the accuracy of risk adjustment claims submitted the prior year." Taylor Compl. ¶ 69.
- The Probe Audits "have consistently identified cancer (HCCs 7-10) as the most upcoded condition." Taylor Compl. ¶ 102.
- "The most significant and consistent error is that Kaiser providers submit diagnosis codes representing active, current treatment of cancer when, in fact, the patient's cancer is cured, in remission, or otherwise irrelevant to the services provided to the patient." Taylor Compl. ¶ 103. Notably, a diagnosis of "history of cancer" does not result in a risk adjustment. *See* Taylor Compl. ¶ 105.

Cancer is not the only HCC/diagnosis called out as problematic. Other conditions that have had high error rates include:

- Stroke. *See, e.g.*, Taylor Compl. ¶ 118 ("Kaiser knew stroke was commonly coded as an active event, when, in fact, the patient should have been classified as having a history of stroke.").
- Vascular disease. *See, e.g.*, Taylor Compl. ¶ 127 ("[S]ome claims erroneously claimed the patient had current vascular disease, when, in fact, they had only a history of the condition."); Taylor Compl. ¶ 129 ("[C]ertain claims were false because of a 'mismapping' problem with HealthConnect, Kaiser's EMR [electronic medical records]. HealthConnect . . . allows physicians to choose a descriptive diagnosis (as opposed to a specific ICD-9 code) when entering clinical information. HealthConnect then 'maps' this descriptive diagnosis to a specific ICD-9 diagnosis code, which is then inserted into the medical record documentation.").
- Chronic bronchitis. *See, e.g.*, Taylor Compl. ¶ 134 ("Kaiser's EMR [electronic

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medical records] . . . pressured physicians to use the diagnosis for chronic bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk adjust)."); Taylor Compl. ¶ 132 ("The probe audits regularly found COPD [chronic obstructive pulmonary disease] claims erroneous based on lack of documentation in the record, or because the doctor failed to document the patient's condition with sufficient specificity to determine if the patient actually had COPD.").

- Malnutrition. *See, e.g.*, Taylor Compl. ¶ 140 ("In some cases, the condition was diagnosed as current when the patient actually only had a 'history of' the condition.").
- Renal insufficiency. *See, e.g.*, Taylor Compl. ¶ 152 ("Chronic kidney disease ('CKD') is a condition that is often miscoded . . . .").

As indicated by the above, Dr. Taylor takes issue with Kaiser for not reacting to the high error rates – *i.e.*, had Kaiser done so then it would have seen that the diagnoses (of high-value conditions) lacked documentation or proper support and/or that the diagnoses were irrelevant to the treatment provided to the patient. Although Dr. Taylor is correct that his claim here is about Kaiser ignoring an upcoding problem (as revealed by error rates) rather than actively creating upcoding, the Court does not see this flip side as creating a material difference with respect to *Osinek*. This is because both *Taylor* and *Osinek* are ultimately based on the same "underlying facts," *Hartpence*, 792 F.3d at 1131: that the high-level condition that was diagnosed did not have documentation or proper support and/or did not affect patient care.

The practical aspect of the material facts test underscores that *Taylor* and *Osinek* are related cases, at least with respect to the above. Here, the Court must ask whether the allegations in *Osinek* "[gave] the government grounds to investigate all that is in" the Taylor Complaint. *Batiste*, 659 F.3d at 1209; *see also id.* at 1209-10 (stating that the first-filed "[c]omplaint would suffice to equip the government to investigate SLM's allegedly fraudulent forbearance practices nationwide" and the "additional details" in the later-filed complaint "would not give rise to a different investigation or recovery"). Based on *Osinek*, the government was put on notice that high-value conditions often did not have proper support and were diagnosed even when a patient

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was not treated for that condition at the time of service. Thus, in light of *Osinek*, the government had grounds to investigate all that is in the Taylor Complaint which points to the same basic problem. That, according to Dr. Taylor, the problem would have been revealed if Kaiser had taken action in response to the high error rates, is somewhat beside the point. The error rates here are not in themselves what is critical; rather, at bottom, Dr. Taylor's broader claim is that high-value conditions were diagnosed without following the practices required by Medicare regulations. This is fundamentally the same charge that Ms. Osinek makes.

b. High Error Rates for Diagnoses Made by External Providers

Dr. Taylor also claims that his complaint is different from the Osinek Complaint because he has alleged that Kaiser failed to act even after audits revealed high error rates with diagnoses submitted by external providers. (Dr. Taylor refers to this as "one-way look chart review" in his papers. *See, e.g.*, Taylor Opp'n at 7.) The relevant allegations in support of this theory are as follows:

- Several of Kaiser's regions, including Colorado, Hawaii, and, until recently, Georgia, "rely heavily on external providers (hospitals or other facilities who are not owned by Kaiser) to provide inpatient care to Kaiser's HMO members." Taylor Compl. ¶ 83.
- The external providers submit claims to Kaiser after they have provided services to Kaiser members, and Kaiser uses the external providers' diagnoses as the basis for the risk adjustment claims that Kaiser submits to CMS. *See* Taylor Compl. ¶ 84.
- Kaiser's audits "have identified significant error rates in risk adjustment claims [that] Kaiser submitted to CMS based on diagnoses provided by external providers." Taylor Compl. ¶ 86. For example, for the Colorado region, the error rates for external providers in some years was over 40% and 60%. *See* Taylor Compl. ¶ 88; *see also* Taylor Compl. ¶ 89 (adding that "[t]he error rates for certain large hospitals . . . are striking" – some more than 90%).
- "Despite knowing of the consistent errors in claims data from external providers, Kaiser Colorado [for example] does not conduct any routine targeted audits of

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claims submitted by external providers. This is particularly egregious because the Colorado region does have a coder review each hospital stay at an external provider *to look for additional diagnoses* present in the chart but not coded by the treating physician." Taylor Compl. ¶ 98 (emphasis added).

Here, the Court agrees with Dr. Taylor that this specific aspect of his case is not related to *Osinek*. Problematic coding related to high-value conditions is different from problematic coding by external providers. Notably, there is no indication that the problematic coding by external providers was related to high-value conditions. Accordingly, this specific claim made by Dr. Taylor involves "different underlying facts." *Hartpence*, 792 F.3d at 1131. Furthermore, it cannot be said that the government would likely have found the particular problem with external providers based on its investigation into the kinds of internal upcoding practices identified in *Osinek*.

c. Natural Language Processing Software

Finally, Dr. Taylor claims that his complaint differs from the Osinek Complaint because he has made allegations about Kaiser's Natural Language Processing ("NLP") software. The main allegations made in the Taylor Complaint with respect to the NLP software are as follows.

- "Broadly speaking, [a] NLP program uses an algorithm to search EMRs [electronic medical records] to find words that, individually or in combination, indicate that a patient has certain diagnoses." Taylor Compl. ¶ 191.
- Kaiser developed its own NLP audit program "to try to find new diagnosis codes to submit." Taylor Compl. ¶ 191.
- "All face-to-face visits to a physician or hospital . . . are run through the NLP software to identify new diagnoses that might be appropriate to use for submission of additional risk adjustment claims. The results are grouped into four categories: (a) True Positive: [meaning] diagnoses . . . have been confirmed by two Kaiser coders; (b) More Information Needed: [meaning] diagnoses . . . may be present, but further analysis is required to confirm; (c) Problem List Only: [meaning] diagnoses . . . show up only on the member's problem list [section of the medical record] with

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no documentation of treatment; and (d) False Positives or Found Elsewhere." Taylor Compl. ¶ 196.

- "Kaiser allows the various regions to decide how to use [the above] information." Taylor Compl. ¶ 197. For some regions, if a result is True Positive, then a claim is submitted to CMS for payment – without any further review. *See* Taylor Compl. ¶ 200. This is true even though audits have revealed that there is a high error rate for True Positives. *See* Taylor Compl. ¶¶ 198, 200.

As indicated by the above, Dr. Taylor is not focusing here on the fact that Kaiser uses the NLP program to mine records for instances where it can upcode. Had he done so, then his case would clearly be related to *Osinek*. Rather, Dr. Taylor's point is that there is a high error rate associated with the NLP program's True Positives, but Kaiser still submits claims based on True Positives without any further inquiry.

The Court finds that the nature of wrongdoing claimed by Dr. Taylor here involves different "material elements" from *Osinek*. *Lujan*, 243 F.3d at 1189. Dr. Taylor is charging Kaiser with exploiting True Positives; this is different from *Osinek* which is focused on the exploitation of high-value conditions. Similar to above, there is nothing that suggests True Positives appear with high-value conditions only, or even primarily. Thus, Dr. Taylor here has "'significant information to contribute of [his] own.'" *Id.* The Court also notes that, under the practical aspect of the material facts test, this part of *Taylor* should not be deemed related to *Osinek*. Based on *Osinek*, the government would likely have looked at the NLP program given that it was purportedly used to data mine; however, that would not lead the government to question the True Positive results yielded by the NLP program. Rather, as a facial matter, the more likely candidates for exploitation by Kaiser would be the categories of "More Information Needed" and "Problem List Only," not the True Positives.

d. Summary

The *Taylor* case is not dismissed in its entirety but only in part. *Taylor* differs materially from *Osinek* in three ways: (1) *Taylor* points to a nationwide or corporate-wide problem whereas *Osinek* is local or regional (*i.e.*, California-centric) in nature; (2) *Taylor* has identified a fraud

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related to external providers rather than high-value conditions; and (3) *Taylor* asserts a problem with Kaiser failing to evaluate the True Positives results yielded by the NLP program.

B. *Osinek* and *Arefi*

As noted above, the *Arefi* Plaintiffs do not oppose the motion to dismiss their complaint. Thus, the Court may move on to the next complaint filed after *Arefi*.

C. *Osinek* and *Stein*

As an initial matter, the Court takes note that the *Stein* plaintiffs contend that the Court should compare the complaint in *Osinek* with their operative SAC, which was filed in November 2021. *See* Opp'n at 3 n.2. The Court rejects that argument for the reasons discussed above.

Based on their original complaint, the *Stein* plaintiffs focus on two specific conditions: sepsis and malnutrition.[15] The main allegations are as follows.

- Sepsis. The criteria for diagnosing sepsis is not straightforward. *See, e.g.*, Stein Compl. ¶¶ 42-43, 49. In 2003, the ICD-9 diagnostic codes and ICD Guidelines were modified to, in essence, reflect that complexity. The Guidelines emphasize that "coders will likely have to query physicians when documenting Sepsis to trigger proper documentation that supports the Sepsis diagnosis due [to] the complex nature of those diseases." Stein Compl. ¶ 48. Defendants engaged in a scheme "to up-code and falsely diagnose MA enrollees with sepsis and/or severe sepsis, i.e., sepsis with acute organ failure[] (collectively referred to as 'Sepsis')[,] when Sepsis was not present." Stein Compl. ¶ 50. "[The] fraudulent scheme [involved] the identification and treatment of Sepsis for . . . MA enrollees that presented in the emergency room (ER) of [Kaiser] hospitals and was accomplished by (a) [Defendants] implementing unwritten policies that prohibited coders employed by [Defendants] from performing physician queries for Sepsis diagnoses as required by the ICD-9 Guidelines, (b) implementing unwritten policies

[15] The *Stein* plaintiffs also included in their original complaint allegations on Kaiser's practice of "refreshing." However, in their opposition, they have conceded that this conduct was sufficiently implicated in earlier-filed actions. *See* Stein Opp'n at 1 (stating that the *Stein* plaintiffs "do not oppose [the] first-to-file attack against [their] Refresh fraud claim").

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requiring Kaiser's coders to code ICD-9 diagnosis codes for Sepsis based solely on the physician's instructions to code Sepsis instead of relying on the supporting clinical findings documented in the medical record, (c) using an improper Sepsis diagnostic standard that overstated the frequency of Sepsis diagnoses, (d) aggressively diagnosing Sepsis as part of a strategy to lower the reported Sepsis mortality rates at [Kaiser] hospitals throughout California, and (e) [Defendants], as an express condition of receiving capitation payments from CMS, routinely and annually falsely certifying that such ICD-9 diagnosis codes for Sepsis were accurate, complete, and truthful . . . ." Stein Compl. ¶ 50.

- Malnutrition. Defendants "participated in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA enrollees." Stein Compl. ¶ 70. The scheme "was conducted at all [Kaiser] Hospitals throughout California and involved the diagnoses and coding of malnutrition and severe malnutrition based upon assessment performed by dieticians . . . . The . . . dietician used a rubber stamp on the MA enrollee's medical record indicating that in his/her opinion the MA enrollee suffered from malnutrition or severe malnutrition. [The] physicians then countersigned the stamp in the MA enrollees' medical record. Based solely on the presence of the physician's countersignature . . . , Kaiser's coders recorded the ICD-9 diagnosis codes for malnutrition or severe malnutrition . . . ." Stein Compl. ¶ 70. There was no face-to-face encounter nor were there clinical findings in support, as required by federal regulations. *See* Stein Compl. ¶ 71.

These claims overlap with *Osinek*. *Osinek* asserts that upcoding was improper because it was based on exploiting high-value conditions – *e.g.*, exaggerating a patient's condition, diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a condition for which the patient was not treated, diagnosing without the necessary support/documentation, and the like. *Stein* implicates the same kind of conduct; essentially, *Stein* involves lesser-included conduct by virtue of the fact that it focuses on two conditions (sepsis and

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malnutrition) specifically. Notably, *Osinek*, like *Stein*, expressly identified malnutrition as one of the high-value conditions that was being exploited.[16] *See* Osinek Compl. ¶ 25. The fact that *Osinek* did not also expressly identify sepsis as a high-value condition (as *Stein* did) is not dispositive since it is but one example of the alleged upcoding. *Cf. Hampton*, 318 F.3d at 219 (concluding actions were related because both alleged that bills were submitted for ineligible and undocumented Medicare services and for services not medically necessary).

The *Stein* plaintiffs suggest that their case is still materially different because the frauds implicated in their complaint were committed when "patients . . . were admitted to a KFH hospital or in the case of Sepsis, treated as a hospital outpatient through the emergency room." Opp'n at 12-13. But nothing about *Osinek* excepts a hospital setting from the alleged upcoding.

The only place where *Stein* is materially different from *Osinek* is with respect to the scope of the alleged misconduct. *Stein* suggests – by virtue of the Kaiser entities sued – that the alleged misconduct goes beyond California. While this does make *Stein* different from *Osinek* (the latter being California-centric in scope), *Stein* runs into a problem still because *Taylor*, the next case filed after *Osinek*, implicates a nationwide or corporate-wide problem and is broad enough to encompass the basic kind of upcoding practices alleged in *Stein*.

The Court therefore dismisses the *Stein* case based on the first-to-file bar – in its entirety. The *Stein* plaintiffs have asked for leave to amend but that is a futile request since the Court's evaluation is limited to the original Stein Complaint.

D. *Osinek* and *Bryant*

As a preliminary matter, the Court takes note that Defendants do not seek to dismiss *Bryant* in its entirety. It recognizes that *Bryant* has retaliation claims (based on the FCA and on

[16] The Stein FAC (filed in May 2016, *i.e.*, a few months after the original Stein Complaint) did add in a new condition – i.e., aortic atherosclerosis ("AA"). *See* Stein FAC ¶ 83 (noting that AA "is a chronic condition that results in the build up of arterial plaque or fatty deposits in the patient's aorta"). According to the Stein Plaintiffs, "Kaiser's coders coded . . . MA patients with an AA diagnosis based solely upon the physician's notation of AA in the medical record, without the medical record reflecting that the patient was treated for his/her AA condition." Stein FAC ¶ 84. Even if the Court were to consider this new condition identified in the Stein FAC (as well as the Stein SAC), there would still be overlap with the *Osinek* complaint. The nature of the conduct is similar such that AA is a condition that the government likely would have investigated given *Osinek*'s description of Kaiser exploiting high-value conditions.

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other federal and state law) which are not subject to the first-to-file bar. *See* Mot at 1 n.3 ("This Motion seeks dismissal of the Later-Filed Complaints . . . in their entirety except for the retaliation causes of action in the operative *Bryant* complaint (Counts 5 through 8) and the California False Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4) . . . .").[17]

According to the *Bryant* plaintiffs, their case is materially different from *Osinek* in that,

> unlike the *Osinek* complaint, the *Bryant*/*Hernandez* Complaint exposes Kaiser's upcoding fraud: (i) relating to a specific high-value diagnosis code, mechanical ventilator dependence status, that first came to light after Osinek filed her suit[[18]]; (ii) not just on the Medicare Advantage program, but on a different government program (the Affordable Care Act) run by a different government agency entirely (the Department of Health and Human Services); and (iii) within Kaiser's insurance and physician-practice behemoths in all regions, not just one region, and also within Kaiser's massive hospital operation across Kaiser's regions, which was not even part of the *Osinek* suit.

Bryant Opp'n at 2.

For (iii), as noted above, it does not matter that the hospital setting was not expressly implicated in *Osinek*. Nothing in *Osinek* suggests that it excludes the hospital setting. The *Bryant* plaintiffs fairly argue that *Osinek* is California-centric; however, as noted above, *Taylor* – the case next in line after *Osinek* – put the government on notice of a nationwide or corporate-wide problem related to the upcoding of high-value conditions.

As for (i), *see* Bryant Compl. ¶¶ 85-86 (alleging that "a patient is vent dependent only if the patient relies on the ventilation to live on a long-term basis and not for the short-term acute phase of a condition" but Defendants fail to comply with that guidance) (emphasis omitted), the *Bryant* plaintiffs are basically making the same kind of argument that the *Stein* plaintiffs did. *See* Bryant Opp'n at 15 ("Given the sheer number of diagnosis codes, it would be impossible for the government to identify fraudulent over-documenting and upcoding in particular diagnoses without

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[17] At one point, the *Bryant* plaintiffs also had California FCA claims but they dropped those claims in their FAC.

[18] In their complaint, the *Bryant* plaintiffs explicitly identified additional high-value HCCs or diagnoses but implicitly recognize that these conditions have already been expressly named by plaintiffs in earlier-filed actions. *See, e.g.*, Bryant Compl. ¶¶ 56, 107, 136, 144, 146-49 (referring to aortic atherosclerosis, sepsis, malnutrition, acute renal failure, acute kidney injury, and respiratory failure, arrythmia for members with pacemakers, major depression, and acute stroke).

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being pointed in the right direction."). But as with *Stein*, this is lesser-included conduct and sufficiently similar to the conduct put at issue in *Osinek* – *i.e.*, Defendants were exploiting high-value conditions by failing to provide support/documentation for the upcoding. *Cf. Hampton*, 318 F.3d at 219 (concluding actions were related because both alleged that bills were submitted for ineligible and undocumented Medicare services and for services not medically necessary). The fact that the practice allegedly was not discovered until after *Osinek* was filed does not mean that *Bryant* cannot be a related case. That Defendants may have allegedly expanded their misconduct to other high-value conditions does not negate the government being put on notice of the fraudulent scheme in the first instance as a result of *Osinek*.

This leaves the *Bryant* plaintiffs with (ii). Here, the *Bryant* plaintiffs correctly point out that their original complaint contains multiple allegations about payments Defendants receive under the Affordable Care Act (and not just Medicare Advantage). For example, the *Bryant* plaintiffs allege as follows:

- "The United States contributes to premiums that individuals pay to private health insurance companies such as Kaiser under the Affordable Care Act. *See* Bryant Compl. ¶ 7; *see also* Bryant Compl. ¶ 52 (alleging that the government contributes through tax credits).
- "The Affordable Care Act sets up a program of risk adjustment in individual and group markets to lessen or eliminate the influence of risk selection on the premiums that plans charge. In the risk adjustment model utilized under the AA, which is named the HHS-Hierarchical Condition Categories ('HHS-HCC') risk adjustment model, HHS [*i.e.*, the Department of Health and Human Services] utilizes criteria and methods similar to those utilized under the Medicare Advantage Program, and adapts Medicare Advantage HCCs for use in the HHS-HCC model." Bryant Compl. ¶ 51; *see also* Bryant Compl. ¶ 7.
- Thus, "as under the Medicare Advantage Program, the ACA risk adjustment model creates powerful incentives for private health insurance companies like Kaiser to over-report diagnosis codes in order to exaggerate the expected healthcare costs for

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their enrollees; the more codes that are reported, the higher premiums the companies are permitted to charge, and the higher contributions will be made to such premiums by the United States." Bryant Compl. ¶ 7.

- "Defendants overdocument and upcode risk adjustment claims relevant to individuals covered by the ACA in the same manner and pursuant to the same schemes as relevant to the Medicare Advantage program . . . ." Bryant Compl. ¶ 11(b).
- The *Bryant* plaintiffs "seek . . . to recover damages and civil penalties arising from the false or fraudulent records, statements and/or claims that the Defendants made or caused to be made in connection with false and/or fraudulent claims for Medicare Advantage risk adjustment payments [and] Affordable Care Act insurance premiums . . . ." Bryant Compl. ¶ 18.

In response, Defendants point out that the actual causes of action asserted by the *Bryant* plaintiffs at the end of their complaint refer to risk adjustment payments under Medicare only. *See, e.g.*, Bryant Compl. ¶¶ 209-10, 214-15, 220, 224-26. Nowhere do the causes of action refer to risk adjustment payments under the Affordable Care Act. Although Defendants are correct, the *Bryant* plaintiffs fairly point out that each cause of action does incorporate all paragraphs previously pled. Accordingly, although the *Bryant* plaintiffs could have drafted a better and clearer pleading, they have not pled themselves out of FCA claims based on the Affordable Care Act as Defendants contend.

At the hearing, Defendants argued that, even if the *Bryant* plaintiffs have claims predicated on the Affordable Care Act, they are nonetheless still barred by the first-to-file provision because the government would have been put on notice of that alleged fraudulent scheme by virtue of *Osinek*. The Court does not agree. The Affordable Care Act is an entirely different scheme, not run by CMS specifically, and covering a broad range of individuals outside of the reach of Medicare. The ACA claims thus state causes of action entirely different and distinct from the Medicare Advantage claims. The government was put on notice of a problem with the Medicare Advantage program only. That the Affordable Care Act also uses risk adjustment does not mean

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that the government's investigation of Medicare Advantage would naturally lead to an investigation of the Affordable Care Act.

Accordingly, the Court dismisses *Bryant* but only in part. The claims that survive are the retaliation claims, as well as the claims based on the Affordable Care Act.

E. *Osinek* and *Bicocca*

Defendants do not seek to dismiss the entirety of *Bicocca*. Specifically, they recognize that Dr. Bicocca has claims pursuant to the California FCA that are not subject to the first-to-file bar. *See* Mot. at 1 n.3 ("This Motion seeks dismissal of the Later-Filed Complaints . . . in their entirety except . . . the California False Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4) . . . .").

Second, the Court takes note that Dr. Bicocca admits his original complaint (filed in February 2020) is barred by the first-to-file provision. He argues, however, that his FAC (filed in October 2020) adds a theory that is not in *Osinek*. *See* Bicocca Opp'n at 2. Because, as discussed above, it is Dr. Bicocca's original complaint that must be compared to the Osinek Complaint, he is out of luck.

However, even if the Court were to consider the FAC, Dr. Bicocca's contention that his case is materially different from *Osinek* is without merit. He states:

> Relator Bicocca's Amended Complaint describes "two sources" of diagnoses that Kaiser requires physicians to add. *Bicocca* Dkt. 16 ¶ 108. One of these sources is addenda that Kaiser gives physicians *after* a patient visit, which include additional diagnoses for the physician to *retroactively* add to the patient's chart. *Id.* at ¶¶ 106, 110. The other is a list of the patient's past diagnoses, which Kaiser gives to physicians *before* the physician meets with the patient, with the intention that the physician will re-diagnose each of the specific diagnoses *during* the visit ("upfront list"). *Id.* at ¶ 109.

Bicocca Opp'n at 2 (emphasis in original); *see also* Bicocca FAC ¶ 109 ("The first source [for diagnoses that physicians are required to add onto Medicare] are diagnoses that these patients had already, confirmed in previous years by other physicians. While, as a matter of first impression, this does not seem to be a violation of regulations, since the patients have already had the diagnoses confirmed by others, having physicians re-confirm these diagnoses without spending sufficient time on it and without having any expertise on these diagnoses is still a violation of

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Medicare's regulations on confirming diagnoses for the purpose of risk adjustment."). The problem for Dr. Bicocca is that the latter is essentially refreshing, which has already been put at issue in *Osinek*.

Accordingly, the Court grants the motion to dismiss Dr. Bicocca's claims, and the only claims that survive are those based on the California FCA which Defendants have not contested for purposes of the first-to-file bar.

IV. CONCLUSION

For the foregoing reasons, the Court grants in part and denies in part Defendants' motion to dismiss based on the first-to-file bar. Specifically:

- *Arefi* and *Stein* are dismissed in their entirety.
- *Taylor* is dismissed except to the extent that it pleads (1) a nationwide or corporate-wide fraud; (2) a fraud based on improper coding by external providers; and (3) a fraud based on True Positive results from the NLP program.
- *Bryant* is dismissed except to the extent that it pleads (1) retaliation claims and (2) claims based on fraud in the Affordable Care Act program.
- *Bicocca* is dismissed except to the extent that it pleads claims based on the California FCA.

This order disposes of Docket No. 141.

IT IS SO ORDERED.

Dated: May 5, 2022

EDWARD M. CHEN
United States District Judge

United States District Court
Northern District of California

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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA, *ex rel.* RONDA OSINEK, Plaintiffs, v. KAISER PERMANENTE, Defendant.	CASE NO. 13-cv-03891-EMC **CONSOLIDATED MEMBER CASES** CASE NO. 16-cv-01558-EMC CASE NO. 16-cv-05337-EMC CASE NO. 18-cv-01347-EMC CASE NO. 21-cv-03124-EMC CASE NO. 21-cv-03894-EMC **NOTICE OF APPEAL**

Notice is hereby given that Plaintiffs and Relators Marcia Stein and Rodolfo Bone hereby appeal to the United States Court of Appeals for the Ninth Circuit from an order entered on May 5, 2022, a copy of which is attached as Exhibit 1. Appellants' Representation Statement is attached as Exhibit 2.

THE ZINBERG LAW FIRM, A.P.C.

HANAGAMI LAW, A.P.C.

Dated: June 3, 2022

By: */s/William K. Hanagami*
William K. Hanagami
Attorneys for Plaintiffs and *Qui Tam* Relators, Marcia Stein and Rodolfo Bone

EXHIBIT 1

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

UNITED STATES OF AMERICA ex rel. RONDA OSINEK,

Plaintiff,

v.

PERMANENTE MEDICAL GROUP, INC, et al.,

Defendants.

Case No. 13-cv-03891-EMC

CONSOLIDATED MEMBER CASES

Case No. 16-cv-01558-EMC
Case No. 16-cv-05337-EMC
Case No. 18-cv-01347-EMC
Case No. 21-cv-03124-EMC
Case No. 21-cv-03894-EMC

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION TO DISMISS

Docket No. 141

United States District Court
Northern District of California

The above cases are all predicated on allegations that various Kaiser entities[1] submitted false claims for payment to the federal government as part of the Medicare Part C program, which is also called Medicare Advantage. *Osinek* was the first-filed case and was followed by five other cases: *Taylor*, *Arefi*, *Stein*, *Bryant*, and *Bicocca*.[2] The cases were consolidated in June 2021. *See Osinek*, Docket No. 61 (order). In July 2021, the United States filed a notice that it was

[1] The Kaiser entities are, generally speaking, various Health Plans, Hospitals, and Medical Groups. These entities "publicly hold themselves out and do business collectively as an integrated healthcare provider called "Kaiser Permanente." U.S. Compl. ¶ 28.

[2] *Taylor* was initially filed in the District of Colorado in 2014; *Arefi* in the Central District of California in 2015; *Stein* in the Central District of California in 2016; *Bryant* in the Northern District of California in 2016; and *Bicocca* in the Eastern District of California in 2020.

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intervening in part and declining to intervene in part.[3] *See Osinek*, Docket No. 64 (notice of election).

Currently pending before the Court is Defendants' motion to dismiss based on the first-to-file bar in the False Claims Act ("FCA"). The relevant FCA provision states as follows: "When a person brings an action under this subsection, no person other than the Government may intervene or *bring a related action based on the facts underlying the pending action*." 31 U.S.C. § 3730(b)(5) (emphasis added). The purpose of the first-to-file bar is twofold: (1) "to promote incentives for whistle-blowing insiders" and (2) "[to] prevent opportunistic successive plaintiffs." *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181, 1187 (9th Cir. 2001). Defendants argue that, with limited exceptions, the claims presented by the cases that follow *Osinek* are barred. The *Arefi* plaintiffs have filed a statement of nonopposition with respect to the motion to dismiss their case. *See* Docket No. 143 (nonopposition). The plaintiffs in all other cases have opposed dismissal.

Having considered the parties' briefs, as well as the oral argument of counsel, the Court hereby **GRANTS** in part and **DENIES** in part Defendants' motion.

I. FACTUAL & PROCEDURAL BACKGROUND

A. United States' Complaint-in-Intervention

Although the United States' Complaint-in-Intervention is not at issue in the pending motion, the Court begins with this pleading as it provides a good overview of the Medicare background.

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[3] The notice stated as follows:

> Specifically, the United States intervenes on the allegations that defendants Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group, Inc.; and Colorado Permanente Medical Group, P.C.; submitted, or caused to be submitted, false claims for risk-adjustment payments based on diagnoses improperly added via addenda under Medicare Part C from the years 2009 until present. The United States declines to intervene on all other allegations.

Osinek, Docket No. 64 (notice).

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"Medicare is a federally operated health insurance program." U.S. Compl. ¶ 52. It has four parts:

- Part A covers inpatient and institutional care.
- Part B covers outpatient care.
- Part C is the Medicare Advantage program at issue in this case.
- Part D covers prescription drugs.

See U.S. Compl. ¶ 52.

Parts A and B are "traditional" Medicare.

> [T]he Government reimburses healthcare providers using a fee-for-service system, in which providers submit claims to CMS [Centers for Medicare and Medicaid Services] for healthcare services actually rendered, such as a provider officer visit or hospital stay. CMS then pays the providers directly for each service based on payment rates predetermined by the Government.

U.S. Compl. ¶ 53.

A Medicare beneficiary can opt out of traditional Medicare and enroll instead in a Medicare Advantage plan managed by a Medicare Advantage Organization ("MAO"). *See* U.S. Compl. ¶ 54. "CMS reimburses [Medicare Advantage] plans differently than traditional Medicare." U.S. Compl. ¶ 58. Specifically, Medicare Advantage uses a "'capitation' payment system." *United States ex rel. Silingo v. Wellpoint, Inc.*, 904 F.3d 667, 672 (9th Cir. 2018). Under that system, "private health insurance organizations provide Medicare benefits in exchange for a fixed monthly fee per person enrolled in the program – regardless of actual healthcare usage." *Id.* The fixed monthly fee for an enrollee is set as follows. First, there is a predetermined base payment for each enrollee in a Medicare Advantage plan. *See* U.S. Compl. ¶ 57. Second, the base payment is then adjusted "to account for (1) demographic factors such as age and gender (among others) and (2) health status. This is known as risk adjustment." U.S. Compl. ¶ 58.

Risk adjustment is accomplished by assigning each beneficiary a risk score, which "acts as a multiplier that is applied to the [Medicare Advantage] plan's base rate to determine the overall monthly payment for the beneficiary." U.S. Compl. ¶ 58. A beneficiary's risk score is determined through a model called the CMS Hierarchical Conditions Category ("CMS-HCC") model, which,

as indicated above, is based on the patient's demographic factors and health status. *See* U.S. Compl. ¶ 59. With respect to health status, the model relies on diagnosis codes from the International Classification of Diseases ("ICD"). *See* U.S. Compl. ¶ 60. "ICD diagnosis codes are alphanumeric codes used by healthcare providers, insurance companies, and public health agencies to represent medical conditions; every disease, injury, infection, and symptom has its own code." U.S. Compl. ¶ 62.

> The ICD diagnosis codes included in the CMS-HCC model are grouped into categories of clinically related medical diagnoses that comprise the HCCs (i.e., the categories). For example, various cancer diagnosis codes are grouped together (e.g., colorectal and bladder cancers). The CMS-HCC model organizes related conditions into hierarchies based on disease severity and expected cost. For example, various cancer HCCs are in the same hierarchy, with the HCC associated with metastatic cancer diagnosis codes as the most severe. If a patient is diagnosed with conditions (diagnosis codes) that correspond to more than one HCC in a hierarchy, only the most severe HCC is kept and any lower-ranking HCCs are dropped.

U.S. Compl. ¶ 63.

> Each HCC is assigned a coefficient. CMS calculates a beneficiary's risk score by adding the coefficients associated with each of the beneficiary's applicable demographic characteristics (such as age and gender) and the applicable HCCs, if any, that apply to the beneficiary. A risk score of 1.0 reflects the average expected Medicare-incurred expenses. A risk score of 0.75 reflects expected costs for a particular beneficiary that are 25% less than the estimated average costs for enrollees in the MA plan, and a risk score of 1.25 reflects expected costs that are 25% greater than the estimated average costs for enrollees in the MA plan.

U.S. Compl. ¶ 65.

The CMS-HCC model is prospective in the sense that it uses diagnoses made in a base year (the 'service year'), along with demographic information (such as age and gender, among others), to predict costs for Medicare benefits and adjust payments for the following year (the 'payment year')." U.S. Compl. ¶ 60.

"To combat the 'incentive for [Medicare Advantage] organizations to potentially over-report diagnoses,' Medicare regulations require risk adjustment data to be produced according to certain best practices." *Silingo*, 904 F.3d at 673. For example,

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> the diagnosis codes that MA Organizations submit to CMS for risk-adjustment purposes must be:
>
> a. established by a qualified physician;
>
> b. based on a face-to-face medical visit between the patient and physician[4];
>
> c. documented in the medical record; and
>
> d. coded in compliance with the ICD [Official Guidelines for Coding and Reporting], including the limitation that the condition must have required or affected patient care, treatment, or management for the visit.[5]

U.S. Compl. ¶ 87 (emphasis added); *see also Silingo*, 904 F.3d at 673 (also noting best practices).

"[I]t is an express condition of payment that a Medicare Advantage organization 'certify (based on best knowledge, information, and belief) that the [risk adjustment] data it submits . . . are accurate, complete, and truthful.'" *Id.* (quoting 42 C.F.R. § 422.504(l)(2)).

B. Osinek Complaint

The Court turns next to the Osinek Complaint as it provides the baseline for the Court – *i.e.*, the Court will have to compare the Osinek Complaint with the complaints in the other cases to determine whether the cases are related. *See* 31 U.S.C. § 3730(b)(5) (providing that, "[w]hen a person brings an action under this subsection, no person other than the Government may intervene or bring a related action based on the facts underlying the pending action").[6]

The allegations below all come from Ms. Osinek's original complaint filed in 2013. (Ms.

---

[4] For example,

> even if an MA organization knows that a patient was diagnosed in a prior year with a chronic condition that tends not to go away, the MA organization may not submit the diagnosis for payment for the current year unless the physician has a face-to-face visit with the patient in the current year and the chronic condition required or affected care, management, or treatment during that patient visit.

U.S. Compl. ¶ 85.

[5] "In other words, only those conditions that specifically mattered to the patient care, treatment, or management that the physician actually provided at the visit could be submitted to CMS for payment." U.S. Compl. ¶ 5.

[6] Similarly, later-filed complaints must be compared with all preceding complaints.

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Osinek filed an amended complaint in 2021. For the reasons discussed below, it is Ms. Osinek's original complaint that matters for purposes of the pending motion.)

Ms. Osinek has sued "Kaiser Permanente," "a private provider of Medicare Advantage insurance under Medicare Part C." Osinek Compl. ¶ 2. Ms. Osinek describes "Kaiser Permanente" as follows:

> Kaiser Permanente is a California corporation with its principal place of business [in] Oakland, California 94612. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage Plans than any other organization in California. At all times relevant, Kaiser conducted business in California, including but not limited to providing healthcare services through Medicare Advantage plans and to the general public in California.

Osinek Compl. ¶ 6.

According to the complaint, starting around 2007, Kaiser Permanente began a "scheme to upcode diagnoses to ensure Medicare payments for reimbursable, high-value conditions." Osinek Compl. ¶ 2. Not surprisingly, Kaiser Permanente "focuses . . . on high value conditions" so that it "can maximize its reimbursement from Medicare." Osinek Compl. ¶ 25. High-value disease conditions included, *e.g.*, chronic kidney disease, congestive heart failure, depression, chronic respiratory failure, cachexia/protein calories malnutrition, severe obesity, and seizure. *See* Osinek Compl. ¶ 25.

Kaiser Permanente effectuated its upcoding scheme in various ways. For example:

- Data mining. Kaiser Permanente used "algorithms to identify [high-value] disease conditions for data mining." Osinek Compl. ¶ 25. "Kaiser identified the higher value HCCs and then determined the diagnoses its doctors would need to make to support the HCCs Kaiser wanted to submit for Medicare reimbursement." Osinek Compl. ¶ 25.
- Refreshing. Although not clearly described in the complaint, refreshing appears to be a process related to chronic conditions. *See* Osinek Compl. ¶ 37 (alleging that "Kaiser tracks and rewards physicians based on the percentage of chronic conditions they are able to capture and refresh"). As indicated above, Medicare

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Advantage plans are compensated based on medical conditions diagnosed in the previous payment year. Therefore, if a patient has a chronic condition, then that condition must be rediagnosed each year – *i.e.*, refreshed. Presumably, Kaiser Permanente used refreshing "to increase its billings for high value . . . HCCs," Osinek Compl. ¶ 24, because a doctor would be told to include the chronic condition as a diagnosis for a visit even if that condition was not at issue in the patient visit.[7]

- Guidance and policies. Kaiser Permanente provided guidance or policies that supported upcoding. For example, "Kaiser told its physicians to diagnose chronic kidney disease instead of the lower value nephritis or nephropathy." Osinek Compl. ¶ 26. As another example, "when CMS announces that HCCs are eliminated (and no longer reimbursable by Medicare), Kaiser tells its physicians to change coding practices to reflect new reimbursable codes. . . . In response to CMS's notification that HC 131 will be eliminated, Kaiser promptly sent materials to its staff to begin prompting physicians to code diagnoses for acute kidney injury instead of chronic kidney disease stage 1, 2, or 3, which will be included in the 2014 HCC list and reimbursable by Medicare." Osinek Compl. ¶ 27.
- Addenda. In theory, "[a]ll relevant documentation is entered into a medical record at the time of service," but CMS recognizes "there may be times that a provider will need to amend, correct, or enter documentation related to an encounter. CMS

[7] The United States' Complaint provides further context on refreshing. *See, e.g.*, U.S. Compl. ¶ 7 ("Kaiser also employed a related data-mining program called 'refresh,' where Kaiser would mine patient medical files to find old diagnoses that had not yet been diagnosed in the current service year. If a physician failed to address any of these old diagnoses at a patient visit, the physician would be provided a list of these 'missed opportunities' – i.e., opportunities for risk-adjustment payment – to create an addendum to retrospectively add these diagnoses to the medical record."); U.S. Compl. ¶ 151 ("Another category of Kaiser's data-mining efforts focused on capturing diagnoses that had been made in a prior year. Kaiser referred to this program as 'refresh' and to conditions that needed to be captured as 'unrefreshed diagnoses.' Kaiser created algorithms that mined patients' electronic medical records for any diagnoses that had been made in any setting during the past several (typically three) years. As detailed below, Kaiser meticulously monitored and tracked these diagnoses, and if a physician failed to re-diagnose these conditions at a patient visit, Kaiser would systematically pressure the physician to add the diagnoses via addenda, as it did with its other data-mining efforts.").

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expects supplemental documentation to be occasional and that delayed or amended entries will be entered within a reasonable time frame. CMS will consider delayed or amended explanations for diagnoses so long as the explanations are for clarification and *not* for substantiating retroactive diagnoses." Osinek Compl. ¶ 20 (emphasis added). Kaiser Permanente had its doctors use addenda to retroactively diagnose – *e.g.*, long after a patient visit, for a condition for which the patient was not treated at the time of the face-to-face visit, based on tests run after the face-to-face visit, to change a diagnosis to a higher value and more complicated form of disease, without proper support/documentation, and/or using boilerplate language. *See, e.g.*, Osinek Compl. ¶¶ 28-32.

- Pressuring doctors. "Kaiser pressures its physicians to addend diagnoses and capture the high value HCCs" – *e.g.*, there is "an escalation process for physicians who do not agree with the data mining prompts"; "[p]hysicians will have to meet one-on-one with Data Quality Trainers if they refused to make diagnoses changes that are presented by data mining"; "physicians have personal report cards based on how they perform in certain areas [including response to refreshing and data mining prompts], which are tied to their compensation"; and there are "mandatory meetings called 'coding parties,' where physicians are gathered in a single room with computers and asked to review past progress notes for addenda related to revised medical diagnoses." Osinek Compl. ¶¶ 33-35.

II. LEGAL ISSUES

Before the Court compares *Osinek* and the later-filed cases, it first takes into consideration four legal issues related to the first-to-file bar, each of which will have an impact on the Court's comparison of the cases.

(1) Is the first-to-file bar jurisdictional in nature?

(2) In comparing the first-filed and later-filed actions, should a court look at the original complaints or any amended complaints instead (assuming amended complaints have been filed)?

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(3) In comparing the first-filed and later-filed actions, must the facts in the actions be identical in order for a court to apply the first-to-file bar?

(4) In comparing the first-filed and later-filed actions, how should a court proceed where there are different defendants?

A. Jurisdiction

Although not all courts agree, the Ninth Circuit has expressly held that the first-to-file provision (§ 3730(b)(5)) is jurisdictional in nature. *See, e.g., United States ex rel. Hartpence v. Kinetic Concepts, Inc.*, 792 F.3d 1121, 1130 (9th Cir. 2015) (stating that "[w]e treat the first-to-file bar as jurisdictional"); *see also United States ex rel. Marshall v. Univ. of TN Med. Ctr. Home Care Servs., LLC*, No. 3:17-CV-96, 2021 U.S. Dist. LEXIS 159167, at *41 & n.4 (E.D. Tenn. Aug. 23, 2021) (noting that the Fourth, Fifth, Sixth, Ninth, and Tenth Circuits have held that § 3730(b)(5) is jurisdictional but that the D.C., First, Second, and Third Circuits have held that it is not; citing cases).

The Ninth Circuit's view of § 3730(b)(5) as jurisdictional is important because it impacts which complaints should be considered when a court compares the first-filed and later-filed actions. *See* Reply at 4 (making this same point). That issue is addressed below.

In their papers, the *Stein* plaintiffs argue that the first-to-file bar is not jurisdictional. In support, they rely on *Gonzalez v. Thaler*, 565 U.S. 134 (2012), where the Supreme Court stated as follows: "A rule is jurisdictional '[i]f the Legislature clearly states that a threshold limitation on a statute's scope shall count as jurisdictional.'" *Id.* at 141. The problem for the *Stein* plaintiffs is that, post-*Gonzalez*, the Ninth Circuit issued *Hartpence* which clearly held that the first-to-file bar is jurisdictional. *See Hartpence*, 792 F.3d at 1130. The *Stein* plaintiffs acknowledge *Hartpence* but contend that the decision should not be given any weight as it relied solely on *Lujan*, 243 F.3d at 1181, a pre-*Gonzalez* decision. The Court rejects the *Stein* Plaintiffs' attempt to avoid *Hartpence*. *Hartpence* is binding authority that is clearly on point and was issued post-*Gonzalez*. It is not up to this Court to decide whether *Hartpence* was wrongly decided because the Ninth Circuit did not explicitly address *Gonzalez*.

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B. Original v. Amended Complaint

The next issue for the Court to consider is which complaints should be evaluated in determining whether the first-filed and later-filed actions are related: the original complaints or the amended complaints? All of the cases before the Court – including *Osinek* – have amended complaints except for *Arefi*. (As noted above, the *Arefi* plaintiffs do not oppose Defendants' motion to dismiss their suit.) Below is a timeline with respect to the filing of the complaints.

Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
8/22/2013 (original complaint)					
	10/22/2014 (original complaint)				
	11/3/2014 (FAC)				
		9/4/2015			
			5/16/2016 (original complaint)		
			11/3/2016 (FAC)		
				3/1/2018 (original complaint)	
					2/10/2020 (original complaint)
					10/9/2020 (FAC)
7/27/2021 – U.S. notice of election to intervene in part					
7/29/2021 – Court order granting U.S. request to unseal complaints					
10/7/2021 (FAC)					
10/25/2021 – U.S. complaint in intervention					
			11/12/2021 (SAC)		
	11/15/2021 (SAC)			11/15/2021 (FAC)	

A number of courts have held that a court should compare (1) the original complaint in the later-filed action with (2) whatever was the operative complaint in the first-filed action at the time the later-filed action was filed (which in this case would be the original complaint in *Osinek*). *See, e.g.*:

- *Grynberg v. Koch Gateway Pipeline Co.*, 390 F.3d 1276, 1279 (10th Cir. 2004) (stating that "[w]e judge whether § 3730(b)(5) barred Grynberg's [later-filed] qui tam action by looking at the facts as they existed at the time the action was brought"; at the time the Grynberg suit was filed, "Precision's 1992 amended complaint [in the first-filed case] was pending in federal district court").
- *U.S. ex rel. Branch Consultants, L.L.C. v. Allstate Ins. Co.*, 782 F. Supp. 2d 248, 259 (E.D. La. 2011) (hereinafter "*Branch II*") (indicating that "the Court should look to the jurisdictional facts that existed at the time the action was filed, as opposed to facts that existed when the relator later filed an amended complaint").
- *United States ex rel. Cestra v. Cephalon, Inc.*, No. 14-01842, 2014 U.S. Dist. LEXIS 143745, at *7-8 (E.D. Pa. Oct. 9, 2014) (agreeing with *Grynberg* and *Branch*).
- *United States ex rel. Carter v. Halliburton*, No. 1:11cv602 (JCC/JFA), 144 F. Supp. 3d 869, 881 (E.D. Va. 2015) (noting, *inter alia*, that "[i]t is consistent with the jurisdictional limitation to apply the first-to-file bar at the time the initial complaint is filed, rather than when the complaint is amended").
- *United States ex rel. Marshall v. Univ. of TN Med. Ctr. Home Care Servs., LLC*, No. 3:17-CV-96, 2021 U.S. Dist. LEXIS 159167, at *24 (E.D. Tenn. Aug. 23, 2021) (also agreeing with *Grynberg* and *Branch*).

In the case at bar, Defendants advocate for this approach, and most of the plaintiffs agree – but not all. *See, e.g.*, Stein Opp'n at 3 n.2 (arguing that the Court should consider the SAC which was filed in November 2021); Bicocca Opp'n at 5 (arguing that the Court should consider the FAC which was filed in October 2020).

The district court in *Branch II* has provided the most extensive analysis as to why the above approach should be followed. *Branch II* was the later-filed action. The first-filed action was known as *Rigsby*. After Branch filed its original complaint in August 2006, it filed two different amended complaints. The court gave several reasons why – for purposes of § 3730(b)(5) – the original complaint in *Branch II* (and not any amended complaint) should be compared with

the complaint in *Rigsby*.

First, the text of § 3730(b)(5) supports this approach.

> The first-to-file bar [in § 3730(b)(5)] and the original source exception to the public disclosure bar [in § 3730(e)(4)] refer specifically to jurisdictional facts that must exist when an "action," not a complaint, is filed. Under 31 U.S.C. § 3730(b)(5), *a qui tam* plaintiff may not "bring a related action based on the facts underlying the pending action." As the Seventh Circuit has noted, "[*o*]*ne 'brings' an action by commencing suit*." *United States ex rel. Chovanec v. Apria Healthcare Group Inc.*, 606 F.3d 361, 362 (7th Cir. 2010). Further, in order to be an original source under 31 U.S.C. § 3730(e)(4)(B), a relator must provide the information on which the allegations are based to the government "before filing an action under this section which is based on the information." Both provisions appear to contemplate that certain requirements must be met at the time a qui tam action is filed. The use of the term "action" in both provisions indicates that the Court should look to the jurisdictional facts that existed at the time the action was filed, as opposed to facts that existed when the relator later filed an amended complaint.
>
> As the Third Circuit has noted, however the FCA is based on the model of a single-count complaint, and it sometimes uses the term "action" when it likely means "claim." *United States ex rel. Merena v. SmithKline Beecham Corp.*, 205 F.3d 97, 101-02 (3d Cir. 2000). For example, under § 3730(b)(2) and (4), the government may choose to "proceed with the action" or may "decline to take over the action," yet it is commonplace for the government to proceed with only certain claims and not with others. *Id.* at 102. But even if "action" can mean "claim" in some contexts, it is perfectly natural to read the first-to-file bar and the original source provision as imposing certain requirements that must be met at the time the suit begins.

Branch II, 782 F. Supp. 2d at 259-60 (emphasis added).

Second, general jurisdictional principles also support the approach.

> The notion that a court cannot proceed if it lacked jurisdiction at the time the original complaint was filed is consistent with the "time-of-filing rule," under which "the jurisdiction of the Court depends upon *the state of things at the time of the action brought*[.]" *Mollan v. Torrance*, 22 U.S. 537, 539 (1824) (diversity jurisdiction exists if the parties are diverse when the action was brought, even if diversity is not maintained throughout the litigation) . . . .

Id. at 260 (emphasis added).

Third, the Supreme Court's decision in *Rockwell International Corp. v. United States*, 549 U.S. 457 (2007), does not conflict with the above approach.

> While the ruling [in *Rockwell*] focused on the original source

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> provision [rather than the first-to-file provision], it also made broader jurisdictional statements that are relevant to the FCA as a whole. In *Rockwell*, the relator brought a *qui tam* action relating to toxic waste disposal at a nuclear weapons plant. The Supreme Court held that the relator was not an original source of new allegations in the amended complaint just because he was an original source of the allegations in the original complaint. *Id.* at 473-74. The Court concluded that the relator, "at a minimum," must be an original source of the claims in the amended complaint. *Id.* at 473. But the Court did not suggest that the original complaint becomes irrelevant for jurisdictional purposes once an amended complaint is filed. To the contrary, the Court stated that its holding was consistent with "[t]he rule that subject-matter jurisdiction 'depends on the state of things at the time of the action brought.'" *Id.* (quoting *Mollan v. Torrance*, 22 U.S. 537, 539 (1824)). . . . [Cases cited in *Rockwell*] indicate that a court cannot proceed if it lacked jurisdiction at the time the initial complaint was filed.
>
> *Rockwell* goes on to state that jurisdiction is also defeated if a plaintiff amends the complaint to withdraw the allegations upon which the court's jurisdiction is based, "unless they are replaced by others that establish jurisdiction." . . . But *Rockwell* does not suggest that a plaintiff can establish jurisdiction by amendment when jurisdiction did not previously exist. Indeed, such a conclusion would be directly contrary to the Court's statement that "demonstration that the original allegations were false will defeat jurisdiction."

Id. at 261-62.

Finally, there are several practical/policy reasons to support the approach. For example,

> the pre-filing disclosure requirement of § 3730(e)(4)(B) could not function if a court could acquire jurisdiction over a *qui tam* complaint through amendment. If a court could gain jurisdiction over a *qui tam* action by amendment, then a relator could neglect to inform the government of the information upon which the allegations are based before filing his or her action. Instead, the relator could provide that information to the government at a later time, and then amend the complaint, even in a trivial fashion, to ensure jurisdiction. Such a procedure would make the statutory language requiring disclosure to the government "before filing an action" meaningless.

Id. at 263.

In addition,

> while the first-to-file bar of 31 U.S.C. § 3730(b)(5) encourages relators to quickly report fraud about which they become aware, problems arise when a relator files without yet having direct and independent knowledge of the information underlying the allegations. As discussed *infra*, the Fifth Circuit has held that even skeletal allegations can bar other actions under the first-to-file bar in at least some circumstances. *See United States ex rel. Branch*

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> *Consultants v. Allstate Ins. Co.*, 560 F.3d 371, 379 (5th Cir. 2009). It would be anomalous if a relator could secure a place in the jurisdictional queue with merely skeletal allegations, only to then file an amended complaint after actually becoming an original source, and thereby trump any meritorious, related actions that were filed in the meantime. *Cf. United States ex rel. Ortega v. Columbia Healthcare, Inc.*, 240 F. Supp.2d 8, 14 (D.D.C. 2003) (amended complaint could not "relate back" to the date the original complaint was filed in order to jump ahead in line). Such an approach would shut out deserving relators while rewarding those who bring actions without having direct and independent knowledge of their publicly disclosed allegations. A relator, under this scenario, could secure first-to-file status before actually conducting the investigation that uncovers direct and independent information about the fraud. Requiring jurisdiction at the time the original complaint was filed allows a court to dismiss such an attempt, regardless of later amendments.

Id. at 264.[8]

> Finally, the time-of-filing rule has the advantage of simplicity. The benefits of a clear-cut rule are apparent in this case, which involves multiple claims, complaints, and defendants, as well as other relators whose complaints have themselves been amended and involve multiple defendants. *See United States ex rel Rigsby v. State Farm Ins. Co.*, No. 06-433, 2006 U.S. Dist. LEXIS 98179 (S.D. Miss. 2006) (discussed *infra*); *United States ex rel Denenea v. Allstate Ins. Co.*, No. 07-2795, 2011 U.S. Dist. LEXIS 6419 (E.D. La.); *United States ex rel Sonnier v. Allstate Ins. Co.*, No. 09-1038 (M.D. La.). The Court's jurisdiction may expand or shrink as amendments are made to the complaint, but that jurisdiction must rest upon a solid foundation.

Id.

The analysis in *Branch II* is sound and persuasive. Furthermore, the analysis in *Branch II* does not conflict with Ninth Circuit law, including *Hartpence*. Admittedly, in *Hartpence*, the Ninth Circuit made the following comment in a footnote: "For purposes of determining jurisdiction, we look to the allegations in the amended complaints. *Rockwell Int'l Corp. v. United States*, 549 U.S. 457, 473-74 (2007)." *Hartpence*, 792 F.3d at 1125 n.2. But this footnote in *Hartpence* does not mean that, for purposes of the first-to-file bar, that a court should look to an amended pleading in a later-filed case.

[8] Relatedly, if the rule were that an amended complaint in the later-filed action should be considered (and not the original), that would give the relator in the later-filed action an incentive to amend its complaint once the first-filed action becomes public – *i.e.*, so as to try to distinguish the later-filed action from the first-filed action.

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First, *Hartpence* referred to two different FCA provisions, not only the first-to-file bar (in § 3730(b)(5)) but also the public disclosure bar (in § 3730(e)(4)). *Hartpence*'s reference to *Rockwell* in footnote 2 may well have related to the public disclosure bar, which would make sense since *Rockwell* was a public disclosure case and not a first-to-file case

Second, as the *Branch II* court pointed out, *Rockwell* (the case that *Hartpence* cited) acknowledged the "rule that subject-matter jurisdiction 'depends on the state of things at the time of the action brought.'" *Rockwell*, 549 U.S. at 473.

Third, *Rockwell*'s statement that "courts look to the amended complaint" must be evaluated in context. The *Rockwell* Court noted that, if "original allegations [related to jurisdiction] were false," then jurisdiction is defeated. *Id.* "So also will the withdrawal of those allegations unless they are replaced by others that establish jurisdiction. Thus, when a plaintiff files a complaint in federal court and then voluntarily amends the complaint, courts look to the amended complaint to determine jurisdiction." *Id.* at 473-74. As indicated by the above text, the *Rockwell* Court made the last statement in the context of a plaintiff *withdrawing* allegations that gave rise to jurisdiction and pleading new allegations.

Finally, courts have recognized the context in which the *Rockwell* statement above was made and thus taken note of the limits of *Rockwell*. For instance, the Fifth Circuit has stated:

> The [*Rockwell*] Court did not hold . . . that the original complaint is irrelevant to jurisdiction or that a relator need not establish jurisdiction from the moment he first files his action. Indeed, *Rockwell* did not speak to the question whether a relator can use an amended complaint to establish jurisdiction when the original complaint is lacking. Consequently, we fall back on the longstanding rule that the amendment process cannot "be used to create jurisdiction retroactively where it did not previously exist." If [the relator's] complaint did not establish jurisdiction, it should have been dismissed; his amendments cannot save it.

U.S. ex rel. Jamison v. McKesson Corp., 649 F.3d 322, 328 (5th Cir. 2011). Similarly, in *Strudley v. Santa Cruz County Bank*, 747 F. App'x 617 (9th Cir. 2019), the Ninth Circuit held that the plaintiffs could not amend as a matter of right to cure a jurisdictional defect in the original complaint. "In line with Supreme Court precedent, this Circuit has adhered to the time-of-filing rule, which provides that '[s]ubject matter jurisdiction must exist as of the time the action is

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commenced.'" *Id.* at 618. The court went on to reject the plaintiffs' reliance on *Rockwell*.

> *Rockwell* stands for the proposition that a plaintiff may voluntarily amend its original complaint to *remove* federal jurisdiction (except when a case has been removed to federal court). Plaintiffs amended their complaint for the exact opposite purpose in this case [*i.e.*, in the attempt to create jurisdiction]. Therefore, the district court correctly looked to the original complaint in concluding that it lacked subject matter jurisdiction over this case.

Id.; *see also Black Hills Media, LLC v. Pioneer Corp.*, No. CV 13-05980 SJO (PJWx), 2014 U.S. Dist. LEXIS 132030, at *9 (C.D. Cal. Jan. 14, 2014) ("The court in *Rockwell* had jurisdiction over the original complaint when it was first filed, and the issue before the Supreme Court was whether the amended complaint *divested* the court of that existing jurisdiction. The Supreme Court determined that it did so. The opposite was true in [a Federal Circuit case], where the court had no jurisdiction over the original complaint, and the amended complaint would therefore grant the court jurisdiction that would not otherwise exist.") (emphasis added).

Accordingly, the Court shall compare the original complaint in *Osinek* (*i.e.*, the operative complaint in the first-filed action at the time the later-filed action was filed) with the original complaints in the later-filed actions.

C. "Identical Facts" Test v. "Material Facts" Test

Turning to the heart of the matter, the Court considers next what is the legal standard for determining whether a first-filed suit and a later-filed suit are related for purposes of § 3730(b)(5). Like other circuit courts, the Ninth Circuit has rejected the position that the first-filed and later-filed actions must be based on "identical facts" in order to be deemed related. Instead of an "identical facts" test, the Ninth Circuit applies a "material facts" test.

> Most of the few courts that have addressed § 3730(b)(5) have rejected an identical facts test. The cases' common principle is that "section 3730(b)(5) precludes a subsequent relator's claim that alleges the defendant engaged in the same type of wrongdoing as that claimed in a prior action even if the allegations cover a different time period or location within a company." *United States ex rel. Capella v. United Technologies Corp.*, 1999 U.S. Dist. LEXIS 10520, 1999 WL 464536, at *9 (D. Conn. June 3, 1999) (summarizing the tests used by other courts). The Third Circuit, the only appellate court to discuss and apply § 3730(b)(5), rejected an identical facts test. *See LaCorte*, 149 F.3d at 233-34. We find the Third Circuit's reasoning persuasive.

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> Section 3730(b)(5)'s plain language refers to "related" not "identical" actions. Therefore, we need not review the legislative history. *See Hockings*, 129 F.3d at 1071. Even if the language were considered ambiguous, the single sentence from the legislative history does not compel a different result. Furthermore, an identical facts test would defeat the congressional objectives for the 1986 amendments: "adequate incentives for whistle-blowing insiders with genuinely valuable information and discouragement of opportunistic plaintiffs who have no significant information to contribute of their own." *United States ex rel. Springfield Terminal Ry. v. Quin*n, 304 U.S. App. D.C. 347, 14 F.3d 645, 649 (D.C. Cir. 1994). Limiting § 3730(b)(5) to only bar actions with identical facts would be contrary to the plain language and legislative intent: (1) using a narrow jurisdictional bar, such as an identical facts test, would decrease incentives to promptly bring qui tam actions; (2) multiple relators would expect a recovery for the same conduct, thereby decreasing the total amount each relator would potentially receive and incentives to bring the suit; and (3) a narrow identical facts bar would encourage piggyback claims, which would have no additional benefit for the government," since once the government knows the essential facts of a fraudulent scheme, it has enough information to discover related frauds." *LaCorte*, 149 F.3d at 234.
>
> Therefore, we hold that § 3730(b)(5) bars later-filed actions alleging the same material elements of fraud described in an earlier suit, regardless of whether the allegations incorporate somewhat different details.

Lujan, 243 F.3d at 1188-89; *see also United States ex rel. St. John LaCorte v. SmithKline Beecham Clinical Labs., Inc.*, 149 F.3d 227, 234 (3d Cir. 1998) (stating that, "once the government knows the essential facts of a fraudulent scheme, it has enough information to discover related frauds").

As a practical matter, the material facts test often has a court consider "whether the [later-filed] Complaint alleges a fraudulent scheme the government already would be equipped to investigate based on the [first-filed] Complaint." *United States ex rel. Batiste v. SLM Corp.*, 659 F.3d 1204, 1209 (D.C. Cir. 2011) (noting, for example, "[i]f the government investigated the facts alleged in [first-filed] complaint on a nationwide basis, it would discover continuing fraud in the New Jersey offices [which was the focus of the later-filed complaint"); *see also id.* at 1210 (stating that "[s]ection 3730(b) is designed to allow recovery when a *qui tam* relator puts the government on notice of potential fraud being worked against the government, but to bar copycat actions that provide no additional material information"); *Hartpence*, 792 F.3d at 1125, 1131-32 ("disagree[ing] that [the later-filed] action provided no additional benefit to the government"; the

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plaintiff in the later-filed suit "provided information about a different form of fraud, and without that information the government might not have investigated beyond [defendant's] fraudulent coding practices").[9]

As a frame of reference, below is a brief discussion of some cases where the material facts test was not met and where the material facts test was met.

1. Material Facts Test Not Satisfied

In *Hartpence*, the Ninth Circuit held that the material facts test was not satisfied. The defendant in *Hartpence* was KCI, a company that manufactured medical devices that speeded the healing of wounds. One such device was a V.A.C. (vacuum assisted closure) device. *See id.* at 1124. "V.A.C. devices perform negative pressure wound therapy ('NPWT')," and Medicare has covered NPWT devices as durable medical equipment. *Id.*

In the first-filed suit, the plaintiff Hartpence alleged that KCI had engaged in fraudulent conduct by submitting claims to Medicare related to the V.A.C. devices. Specifically, Hartpence asserted that KCI had submitted claims with a certain billing code, which indicated compliance with certain requirements even though those requirements had not, in fact, been met in various ways. *See, e.g., id.* at 1125 (noting that "Hartpence alleges that KCI improperly submitted claims with the KX modifier [*i.e.*, billing code]: (1) when there was no wound improvement in the

[9] Dr. Taylor contends that this notice standard is no longer applicable after *Kellogg Brown & Root Servs. v. United States ex rel. Carter*, 575 U.S. 650 (2015). *See* Taylor Opp'n at 21-22 n.23. In support, he cites an opinion from a Washington district court, *United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*, No. 4:14-cv-5002-EFS, 2015 U.S. Dist. LEXIS 137979 (E.D. Wash. Oct. 1, 2015). There, the court stated: "The Supreme Court's ruling in *Brown* inherently limits this 'notice' analysis. Applying a broad 'notice' test does not serve the FCA's purpose of providing private parties the opportunity to pursue actions alleging fraud against the government *once the first-to-file bar lifts following the dismissal of the earlier action*." *Id.* at *22 (emphasis added).

As indicated by the language italicized above, *Savage* has no application here because the first-filed action – *Osinek* – has not been dismissed and therefore the first-to-file bar cannot have not been lifted. *See also Brown*, 575 U.S. at 662 (indicating that "an earlier suit bars a later suit while the earlier suit remains undecided but ceases to bar that suit once it is dismissed"; rejecting the argument that the first-filed action remains pending even after it has been dismissed).

Moreover, the Ninth Circuit's decision in *Hartpence* – which applied the notice standard above – was issued *after* the Supreme Court's decision in *Brown*. *Brown* was decided in May 2015, and *Hartpence* in July 2015.

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previous month; (2) for the treatment of wounds for which V.A.C. therapy was neither reasonable nor necessary; (3) when the required wound measurement documentation was absent; [etc.]").

In the later-filed suit, the plaintiff Godecke also claimed that KCI had improperly used the same billing code – albeit for a different reason. *See id.* (taking note of allegation that "KCI violated the FCA by knowingly misusing the KX modifier in submitting claims for a full month of V.A.C. therapy, even when the therapy . . . had been stopped and restarted within the same month"). In addition, Godecke claimed that there was a FCA violation related to DWOs (detailed written orders). Suppliers of durable medical requirement were required to obtain DWOs from a patient's treating physician before dispensing the supplied for which they sought reimbursement from Medicare. *See id.* at 1125 n.4. According to Godecke, "KCI ignored the requirement to receive correct and completed [DWOs] before delivering supplies and beginning therapy." *Id.* at 1125.

The Ninth Circuit effectively acknowledged the similarity of the Hartpence and Godecke complaints in that both implicated improper use of the same billing code (even though there were different reasons why the billing code was not properly used). However,

> Godecke's second claim involves different underlying facts. Whereas Hartpence's claims all allege knowing misuse of the KX modifier [*i.e.*, billing code], Godecke's second claim is based on facts which show KCI's violation of a *different Medicare program requirement* – the requirement that a provider receive Detailed Written Orders for the V.A.C. device before beginning to treat patients with the device. . . . [T]he claims are based on different material facts. The rules governing use of KX modifiers and DWOs were disseminated at different times, in different publications, and are plainly treated as separate regulations under the program.
>
> We further disagree that Godecke's action provided no additional benefit to the government. Unaided by Godecke's complaint, the government may have never discovered that KCI, in addition allegedly to misusing the KX coding system, was allegedly submitting V.A.C. claims before receiving DWOs. The two alleged frauds are materially different: the KX fraud allegations are based on *government payment for devices which were used, but unnecessary for treatment*, while the DWOs fraud allegations are based on the *government paying for devices that were never used at all*. The alleged frauds, in short, exist completely independent of one another.

Id. at 1131 (emphasis added).

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2. Material Facts Test Satisfied

In *United States ex rel. Hampton v. Columbia/Hca Healthcare Corp.*, 318 F.3d 214 (D.C. Cir. 2003), the D.C. Circuit concluded that the material facts test was satisfied. The plaintiff Hampton's suit was the later-filed suit. The first-filed suit was brought by Boston. According to Hampton, the defendant companies and several employees had improperly billed the government under the Medicare program for home health services – *e.g.*,

> the companies billed for services that were miscoded; already paid for; performed by others; never administered; or supposedly administered to Hampton's mother after she died in 1996. Hampton also claimed that [the companies] submitted bills for supplies and medications that were unnecessary or never received; and that they billed for services to patients who did not qualify under the Medicare guidelines, did not need treatment, or were not charged required copayments. The companies submitted false or inaccurate documentation to the government and, so she alleged, shredded documents in order to destroy evidence of the fraud.
>
> [The D.C. Circuit held that Hampton's case and Boston's case were related because] Boston's allegations were along very much the same lines. He asserted that HCA home health subsidiaries billed the government for services that did not meet the Medicare eligibility criteria, for undocumented services, and for services not medically necessary. He also alleged that they submitted false or inaccurate Medicare documentation and destroyed documents.

Id. at 219.

Likewise, in *Batiste*, the D.C. Circuit also found the first- and later-filed cases related. The plaintiff Batiste filed the later action. Zahara filed the earlier action. The court found that "[a] side-by-side comparison has persuaded us that, although the complaints allege somewhat different facts, Zahara's complaint suffices to put the U.S. government on notice of allegedly fraudulent forbearance practices at [Sallie Mae] and its subsidiaries, and Batiste's complaint alleges the same material elements of the same fraud." *Id.* at 1209. In particular,

> Zahara and Batiste broadly allege that the same fraudulent activities occurred at each of their offices, for the same reasons, and that similar SLM corporate policies promoted the fraudulent behavior. They both allege SLM fraudulently increased its profits and promoted its standing with the Department of Education by falsifying forbearances. And both allege that SLM's corporate culture promoted increasing the dispensation of forbearances through quotas and a team bonus system. Though Zahara focused on the fabrication of oral forbearance requests, and Batiste focused

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> on the offering of forbearances to unqualified borrowers, the allegations of the first complaint give the government grounds to investigate all that is in the second.
>
> Under the . . . material facts test, these complaints allege essentially the same corporation-wide scheme. The Zahara Complaint would suffice to equip the government to investigate SLM's allegedly fraudulent forbearance practices nationwide. Batiste's additional details would not give rise to a different investigation or recovery.

Id. at 1209-10.

D. Different Defendants

Finally, the Court must consider whether it makes a difference in "material facts" when different defendants are sued in the first-filed and later-filed actions. In *Osinek*, the original complaint named only one defendant – Kaiser Permanente – which Ms. Osinek described as "a private provider of Medicare Advantage insurance under Medicare Part C." Osinek Compl. ¶ 2.

> Kaiser Permanente is a California corporation with its principal place of business [in] Oakland, California 94612. Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage Plans than any other organization in California. At all times relevant, Kaiser conducted business in California, including but not limited to providing healthcare services through Medicare Advantage plans and to the general public in California.

Osinek Compl. ¶ 6. The later-filed actions named a variety of different Kaiser entities, including but not limited to Kaiser Permanente.

COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
Kaiser Permanente	Kaiser Permanente		Kaiser Permanente	Kaiser Permanente	
	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	Kaiser Foundation Health Plan, Inc.	
	Kaiser Foundation Health Plan of Colorado	Kaiser Foundation Health Plan of Colorado	Kaiser Foundation Health Plan of Colorado		

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COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
	Kaiser Foundation Health Plan of Georgia	Kaiser Foundation Health Plan of Georgia, Inc.	Kaiser Foundation Health Plan of Georgia, Inc.		
	Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest	Kaiser Foundation Health Plan of the Northwest		
		Kaiser Foundation Hospitals	Kaiser Foundation Hospitals	Kaiser Foundation Hospitals	
		Southern California Permanente Medical Group	Southern California Permanente Medical Group	Southern California Permanente Medical Group	Southern California Permanente Medical Group, Inc.
		The Permanente Medical Group	The Permanente Medical Group	The Permanente Medical Group	Permanente Medical Group, Inc.
		Colorado Permanente Medical Group, P.C.	Colorado Permanente Medical Group	Colorado Permanente Medical Group P.C.	
		The Southeast Permanente Medical Group	The Southeast Permanente Medical Group	Southeast Permanente Medical Group	
		Hawaii Permanente Medical Group	Hawaii Permanente Medical Group	Hawaii Permanente Medical Group	
		Northwest Permanente, P.C.	Northwest Permanente, P.C.		
			Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.		
			Kaiser Foundation Health Plan of Washington		

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COMPARISON OF DEFENDANTS NAMED IN ORIGINAL COMPLAINTS					
Osinek (2013)	**Taylor (2014)**	**Arefi (2015)**	**Stein (2016)**	**Bryant (2018)**	**Bicocca (2020)**
			Mid-Atlantic Permanente Medical Group	Mid-Atlantic Permanente Medical Group, PC	
			Group Health Permanente		
				The Permanente Federation, LLC	The Permanente Federation, LLC
				Northwest Permanente Physicians & Surgeons, P.C.	
				Washington Permanente Medical Group	

The Ninth Circuit has not expressly addressed the issue of different defendants, but other circuit courts have. Most have indicated that "adding a new defendant to the mix does not *necessarily* allow a later-filed action to evade the first-to-file bar." *Cho v. Surgery Partners, Inc.*, No. 20-14109, 2022 U.S. App. LEXIS 8774, at *15 (11th Cir. Apr. 1, 2022) (emphasis in original). This is particularly true where the new defendant(s) named in the later-filed action is a subsidiary or affiliate of the defendant(s) named in the first-filed action. *See Branch I*, 560 F.3d at 379 (noting that "allegations of fraud against a corporation may bar subsequent allegations of fraud against the corporation's subsidiaries").

That being said, the fact that the new defendant(s) in the later-filed action is a subsidiary or affiliate of the defendant(s) in the first-filed action does not automatically mean that the first-filed and later-filed actions are related either. Ultimately, resolution depends on how the first-filed action defines the scope of the misconduct. If there are, *e.g.*, allegations in the first-filed suit that there was a nationwide problem or a corporate-wide problem, then, most likely, the fact that new subsidiaries or affiliates are named in the later-filed action will not make that action unrelated for purposes of § 3730(b)(5). *Cf. Batiste*, 659 F.3d at 1210 (related complaints "essentially alleged

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same corporate-wide scheme"). On the other hand, if the first-filed action focuses on a local problem, then, most likely, a broader-in-scope later-filed action will not be related, even if the new defendant(s) in the latter action is an affiliate of the defendant named in the earlier action. *Cf. United States ex rel. Chovanec v. Apria Healthcare Group, Inc.*, 606 F.3d 361, 364 (7th Cir. 2010) (stating that, "to understand whether the suits materially overlap we must know whether the initial suits alleged frauds by rogue personnel at scattered offices or instead alleged a scheme orchestrated by Apria's national management").

"Two cases from the D.C. Circuit, *Hampton* and *Heath*, serve as useful bookends for this analysis." *Cho*, 2022 U.S. App. LEXIS 8774, at *15. *Hampton* found the first- and later-filed actions at issue related; *Heath* found the first- and later-filed actions at issue unrelated.

1. *Hampton*

In *Hampton*, the plaintiff Hampton named the following defendants in her later-filed action: HCA; Clinical Arts (Georgia subsidiary of HCA); and several Clinical Arts employees. She alleged that the defendants "had improperly billed the government under the Medicare program for home health services." *Hampton*, 318 F.3d at 218. The court was asked to decide whether Hampton's action was barred by an earlier lawsuit, filed by Boston. The D.C. Circuit noted that

> Hampton thinks her complaint differs significantly from Boston's because it named different defendants. Boston sued only HCA. Hampton sued not only HCA but also HCA's subsidiary Clinical Arts and several Clinical Arts employees. As Hampton sees it, Boston's complaint cannot possibly have covered fraud by Clinical Arts and its employees because it (1) fails to name Clinical Arts or its employees as defendants and (2) specifically mentions fraud at HCA home health care subsidiaries in six states that do not include Georgia.

Id. The court, however, found that

> these are not differences in the material elements of the fraud. Boston was a senior manager in HCA's home care group. *He alleged a corporate-wide problem*, revealed through internal audits, in which HCA perpetrated fraud in providing home health care services *through numerous subsidiaries*. It is true that Boston's complaint mentioned instances of fraud at particular home health agencies in only six specific states, not including Georgia. But Boston's complaint described these as *"examples" and "samplings"* of "a huge number of illegal payments from Medicare . . . received

> by Columbia/HCA's 550 home health locations *in 37 states*." Given Boston's broad allegations based on his position as an HCA insider, Hampton's naming Clinical Arts – a specific HCA subsidiary – and naming individual employees of Clinical Arts were merely variations on the fraud Boston's complaint described.

Id. (emphasis added); *see also Batiste*, 659 F.3d at 1209 (acknowledging that plaintiff in first-filed suit "discusses activities at [a Sallie Mae] subsidiary office in Nevada, but [still] alleges a nationwide scheme attributable not only to the subsidiary, but also to [Sallie Mae]"; thus, "[i]f the government investigated the facts alleged in [that plaintiff's] complaint on a nationwide basis, it would discover continuing fraud in the New Jersey offices"); *Chovanec*, 606 F.3d at 364 (taking note of allegations that fraud was enabled by changes made to a computer system used in all of a company's offices; also taking note of allegations that national headquarters provided guidance that enabled fraud); *United States ex rel. Marion v. Heald Coll., LLC*, No. 5:12-cv-02067-PSG, 2015 U.S. Dist. LEXIS 97767, at *11 (N.D. Cal. July 24, 2015) (stating that "[a]llowing plaintiffs to escape the first-to-file bar by naming specific employees who carried out a previously-alleged corporate fraud contravenes the purpose of Section 3730(b)(5) – to prevent piggyback claims[;] [h]ere, the previously-filed complaints against Corinthian [Colleges] allege that fraudulent conduct extended far beyond individual campuses and pervaded the entire company").

2. *Heath*

In *United States ex rel. Todd Heath v. AT&T, Inc.*, 791 F.3d 112 (D.C. Cir. 2015), the plaintiff Heath filed the later-filed action against AT&T and nineteen of its subsidiaries. The lawsuit was related to a federal program known as the Universal Service Fund. *See id.* at 117. Under federal law, "every interstate telecommunications carrier must contribute a portion of its quarterly interstate and international telecommunications revenue to the . . . Fund." *Id.* at 116. One of the programs administered through the Fund is "E-Rate," which "entitles qualifying schools and libraries to receive Internet and telephone services at discounted rates." *Id.* at 116-17. According to Heath,

> AT&T orchestrated and implemented through its subsidiaries a corporate-wide scheme to have false claims submitted to the Universal Service Fund by depriving schools and libraries in the E-Rate program of the lowest corresponding price for services. Schools and libraries, unaware of those overcharges, then passed

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> those inflated costs on to the federal government for reimbursement through the Universal Service Fund.

Id. at 117. Of particular note, Heath asserted that AT&T deliberately or recklessly chose not to train its employees in the lowest-corresponding-price requirement. *See id.* (taking note of allegation that AT&T was a recidivist violator of the E-Rate Program).

Heath had also filed an earlier lawsuit but only against Wisconsin Bell, which was a wholly owned subsidiary of AT&T. *See id.* at 118. In this suit, Heath asserted that "Wisconsin Bell charged some E-Rate eligible schools more than others, and that Wisconsin Bell generally failed to provide school districts with the benefit of the favorable pricing it offered to state departments, agencies, and universities." *Id.* Furthermore, "[w]hen informed of this pricing discrepancy, Wisconsin Bell's sales representatives 'regularly denied the existence of the agreements' between Wisconsin Bell and other Wisconsin agencies." *Id.*

One issue before the D.C. Circuit was whether Heath's first-filed suit was a bar to his later-filed action. The court held that the first-filed suit was not a bar because the

> two complaints target factually distinct types of frauds. The Wisconsin Bell Complaint alerted the federal government only to a limited scheme by Wisconsin Bell to defraud the E-Rate program within Wisconsin. That alleged fraud was accomplished, in part, through affirmative misrepresentations by Wisconsin Bell employees to schools and libraries within Wisconsin, in which those employees openly denied the existence of a state contract with a lower corresponding price.
>
> In contrast, the AT&T Nationwide Complaint alleges a different and more far-reaching scheme to defraud the federal government through service contracts entered into across the Nation, and then to cover up that fraud. Critically, the alleged fraud was accomplished not through affirmative misrepresentations about the lowest corresponding price, but through institutionalized disregard of the lowest-corresponding-price requirement altogether in AT&T's employee-training and billing procedures. According to the AT&T Nationwide Complaint, AT&T and its subsidiaries deliberately failed to enforce that lowest-price mandate by refusing to train or even tell employees about that limitation on charges, and by failing to incorporate that limitation into its billing practices.

Id. at 121.

The court continued:

> On its face, the Wisconsin Bell complaint discloses nothing more than the rogue actions of individuals within a single AT&T subsidiary and their specific, overt misrepresentations. Nothing in

> the complaint would have alerted the United States government to a nationwide scheme centered in AT&T's corporate headquarters of mischarging the E-Rate program and subsequently concealing those overpayments. Nor, given the affirmative misrepresentations at issue, would the Wisconsin Bell Complaint have pointed the federal government to AT&T's systematic refusal to institutionalize compliance by employees with the lowest-corresponding-price requirement.
>
> The fraud thus manifested itself in sufficiently distinct ways in the two cases that the material elements of the fraud differ. As the Seventh Circuit has recognized, "to understand whether the suits materially overlap we must know whether the initial suit[] alleged frauds by rogue personnel at scattered offices or instead alleged a scheme orchestrated by * * * national management." Because the Wisconsin Bell Complaint alleged only the former, it did not disclose the nationwide fraud grounded in institutionalized training and enforcement failures, and compounded by efforts at concealment, that is the focus of Heath's later complaint.

Id. at 121-22 (citation omitted). The D.C. Circuit distinguished, *inter alia*, *Hampton* because, there, "the first complaint alleged a broad fraudulent scheme orchestrated by a national or parent company, and the second complaint merely added additional facts or widened the circle of victims of the same fraudulent conduct." *Id.*

> Those cases stand for the simple proposition that the greater fraud often includes the lesser. The problem for AT&T is that the lesser fraud does not, without more, include the greater. The Wisconsin Bell Complaint did not allege that AT&T encouraged Wisconsin Bell's fraud or affirmative misrepresentations, or even knew anything about them. Nor did the Wisconsin Bell Complaint suggest that AT&T and its subsidiaries engaged in "uniform billing practices" across the United States. There simply is no hint in the Wisconsin Bell Complaint of a country-wide, institutionalized corporate practice of disregarding the lowest-price requirement or of a calculated refusal to educate or train employees.

Id. at 122-23.

The court acknowledged AT&T's point that the E-Rate program is a national program but, it pointed out, so too "is virtually every law policed by the *federal* False Claims Act." *Id.* at 123 (emphasis in original). The first-to-file bar could not be triggered "every time an initial complaint alleges that a subsidiary of a national company violated a national law" or "a broad swath of False Claims Act coverage" would be "erase[d]." *Id.* The court underscored that the purpose of the first-to-file bar was "to prevent copycat litigation, which tells the government nothing it does not already know" but, here, "Heath's complaints go after two materially distinct fraud schemes." *Id.*;

see also United States ex rel. Branch Consultants v. Allstate Ins. Co., 560 F.3d 371, 379 (5th Cir. 2009) (stating that the first-filed action "*Rigsby* does not allege a true industry-wide fraud or concerted action among a narrow group of participants[;] [r]ather, looking only at the facts pleaded . . . , *Rigsby* implicates, at most, four specific [write-your-own] insurers among the approximately ninety-five WYI insurers conducting business in the Louisiana and Mississippi areas during Hurricane Katrina," and, therefore, "*Rigsby* tells the government nothing about which of the ninety-one other WYO insurers . . . , if any, actually engaged in any fraud").

III. COMPARING RELATOR ACTIONS

Having reviewed the major legal issues, the Court may now turn to a comparison of the first-filed action, *Osinek*, with the various later-filed actions. The Court makes the comparisons in the order listed below because, *e.g.*, if there are material differences between *Osinek* and *Taylor*, that would effectively make *Taylor* the first-filed action for the new material facts. In other words, the remaining cases would then need to be compared to both *Osinek* and *Taylor*.

- Case No. C-21-3894 EMC *Taylor* (filed in the District of Colorado in 2014 and transferred to this District in 2021).
- Case No. C-16-1558 EMC *Arefi* (filed in the Central District of California in 2015 and transferred to this District in 2016).
- Case No. C-16-5337 EMC *Stein* (filed in the Central District of California in 2016 and transferred this District in 2016).
- Case No. C-18-1347 EMC *Bryant*.
- Case No. C-21-3124 EMC *Bicocca* (filed in the Eastern District of California in 2020 and transferred to this District in 2021).

A. *Osinek* and *Taylor*[10]

Dr. Taylor argues that his case is materially different from *Osinek* in two ways: (1) different defendants were sued in each case and (2) different frauds were implicated in each case.

[10] Dr. Taylor argues his FAC is the operative complaint for purposes of comparing his case to cases filed after his. *See* Taylor Opp'n at 6 n.4. But for purposes of comparing *Osinek* and *Taylor*, the Court compares the *Osinek* complaint to Dr. Taylor's original complaint. At the time Dr. Taylor brought his case, there was only the original complaint in *Osinek* on file.

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1. Different Defendants

Ms. Osinek sued only one entity: Kaiser Permanente. In contrast, Dr. Taylor sued multiple Kaiser entities: Kaiser Permanente; Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; Kaiser Foundation Health Plan of Georgia; and Kaiser Foundation Health Plan of the Northwest.

Dr. Taylor argues that the difference in defendants is meaningful. Defendants argue to the contrary. They take the position that, by suing "Kaiser Permanente," Ms. Osinek implicitly sued a national defendant which therefore covered all regional or local subsidiaries or affiliates. Defendants further argue that allegations made in the Osinek Complaint show that Ms. Osinek was implicating a nationwide fraud. *See* Mot. at 20. The Court finds that the Osinek complaint does not allege a nationwide fraud.

As a starting point, the Court takes note that there does not appear to be any legal entity with the name "Kaiser Permanente." Rather, "Kaiser Permanente" seems to be a trade name used by various Kaiser entities. *See* Mot. at 1 (asserting that there are "various healthcare organizations operating under the Kaiser Permanente trade name"); *cf.* U.S. Compl. ¶ 28 (noting Kaiser's Health Plans, Permanente Medical Groups, and hospitals publicly hold themselves out and do business collectively as an integrated healthcare providers called 'Kaiser Permanente'"); Taylor Compl. ¶ 16 (alleging that "Kaiser Permanente is a non-profit care consortium" that "includes three main groups: (1) the Kaiser Foundation Health Plan, Inc. and its subsidiaries; (2) the Kaiser Foundation Hospitals and their subsidiaries; and (3) the Permanente Medical Groups"). Thus, the fact that Ms. Osinek (not to mention Dr. Taylor and others) sued "Kaiser Permanente" is not particularly telling one way or the other.

What is more significant are the allegations in Ms. Osinek's complaint – specifically, the geographic scope of the allegations. The complaint implicates California only. For example, Ms. Osinek describes "Kaiser Permanente" as follows:

> a California corporation with its principal place of business *[in] Oakland* . . . . Kaiser is one of the largest Medicare Advantage organizations in the country and has more enrollees in its Medicare Advantage plans than any other organization *in California*. At all times relevant, Kaiser conducted business *in California*, including

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> but not limited to providing healthcare services through Medicare Advantage plans and to the general public *in California*.

Osinek Compl. ¶ 6 (emphasis added).

One might argue that the above paragraph is California-centric because Ms. Osinek was simply trying to establish that jurisdiction in California is proper. However, nowhere in the complaint does Ms. Osinek allege that there is a problem outside of California. She does not mention any other state. She does not allege a "corporate-wide problem" as in *Hampton*, 318 F.3d at 218. She never even uses the term "nationwide" or "corporate-wide" or otherwise suggest a "'scheme orchestrated by . . . national management.'" *Heath*, 791 F.3d at 122 (quoting *Chovanec*, 606 F.3d at 364). Nor is it not clear that any practice identified by Ms. Osinek was necessarily nationwide or corporate-wide in nature – *e.g.*, there is no suggestion that data mining through the use of algorithms was implemented through a nationwide computer system.

Defendants contend that just because the Osinek Complaint gave California examples does not mean that the pleading is limited in scope to California. In principle, this is true. But there must be some indication in the pleading that the problem extends outside of California.[11] *Compare Hampton*, 318 F.3d at 218 ("It is true that Boston's complaint mentioned instances of fraud at particular home health agencies in only six specific states, not including Georgia. But Boston's complaint described these as 'examples' and 'samplings' of 'a huge number of illegal payments from Medicare . . . received by Columbia/HCA's 550 home health locations in 37 states.'"). Indeed, if the rule were to the contrary, then there would seem to be serious policy concerns. The mere fact that a defendant company is part of a larger network of affiliated companies would be enough to deem the government on notice of a nationwide or corporate-wide problem – which would then, under the first-to-file bar, cut off all other actions. But if the government declined to investigate on a nationwide or corporate-wide scale (*e.g.*, because of limited resources), and the first filer stayed within the limited scope of its complaint as pled, then no one else would be able to bring a FCA claim to address a potentially broader problem. This

[11] Notably, where the Osinek Complaint does at one point refer to different regions, both of the regions identified are still based in California. *See* Mot. at 20 (citing Osinek Compl. ¶ 37); Osinek Compl. ¶ 37 (alleging that "Kaiser positioned the Southern California Region against Northern California in competition for the highest risk scores and physician approval rates").

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would run counter to the FCA which is meant to encourage the uncovering of fraud against the government. The first-to-file bar would not only "prevent copycat litigation," *Heath*, 791 F.3d at 123, but also a wide swath of litigation far broader than the first-filed suit. Here, *Taylor* is not simply an "opportunistic successive suit," *Lujan*, 243, F.3d at 1187; *Taylor* cannot be said to have "provided no additional benefit to the government." *Hartpence*, 792 F.3d at 1131.

Confronted with this obstacle, Defendants invoke the practical aspect of the material facts test, which asks whether "[t]he first-filed claim provides the government notice of the essential facts of an alleged fraud." *Lujan*, 243 F.3d at 1187. Defendants note that, a few months after the *Osinek* complaint was filed in 2013, the government issued four subpoenas to (1) the Kaiser Foundation Health Plan; (2) the Permanente Medical Group; (3) Southern California Permanente Medical Group; and (4) Kaiser Foundational Hospitals. The subpoenas covered not only the named entities but also *all subsidiaries and affiliates*.[12] *See* RJN, Exs. A-D (subpoenas). Thus, Defendants argue, the government implicitly understood that *Osinek* pointed to a nationwide or corporate-wide problem. Defendants add that, in 2017, the government sent a letter to Defendants seeking the production of documents from the Colorado regions specifically – and cited to the 2013 subpoenas in support of that request. *See* RJN, Ex. E.

Defendants' contention is not convincing for several reasons. First, Dr. Taylor raises a legitimate argument that only the complaints should be considered in determining whether the first-to-file bar applies – not evidence outside of the complaints. *Cf. In re Natural Gas Royalties ex rel. United States*, 562 F.3d 1023, 1031 (10th Cir. 2009) (stating that "[t]he first-to-file bar is designed to be quickly and easily determinable, simply requiring a side-by-side comparison of the complaints"); *Batiste*, 659 F.3d at 1209 (making a "side-by-side comparison" of the complaints in the first-filed and later-filed suits). Dr. Taylor has not been privy to all of the communications

[12] *See, e.g.*, RJN, Ex. A (Subpoena at 2) ("The term 'KAISER FOUNDATION HEALTH PLAN, INC.' refers to the person or entity with its primary offices located at One Kaiser Plaza, Oakland, California, and also includes all current and former: directors, officers, principals, partners, managers, and employees; independent contractors, attorneys, consultants, experts, investigators, agents and/or other persons or other representatives acting on your behalf, even if their actions were not authorized by you or were outside the proper scope of their authority; corporate parents, predecessors, *subsidiaries*, regions, segments, branches, groups, *affiliates*, and divisions; and joint ventures of which it is a part.") (emphasis added).

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between the United States and Defendants. It is entirely possible that some communications might support his position here rather than Defendants.[13] And if the Court were to permit Dr. Taylor to, in effect, conduct discovery into the government's communications – or more generally, into the government's understanding of the *Osinek* complaint – then there would effectively be a mini trial on a secondary matter that would only delay the process of moving forward with the case. The task before the Court at this juncture is to compare the complaints, not conduct a mini-trial based on facts.

Accordingly, the Court does not dismiss *Taylor* based on the first-to-file bar because *Taylor* is broader in scope than *Osinek* in terms of defendants. *See Heath*, 791 F.3d at 122 ("Those cases [such as *Hampton*] stand for the simple proposition that the greater fraud often includes the lesser. The problem for AT&T is that the lesser fraud does not, without more, include the greater.").

2. Different Frauds

The closer question is whether *Taylor* implicates different frauds than does *Osinek*.

As noted above, *Osinek* is about mining records to look for places to upcode, particularly for high-value conditions. Upcoding was ultimately improper because it was based on, *e.g.*, exaggerating a patient's condition, diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a condition for which the patient was not treated, diagnosing without the proper support/documentation, and the like.

Taylor is essentially the flip side. It asserts the theory that, as a result of regular internal audits, Kaiser knew there were high error rates in risk adjustment claims in certain areas but *failed* to take action to find the false claims retroactively – and thus improperly retained the

[13] Even if the Court were to consider the 2013 subpoenas issued by the government and its 2017 letter to Defendants, Defendants do not fare any better. Although the subpoenas did refer to subsidiaries and affiliates, that language is boilerplate in nature. And fact that the government only issued subpoenas to four specific Kaiser entities (all of which appear to be based in California) points to a more limited scope of inquiry. As for the letter, the fact that the government relied on the 2013 subpoenas to justify an inquiry into Colorado in 2017 largely seems a litigation tactic. Notably, by 2017, the *Taylor* complaint – which expressly implicated the Colorado region – had been filed. (The original complaint in *Taylor* was filed in October 2014.)

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government's overpayment for those false claims (essentially, a reverse false claim theory).[14] *See, e.g.*, Taylor Compl. ¶¶ 81-82 (citing "[e]xamples of risk adjustment claims that the Kaiser audits have identified as routinely false" and alleging that, "despite its knowledge that the categories of risk adjustment claims . . . are false a significant percentage of the time, Kaiser routinely fails to take reasonable steps to identify which of these claims are false . . . and then to prevent their submission in the first place or to delete them after submission"). *Taylor* contrasts the lack of effort by the Kaiser entities to take action to address the errors with their zealous pursuit of reviewing records to find instances where diagnoses could be added (*i.e.*, upcoding). *See* Taylor Compl. ¶ 62 (alleging that Kaiser's "lack of diligence contrasts starkly with [its] considerable efforts and substantial commitment of resources to audit current and past claims to identify new diagnoses that it could use to submit additional risk adjustment claims and thereby increase the amount of the risk adjustment payments it receives from CMS.").

Dr. Taylor argues that the flip side makes his case materially different from *Osinek*. Specifically, he argues that his case, unlike *Osinek*, focuses on (1) Kaiser's failure to act even after audits revealed high error rates for certain HCCs or diagnoses; (2) Kaiser's failure to act even after audits revealed high error rates for diagnoses made by external providers; and (3) Kaiser's failure to act even after audits revealed high error rates for "True Positive" results associated with Kaiser's Natural Language Processing program. Each of these claimed differences is discussed below.

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[14] In their papers, Defendants suggest that Dr. Taylor does not have a viable claim here: "Taylor's allegations about error rates identified in audits of diagnosis-code data do not identify a unique fraud scheme. Rather they purport to show that Defendants had *knowledge* of the upcoding scheme that Osinek already alleged." Reply at 3 (emphasis added). Defendants likely make this argument because, in its complaint, the United States alleges that "Kaiser's internal audits put [it] on . . . notice of fraudulent diagnoses." U.S. Compl. at 68; *see also* U.S. Compl. ¶ 304 (alleging that "[a] variety of internal audits provided further notice that Kaiser's addenda and query practices were resulting in false claims to CMS").

Although Defendants fairly argue that the audits are relevant to Kaiser's knowledge, it is not clear why Dr. Taylor would not also have a viable claim based on the theory that Kaiser failed to take corrective action which resulted in its being able to keep government overpayments for false claims in violation of the FCA. *Cf. United States v. United Healthcare Ins. Co.*, 848 F.3d 1161, 1173 (9th Cir. 2016) (indicating that plaintiff had a viable theory based on allegations that, in the face of audit error rates in excess of 20%, defendants conceived and directed retrospective reviews that were "designed to identify only favorable reporting errors").

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a. High Error Rates for Certain HCCs or Diagnoses

Dr. Taylor first claims a violation of the FCA because Kaiser failed to act even after audits revealed high error rates in risk adjustment claims for certain HCCs or diagnoses. For example, Dr. Taylor alleges as follows with respect to cancer:

- "Every year, Kaiser's National Compliance Office ('NCO') conducts a nationwide 'Probe' audit to test the accuracy of risk adjustment claims submitted the prior year." Taylor Compl. ¶ 69.
- The Probe Audits "have consistently identified cancer (HCCs 7-10) as the most upcoded condition." Taylor Compl. ¶ 102.
- "The most significant and consistent error is that Kaiser providers submit diagnosis codes representing active, current treatment of cancer when, in fact, the patient's cancer is cured, in remission, or otherwise irrelevant to the services provided to the patient." Taylor Compl. ¶ 103. Notably, a diagnosis of "history of cancer" does not result in a risk adjustment. *See* Taylor Compl. ¶ 105.

Cancer is not the only HCC/diagnosis called out as problematic. Other conditions that have had high error rates include:

- Stroke. *See, e.g.*, Taylor Compl. ¶ 118 ("Kaiser knew stroke was commonly coded as an active event, when, in fact, the patient should have been classified as having a history of stroke.").
- Vascular disease. *See, e.g.*, Taylor Compl. ¶ 127 ("[S]ome claims erroneously claimed the patient had current vascular disease, when, in fact, they had only a history of the condition."); Taylor Compl. ¶ 129 ("[C]ertain claims were false because of a 'mismapping' problem with HealthConnect, Kaiser's EMR [electronic medical records]. HealthConnect . . . allows physicians to choose a descriptive diagnosis (as opposed to a specific ICD-9 code) when entering clinical information. HealthConnect then 'maps' this descriptive diagnosis to a specific ICD-9 diagnosis code, which is then inserted into the medical record documentation.").
- Chronic bronchitis. *See, e.g.*, Taylor Compl. ¶ 134 ("Kaiser's EMR [electronic

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medical records] . . . pressured physicians to use the diagnosis for chronic bronchitis (which risk adjusts) rather than acute bronchitis (which does not risk adjust)."); Taylor Compl. ¶ 132 ("The probe audits regularly found COPD [chronic obstructive pulmonary disease] claims erroneous based on lack of documentation in the record, or because the doctor failed to document the patient's condition with sufficient specificity to determine if the patient actually had COPD.").

- Malnutrition. *See, e.g.*, Taylor Compl. ¶ 140 ("In some cases, the condition was diagnosed as current when the patient actually only had a 'history of' the condition.").
- Renal insufficiency. *See, e.g.*, Taylor Compl. ¶ 152 ("Chronic kidney disease ('CKD') is a condition that is often miscoded . . . .").

As indicated by the above, Dr. Taylor takes issue with Kaiser for not reacting to the high error rates – *i.e.*, had Kaiser done so then it would have seen that the diagnoses (of high-value conditions) lacked documentation or proper support and/or that the diagnoses were irrelevant to the treatment provided to the patient. Although Dr. Taylor is correct that his claim here is about Kaiser ignoring an upcoding problem (as revealed by error rates) rather than actively creating upcoding, the Court does not see this flip side as creating a material difference with respect to *Osinek*. This is because both *Taylor* and *Osinek* are ultimately based on the same "underlying facts," *Hartpence*, 792 F.3d at 1131: that the high-level condition that was diagnosed did not have documentation or proper support and/or did not affect patient care.

The practical aspect of the material facts test underscores that *Taylor* and *Osinek* are related cases, at least with respect to the above. Here, the Court must ask whether the allegations in *Osinek* "[gave] the government grounds to investigate all that is in" the Taylor Complaint. *Batiste*, 659 F.3d at 1209; *see also id.* at 1209-10 (stating that the first-filed "[c]omplaint would suffice to equip the government to investigate SLM's allegedly fraudulent forbearance practices nationwide" and the "additional details" in the later-filed complaint "would not give rise to a different investigation or recovery"). Based on *Osinek*, the government was put on notice that high-value conditions often did not have proper support and were diagnosed even when a patient

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was not treated for that condition at the time of service. Thus, in light of *Osinek*, the government had grounds to investigate all that is in the Taylor Complaint which points to the same basic problem. That, according to Dr. Taylor, the problem would have been revealed if Kaiser had taken action in response to the high error rates, is somewhat beside the point. The error rates here are not in themselves what is critical; rather, at bottom, Dr. Taylor's broader claim is that high-value conditions were diagnosed without following the practices required by Medicare regulations. This is fundamentally the same charge that Ms. Osinek makes.

b. High Error Rates for Diagnoses Made by External Providers

Dr. Taylor also claims that his complaint is different from the Osinek Complaint because he has alleged that Kaiser failed to act even after audits revealed high error rates with diagnoses submitted by external providers. (Dr. Taylor refers to this as "one-way look chart review" in his papers. *See, e.g.*, Taylor Opp'n at 7.) The relevant allegations in support of this theory are as follows:

- Several of Kaiser's regions, including Colorado, Hawaii, and, until recently, Georgia, "rely heavily on external providers (hospitals or other facilities who are not owned by Kaiser) to provide inpatient care to Kaiser's HMO members." Taylor Compl. ¶ 83.
- The external providers submit claims to Kaiser after they have provided services to Kaiser members, and Kaiser uses the external providers' diagnoses as the basis for the risk adjustment claims that Kaiser submits to CMS. *See* Taylor Compl. ¶ 84.
- Kaiser's audits "have identified significant error rates in risk adjustment claims [that] Kaiser submitted to CMS based on diagnoses provided by external providers." Taylor Compl. ¶ 86. For example, for the Colorado region, the error rates for external providers in some years was over 40% and 60%. *See* Taylor Compl. ¶ 88; *see also* Taylor Compl. ¶ 89 (adding that "[t]he error rates for certain large hospitals . . . are striking" – some more than 90%).
- "Despite knowing of the consistent errors in claims data from external providers, Kaiser Colorado [for example] does not conduct any routine targeted audits of

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claims submitted by external providers. This is particularly egregious because the Colorado region does have a coder review each hospital stay at an external provider *to look for additional diagnoses* present in the chart but not coded by the treating physician." Taylor Compl. ¶ 98 (emphasis added).

Here, the Court agrees with Dr. Taylor that this specific aspect of his case is not related to *Osinek*. Problematic coding related to high-value conditions is different from problematic coding by external providers. Notably, there is no indication that the problematic coding by external providers was related to high-value conditions. Accordingly, this specific claim made by Dr. Taylor involves "different underlying facts." *Hartpence*, 792 F.3d at 1131. Furthermore, it cannot be said that the government would likely have found the particular problem with external providers based on its investigation into the kinds of internal upcoding practices identified in *Osinek*.

c. Natural Language Processing Software

Finally, Dr. Taylor claims that his complaint differs from the Osinek Complaint because he has made allegations about Kaiser's Natural Language Processing ("NLP") software. The main allegations made in the Taylor Complaint with respect to the NLP software are as follows.

- "Broadly speaking, [a] NLP program uses an algorithm to search EMRs [electronic medical records] to find words that, individually or in combination, indicate that a patient has certain diagnoses." Taylor Compl. ¶ 191.
- Kaiser developed its own NLP audit program "to try to find new diagnosis codes to submit." Taylor Compl. ¶ 191.
- "All face-to-face visits to a physician or hospital . . . are run through the NLP software to identify new diagnoses that might be appropriate to use for submission of additional risk adjustment claims. The results are grouped into four categories: (a) True Positive: [meaning] diagnoses . . . have been confirmed by two Kaiser coders; (b) More Information Needed: [meaning] diagnoses . . . may be present, but further analysis is required to confirm; (c) Problem List Only: [meaning] diagnoses . . . show up only on the member's problem list [section of the medical record] with

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no documentation of treatment; and (d) False Positives or Found Elsewhere." Taylor Compl. ¶ 196.

- "Kaiser allows the various regions to decide how to use [the above] information." Taylor Compl. ¶ 197. For some regions, if a result is True Positive, then a claim is submitted to CMS for payment – without any further review. *See* Taylor Compl. ¶ 200. This is true even though audits have revealed that there is a high error rate for True Positives. *See* Taylor Compl. ¶¶ 198, 200.

As indicated by the above, Dr. Taylor is not focusing here on the fact that Kaiser uses the NLP program to mine records for instances where it can upcode. Had he done so, then his case would clearly be related to *Osinek*. Rather, Dr. Taylor's point is that there is a high error rate associated with the NLP program's True Positives, but Kaiser still submits claims based on True Positives without any further inquiry.

The Court finds that the nature of wrongdoing claimed by Dr. Taylor here involves different "material elements" from *Osinek*. *Lujan*, 243 F.3d at 1189. Dr. Taylor is charging Kaiser with exploiting True Positives; this is different from *Osinek* which is focused on the exploitation of high-value conditions. Similar to above, there is nothing that suggests True Positives appear with high-value conditions only, or even primarily. Thus, Dr. Taylor here has "'significant information to contribute of [his] own.'" *Id.* The Court also notes that, under the practical aspect of the material facts test, this part of *Taylor* should not be deemed related to *Osinek*. Based on *Osinek*, the government would likely have looked at the NLP program given that it was purportedly used to data mine; however, that would not lead the government to question the True Positive results yielded by the NLP program. Rather, as a facial matter, the more likely candidates for exploitation by Kaiser would be the categories of "More Information Needed" and "Problem List Only," not the True Positives.

d. Summary

The *Taylor* case is not dismissed in its entirety but only in part. *Taylor* differs materially from *Osinek* in three ways: (1) *Taylor* points to a nationwide or corporate-wide problem whereas *Osinek* is local or regional (*i.e.*, California-centric) in nature; (2) *Taylor* has identified a fraud

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related to external providers rather than high-value conditions; and (3) *Taylor* asserts a problem with Kaiser failing to evaluate the True Positives results yielded by the NLP program.

B. *Osinek* and *Arefi*

As noted above, the *Arefi* Plaintiffs do not oppose the motion to dismiss their complaint. Thus, the Court may move on to the next complaint filed after *Arefi*.

C. *Osinek* and *Stein*

As an initial matter, the Court takes note that the *Stein* plaintiffs contend that the Court should compare the complaint in *Osinek* with their operative SAC, which was filed in November 2021. *See* Opp'n at 3 n.2. The Court rejects that argument for the reasons discussed above.

Based on their original complaint, the *Stein* plaintiffs focus on two specific conditions: sepsis and malnutrition.[15] The main allegations are as follows.

- Sepsis. The criteria for diagnosing sepsis is not straightforward. *See, e.g.*, Stein Compl. ¶¶ 42-43, 49. In 2003, the ICD-9 diagnostic codes and ICD Guidelines were modified to, in essence, reflect that complexity. The Guidelines emphasize that "coders will likely have to query physicians when documenting Sepsis to trigger proper documentation that supports the Sepsis diagnosis due [to] the complex nature of those diseases." Stein Compl. ¶ 48. Defendants engaged in a scheme "to up-code and falsely diagnose MA enrollees with sepsis and/or severe sepsis, i.e., sepsis with acute organ failure[] (collectively referred to as 'Sepsis')[,] when Sepsis was not present." Stein Compl. ¶ 50. "[The] fraudulent scheme [involved] the identification and treatment of Sepsis for . . . MA enrollees that presented in the emergency room (ER) of [Kaiser] hospitals and was accomplished by (a) [Defendants] implementing unwritten policies that prohibited coders employed by [Defendants] from performing physician queries for Sepsis diagnoses as required by the ICD-9 Guidelines, (b) implementing unwritten policies

[15] The *Stein* plaintiffs also included in their original complaint allegations on Kaiser's practice of "refreshing." However, in their opposition, they have conceded that this conduct was sufficiently implicated in earlier-filed actions. *See* Stein Opp'n at 1 (stating that the *Stein* plaintiffs "do not oppose [the] first-to-file attack against [their] Refresh fraud claim").

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requiring Kaiser's coders to code ICD-9 diagnosis codes for Sepsis based solely on the physician's instructions to code Sepsis instead of relying on the supporting clinical findings documented in the medical record, (c) using an improper Sepsis diagnostic standard that overstated the frequency of Sepsis diagnoses, (d) aggressively diagnosing Sepsis as part of a strategy to lower the reported Sepsis mortality rates at [Kaiser] hospitals throughout California, and (e) [Defendants], as an express condition of receiving capitation payments from CMS, routinely and annually falsely certifying that such ICD-9 diagnosis codes for Sepsis were accurate, complete, and truthful . . . ." Stein Compl. ¶ 50.

- Malnutrition. Defendants "participated in a fraudulent scheme to up-code and falsely diagnose malnutrition and severe malnutrition of their MA enrollees." Stein Compl. ¶ 70. The scheme "was conducted at all [Kaiser] Hospitals throughout California and involved the diagnoses and coding of malnutrition and severe malnutrition based upon assessment performed by dieticians . . . . The . . . dietician used a rubber stamp on the MA enrollee's medical record indicating that in his/her opinion the MA enrollee suffered from malnutrition or severe malnutrition. [The] physicians then countersigned the stamp in the MA enrollees' medical record. Based solely on the presence of the physician's countersignature . . . , Kaiser's coders recorded the ICD-9 diagnosis codes for malnutrition or severe malnutrition . . . ." Stein Compl. ¶ 70. There was no face-to-face encounter nor were there clinical findings in support, as required by federal regulations. *See* Stein Compl. ¶ 71.

These claims overlap with *Osinek*. *Osinek* asserts that upcoding was improper because it was based on exploiting high-value conditions – *e.g.*, exaggerating a patient's condition, diagnosing a patient based on a test that took place after the patient visit, diagnosing a patient for a condition for which the patient was not treated, diagnosing without the necessary support/documentation, and the like. *Stein* implicates the same kind of conduct; essentially, *Stein* involves lesser-included conduct by virtue of the fact that it focuses on two conditions (sepsis and

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malnutrition) specifically. Notably, *Osinek*, like *Stein*, expressly identified malnutrition as one of the high-value conditions that was being exploited.[16] *See* Osinek Compl. ¶ 25. The fact that *Osinek* did not also expressly identify sepsis as a high-value condition (as *Stein* did) is not dispositive since it is but one example of the alleged upcoding. *Cf. Hampton*, 318 F.3d at 219 (concluding actions were related because both alleged that bills were submitted for ineligible and undocumented Medicare services and for services not medically necessary).

The *Stein* plaintiffs suggest that their case is still materially different because the frauds implicated in their complaint were committed when "patients . . . were admitted to a KFH hospital or in the case of Sepsis, treated as a hospital outpatient through the emergency room." Opp'n at 12-13. But nothing about *Osinek* excepts a hospital setting from the alleged upcoding.

The only place where *Stein* is materially different from *Osinek* is with respect to the scope of the alleged misconduct. *Stein* suggests – by virtue of the Kaiser entities sued – that the alleged misconduct goes beyond California. While this does make *Stein* different from *Osinek* (the latter being California-centric in scope), *Stein* runs into a problem still because *Taylor*, the next case filed after *Osinek*, implicates a nationwide or corporate-wide problem and is broad enough to encompass the basic kind of upcoding practices alleged in *Stein*.

The Court therefore dismisses the *Stein* case based on the first-to-file bar – in its entirety. The *Stein* plaintiffs have asked for leave to amend but that is a futile request since the Court's evaluation is limited to the original Stein Complaint.

D. *Osinek* and *Bryant*

As a preliminary matter, the Court takes note that Defendants do not seek to dismiss *Bryant* in its entirety. It recognizes that *Bryant* has retaliation claims (based on the FCA and on

[16] The Stein FAC (filed in May 2016, *i.e.*, a few months after the original Stein Complaint) did add in a new condition – i.e., aortic atherosclerosis ("AA"). *See* Stein FAC ¶ 83 (noting that AA "is a chronic condition that results in the build up of arterial plaque or fatty deposits in the patient's aorta"). According to the Stein Plaintiffs, "Kaiser's coders coded . . . MA patients with an AA diagnosis based solely upon the physician's notation of AA in the medical record, without the medical record reflecting that the patient was treated for his/her AA condition." Stein FAC ¶ 84. Even if the Court were to consider this new condition identified in the Stein FAC (as well as the Stein SAC), there would still be overlap with the *Osinek* complaint. The nature of the conduct is similar such that AA is a condition that the government likely would have investigated given *Osinek*'s description of Kaiser exploiting high-value conditions.

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other federal and state law) which are not subject to the first-to-file bar. *See* Mot at 1 n.3 ("This Motion seeks dismissal of the Later-Filed Complaints . . . in their entirety except for the retaliation causes of action in the operative *Bryant* complaint (Counts 5 through 8) and the California False Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4) . . . .").[17]

According to the *Bryant* plaintiffs, their case is materially different from *Osinek* in that,

> unlike the *Osinek* complaint, the *Bryant*/*Hernandez* Complaint exposes Kaiser's upcoding fraud: (i) relating to a specific high-value diagnosis code, mechanical ventilator dependence status, that first came to light after Osinek filed her suit[[18]]; (ii) not just on the Medicare Advantage program, but on a different government program (the Affordable Care Act) run by a different government agency entirely (the Department of Health and Human Services); and (iii) within Kaiser's insurance and physician-practice behemoths in all regions, not just one region, and also within Kaiser's massive hospital operation across Kaiser's regions, which was not even part of the *Osinek* suit.

Bryant Opp'n at 2.

For (iii), as noted above, it does not matter that the hospital setting was not expressly implicated in *Osinek*. Nothing in *Osinek* suggests that it excludes the hospital setting. The *Bryant* plaintiffs fairly argue that *Osinek* is California-centric; however, as noted above, *Taylor* – the case next in line after *Osinek* – put the government on notice of a nationwide or corporate-wide problem related to the upcoding of high-value conditions.

As for (i), *see* Bryant Compl. ¶¶ 85-86 (alleging that "a patient is vent dependent only if the patient relies on the ventilation to live on a long-term basis and not for the short-term acute phase of a condition" but Defendants fail to comply with that guidance) (emphasis omitted), the *Bryant* plaintiffs are basically making the same kind of argument that the *Stein* plaintiffs did. *See* Bryant Opp'n at 15 ("Given the sheer number of diagnosis codes, it would be impossible for the government to identify fraudulent over-documenting and upcoding in particular diagnoses without

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[17] At one point, the *Bryant* plaintiffs also had California FCA claims but they dropped those claims in their FAC.

[18] In their complaint, the *Bryant* plaintiffs explicitly identified additional high-value HCCs or diagnoses but implicitly recognize that these conditions have already been expressly named by plaintiffs in earlier-filed actions. *See, e.g.*, Bryant Compl. ¶¶ 56, 107, 136, 144, 146-49 (referring to aortic atherosclerosis, sepsis, malnutrition, acute renal failure, acute kidney injury, and respiratory failure, arrythmia for members with pacemakers, major depression, and acute stroke).

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being pointed in the right direction."). But as with *Stein*, this is lesser-included conduct and sufficiently similar to the conduct put at issue in *Osinek* – *i.e.*, Defendants were exploiting high-value conditions by failing to provide support/documentation for the upcoding. *Cf. Hampton*, 318 F.3d at 219 (concluding actions were related because both alleged that bills were submitted for ineligible and undocumented Medicare services and for services not medically necessary). The fact that the practice allegedly was not discovered until after *Osinek* was filed does not mean that *Bryant* cannot be a related case. That Defendants may have allegedly expanded their misconduct to other high-value conditions does not negate the government being put on notice of the fraudulent scheme in the first instance as a result of *Osinek*.

This leaves the *Bryant* plaintiffs with (ii). Here, the *Bryant* plaintiffs correctly point out that their original complaint contains multiple allegations about payments Defendants receive under the Affordable Care Act (and not just Medicare Advantage). For example, the *Bryant* plaintiffs allege as follows:

- "The United States contributes to premiums that individuals pay to private health insurance companies such as Kaiser under the Affordable Care Act. *See* Bryant Compl. ¶ 7; *see also* Bryant Compl. ¶ 52 (alleging that the government contributes through tax credits).
- "The Affordable Care Act sets up a program of risk adjustment in individual and group markets to lessen or eliminate the influence of risk selection on the premiums that plans charge. In the risk adjustment model utilized under the AA, which is named the HHS-Hierarchical Condition Categories ('HHS-HCC') risk adjustment model, HHS [*i.e.*, the Department of Health and Human Services] utilizes criteria and methods similar to those utilized under the Medicare Advantage Program, and adapts Medicare Advantage HCCs for use in the HHS-HCC model." Bryant Compl. ¶ 51; *see also* Bryant Compl. ¶ 7.
- Thus, "as under the Medicare Advantage Program, the ACA risk adjustment model creates powerful incentives for private health insurance companies like Kaiser to over-report diagnosis codes in order to exaggerate the expected healthcare costs for

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their enrollees; the more codes that are reported, the higher premiums the companies are permitted to charge, and the higher contributions will be made to such premiums by the United States." Bryant Compl. ¶ 7.

- "Defendants overdocument and upcode risk adjustment claims relevant to individuals covered by the ACA in the same manner and pursuant to the same schemes as relevant to the Medicare Advantage program . . . ." Bryant Compl. ¶ 11(b).
- The *Bryant* plaintiffs "seek . . . to recover damages and civil penalties arising from the false or fraudulent records, statements and/or claims that the Defendants made or caused to be made in connection with false and/or fraudulent claims for Medicare Advantage risk adjustment payments [and] Affordable Care Act insurance premiums . . . ." Bryant Compl. ¶ 18.

In response, Defendants point out that the actual causes of action asserted by the *Bryant* plaintiffs at the end of their complaint refer to risk adjustment payments under Medicare only. *See, e.g.*, Bryant Compl. ¶¶ 209-10, 214-15, 220, 224-26. Nowhere do the causes of action refer to risk adjustment payments under the Affordable Care Act. Although Defendants are correct, the *Bryant* plaintiffs fairly point out that each cause of action does incorporate all paragraphs previously pled. Accordingly, although the *Bryant* plaintiffs could have drafted a better and clearer pleading, they have not pled themselves out of FCA claims based on the Affordable Care Act as Defendants contend.

At the hearing, Defendants argued that, even if the *Bryant* plaintiffs have claims predicated on the Affordable Care Act, they are nonetheless still barred by the first-to-file provision because the government would have been put on notice of that alleged fraudulent scheme by virtue of *Osinek*. The Court does not agree. The Affordable Care Act is an entirely different scheme, not run by CMS specifically, and covering a broad range of individuals outside of the reach of Medicare. The ACA claims thus state causes of action entirely different and distinct from the Medicare Advantage claims. The government was put on notice of a problem with the Medicare Advantage program only. That the Affordable Care Act also uses risk adjustment does not mean

that the government's investigation of Medicare Advantage would naturally lead to an investigation of the Affordable Care Act.

Accordingly, the Court dismisses *Bryant* but only in part. The claims that survive are the retaliation claims, as well as the claims based on the Affordable Care Act.

E. *Osinek* and *Bicocca*

Defendants do not seek to dismiss the entirety of *Bicocca*. Specifically, they recognize that Dr. Bicocca has claims pursuant to the California FCA that are not subject to the first-to-file bar. *See* Mot. at 1 n.3 ("This Motion seeks dismissal of the Later-Filed Complaints . . . in their entirety except . . . the California False Claims Act causes of action in the operative *Bicocca* complaint (Counts 3 and 4) . . . .").

Second, the Court takes note that Dr. Bicocca admits his original complaint (filed in February 2020) is barred by the first-to-file provision. He argues, however, that his FAC (filed in October 2020) adds a theory that is not in *Osinek*. *See* Bicocca Opp'n at 2. Because, as discussed above, it is Dr. Bicocca's original complaint that must be compared to the Osinek Complaint, he is out of luck.

However, even if the Court were to consider the FAC, Dr. Bicocca's contention that his case is materially different from *Osinek* is without merit. He states:

> Relator Bicocca's Amended Complaint describes "two sources" of diagnoses that Kaiser requires physicians to add. *Bicocca* Dkt. 16 ¶ 108. One of these sources is addenda that Kaiser gives physicians *after* a patient visit, which include additional diagnoses for the physician to *retroactively* add to the patient's chart. *Id.* at ¶¶ 106, 110. The other is a list of the patient's past diagnoses, which Kaiser gives to physicians *before* the physician meets with the patient, with the intention that the physician will re-diagnose each of the specific diagnoses *during* the visit ("upfront list"). *Id.* at ¶ 109.

Bicocca Opp'n at 2 (emphasis in original); *see also* Bicocca FAC ¶ 109 ("The first source [for diagnoses that physicians are required to add onto Medicare] are diagnoses that these patients had already, confirmed in previous years by other physicians. While, as a matter of first impression, this does not seem to be a violation of regulations, since the patients have already had the diagnoses confirmed by others, having physicians re-confirm these diagnoses without spending sufficient time on it and without having any expertise on these diagnoses is still a violation of

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Medicare's regulations on confirming diagnoses for the purpose of risk adjustment."). The problem for Dr. Bicocca is that the latter is essentially refreshing, which has already been put at issue in *Osinek*.

Accordingly, the Court grants the motion to dismiss Dr. Bicocca's claims, and the only claims that survive are those based on the California FCA which Defendants have not contested for purposes of the first-to-file bar.

IV. CONCLUSION

For the foregoing reasons, the Court grants in part and denies in part Defendants' motion to dismiss based on the first-to-file bar. Specifically:

- *Arefi* and *Stein* are dismissed in their entirety.
- *Taylor* is dismissed except to the extent that it pleads (1) a nationwide or corporate-wide fraud; (2) a fraud based on improper coding by external providers; and (3) a fraud based on True Positive results from the NLP program.
- *Bryant* is dismissed except to the extent that it pleads (1) retaliation claims and (2) claims based on fraud in the Affordable Care Act program.
- *Bicocca* is dismissed except to the extent that it pleads claims based on the California FCA.

This order disposes of Docket No. 141.

IT IS SO ORDERED.

Dated: May 5, 2022

EDWARD M. CHEN
United States District Judge

United States District Court
Northern District of California

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TAB 35

ADRMOP,CLOSED,RELATE

U.S. District Court
California Northern District (San Francisco)
CIVIL DOCKET FOR CASE #: 3:16-cv-01558-EMC

United States of America et al v. Kaiser Foundation Health Plan Inc et al
Assigned to: Edward M. Chen
Demand: $9,999,000
Lead case: 3:13-cv-03891-EMC
Member case: (View Member Case)
Case in other court: California Central, 2:15-cv-07050
Cause: 31:3729 False Claims Act

Date Filed: 03/30/2016
Date Terminated: 05/05/2022
Jury Demand: Plaintiff
Nature of Suit: 375 Other Statutes: False Claims Act
Jurisdiction: Federal Question

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ATTORNEY TO BE NOTICED

Defendant

Kaiser Foundation Health Plan of Colorado
a Colorado corporation

represented by **Anne Miller Steinberg**
(See above for address)
ATTORNEY TO BE NOTICED

Caitlin Bair
(See above for address)
ATTORNEY TO BE NOTICED

David Deaton
(See above for address)
ATTORNEY TO BE NOTICED

David J. Leviss
(See above for address)
ATTORNEY TO BE NOTICED

Dimitri Portnoi
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ATTORNEY TO BE NOTICED

K. Lee Blalack , II
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ATTORNEY TO BE NOTICED

Kelsey A Chandrasoma
(See above for address)
ATTORNEY TO BE NOTICED

Stephen M Sullivan
(See above for address)
ATTORNEY TO BE NOTICED

Defendant

Kaiser Foundation Health Plan of Georgia, Inc.
a Georgia corporation

Defendant

Kaiser Foundation Health Plan of The Northwest
an Oregon corporation

Defendant

Kaiser Foundation Hospitals
a California corporation

Defendant

Southern California Permanente Medical Group
a California corporation

represented by **Anne Miller Steinberg**
(See above for address)
ATTORNEY TO BE NOTICED

Caitlin Bair
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ATTORNEY TO BE NOTICED

David Deaton
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David J. Leviss
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Dimitri Portnoi
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K. Lee Blalack , II
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Kelsey A Chandrasoma
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ATTORNEY TO BE NOTICED

Stephen M Sullivan
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ATTORNEY TO BE NOTICED

Defendant

The Permanente Medical Group
a California corporation

represented by **Anne Miller Steinberg**
(See above for address)
ATTORNEY TO BE NOTICED

Caitlin Bair
(See above for address)
ATTORNEY TO BE NOTICED

David Deaton
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ATTORNEY TO BE NOTICED

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Kelsey A Chandrasoma
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ATTORNEY TO BE NOTICED

Stephen M Sullivan
(See above for address)
ATTORNEY TO BE NOTICED

Defendant

Colorado Permanente Medical Group, PC
a Colorado corporation

represented by **Anne Miller Steinberg**
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ATTORNEY TO BE NOTICED

Caitlin Bair
(See above for address)
ATTORNEY TO BE NOTICED

David Deaton
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David J. Leviss
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Kelsey A Chandrasoma
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ATTORNEY TO BE NOTICED

Stephen M Sullivan
(See above for address)
ATTORNEY TO BE NOTICED

Defendant

The Southeast Permanente Medical Group
a Georgia corporation

Defendant

Hawaii Permanente Medical Group, Inc.
a Hawaiian corporation

Defendant

Northwest Permanente, PC
an Oregon corporation

Date Filed	#	Docket Text
09/04/2015	1	FILED IN CAMERA-COMPLAINT against Defendants Colorado Permanente Medical Group PC, Hawaii Permanente Medical Group Inc, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia Inc, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Hospitals, Northwest Permanente PC, Southern California Permanente Medical Group, The Permanente Medical Group, The Southeast Permanente Medical Group.Case assigned to Judge R. Gary Klausner for all further proceedings. Discovery referred to Magistrate Judge Jacqueline Chooljian.(Filing fee $ 400 PAID.) Jury Demanded., filed by Plaintiffs Ajith Kumar, Prime Healthcare Services Inc, Naser Arefi. (et)[Summons not Issued on 9/4/2015.] (Main Document 1 replaced on 8/6/2021) (wsnS, COURT STAFF). (Entered: 09/09/2015)
06/25/2021	50	**ORDER by Judge Edward M. Chen granting (57) Motion to Consolidate Cases in case 3:13-cv-03891-EMC *SEALED*. (Manual service sent to parties listed in certificate of service on motion). (afmS, COURT STAFF) (Filed on 6/25/2021) (Entered: 06/27/2021)**
07/27/2021	52	Notice of Election to Intervene in part and to decline to Intervene in part ; [Proposed] Order to unseal by United States of America. (mclS, COURT STAFF) (Filed on 7/27/2021) (Entered: 07/28/2021)
08/25/2021	53	NOTICE of Appearance by Dimitri Portnoi *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Portnoi, Dimitri) (Filed on 8/25/2021) (Entered: 08/25/2021)

08/25/2021	54	NOTICE of Appearance by David Deaton *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Deaton, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	55	NOTICE of Appearance by Stephen M Sullivan *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Sullivan, Stephen) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	56	NOTICE of Appearance by Caitlin Bair *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Bair, Caitlin) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	57	NOTICE of Appearance by Anne Miller Steinberg *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Steinberg, Anne) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	58	NOTICE of Appearance by Kelsey Chandrasoma *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Chandrasoma, Kelsey) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	59	NOTICE of Appearance by K. Lee Blalack II *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Blalack II, K. Lee) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	60	MOTION for leave to appear in Pro Hac Vice *for K. Lee Blalack, II* (Filing fee $ 317, receipt number 0971-16321851.) filed by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado, Southern California Permanente Medical Group, The Permanente Medical Group. (Blalack II, K. Lee) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	61	MOTION for leave to appear in Pro Hac Vice *for David J. Leviss* (Filing fee $ 317, receipt number 0971-16321875.) filed by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado, Southern California Permanente Medical Group, The Permanente Medical Group. (Leviss, David) (Filed on 8/25/2021) (Entered: 08/25/2021)

08/25/2021	62	NOTICE of Appearance by David J. Leviss *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Leviss, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	63	Certificate of Interested Entities by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado, Southern California Permanente Medical Group, The Permanente Medical Group identifying Corporate Parent No Parent Corp. for Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado, Southern California Permanente Medical Group, The Permanente Medical Group. (Deaton, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/27/2021	64	**ORDER by Judge Edward M. Chen granting 60 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**
08/27/2021	65	**ORDER by Judge Edward M. Chen granting 61 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**
12/18/2021	66	Transcript of Proceedings held on 11/16/21, before Judge Edward M. Chen. Court Reporter Belle Ball, CSR, telephone number (415)373-2529, belle_ball@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (120 in 3:13-cv-03891-EMC) Transcript Order) Redaction Request due 1/10/2022. Redacted Transcript Deadline set for 1/18/2022. Release of Transcript Restriction set for 3/18/2022. (Ball, Belle) (Filed on 12/18/2021) (Entered: 12/18/2021)
12/30/2021	67	STIPULATION WITH PROPOSED ORDER *re Dismissal of Non-Intervened Claims* filed by Naser Arefi, Ajith Kumar, Prime Healthcare Services, Inc.. (Hardiman, Mark) (Filed on 12/30/2021) (Entered: 12/30/2021)
01/07/2022	68	**Order by Judge Edward M. Chen granting 67 Stipulation Re Dismissal of Realtors' Non-Intervened Claims for Violations of The False Claims Act, 31 U.S.C. Sections 3729-3733.(vla, COURT STAFF) (Filed on 1/7/2022) (Entered: 01/08/2022)**
01/20/2022	69	WAIVER OF SERVICE Returned Executed filed by Ajith Kumar, Prime Healthcare Services, Inc., Naser Arefi. Service waived by Colorado Permanente Medical Group, PC waiver sent on 1/12/2022, answer due 3/14/2022; Kaiser Foundation Health Plan Inc. waiver sent on 1/12/2022, answer due 3/14/2022; Kaiser Foundation Health Plan of Colorado waiver sent on 1/12/2022, answer due 3/14/2022; Southern California Permanente Medical Group waiver sent on 1/12/2022, answer due 3/14/2022; The Permanente Medical Group waiver sent on 1/12/2022, answer due 3/14/2022. (Hardiman, Mark) (Filed on 1/20/2022) (Entered: 01/20/2022)

02/07/2022	70	**ORDER by Judge Edward M. Chen Granting 144 UNITED STATES' NOTICE OF WITHDRAWAL OF COUNSEL VANESSA I. REED (vla, COURT STAFF) (Filed on 2/7/2022) (Entered: 02/07/2022)**
05/30/2022	71	Transcript of Remote Zoom Video Conference Proceedings held on April 21, 2022, before Judge Edward M. Chen. Court Reporter Ana Dub, CSR 7445, RDR, RMR, CRR, CCRR, CRG, CCG, telephone number 415-290-1651; ana_dub@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date, it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (168 in 3:13-cv-03891-EMC) Transcript Order,,,) Release of Transcript Restriction set for 8/29/2022. (amd, COURT STAFF) (Filed on 5/30/2022) (Entered: 05/30/2022)

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Description:	Docket Report	**Search Criteria:**	3:16-cv-01558-EMC
Billable Pages:	10	**Cost:**	1.00

TAB 36

ADRMOP,RELATE

U.S. District Court
California Northern District (San Francisco)
CIVIL DOCKET FOR CASE #: 3:18-cv-01347-EMC

United States of America et al v. Kaiser Permanente et al
Assigned to: Judge Edward M. Chen
Lead case: 3:13-cv-03891-EMC
Member case: (View Member Case)
Cause: 31:3729 False Claims Act

Date Filed: 03/01/2018
Jury Demand: Plaintiff
Nature of Suit: 376 Qui Tam (31 U.S.C. § 3729(a))
Jurisdiction: Federal Question

Plaintiff

United States of America
ex rel.

represented by **Shiwon Choe**
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TERMINATED: 05/21/2021

Plaintiff

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ex rel.

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Plaintiff

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Roger A. Lewis
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LEAD ATTORNEY
PRO HAC VICE
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Matthew K. Organ
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PRO HAC VICE
ATTORNEY TO BE NOTICED

W. Kyle Walther
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

V.

Defendant

Kaiser Permanente

Defendant

Kaiser Foundation Health Plan Inc. represented by **David J. Leviss**
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Email: dleviss@omm.com
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Washington, DC 20006
(202) 383-5374
Email: lblalack@omm.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Defendant

The Permanente Federation, LLC

Defendant

Kaiser Foundation Hospitals

Defendant

The Permanente Medical Group	represented by	**David J. Leviss** (See above for address) *PRO HAC VICE* *ATTORNEY TO BE NOTICED* **K. Lee Blalack , II** (See above for address) *PRO HAC VICE* *ATTORNEY TO BE NOTICED*

Defendant

Southern California Permanente Medical Group	represented by	**David J. Leviss** (See above for address) *PRO HAC VICE* *ATTORNEY TO BE NOTICED* **K. Lee Blalack , II** (See above for address) *PRO HAC VICE* *ATTORNEY TO BE NOTICED*

Defendant

Colorado Permanente Medical Group, PC	represented by	**David J. Leviss** (See above for address) *PRO HAC VICE* *ATTORNEY TO BE NOTICED* **K. Lee Blalack , II** (See above for address) *PRO HAC VICE* *ATTORNEY TO BE NOTICED*

Defendant

Southeast Permanente Medical Group

Defendant

Hawaii Permanente Medical Group

Defendant

Mid-Atlantic Permanente Medical Group, PC

Defendant

Northwest Permanente Physicians & Surgeons P.C.

Date Filed	#	Docket Text
03/01/2018	1	COMPLAINT WITH JURY DEMAND against Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Hospitals, Kaiser Permanente, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente Physicians & Surgeons P.C., Southeast Permanente Medical Group, Southern California Permanente Medical Group, The Permanente Federation, LLC, The Permanente Medical Group (Filing fee $ 400; Receipt No. 34611131647). Filed by Gloryanne Bryant, Victoria M. Hernandez. Consent/Declination due by 3/15/2018. (Attachments: # 1 Exhibits 1 - 21, # 2 Exhibits 22 - 26, # 3 Exhibits 27 - 29, # 4 Exhibits 30 - 48, # 5 Civil Cover Sheet) (slhS, COURT STAFF) (Filed on 3/1/2018) (Attachment 1 replaced on 8/10/2021) (wsnS, COURT STAFF). (Attachment 2 replaced on 8/10/2021) (wsnS, COURT STAFF). (Attachment 3 replaced on 8/10/2021) (wsnS, COURT STAFF). (Attachment 4 replaced on 8/10/2021) (wsnS, COURT STAFF). (Entered: 03/01/2018)
06/25/2021	53	**ORDER by Judge Edward M. Chen granting (57) Motion to Consolidate Cases in case 3:13-cv-03891-EMC *SEALED*. (Manual service sent to parties listed in certificate of service on motion). (afmS, COURT STAFF) (Filed on 6/25/2021) (Entered: 06/27/2021)**
07/27/2021	55	Notice of Election to Intervene in part and to decline to Intervene in part ; [Proposed] Order to unseal by United States of America. (mclS, COURT STAFF) (Filed on 7/27/2021) (Entered: 07/28/2021)
08/02/2021	56	ADMINISTRATIVE MOTION to Allow Replacement of Redacted Versions of Exhibits re 1 Complaint,, filed by Gloryanne Bryant, Victoria M. Hernandez. Responses due by 8/6/2021. (Attachments: # 1 Declaration of Roger A. Lewis, # 2 Proposed Order)(Rukin, Peter) (Filed on 8/2/2021) (Entered: 08/02/2021)
08/03/2021	57	**ORDER by Judge Edward M. Chen granting 56 Administrative Motion to Allow Replacement of Redacted Versions of Exhibits re 1 Complaint. (afmS, COURT STAFF) (Filed on 8/3/2021) (Entered: 08/03/2021)**
08/06/2021	58	ADMINISTRATIVE MOTION to Make Additional Redactions to Exhibits in Complaint re 1 Complaint,, filed by Gloryanne Bryant, Victoria M. Hernandez. Responses due by 8/10/2021. (Attachments: # 1 Declaration, # 2 Proposed Order) (Rukin, Peter) (Filed on 8/6/2021) (Entered: 08/06/2021)
08/10/2021	59	**ORDER by Judge Edward M. Chen granting 58 Administrative Motion to Make Additional Redactions to Exhibits to Complaint. (afmS, COURT STAFF) (Filed on 8/10/2021) (Entered: 08/10/2021)**
08/25/2021	60	MOTION for leave to appear in Pro Hac Vice *for David J. Leviss* (Filing fee $ 317, receipt number 0971-16322044.) filed by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc., Southern California Permanente Medical

		Group, The Permanente Medical Group. (Leviss, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	61	MOTION for leave to appear in Pro Hac Vice *for K. Lee Blalack, II* (Filing fee $ 317, receipt number 0971-16322064.) filed by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc., Southern California Permanente Medical Group, The Permanente Medical Group. (Blalack II, K. Lee) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/27/2021	62	**ORDER by Judge Edward M. Chen granting 60 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**
08/27/2021	63	**ORDER by Judge Edward M. Chen granting 61 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**
10/04/2021	64	REDACTION to 1 Complaint,,, *Exhibits Pursuant to Court Order* by Gloryanne Bryant, Victoria M. Hernandez. (Attachments: # 1 Exhibits 1-21, # 2 Exhibits 22-26, # 3 Exhibits 27-29, # 4 Exhibits 30-48)(Rukin, Peter) (Filed on 10/4/2021) (Entered: 10/04/2021)
12/18/2021	65	Transcript of Proceedings held on 11/16/21, before Judge Edward M. Chen. Court Reporter Belle Ball, CSR, telephone number (415)373-2529, belle_ball@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (120 in 3:13-cv-03891-EMC) Transcript Order) Redaction Request due 1/10/2022. Redacted Transcript Deadline set for 1/18/2022. Release of Transcript Restriction set for 3/18/2022. (Ball, Belle) (Filed on 12/18/2021) (Entered: 12/18/2021)
02/07/2022	66	**ORDER by Judge Edward M. Chen Granting 144 UNITED STATES' NOTICE OF WITHDRAWAL OF COUNSEL VANESSA I. REED (vla, COURT STAFF) (Filed on 2/7/2022) (Entered: 02/07/2022)**
02/24/2022	67	MOTION for leave to appear in Pro Hac Vice (Filing fee $ 317, receipt number ACANDC-16933306.) filed by Gloryanne Bryant, Victoria M. Hernandez. (Walther, W.) (Filed on 2/24/2022) (Entered: 02/24/2022)
02/28/2022	68	**Order by Judge Edward M. Chen Granting as to 160 STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION (Filed in case 3:13-cv-03891-EMC). Associated Cases: 3:16-cv-05337-EMC, 3:18-cv-01347-EMC, 3:21-cv-03124-EMC, 3:21-cv-03894-EMC (vla, COURT STAFF) (Filed on 2/28/2022) (Entered: 02/28/2022)**
02/28/2022	70	**Order by Judge Edward M. Chen granting 67 Motion for Pro Hac Vice as to William Walther.(vla, COURT STAFF) (Filed on 2/28/2022) (Entered: 03/03/2022)**
03/01/2022	69	NOTICE of Withdrawal of Matthew K. Organ; Proposed Order by Gloryanne Bryant, Victoria M. Hernandez (Lewis, Roger) (Filed on 3/1/2022) Modified on 3/4/2022 (gba, COURT STAFF). (Entered: 03/01/2022)

05/30/2022	71	Transcript of Remote Zoom Video Conference Proceedings held on April 21, 2022, before Judge Edward M. Chen. Court Reporter Ana Dub, CSR 7445, RDR, RMR, CRR, CCRR, CRG, CCG, telephone number 415-290-1651; ana_dub@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date, it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (168 in 3:13-cv-03891-EMC) Transcript Order,,,) Release of Transcript Restriction set for 8/29/2022. (amd, COURT STAFF) (Filed on 5/30/2022) (Entered: 05/30/2022)

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Description:	Docket Report	**Search Criteria:**	3:18-cv-01347-EMC
Billable Pages:	5	**Cost:**	0.50

TAB 37

ADRMOP,CLOSED,CONSOL

U.S. District Court
California Northern District (San Francisco)
CIVIL DOCKET FOR CASE #: 3:21-cv-03124-EMC

Bicocca v. Permanente Medical Group, Inc. et al
Assigned to: Judge Edward M. Chen
Lead case: 3:13-cv-03891-EMC
Member case: (View Member Case)
Case in other court: California Eastern, 2:20-cv-00296
Cause: 31:3729 False Claims Act

Date Filed: 04/29/2021
Date Terminated: 06/25/2021
Jury Demand: Plaintiff
Nature of Suit: 376 Qui Tam (31 U.S.C. § 3729(a))
Jurisdiction: Federal Question

Plaintiff

Michael Bicocca

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02/10/2020	1	COMPLAINT against Permanente Federation, LLC, Permanente Medical Group, Inc., Southern California Permanente Medical Group, Inc. by Michael Bicocca. (Attachments: # 1 Civil Cover Sheet)(Reader, L) (Entered: 02/10/2020)
10/09/2020	16	FIRST AMENDED COMPLAINT against All Defendants by Michael Bicocca. (Benson, A.) (Entered: 10/09/2020)
06/25/2021	33	**ORDER by Judge Edward M. Chen granting (57) Motion to Consolidate Cases in case 3:13-cv-03891-EMC *SEALED*. (Manual service sent to parties listed in certificate of service on motion). (afmS, COURT STAFF) (Filed on 6/25/2021) (Entered: 06/27/2021)**
07/27/2021	36	Notice of Election to Intervene in part and to decline to Intervene in part ; [Proposed] Order to unseal by United States of America. (mclS, COURT STAFF) (Filed on 7/27/2021) (Entered: 07/28/2021)
08/25/2021	37	MOTION for leave to appear in Pro Hac Vice *for David J. Leviss* (Filing fee $ 317, receipt number 0971-16322058.) filed by Kaiser Foundation Health Plan Inc., Permanente Medical Group, Inc, Southern California Permanente Medical Group, Inc.. (Leviss, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	38	MOTION for leave to appear in Pro Hac Vice *for K. Lee Blalack, II* (Filing fee $ 317, receipt number 0971-16322075.) filed by Kaiser Foundation Health Plan Inc., Permanente Medical Group, Inc, Southern California Permanente Medical Group, Inc.. (Blalack II, K. Lee) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/27/2021	39	**ORDER by Judge Edward M. Chen granting 37 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**
08/27/2021	40	**ORDER by Judge Edward M. Chen granting 38 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**

12/18/2021	41	Transcript of Proceedings held on 11/16/21, before Judge Edward M. Chen. Court Reporter Belle Ball, CSR, telephone number (415)373-2529, belle_ball@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (120 in 3:13-cv-03891-EMC) Transcript Order) Redaction Request due 1/10/2022. Redacted Transcript Deadline set for 1/18/2022. Release of Transcript Restriction set for 3/18/2022. (Ball, Belle) (Filed on 12/18/2021) (Entered: 12/18/2021)
02/07/2022	42	**ORDER by Judge Edward M. Chen Granting 144 UNITED STATES' NOTICE OF WITHDRAWAL OF COUNSEL VANESSA I. REED (vla, COURT STAFF) (Filed on 2/7/2022) (Entered: 02/07/2022)**
02/28/2022	43	**Order by Judge Edward M. Chen Granting as to 160 STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION (Filed in case 3:13-cv-03891-EMC). Associated Cases: 3:16-cv-05337-EMC, 3:18-cv-01347-EMC, 3:21-cv-03124-EMC, 3:21-cv-03894-EMC (vla, COURT STAFF) (Filed on 2/28/2022) (Entered: 02/28/2022)**
05/30/2022	44	Transcript of Remote Zoom Video Conference Proceedings held on April 21, 2022, before Judge Edward M. Chen. Court Reporter Ana Dub, CSR 7445, RDR, RMR, CRR, CCRR, CRG, CCG, telephone number 415-290-1651; ana_dub@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date, it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (168 in 3:13-cv-03891-EMC) Transcript Order,,,) Release of Transcript Restriction set for 8/29/2022. (amd, COURT STAFF) (Filed on 5/30/2022) (Entered: 05/30/2022)

PACER Service Center			
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Description:	Docket Report	**Search Criteria:**	3:21-cv-03124-EMC
Billable Pages:	4	**Cost:**	0.40

TAB 38

ADRMOP,CLOSED,CONSOL

U.S. District Court
California Northern District (San Francisco)
CIVIL DOCKET FOR CASE #: 3:21-cv-03894-EMC

Taylor v. Kaiser Permanente et al
Assigned to: Judge Edward M. Chen
Lead case: 3:13-cv-03891-EMC
Member case: (View Member Case)
Case in other court: Colorado, 1:14-cv-02889
Cause: 31:3729 False Claims Act

Date Filed: 05/24/2021
Date Terminated: 06/25/2021
Jury Demand: Plaintiff
Nature of Suit: 375 Other Statutes: False Claims Act
Jurisdiction: Federal Question

Plaintiff

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Defendant

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Defendant

Kaiser Foundation Health Plan of Georgia

Defendant

Kaiser Foundation Health Plan of The Northwest

Date Filed	#	Docket Text
10/22/2014	1	COMPLAINT against Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan, Inc., Kaiser Permanente (Filing Fee: $400.00 Receipt Number:065337), filed by James M. Taylor. (Attachments: # 1 Civil Cover Sheet)(sphil) (Entered: 10/23/2014)
11/03/2014	4	AMENDED COMPLAINT against All Defendants, filed by James M. Taylor. (Twetten, Daniel) (Entered: 11/03/2014)
06/25/2021	43	**ORDER by Judge Edward M. Chen granting (57) Motion to Consolidate Cases in case 3:13-cv-03891-EMC *SEALED*. (Manual service sent to parties listed in certificate of service on motion). (afmS, COURT STAFF) (Filed on 6/25/2021) (Entered: 06/27/2021)**
07/27/2021	45	Notice of Election to Intervene in part and to decline to Intervene in part ; [Proposed] Order to unseal by United States of America. (mclS, COURT STAFF) (Filed on 7/27/2021) (Entered: 07/28/2021)
08/25/2021	46	MOTION for leave to appear in Pro Hac Vice *for David J. Leviss* (Filing fee $ 317, receipt number 0971-16322055.) filed by Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado. (Leviss, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	47	MOTION for leave to appear in Pro Hac Vice *for K. Lee Blalack, II* (Filing fee $ 317, receipt number 0971-16322067.) filed by Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado. (Blalack II, K. Lee) (Filed on 8/25/2021) (Entered: 08/25/2021)

08/27/2021	48	**ORDER by Judge Edward M. Chen granting 46 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**
08/27/2021	49	**ORDER by Judge Edward M. Chen granting 47 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**
09/01/2021	50	NOTICE of Change In Counsel by Mary Alice Inman (Inman, Mary) (Filed on 9/1/2021) (Entered: 09/01/2021)
09/01/2021	51	MOTION for leave to appear in Pro Hac Vice (Filing fee $ 317, receipt number 0971-16347939.) filed by James M. Taylor. (Baker, Edward) (Filed on 9/1/2021) (Entered: 09/01/2021)
09/01/2021	52	MOTION for leave to appear in Pro Hac Vice (Filing fee $ 317, receipt number 0971-16347964.) filed by James M. Taylor. (Voldman, Max) (Filed on 9/1/2021) (Entered: 09/01/2021)
09/02/2021	53	**ORDER by Judge Edward M. Chen granting 51 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 9/2/2021) (Entered: 09/02/2021)**
09/02/2021	54	**ORDER by Judge Edward M. Chen granting 52 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 9/2/2021) (Entered: 09/02/2021)**
12/18/2021	55	Transcript of Proceedings held on 11/16/21, before Judge Edward M. Chen. Court Reporter Belle Ball, CSR, telephone number (415)373-2529, belle_ball@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (120 in 3:13-cv-03891-EMC) Transcript Order) Redaction Request due 1/10/2022. Redacted Transcript Deadline set for 1/18/2022. Release of Transcript Restriction set for 3/18/2022. (Ball, Belle) (Filed on 12/18/2021) (Entered: 12/18/2021)
02/07/2022	56	**ORDER by Judge Edward M. Chen Granting 144 UNITED STATES' NOTICE OF WITHDRAWAL OF COUNSEL VANESSA I. REED (vla, COURT STAFF) (Filed on 2/7/2022) (Entered: 02/07/2022)**
02/28/2022	57	**Order by Judge Edward M. Chen Granting as to 160 STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION (Filed in case 3:13-cv-03891-EMC). Associated Cases: 3:16-cv-05337-EMC, 3:18-cv-01347-EMC, 3:21-cv-03124-EMC, 3:21-cv-03894-EMC (vla, COURT STAFF) (Filed on 2/28/2022) (Entered: 02/28/2022)**
05/30/2022	58	Transcript of Remote Zoom Video Conference Proceedings held on April 21, 2022, before Judge Edward M. Chen. Court Reporter Ana Dub, CSR 7445, RDR, RMR, CRR, CCRR, CRG, CCG, telephone number 415-290-1651; ana_dub@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date, it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business

		days from date of this filing. (Re (168 in 3:13-cv-03891-EMC) Transcript Order,,,) Release of Transcript Restriction set for 8/29/2022. (amd, COURT STAFF) (Filed on 5/30/2022) (Entered: 05/30/2022)

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PACER Login:	billhanagami	**Client Code:**	
Description:	Docket Report	**Search Criteria:**	3:21-cv-03894-EMC
Billable Pages:	4	**Cost:**	0.40

TAB 39

ADRMOP,APPEAL,CONSOL,REFDIS,RELATE

U.S. District Court
California Northern District (San Francisco)
CIVIL DOCKET FOR CASE #: 3:13-cv-03891-EMC

Osinek et al v. Kaiser Permanente
Assigned to: Edward M. Chen
Referred to: Magistrate Judge Joseph C. Spero
Cause: 31:3729 False Claims Act

Date Filed: 08/22/2013
Jury Demand: Plaintiff
Nature of Suit: 375 Other Statutes: False Claims Act
Jurisdiction: Federal Question

Plaintiff

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V.

Defendant

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Defendant

Kaiser Permanente

Defendant

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Defendant

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Defendant

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Defendant

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Defendant

Southern California Permanente Medical Group

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Defendant

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Defendant

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Defendant

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Defendant

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Defendant

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Defendant

Northwest Permanente Physicians & Surgeons P.C.

Defendant

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Defendant

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Defendant

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Date Filed	#	Docket Text
08/22/2013	1	COMPLAINT for Money Damages and Civil Penalties for Violations of The False Claims Act; Demand for Jury Trial against Kaiser Permanente (Filing fee $ 400.00., Receipt Number 34611089079). Filed by Ronda Osinek. (Attachments: # 1 Civil Cover Sheet) (gbaS, COURT STAFF) (Filed on 8/22/2013) (Entered: 08/26/2013)
06/25/2021	61	**ORDER by Judge Edward M. Chen granting (57) Motion to Consolidate Cases in case 3:13-cv-03891-EMC *SEALED*. (Manual service sent to parties listed in certificate of service on motion). (afmS, COURT STAFF) (Filed on 6/25/2021) (Entered: 06/27/2021)**
07/27/2021	64	Notice of Election to Intervene in part and to decline to Intervene in part ; [Proposed] Order to unseal by United States of America. (mclS, COURT STAFF) (Filed on 7/27/2021) (Entered: 07/28/2021)
07/29/2021	65	**UNITED STATES NOTICE OF ELECTION TO INTERVENE IN PART AND TO DECLINE TO INTERVENE IN PART; ORDER TO UNSEAL re 64 . Signed by Judge Edward M. Chen on 7/28/2021. (Manual notification to parties listed on certificate of service) (afmS, COURT STAFF) (Filed on 7/29/2021) (Entered: 07/29/2021)**
08/23/2021	66	Mail sent to Salvatore John Zimmitti returned as undeliverable re 65 Order. (mclS, COURT STAFF) (Filed on 8/23/2021) (Entered: 08/24/2021)
08/24/2021	67	Mail sent to Mark Steven Hardiman returned as undeliverable re 65 Order. (mclS, COURT STAFF) (Filed on 8/24/2021) (Entered: 08/24/2021)
08/25/2021	68	NOTICE of Change of Address by William K. Hanagami (Hanagami, William) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	69	NOTICE of Appearance by Dimitri Portnoi *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado*

		Permanente Medical Group, P.C. (Portnoi, Dimitri) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	70	NOTICE of Appearance by David Deaton *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Deaton, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	71	NOTICE of Appearance by Stephen M Sullivan *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Sullivan, Stephen) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	72	NOTICE of Appearance by Caitlin Bair *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Bair, Caitlin) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	73	NOTICE of Appearance by Anne Miller Steinberg *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Steinberg, Anne) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	74	NOTICE of Appearance by Kelsey Chandrasoma *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Chandrasoma, Kelsey) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	75	NOTICE of Appearance by K. Lee Blalack II *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Blalack II, K. Lee) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	76	NOTICE of Appearance by David J. Leviss *on behalf of Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.* (Leviss, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	77	Certificate of Interested Entities by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. (Deaton, David) (Filed on 8/25/2021) Modified on 8/26/2021 (mclS, COURT STAFF). (Entered: 08/25/2021)
09/01/2021	78	NOTICE of Change In Counsel by Mary Alice Inman (Inman, Mary) (Filed on 9/1/2021) (Entered: 09/01/2021)

09/01/2021	79	MOTION for leave to appear in Pro Hac Vice (Filing fee $ 317, receipt number 0971-16348135.) filed by James M. Taylor. (Baker, Edward) (Filed on 9/1/2021) (Entered: 09/01/2021)
09/01/2021	80	MOTION for leave to appear in Pro Hac Vice (Filing fee $ 317, receipt number 0971-16348162.) filed by James M. Taylor. (Voldman, Max) (Filed on 9/1/2021) (Entered: 09/01/2021)
09/05/2021	81	**ORDER by Judge Edward M. Chen granting 79 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 9/5/2021) (Entered: 09/05/2021)**
09/05/2021	82	**ORDER by Judge Edward M. Chen granting 80 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 9/5/2021) (Entered: 09/05/2021)**
09/07/2021	83	MOTION for leave to appear in Pro Hac Vice *for Janel Quinn* (Filing fee $ 317, receipt number 0971-16362138.) filed by Michael Bicocca. (Quinn, Janel) (Filed on 9/7/2021) (Entered: 09/07/2021)
09/07/2021	84	MOTION for leave to appear in Pro Hac Vice *for R. Scott Oswald* (Filing fee $ 317, receipt number 0971-16362251.) filed by Michael Bicocca. (Oswald, R.) (Filed on 9/7/2021) (Entered: 09/07/2021)
09/08/2021	85	**ORDER Granting Application for Admission of Attorney Pro Hac Vice signed by Judge Edward M. Chen: granting 83 Application. (shyS, COURT STAFF) (Filed on 9/8/2021) (Entered: 09/08/2021)**
09/08/2021	86	**ORDER Granting Application for Admission of Attorney Pro Hac Vice signed by Judge Edward M. Chen: granting 84 Application. (shyS, COURT STAFF) (Filed on 9/8/2021) (Entered: 09/08/2021)**
10/07/2021	87	AMENDED COMPLAINT against Kaiser Foundation Health Plan Inc, Kaiser Permanente, Permanente Medical Group, Inc. Filed byRonda Osinek. (Attachments: # 1 Summons to Kaiser Permanente, # 2 Summons to Kaiser Foundation Health Plan, Inc., # 3 Summons to The Permanente Medical Group, Inc.)(Zeman, Amy) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	88	MOTION for leave to appear in Pro Hac Vice (Filing fee $ 317, receipt number 0971-16476983.) filed by Kaiser Foundation Health Plan Inc, Permanente Medical Group, Inc. (Blalack, K.) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	89	MOTION for leave to appear in Pro Hac Vice (Filing fee $ 317, receipt number 0971-16477020.) filed by Kaiser Foundation Health Plan Inc, Permanente Medical Group, Inc. (Leviss, David) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	90	NOTICE of Appearance by Caitlin Bair *on behalf of Kaiser Foundation Health Plan, Inc. and The Permanente Medical Group, Inc.* (Bair, Caitlin) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	91	NOTICE of Appearance by K. Lee Blalack, II *on behalf of Kaiser Foundation Health Plan, Inc. and The Permanente Medical Group, Inc.* (Blalack, K.) (Filed on 10/7/2021) (Entered: 10/07/2021)

10/07/2021	92	NOTICE of Appearance by Kelsey Chandrasoma *on behalf of Kaiser Foundation Health Plan, Inc. and The Permanente Medical Group, Inc.* (Chandrasoma, Kelsey) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	93	NOTICE of Appearance by David Deaton *on behalf of Kaiser Foundation Health Plan, Inc. and The Permanente Medical Group, Inc.* (Deaton, David) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	94	NOTICE of Appearance by David J. Leviss *on behalf of Kaiser Foundation Health Plan, Inc. and The Permanente Medical Group, Inc.* (Leviss, David) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	95	NOTICE of Appearance by Dimitri Portnoi *on behalf of Kaiser Foundation Health Plan, Inc. and The Permanente Medical Group, Inc.* (Portnoi, Dimitri) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	96	NOTICE of Appearance by Anne Miller Steinberg *on behalf of Kaiser Foundation Health Plan, Inc. and The Permanente Medical Group, Inc.* (Steinberg, Anne) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	97	NOTICE of Appearance by Stephen M Sullivan *on behalf of Kaiser Foundation Health Plan, Inc. and The Permanente Medical Group, Inc.* (Sullivan, Stephen) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	98	Certificate of Interested Entities by Kaiser Foundation Health Plan Inc, Permanente Medical Group, Inc identifying Corporate Parent No Parent Corp. for Kaiser Foundation Health Plan Inc, Permanente Medical Group, Inc. (Blalack, K.) (Filed on 10/7/2021) (Entered: 10/07/2021)
10/07/2021	99	STIPULATION WITH PROPOSED ORDER filed by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group, United States of America, Ronda Osinek, James Taylor, Naser Arefi, Ajith Kumar, Prime Healthcare Services, Inc., Marcia Stein, Rodolfo Bone, Michael Bicocca, Gloryanne Bryant and Victoria Hernandez. (Attachments: # 1 Declaration of K. Lee Blalack, II)(Blalack, K.) (Filed on 10/7/2021) Modified on 10/8/2021 (jmlS, COURT STAFF). (Entered: 10/07/2021)
10/07/2021		Electronic filing error. Incorrect event used. [err101] The correct event is Proposed Summons. The summons should NOT be filed as an attachment to the Complaint. The correct event can be found at Civil Events > Other Filings > Other Documents > Proposed Summons. Please re-file the SUMMONS ONLY in its entirety.Re: 87 Amended Complaint, filed by Ronda Osinek (jmlS, COURT STAFF) (Filed on 10/7/2021) (Entered: 10/08/2021)
10/08/2021	100	Proposed Summons. (Zeman, Amy) (Filed on 10/8/2021) (Entered: 10/08/2021)
10/08/2021	101	Proposed Summons. (Zeman, Amy) (Filed on 10/8/2021) (Entered: 10/08/2021)
10/08/2021	102	Proposed Summons. (Zeman, Amy) (Filed on 10/8/2021) (Entered: 10/08/2021)
10/08/2021	103	Summons Issued as to Kaiser Foundation Health Plan Inc, Kaiser Permanente, Permanente Medical Group, Inc. (Attachments: # 1 Summons, # 2 Summons)(jmlS, COURT STAFF) (Filed on 10/8/2021) (Entered: 10/08/2021)

10/10/2021	104	**ORDER GRANTING 99 JOINT STIPULATION TO CONTINUE CASE MANAGEMENT CONFERENCE AND SET INITIAL CASE DEADLINES. Joint Case Management Statement due by 2/8/2022. Initial Case Management Conference set for 10/26/2021 is vacated and rescheduled for 2/15/2022 01:30 PM in San Francisco, - Videoconference Only. Signed by Judge Edward M. Chen on 10/8/2021.(afmS, COURT STAFF) (Filed on 10/10/2021) (Entered: 10/10/2021)**
10/10/2021	105	**ORDER by Judge Edward M. Chen granting 88 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 10/10/2021) (Entered: 10/10/2021)**
10/10/2021	106	**ORDER by Judge Edward M. Chen granting 89 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 10/10/2021) (Entered: 10/10/2021)**
10/22/2021	107	MOTION to Stage Fed. R. Civ. P. 12 Briefing *; Memorandum of Points and Authorities; [Proposed] Order* filed by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. Responses due by 11/5/2021. Replies due by 11/12/2021. (Blalack, K.) (Filed on 10/22/2021) (Entered: 10/22/2021)
10/22/2021	108	**CLERK'S NOTICE: Kaiser has filed 107 a motion to stage Rule 12 briefing. Instead of having full briefing on a 35-day schedule, it seems more efficient to have all parties meet and confer to see if they can reach an agreement on whether Rule 12 motions should be staged and, if so, how. Accordingly, the Court orders all parties to meet and confer now (instead of waiting for the CMC) to discuss this specific issue. The parties should report back on their meet and confer by 11/4/2021. If they are not able to reach agreement, each party should state its last proposal/offer of compromise. *(This is a text-only entry generated by the court. There is no document associated with this entry.)* (afmS, COURT STAFF) (Filed on 10/22/2021) (Entered: 10/22/2021)**
10/25/2021	109	NOTICE of Appearance by Gary R. Dyal (Dyal, Gary) (Filed on 10/25/2021) (Entered: 10/25/2021)
10/25/2021	110	COMPLAINT *in Intervention* against Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. Filed byUnited States of America. (Choe, Shiwon) (Filed on 10/25/2021) (Entered: 10/25/2021)
10/26/2021	111	CERTIFICATE OF SERVICE by United States of America (Wolinsky, Benjamin) (Filed on 10/26/2021) (Entered: 10/26/2021)
11/04/2021	112	*Joint Report on Court-Ordered Meet and Confer Regarding Defendants' Motion to Stage Fed. R. Civ. P. 12 Briefing* re 108 Clerk's Notice,,,, Terminate Hearings by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. (Leviss, David) (Filed on 11/4/2021) Modified on 11/5/2021 (jml, COURT STAFF). (Entered: 11/04/2021)

11/08/2021	113	**CLERK'S NOTICE SCHEDULING INITIAL CASE MANAGEMENT CONFERENCE FOR 11/16/2021 AT 1:30PM: Initial Case Management Conference set for 11/16/2021 01:30 PM in San Francisco, - Videoconference Only. This proceeding will be held via a Zoom webinar. Joint report 112 received. No need to resubmit a joint report.** **Webinar Access: All counsel, members of the public, and media may access the webinar information at https:// www.cand.uscourts.gov/emc** **General Order 58. Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited.** **Zoom Guidance and Setup: https://www.cand.uscourts.gov/zoom/.** **Initial Case Management Conference set fo r 11/16/2021 01:30 PM in San Francisco, - Videoconference Only. *(This is a text-only entry generated by the court. There is no document associated with this entry.)*(afm, COURT STAFF) (Filed on 11/8/2021) (Entered: 11/08/2021)**
11/10/2021	114	Notice to Court Regarding Availability of Lead Defense Counsel K. Lee Blalack, II for Upcoming Case Management Conference by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. (Blalack, K.) (Filed on 11/10/2021) Modified on 11/10/2021 (cjl, COURT STAFF). (Entered: 11/10/2021)
11/11/2021	115	**CLERK'S NOTICE: Relative to 114 Notice, attendance by the co-counsel/partner is acceptable. *(This is a text-only entry generated by the court. There is no document associated with this entry.)* (afm, COURT STAFF) (Filed on 11/11/2021) (Entered: 11/11/2021)**
11/12/2021	116	AMENDED COMPLAINT *Second Amended Complaint* against All Defendants. Filed byMarcia Stein, Rodolfo Bone. (Hanagami, William) (Filed on 11/12/2021) (Entered: 11/12/2021)
11/15/2021	117	AMENDED COMPLAINT *BY RELATORS GLORYANNE BRYANT AND VICTORIA M. HERNANDEZ FOR VIOLATIONS OF FEDERAL FALSE CLAIMS ACT in CASE# 3:18-cv-01347-EMC* against All Defendants. Filed byGloryanne Bryant, Victoria M. Hernandez. (Attachments: # 1 Exhibit 1-10, # 2 Exhibit 11-19, # 3 Exhibit 20-33)(Lewis, Roger) (Filed on 11/15/2021) (Entered: 11/15/2021)
11/15/2021	118	AMENDED COMPLAINT *Second Amended Complaint* against All Defendants. Filed byJames M. Taylor. (Ronickher, Michael) (Filed on 11/15/2021) (Entered: 11/15/2021)
11/16/2021	119	**Minute Entry for proceedings held before Judge Edward M. Chen:** **Initial Case Management Conference held on 11/16/2021. Kaisers first-to-file motion shall be filed by 1/18/2022; opposition by 3/18/2022; and reply by 4/18/2022. The hearing on the first-to-file motion is set for 5/5/2022. Court**

		further confirmed that discovery is keyed to the original cmc date (2/15/2022). Further Case Management Conference set for 2/15/2022 is vacated and advanced to 1/11/2022 02:30 PM in San Francisco, - Videoconference Only. This proceeding will be held via a Zoom webinar. Joint cmc statement due 1/4/2022. **Webinar Access: All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/emc** **General Order 58. Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcas ting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited.** **Zoom Guidance and Setup: https://www.cand.uscourts.gov/zoom/.** **Joint Case Management Statement due by 1/4/2022. Further Case Management Conference set for 1/11/2022 02:30 PM in San Francisco, - Videoconference Only.** **Total Time in Court: 14 Minutes.** **Court Reporter: Belle Ball.** **Plaintiff Attorneys: Ben Wolinsky, Amy Zeman, Shiwon Choe, Abram Zinberg, Michael Ronickher, Janel Quinn.** **Defendant Attorneys: David Leviss, Anne Steinberg.** **Attachment: Minute Order.** **(afm, COURT STAFF) (Date Filed: 11/16/2021) (Entered: 11/22/2021)**
11/23/2021	120	TRANSCRIPT ORDER for proceedings held on 11/16/2021 before Judge Edward M. Chen by Kaiser Foundation Health Plan Inc, Permanente Medical Group, Inc, for Court Reporter Belle Ball. (Steinberg, Anne) (Filed on 11/23/2021) (Entered: 11/23/2021)
11/24/2021	121	WAIVER OF SERVICE Returned Executed filed by Gloryanne Bryant, Victoria M. Hernandez. Service waived by Colorado Permanente Medical Group, PC waiver sent on 11/15/2021, answer due 1/14/2022; Hawaii Permanente Medical Group waiver sent on 11/15/2021, answer due 1/14/2022; Kaiser Foundation Health Plan Inc waiver sent on 11/15/2021, answer due 1/14/2022; Kaiser Foundation Health Plan of Colorado waiver sent on 11/15/2021, answer due 1/14/2022; Kaiser Foundation Health Plan of Georgia waiver sent on 11/15/2021, answer due 1/14/2022; Kaiser Foundation Health Plan of The Northwest waiver sent on 11/15/2021, answer due 1/14/2022; Kaiser Foundation Health Plan of Washington waiver sent on 11/15/2021, answer due 1/14/2022; Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. waiver sent on 11/15/2021, answer due 1/14/2022; Kaiser Foundation Hospitals waiver sent on 11/15/2021, answer due 1/14/2022; Mid-Atlantic Permanente Medical Group, PC waiver sent on 11/15/2021, answer due 1/14/2022; Northwest Permanente, P.C. waiver sent on 11/15/2021, answer due 1/14/2022; Permanente Medical Group, Inc waiver sent on 11/15/2021, answer due 1/14/2022; Southeast Permanente Medical Group waiver sent on 11/15/2021

		answer due 1/14/2022; Southern California Permanente Medical Group waiver sent on 11/15/2021, answer due 1/14/2022; Washington Permanente Medical Group, P.C. waiver sent on 11/15/2021, answer due 1/14/2022. (Rukin, Peter) (Filed on 11/24/2021) (Entered: 11/24/2021)
12/01/2021	122	NOTICE of Change of Address by Abram Zinberg (Zinberg, Abram) (Filed on 12/1/2021) (Entered: 12/01/2021)
12/07/2021	123	WAIVER OF SERVICE Returned Executed filed by Ronda Osinek. Service waived by Kaiser Foundation Health Plan Inc waiver sent on 11/30/2021, answer due 1/31/2022. (Zeman, Amy) (Filed on 12/7/2021) (Entered: 12/07/2021)
12/07/2021	124	WAIVER OF SERVICE Returned Executed filed by Ronda Osinek. Service waived by Permanente Medical Group, Inc waiver sent on 11/30/2021, answer due 1/31/2022. (Zeman, Amy) (Filed on 12/7/2021) (Entered: 12/07/2021)
12/08/2021	125	WAIVER OF SERVICE Returned Executed filed by Marcia Stein, Rodolfo Bone. Service waived by All Defendants. (Hanagami, William) (Filed on 12/8/2021) (Entered: 12/08/2021)
12/16/2021	126	WAIVER OF SERVICE Returned Executed filed by James M. Taylor. Service waived by Colorado Permanente Medical Group, PC waiver sent on 11/15/2021, answer due 1/14/2022; Kaiser Foundation Health Plan Inc answer due 1/14/2022; Kaiser Foundation Health Plan of Colorado waiver sent on 11/15/2021, answer due 1/14/2022; Permanente Medical Group, Inc answer due 1/14/2022; Southern California Permanente Medical Group waiver sent on 11/15/2021, answer due 1/14/2022. *Response due 1/18/2022 per Court order.* (Ronickher, Michael) (Filed on 12/16/2021) (Entered: 12/16/2021)
12/18/2021	127	Transcript of Proceedings held on 11/16/21, before Judge Edward M. Chen. Court Reporter Belle Ball, CSR, telephone number (415)373-2529, belle_ball@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (120 in 3:13-cv-03891-EMC) Transcript Order) Redaction Request due 1/10/2022. Redacted Transcript Deadline set for 1/18/2022. Release of Transcript Restriction set for 3/18/2022. (Ball, Belle) (Filed on 12/18/2021) (Entered: 12/18/2021)
12/21/2021	128	STIPULATION WITH PROPOSED ORDER *REGARDING FIRST-TO-FILE BRIEFING SCHEDULE* filed by Ronda Osinek, James Taylor, M.D., Naser Arefi, Ajith Kumar, Prime Healthcare Services, Inc., Marcia Stein, Rodolfo Bone, Gloryanne Bryant, Victoria Hernandez, Michael Bicocca, M.D., the United States of America; Kaiser Foundation Health Plan, Inc., Kaiser Foundation Health Plan of Colorado, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, and Colorado Permanente Medical Group, P.C.. (Zeman, Amy) (Filed on 12/21/2021) Modified on 12/21/2021 (jml, COURT STAFF). (Entered: 12/21/2021)

12/30/2021	129	**ORDER GRANTING 128 STIPULATION REGARDING FIRST-TO-FILE BRIEFING SCHEDULE. Signed by Judge Edward M. Chen on 12/29/2021. (afm, COURT STAFF) (Filed on 12/30/2021) (Entered: 12/30/2021)**
12/30/2021	130	**CLERK'S NOTICE RESCHEDULING FURTHER CASE MANAGEMENT CONFERENCE FROM 1/11/2022 TO 2/15/2022 AT 2:30PM: Joint Case Management Statement due by 2/8/2022. Further Case Management Conference set for 2/15/2022 02:30 PM in San Francisco, - Videoconference Only. This proceeding will be held via a Zoom webinar.** **Webinar Access: All counsel, members of the public, and media may access the webinar information at https://www .cand.uscourts.gov/emc** **General Order 58. Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited.** **Zoom Guidance and Setup: https://www.cand.uscourts.gov/zoom/.** **Joint Case Management Statement due by 2/8/2 022. Further Case Management Conference set for 2/15/2022 02:30 PM in San Francisco, - Videoconference Only. *(This is a text-only entry generated by the court. There is no document associated with this entry.)*(afm, COURT STAFF) (Filed on 12/30/2021) (Entered: 12/30/2021)**
01/03/2022	131	WAIVER OF SERVICE Returned Executed filed by Michael Bicocca. Service waived by Kaiser Foundation Health Plan Inc waiver sent on 11/19/2021, answer due 1/18/2022; Permanente Federation, LLC waiver sent on 11/19/2021, answer due 1/18/2022; Permanente Medical Group, Inc waiver sent on 11/19/2021, answer due 1/18/2022; Southern California Permanente Medical Group waiver sent on 11/19/2021, answer due 1/18/2022. *Waivers of Service of Summons for First Amended Complaint filed in case no. 3:21-cv-03124 on October 9, 2020, docket no. 16.* (Oswald, R.) (Filed on 1/3/2022) (Entered: 01/03/2022)
01/18/2022	132	NOTICE of Appearance by Caitlin Bair *on behalf of Defendants Kaiser Foundation Hospitals, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.), Northwest Permanente, P.C., and The Permanente Federation, LLC* (Bair, Caitlin) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	133	NOTICE of Appearance by K. Lee Blalack, II *on behalf of Defendants Kaiser Foundation Hospitals, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington*

		Permanente Medical Group, P.C.), Northwest Permanente, P.C., and The Permanente Federation, LLC (Blalack, K.) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	134	NOTICE of Appearance by David J. Leviss *on behalf of Defendants Kaiser Foundation Hospitals, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.), Northwest Permanente, P.C., and The Permanente Federation, LLC* (Leviss, David) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	135	NOTICE of Appearance by Kelsey Chandrasoma *on behalf of Defendants Kaiser Foundation Hospitals, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.), Northwest Permanente, P.C., and The Permanente Federation, LLC* (Chandrasoma, Kelsey) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	136	NOTICE of Appearance by David Deaton *on behalf of Defendants Kaiser Foundation Hospitals, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.), Northwest Permanente, P.C., and The Permanente Federation, LLC* (Deaton, David) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	137	NOTICE of Appearance by Stephen M Sullivan *on behalf of Defendants Kaiser Foundation Hospitals, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.), Northwest Permanente, P.C., and The Permanente Federation, LLC* (Sullivan, Stephen) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	138	NOTICE of Appearance by Dimitri Portnoi *on behalf of Defendants Kaiser Foundation Hospitals, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.), Northwest Permanente, P.C., and The Permanente Federation, LLC* (Portnoi, Dimitri) (Filed on 1/18/2022) (Entered:

		01/18/2022)
01/18/2022	139	NOTICE of Appearance by Anne Miller Steinberg *on behalf of Defendants Kaiser Foundation Hospitals, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of the Mid-Atlantic States, Kaiser Foundation Health Plan of the Northwest, Kaiser Foundation Health Plan of Washington, The Southeast Permanente Medical Group, Hawaii Permanente Medical Group, Mid-Atlantic Permanente Medical Group, Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.), Northwest Permanente, P.C., and The Permanente Federation, LLC* (Steinberg, Anne) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	140	Certificate of Interested Entities by Hawaii Permanente Medical Group, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Southeast Permanente Medical Group, Washington Permanente Medical Group, P.C. (Blalack, K.) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	141	MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities* filed by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C.. Motion Hearing set for 3/31/2022 01:30 PM in San Francisco, Courtroom 05, 17th Floor before Judge Edward M. Chen. Responses due by 2/15/2022. Replies due by 3/17/2022. (Attachments: # 1 Appendix A, # 2 Proposed Order)(Blalack, K.) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/18/2022	142	Request for Judicial Notice re 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities* filed byColorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C.. (Attachments: # 1 Declaration of David Deaton in Support of Request For Judicial Notice)(Related document(s) 141) (Blalack, K.) (Filed on 1/18/2022) (Entered: 01/18/2022)
01/24/2022	143	OPPOSITION/RESPONSE AND STATEMENT OF NON-OPPOSITION (re 141 MOTION to Dismiss Pursuant to False Claims Act's First-To-File Bar filed by Naser Arefi, Ajith Kumar, Prime Healthcare Services, Inc. (Hardiman, Mark)

		(Filed on 1/24/2022) Modified on 1/25/2022 (cjl, COURT STAFF). (Entered: 01/24/2022)
01/31/2022	144	*NOTICE OF WITHDRAWAL OF COUNSEL VANESSA I. REED; [Proposed] Order* by Shiwon Choe (Choe, Shiwon) (Filed on 1/31/2022) Modified on 2/1/2022 (jml, COURT STAFF). (Entered: 01/31/2022)
02/04/2022	145	Certificate of Interested Entities by James M. Taylor (Ronickher, Michael) (Filed on 2/4/2022) (Entered: 02/04/2022)
02/07/2022	146	Certificate of Interested Entities by Michael Bicocca (Oswald, R.) (Filed on 2/7/2022) (Entered: 02/07/2022)
02/07/2022	147	NOTICE of Appearance by Laurie Oberembt (Oberembt, Laurie) (Filed on 2/7/2022) (Entered: 02/07/2022)
02/07/2022	148	Certificate of Interested Entities by Rodolfo Bone, Marcia Stein (Hanagami, William) (Filed on 2/7/2022) (Entered: 02/07/2022)
02/07/2022	149	**ORDER by Judge Edward M. Chen Granting 144 UNITED STATES' NOTICE OF WITHDRAWAL OF COUNSEL VANESSA I. REED (vla, COURT STAFF) (Filed on 2/7/2022) (Entered: 02/07/2022)**
02/08/2022	150	JOINT CASE MANAGEMENT STATEMENT *and Rule 26(F) Report* filed by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C., Ronda Osinek, James Taylor, M.D., Marcia Stein, Rodolfo Bone, Gloryanne Bryant, Victoria Hernandez, Michael Bicocca, M.D. and the United States of America. (Attachments: # 1 Proposed Order)(Blalack, K.) (Filed on 2/8/2022) Modified on 2/9/2022 (jml, COURT STAFF). (Entered: 02/08/2022)
02/09/2022	151	**ORDER REFERRING CASE to Magistrate Judge for Discovery purposes. Signed by Judge Edward M. Chen on 2/9/2022. (vla, COURT STAFF) (Filed on 2/9/2022) (Entered: 02/09/2022)**
02/10/2022		CASE REFERRED to Magistrate Judge Joseph C. Spero for Discovery (ahm, COURT STAFF) (Filed on 2/10/2022) (Entered: 02/10/2022)
02/11/2022	152	**NOTICE OF REFERENCE AND ORDER RE DISCOVERY PROCEDURES. Signed by Chief Magistrate Judge Joseph C. Spero on 2/11/2022. (klh, COURT STAFF) (Filed on 2/11/2022) (Entered: 02/11/2022)**
02/14/2022	153	NOTICE of Appearance by Jeffrey John Fowler (Fowler, Jeffrey) (Filed on 2/14/2022) (Entered: 02/14/2022)
02/15/2022	154	OPPOSITION/RESPONSE (re 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities*) filed byMichael Bicocca. (Quinn, Janel) (Filed on 2/15/2022) (Entered: 02/15/2022)

02/15/2022	155	OPPOSITION/RESPONSE (re 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities*) filed byGloryanne Bryant, Victoria M. Hernandez. (Attachments: # 1 Proposed Order) (Lewis, Roger) (Filed on 2/15/2022) (Entered: 02/15/2022)
02/15/2022	156	OPPOSITION/RESPONSE (re 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities*) filed byJames M. Taylor. (Attachments: # 1 Proposed Order)(Ronickher, Michael) (Filed on 2/15/2022) (Entered: 02/15/2022)
02/15/2022	157	OPPOSITION/RESPONSE (re 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities*) filed byRodolfo Bone, Marcia Stein. (Attachments: # 1 Proposed Order)(Hanagami, William) (Filed on 2/15/2022) (Entered: 02/15/2022)
02/15/2022	184	**Minute Entry for proceedings held before Judge Edward M Chen: Further Case Management Conference held on 2/15/2022.** **Close of Expert Discovery due by 9/13/2024. Close of Fact Discovery due by 3/25/2024. Designation of Experts due by 5/24/2024. Rebuttal Reports due by 7/23/2024. L/D to file Dispositive Motions 2/14/2025. Pretrial Conference set for 1/20/2026 02:30 PM in San Francisco, - Videoconference Only before Judge Edward M Chen. See Attached PDF for all Further Deadlines.** **Jury Selection set for 2/17/2026, at 8:30 AM in San Francisco, Courtroom 05, 17th Floor before Judge Edward M Chen.** **Jury Trial set for 2/17/2026, at 8:30 AM in San Francisco, Courtroom 05, 17th Floor before Judge Edward M Chen. Further Jury Trial set for 2/18/2026, 2/20/2026, 2/23/2026, 2/24/2026, 2/25/2026, 2/27/2026, 3/2/2026, 3/3/2026, 3/4/2026, 3/6/2026, 3/9/2026, 3/10/2026, 3/11/2026, 3/13/2026, 3/16/2026, 3/17/2026, 3/18/2026, 3/20/2026, 3/23/2026, 3/24/2026, 3/25/2026, 3/27/2026, 3/30/2026, 3/31/2026, 4/1/2026, 4/3/2026, 4/6/2026, 4/7/2026, 4/8/2026, 4/10/2026, 4/13/2026, 4/14/2026, 4/15/2026, 4/17/2026, and 4/20/2026, at 8:30 AM in San Francisco, Courtroom 05, 17th Floor before Judge Edward M Chen.** **Digital Recording Time: 2:29-2:41. (vla, COURT STAFF) (Date Filed: 2/15/2022) (Entered: 06/29/2022)**
02/24/2022	158	MOTION for leave to appear in Pro Hac Vice (Filing fee $ 317, receipt number ACANDC-16933278.) filed by Gloryanne Bryant, Victoria M. Hernandez. (Walther, W.) (Filed on 2/24/2022) (Entered: 02/24/2022)
02/24/2022	159	NOTICE of Voluntary Dismissal *(Partial Dismissal)* by Michael Bicocca (Quinn, Janel) (Filed on 2/24/2022) (Entered: 02/24/2022)
02/24/2022	160	STIPULATION WITH PROPOSED ORDER *TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION* re 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities* filed by Colorado Permanente Medical Group, PC, Hawaii Permanente

		Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C., James Taylor, M.D., Marcia Stein, Rodolfo Bone, Gloryanne Bryant, Victoria Hernandez, and Michael Bicocca, M.D.. (Blalack, K.) (Filed on 2/24/2022) Modified on 2/25/2022 (jml, COURT STAFF). (Entered: 02/24/2022)
02/28/2022	161	**Order by Judge Edward M. Chen Granting as to 160 STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION (Filed in case 3:13-cv-03891-EMC). Associated Cases: 3:16-cv-05337-EMC, 3:18-cv-01347-EMC, 3:21-cv-03124-EMC, 3:21-cv-03894-EMC (vla, COURT STAFF) (Filed on 2/28/2022) (Entered: 02/28/2022)**
03/01/2022	162	**Order by Judge Edward M. Chen Granting 158 Motion for Pro Hac Vice as to William Walther.(vla, COURT STAFF) (Filed on 3/1/2022) (Entered: 03/01/2022)**
03/01/2022	163	NOTICE OF WITHDRAWAL OF MATTHEW K. ORGAN AS COUNSEL by Gloryanne Bryant, Victoria M. Hernandez. (Lewis, Roger) (Filed on 3/1/2022) Modified on 3/1/2022 (cjl, COURT STAFF). (Entered: 03/01/2022)
03/02/2022	164	CLERK'S NOTICE CONTINUING 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities* HEARING SET FOR 3/31/2022. Motion Hearing reset to 4/14/2022 at 01:30 PM by Videoconference Only before Judge Edward M. Chen. This proceeding will be held via a Zoom webinar. Briefing schedule previously set remains unchanged. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/emc **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, rec ording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.can d.uscourts.gov/zoom/. *(This is a text-only entry generated by the court. There is no document associated with this entry.)*, (bxs, COURT STAFF) (Filed on 3/2/2022) (Entered: 03/02/2022)
03/17/2022	165	REPLY (re 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities*) *IN SUPPORT OF MOTION TO DISMISS PURSUANT TO FALSE CLAIMS ACT'S FIRST-TO-FILE BAR* filed byColorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado,

		Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C.. (Blalack, K.) (Filed on 3/17/2022) (Entered: 03/17/2022)
04/05/2022	166	CLERK'S NOTICE CONTINUING MOTION HEARING RE 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar; Memorandum of Points and Authorities.* Motion Hearing previously set for 4/14/2022 is reset to 4/21/2022 at 01:30 PM by Videoconference Only before Judge Edward M. Chen. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/emc **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. *(This is a text-only entry generated by the court. There is no document associated with this entry.)*(bxs, COURT STAFF) (Filed on 4/5/2022) (Entered: 04/05/2022)
04/21/2022	167	**Minute Entry for proceedings held before Judge Edward M. Chen: Motion Hearing held on 4/21/2022 as to 141 MOTION to Dismiss *Pursuant to False Claims Act's First-To-File Bar.*** ***Total Time in Court: 56 Minutes.*** ***Court Reporter: Ana Dub.*** ***(vla, COURT STAFF) (Date Filed: 4/21/2022) (Entered: 04/25/2022)***
04/26/2022	168	TRANSCRIPT ORDER for proceedings held on 4/21/2022 before Judge Edward M. Chen by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C., for Court Reporter Ana Dub. (Steinberg, Anne) (Filed on 4/26/2022) (Entered: 04/26/2022)

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04/27/2022	169	TRANSCRIPT ORDER for proceedings held on 4/21/2022 before Judge Edward M. Chen by James M. Taylor, for Court Reporter Ana Dub. (Ronickher, Michael) (Filed on 4/27/2022) (Entered: 04/27/2022)
04/28/2022	170	TRANSCRIPT ORDER for proceedings held on 04/21/2022 before Judge Edward M. Chen by Gloryanne Bryant, Victoria M. Hernandez, for Court Reporter Ana Dub. (Lewis, Roger) (Filed on 4/28/2022) (Entered: 04/28/2022)
05/05/2022	171	**ORDER by Judge Edward M. Chen Granting in Part and Denying in Part 141 Defendants' Motion to Dismiss. (emcsec, COURT STAFF) (Filed on 5/5/2022) (Entered: 05/05/2022)**
05/13/2022	172	NOTICE of Change of Address by Amy Marie Zeman (Zeman, Amy) (Filed on 5/13/2022) (Entered: 05/13/2022)
05/13/2022		Electronic filing error. **REMINDER**: Counsel must update personal profile in ECF for change of contact information to be in effect. Re: 172 Notice of Change of Address fi led by Ronda Osinek (jml, COURT STAFF) (Filed on 5/13/2022) (Entered: 05/16/2022)
05/30/2022	173	Transcript of Remote Zoom Video Conference Proceedings held on April 21, 2022, before Judge Edward M. Chen. Court Reporter Ana Dub, CSR 7445, RDR, RMR, CRR, CCRR, CRG, CCG, telephone number 415-290-1651; ana_dub@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date, it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (168 in 3:13-cv-03891-EMC) Transcript Order,,,) Release of Transcript Restriction set for 8/29/2022. (amd, COURT STAFF) (Filed on 5/30/2022) (Entered: 05/30/2022)
06/03/2022	174	NOTICE OF APPEAL to the 9th Circuit Court of Appeals filed by Rodolfo Bone, Marcia Stein. Appeal of Order on Motion to Dismiss 171 (Appeal fee of $505 receipt number ACANDC-17235529 paid.) (Attachments: # 1 Exhibit 1 - 05/05/2022 Order, # 2 Exhibit 2 - Representation Statement)(Hanagami, William) (Filed on 6/3/2022) (Entered: 06/03/2022)
06/17/2022	175	Notice of Withdrawal of Counsel David J. Leviss; [Proposed] Order by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C. (Portnoi, Dimitri) (Filed on 6/17/2022) Modified on 6/21/2022 (cjl, COURT STAFF). (Entered: 06/17/2022)
06/17/2022	176	NOTICE of Appearance by Kyle Grossman *on behalf of Defendants Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medica*

		Group; Colorado Permanente Medical Group, P.C.; Kaiser Foundation Hospitals; Kaiser Foundation Health Plan of Georgia, Inc.; Kaiser Foundation Health Plan of the Mid-Atlantic States; Kaiser Foundation Health Plan of the Northwest; Kaiser Foundation Health Plan of Washington; The Southeast Permanente Medical Group; Hawaii Permanente Medical Group; Mid-Atlantic Permanente Medical Group; Group Health Permanente (n/k/a Washington Permanente Medical Group, P.C.); Northwest Permanente, P.C.; and Permanente Federation, LLC (Grossman, Kyle) (Filed on 6/17/2022) (Entered: 06/17/2022)
06/21/2022	177	**ORDER re 175 Defendant's Notice of Withdrawal of Counsel: David J. Leviss. Signed by Judge Edward M. Chen on 6/21/2022. (bxs, COURT STAFF) (Filed on 6/21/2022) (Entered: 06/21/2022)**
06/21/2022	178	MOTION to Dismiss *UNITED STATES' COMPLAINT-IN-INTERVENTION; MEMORANDUM OF POINTS AND AUTHORITIES* filed by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. Responses due by 8/5/2022. (Attachments: # 1 Proposed Order) (Blalack, K.) (Filed on 6/21/2022) (Entered: 06/21/2022)
06/21/2022	179	Request for Judicial Notice re 178 MOTION to Dismiss *UNITED STATES' COMPLAINT-IN-INTERVENTION; MEMORANDUM OF POINTS AND AUTHORITIES* filed byColorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. (Attachments: # 1 Declaration of David Deaton in Support of Request for Judicial Notice and for Incorporation of Documents by Reference)(Related document(s) 178) (Blalack, K.) (Filed on 6/21/2022) (Entered: 06/21/2022)
06/21/2022	180	MOTION to Dismiss *RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES* filed by Kaiser Foundation Health Plan Inc, Permanente Medical Group, Inc. Responses due by 8/5/2022. (Attachments: # 1 Proposed Order)(Blalack, K.) (Filed on 6/21/2022) (Entered: 06/21/2022)
06/21/2022	181	MOTION to Dismiss *RELATOR TAYLOR'S SECOND AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES* filed by Colorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. Responses due by 8/5/2022. (Attachments: # 1 Proposed Order) (Blalack, K.) (Filed on 6/21/2022) (Entered: 06/21/2022)
06/21/2022	182	MOTION to Dismiss *RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES* filed by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical

		Group, P.C.. Responses due by 8/5/2022. (Attachments: # 1 Proposed Order) (Blalack, K.) (Filed on 6/21/2022) (Entered: 06/21/2022)
06/22/2022	183	CLERK'S NOTICE SETTING ZOOM HEARINGS RE 178 MOTION to Dismiss *UNITED STATES' COMPLAINT-IN-INTERVENTION*, 180 MOTION to Dismiss *RELATOR OSINEK'S FIRST AMENDED COMPLAINT*, 181 MOTION to Dismiss *RELATOR TAYLOR'S SECOND AMENDED COMPLAINT* , 182 MOTION to Dismiss *RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT* Motion Hearing set for 10/14/2022 at 01:30 PM by Videoconference Only before Judge Edward M Chen. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/emc< /p> **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. *(This is a text-only entry generated by the court. There is no document associated with this entry.)*(bxs, COURT STAFF) (Filed on 6/22/2022) (Entered: 06/22/2022)
07/07/2022	185	Transcript Designation Form for proceedings held on 04/21/2022 before Judge Edward M. Chen, re 174 Notice of Appeal to the Ninth Circuit, *USCA Case No. 22-15862* Transcript due by 8/8/2022. (Hanagami, William) (Filed on 7/7/2022) (Entered: 07/07/2022)
07/13/2022	186	STIPULATION WITH PROPOSED ORDER *RE: DISCOVERY OF ELECTRONICALLY STORED INFORMATION* filed by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C., United States of America, Ronda Osinek, James Taylor, Gloryanne Bryant and Victoria Hernandez. (Sullivan, Stephen) (Filed on 7/13/2022) Modified on 7/14/2022 (jml, COURT STAFF). (Entered: 07/13/2022)
07/13/2022	187	STIPULATION WITH PROPOSED ORDER *RE: NON-WAIVER OF PRIVILEGE AND PROTECTED MATERIAL* filed by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC,

		Northwest Permanente, P.C., Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C., United States of America, Ronda Osinek, James Taylor, Gloryanne Bryant and Victoria Hernandez. (Sullivan, Stephen) (Filed on 7/13/2022) Modified on 7/14/2022 (jml, COURT STAFF). (Entered: 07/13/2022)
07/13/2022	188	STIPULATION WITH PROPOSED ORDER *PROTECTIVE ORDER GOVERNING THE TREATMENT OF PROTECTED MATERIAL* filed by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C., United States of America, Ronda Osinek, James Taylor, Gloryanne Bryant and Victoria Hernandez. (Sullivan, Stephen) (Filed on 7/13/2022) Modified on 7/14/2022 (jml, COURT STAFF). (Entered: 07/13/2022)
07/14/2022	189	**Order. Signed 7/14/2022 by Chief Ma Magistrate Judge Joseph C. Spero granting 186 Stipulation RE: DISCOVERY OF ELECTRONICALLY STORED INFORMATION.(klh, COURT STAFF) (Filed on 7/14/2022) (Entered: 07/14/2022)**
07/14/2022	190	**ORDER. Signed 7/14/2022 by Chief Magistrate Judge Joseph C. Spero granting 187 Stipulation RE: NON-WAIVER OF PRIVILEGE AND PROTECTED MATERIAL. (klh, COURT STAFF) (Filed on 7/14/2022) (Entered: 07/14/2022)**
07/14/2022	191	**ORDER. Signed 7/14/2022 by Chief Magistrate Judge Joseph C. Spero granting 188 Stipulated PROTECTIVE ORDER GOVERNING THE TREATMENT OF PROTECTED MATERIAL. (klh, COURT STAFF) (Filed on 7/14/2022) (Entered: 07/14/2022)**
07/26/2022	192	STIPULATION WITH PROPOSED ORDER *for Five-Page Extension of Page Limits for the United States' Opposition to Defendants' Motion to Dismiss and for Defendants' Reply* filed by United States of America, Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Health Plan of Colorado; The Permanente Medical Group, Inc.; Southern California Permanente Medical Group; and Colorado Permanente Medical Group, P.C.. (Choe, Shiwon) (Filed on 7/26/2022) Modified on 7/27/2022 (jml, COURT STAFF). (Entered: 07/26/2022)
08/04/2022	193	NOTICE of Appearance by David Z. Moskowitz (Moskowitz, David) (Filed on 8/4/2022) (Entered: 08/04/2022)
08/05/2022	194	OPPOSITION/RESPONSE (re 180 MOTION to Dismiss *RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES*) filed byRonda Osinek. (Zeman, Amy) (Filed on 8/5/2022) (Entered: 08/05/2022)

08/05/2022	195	OPPOSITION/RESPONSE (re 182 MOTION to Dismiss *RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES*) filed byGloryanne Bryant, Victoria M. Hernandez. (Lewis, Roger) (Filed on 8/5/2022) (Entered: 08/05/2022)
08/05/2022	196	OPPOSITION/RESPONSE (re 181 MOTION to Dismiss *RELATOR TAYLOR'S SECOND AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES*) filed byJames M. Taylor. (Attachments: # 1 Proposed Order) (Ronickher, Michael) (Filed on 8/5/2022) (Entered: 08/05/2022)
08/05/2022	197	OPPOSITION/RESPONSE (re 178 MOTION to Dismiss *UNITED STATES' COMPLAINT-IN-INTERVENTION; MEMORANDUM OF POINTS AND AUTHORITIES*) filed byUnited States of America. (Attachments: # 1 Proposed Order)(Choe, Shiwon) (Filed on 8/5/2022) (Entered: 08/05/2022)
08/05/2022	198	RESPONSE *to 179 Request for Judicial Notice re 178 MOTION to Dismiss UNITED STATES' COMPLAINT-IN-INTERVENTION* by United States of America. (Choe, Shiwon) (Filed on 8/5/2022) (Entered: 08/05/2022)
08/08/2022	199	Proposed Order re 195 Opposition/Response to Motion, by Gloryanne Bryant, Victoria M. Hernandez. (Lewis, Roger) (Filed on 8/8/2022) (Entered: 08/08/2022)
09/02/2022	200	CLERK'S NOTICE SETTING ZOOM HEARING AND MOVING MOTIONS TO CORRECT MOTION HEARING DAY. Motions Hearing as to 178 MOTION to Dismiss *UNITED STATES' COMPLAINT-IN-INTERVENTION;* 180 MOTION to Dismiss *RELATOR OSINEK'S FIRST AMENDED COMPLAINT;* 181 MOTION to Dismiss *RELATOR TAYLOR'S SECOND AMENDED COMPLAINT;* 182 MOTION to Dismiss *RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT;* reset from 10/14/2022 to 10/13/2022, at 1:30 PM in San Francisco, - Videoconference Only before Judge Edward M Chen. This proceeding will be held via a Zoom webinar. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/emc **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and reb roadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/ zoom/. *(This is a text-only entry generated by the court. There is no document associated with this entry.)*,(vla, COURT STAFF) (Filed on 9/2/2022) (Entered: 09/02/2022)
09/06/2022	201	REPLY (re 178 MOTION to Dismiss *UNITED STATES' COMPLAINT-IN-INTERVENTION; MEMORANDUM OF POINTS AND AUTHORITIES*) filed byColorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. (Blalack, K.) (Filed on 9/6/2022) (Entered: 09/06/2022)

09/06/2022	202	REPLY (re 180 MOTION to Dismiss *RELATOR OSINEK'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES*) filed byKaiser Foundation Health Plan Inc, Permanente Medical Group, Inc. (Blalack, K.) (Filed on 9/6/2022) (Entered: 09/06/2022)
09/06/2022	203	REPLY (re 181 MOTION to Dismiss *RELATOR TAYLOR'S SECOND AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES*) filed byColorado Permanente Medical Group, PC, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Permanente Medical Group, Inc, Southern California Permanente Medical Group. (Blalack, K.) (Filed on 9/6/2022) (Entered: 09/06/2022)
09/06/2022	204	REPLY (re 182 MOTION to Dismiss *RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT; MEMORANDUM OF POINTS AND AUTHORITIES*) filed byColorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C.. (Blalack, K.) (Filed on 9/6/2022) (Entered: 09/06/2022)
10/03/2022	205	STATEMENT OF RECENT DECISION pursuant to Civil Local Rule 7-3.d filed byJames M. Taylor. (Attachments: # 1 Exhibit US v. Anthem Decision)(Related document(s) 196) (Ronickher, Michael) (Filed on 10/3/2022) (Entered: 10/03/2022)
10/12/2022	206	**CLERK'S NOTICE SETTING ZOOM HEARING.** **Motions Hearing as to 178 MOTION to Dismiss *UNITED STATES' COMPLAINT-IN-INTERVENTION,* 180 MOTION to Dismiss *RELATOR OSINEK'S FIRST AMENDED COMPLAINT,* 181 MOTION to Dismiss *RELATOR TAYLOR'S SECOND AMENDED COMPLAINT,* 182 MOTION to Dismiss *RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT* , set for 10/13/2022, at 1:30 PM in San Francisco, - Videoconference Only before Judge Edward M Chen. This proceeding will be held via a Zoom webinar.** **Webinar Access: All counsel, members of the public, and media may access the webinar information at https:// www.cand.uscourts.gov/emc** **General Order 58. Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited.** **Zoom Guidance and Setup: https://www.cand.uscourts.gov/zoom/.** ***(This is a text-only entry genera ted by the court. There is no document associated with this entry.)*(vla, COURT STAFF) (Filed on 10/12/2022)**

		(Entered: 10/12/2022)
10/13/2022	207	**Minute Entry for proceedings held before Judge Edward M Chen:** **Motions Hearing held on 10/13/2022 re 178 MOTION to Dismiss *UNITED STATES' COMPLAINT-IN-INTERVENTION.*** ***180 MOTION to Dismiss RELATOR OSINEK'S FIRST AMENDED COMPLAINT.*** ***181 MOTION to Dismiss RELATOR TAYLOR'S SECOND AMENDED COMPLAINT.*** ***182 MOTION to Dismiss RELATORS BRYANT AND HERNANDEZ'S FIRST AMENDED COMPLAINT. Matters taken under submissions.*** ***Plaintiff's Attorneys: Shiwon Choe, David Moskowitz (USA), Amy Zeman (Osinek), Max Voldeman (Taylor), Roger Lewis (Hernandez, Bryant).*** ***Defendant's Attorneys: Dimitri Portnoi, K. Lee Blalack (Kaiser).*** ***Total Time in Court: 1 hour, 30 Minutes (2:45-4:15). Court Reporter: Belle Ball.*** ***(This is a text-only entry generated by the court. There is no document associated with this entry.) (vla, COURT STAFF) (Date Filed: 10/13/2022) (Entered: 10/17/2022)***
10/17/2022	208	Letter Brief *re: Discovery Dispute* filed by Kaiser Foundation Health Plan Inc. and United States of America. (Attachments: # 1 Exhibit 1, # 2 Exhibit 2, # 3 Exhibit 3, # 4 Exhibit 4, # 5 Exhibit 5, # 6 Exhibit 6, # 7 Exhibit 7, # 8 Exhibit 7-1, # 9 Exhibit 8, # 10 Exhibit 9, # 11 Exhibit 10)(Sullivan, Stephen) (Filed on 10/17/2022) Modified on 10/18/2022 (jml, COURT STAFF). (Entered: 10/17/2022)
10/17/2022	209	Administrative Motion to File Under Seal *Pursuant to Civ. L.R. 79-5(f) to Consider Whether Kaiser's Material Should Be Sealed re 208 Letter Brief* filed by United States of America. (Attachments: # 1 Exhibit 10)(Choe, Shiwon) (Filed on 10/17/2022) (Entered: 10/17/2022)
10/18/2022	210	TRANSCRIPT ORDER for proceedings held on 10/13/2022 before Judge Edward M Chen by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C., for Court Reporter Belle Ball. (Grossman, Kyle) (Filed on 10/18/2022) (Entered: 10/18/2022)
10/19/2022	211	TRANSCRIPT ORDER for proceedings held on 10/13/2022 before Judge Edward M Chen by Gloryanne Bryant, Victoria M. Hernandez, for Court Reporter Belle Ball. (Lewis, Roger) (Filed on 10/19/2022) (Entered: 10/19/2022)

10/19/2022	212	TRANSCRIPT ORDER for proceedings held on 10/13/2022 before Judge Edward M Chen by United States of America, for Court Reporter Belle Ball. (Choe, Shiwon) (Filed on 10/19/2022) (Entered: 10/19/2022)
10/20/2022	213	TRANSCRIPT ORDER for proceedings held on 10/13/2022 before Judge Edward M Chen by James M. Taylor, for Court Reporter Belle Ball. (Ronickher, Michael) (Filed on 10/20/2022) (Entered: 10/20/2022)
10/21/2022	214	NOTICE of Appearance by Jonathan Thrope (Thrope, Jonathan) (Filed on 10/21/2022) (Entered: 10/21/2022)
10/21/2022	215	Notice of Withdrawal of Motion *to Consider Whether Kaiser's Material Should Be Sealed* (Choe, Shiwon) (Filed on 10/21/2022) (Entered: 10/21/2022)
10/21/2022	216	CLERKS NOTICE SETTING ZOOM HEARING. Discovery Hearing as to Joint Discovery Letter 208 set for 11/4/2022 09:30 AM in San Francisco, - Videoconference Only before Chief Magistrate Judge Joseph C. Spero. This proceeding will be held via a Zoom webinar. Immediately following the Discovery Hearing lead counsel shall set up their own Zoom video conference to meet and confer in an effort to resolve the Motion. Lead trial counsel shall attend both hearings. **Webinar Access:** All counsel, members of the public, and media may access the webinar information at https://www.cand.uscourts.gov/jcs **Court Appearances:** Advanced notice is required of c ounsel or parties who wish to be identified by the court as making an appearance or will be participating in the argument at the hearing. A list of names and emails must be sent to the CRD at jcscrd@cand.uscourts.gov no later than 11/2/2022 by 3:00 PDT. **General Order 58.** Persons granted access to court proceedings held by telephone or videoconference are reminded that photographing, recording, and rebroadcasting of court proceedings, including screenshots or other visual copying of a hearing, is absolutely prohibited. **Zoom Guidance and Setup:** https://www.cand.uscourts.gov/zoom/. (Related documents(s) 208) *(This is a text-only entry generated by the court. There is no document associated with this entry.)* (klh, COURT STAFF) (Filed on 10/21/2022) (Entered: 10/21/2022)
10/24/2022	217	ERRATA re 208 Letter Brief, *PARTIES' JOINT NOTICE OF ERRATA RE EXHIBIT 10 TO PARTIES' JOINT LETTER RE DISCOVERY DISPUTE* by Kaiser Foundation Health Plan Inc. (Attachments: # 1 Exhibit A)(Sullivan, Stephen) (Filed on 10/24/2022) (Entered: 10/24/2022)
10/28/2022	218	MOTION DEFENDANTS' REQUEST FOR ENTRY OF FINAL JUDGMENT PURSUANT TO FED. R. CIV. P. 58(D) re 171 Order on Motion to Dismiss filed by Colorado Permanente Medical Group, PC, Hawaii Permanente Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation

		Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Mid-Atlantic Permanente Medical Group, PC, Northwest Permanente, P.C., Permanente Federation, LLC, Permanente Medical Group, Inc, Southeast Permanente Medical Group, Southern California Permanente Medical Group, Washington Permanente Medical Group, P.C.. Responses due by 11/14/2022. (Attachments: # 1 Proposed Final Judgment - Arefi, # 2 Proposed Final Judgment - Bicocca, # 3 Proposed Final Judgment - Stein)(Portnoi, Dimitri) (Filed on 10/28/2022) (Entered: 10/28/2022)
11/04/2022	219	**Minute Entry for Zoom proceedings held before Chief Magistrate Judge Joseph C. Spero: Discovery Hearing re: Joint Discovery Letter 208 held on 11/4/2022. Supplemental report on the meet-and-confer to be filed by 11/18/2022.** **Total Time in Court: 18 M.** **Court Reporter: Marla Knox.** **Attorney for Plaintiff: Gary Dyal, Laurie Oberembt, Shiwon Choe on behalf of the USA.** **Attorney for Defendant: Lee Blalack, Stephen Sullivan.** **(klh, COURT STAFF) (Date Filed: 11/4/2022) (Entered: 11/04/2022)**
11/04/2022	220	TRANSCRIPT ORDER for proceedings held on 11/04/2022 before Magistrate Judge Joseph C. Spero by Kaiser Foundation Health Plan Inc, for Court Reporter Marla Knox. (Sullivan, Stephen) (Filed on 11/4/2022) (Entered: 11/04/2022)
11/07/2022	221	TRANSCRIPT ORDER for proceedings held on November 4, 2022 before Judge Edward M Chen by United States of America, for Court Reporter Marla Knox. (Choe, Shiwon) (Filed on 11/7/2022) (Entered: 11/07/2022)
11/10/2022	222	OPPOSITION/RESPONSE (re 218 MOTION DEFENDANTS' REQUEST FOR ENTRY OF FINAL JUDGMENT PURSUANT TO FED. R. CIV. P. 58(D) re 171 Order on Motion to Dismiss) filed byMichael Bicocca. (Attachments: # 1 Proposed Order)(Quinn, Janel) (Filed on 11/10/2022) (Entered: 11/10/2022)
11/14/2022	223	**ORDER by Judge Edward M. Chen Granting in Part and Denying in Part 178 Defendants' Motion to Dismiss Untied States' Complaint in Intervention. Amended Complaint/Pleadings due by 12/12/2022. (emcsec, COURT STAFF) (Filed on 11/14/2022) (Entered: 11/14/2022)**
11/14/2022	224	**ORDER by Judge Edward M. Chen Granting 180 Defendants' Motion to Dismiss Osinek's First Amended Complaint. (emcsec, COURT STAFF) (Filed on 11/14/2022) (Entered: 11/14/2022)**
11/14/2022	225	**ORDER by Judge Edward M. Chen Granting in Part and Denying in P 181 Defendants' Motion to Dismiss Taylor's Second Amended Complaint With Leave to Amend. Amended Complaint/Pleadings due by 12/12/2022. (emcsec, COURT STAFF) (Filed on 11/14/2022) (Entered: 11/14/2022)**
11/14/2022	226	**ORDER by Judge Edward M. Chen Granting in Part and Denying in Part 182 Defendants' Motion to Dismiss Relators Bryant and Hernandez's First Amended Complaint. Amended Complaint/Pleadings due by 12/12/2022. (emcsec, COURT STAFF) (Filed on 11/14/2022) (Entered: 11/14/2022)**

11/14/2022	227	REPLY (re 218 MOTION DEFENDANTS' REQUEST FOR ENTRY OF FINAL JUDGMENT PURSUANT TO FED. R. CIV. P. 58(D) re 171 Order on Motion to Dismiss) filed byRodolfo Bone, Marcia Stein. (Hanagami, William) (Filed on 11/14/2022) (Entered: 11/14/2022)
11/14/2022	228	Transcript of Videoconference Proceedings held on November 4, 2022, before Judge Joseph C. Spero. Court Reporter, Marla F. Knox, RPR, CRR, RMR, telephone number (602) 391-6990/email marla_knox@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter/Transcriber until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re 220 Transcript Order) Release of Transcript Restriction set for 2/13/2023. (Related documents(s) 220) (mfk, COURT STAFF) (Filed on 11/14/2022) (Entered: 11/14/2022)
11/15/2022	229	**ORDER by Judge Edward M. Chen Granting 218 Defendants' Request for Entry of Final Judgment. (emcsec, COURT STAFF) (Filed on 11/15/2022) (Entered: 11/15/2022)**
11/15/2022	230	**JUDGMENT (C-16-1558 EMC; C-16-5337 EMC; C-21-3124 EMC). Signed by Judge Edward M. Chen on 11/15/2022. (emcsec, COURT STAFF) (Filed on 11/15/2022) (Entered: 11/15/2022)**
11/16/2022	231	MOTION to Clarify Order Granting Defendants' Motion to Dismiss Relator Osinek's First Amended Complaint re 224 Order on Motion to Dismiss filed by United States of America. Responses due by 11/30/2022. Replies due by 12/7/2022. (Choe, Shiwon) (Filed on 11/16/2022) (Entered: 11/16/2022)
11/16/2022	232	Statement of Non-Opposition re 231 MOTION to Clarify Order Granting Defendants' Motion to Dismiss Relator Osinek's First Amended Complaint re 224 Order on Motion to Dismiss filed byKaiser Foundation Health Plan Inc, Permanente Medical Group, Inc. (Related document(s) 231) (Portnoi, Dimitri) (Filed on 11/16/2022) (Entered: 11/16/2022)
11/16/2022	233	**Order by Judge Edward M Chen granting 231 Motion to Clarify Order Granting Defendants' Motion to Dismiss Relator Osinek's First Amended Complaint. (bxs, COURT STAFF) (Filed on 11/16/2022) (Entered: 11/16/2022)**

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PACER Login:	billhanagami	**Client Code:**	
Description:	Docket Report	**Search Criteria:**	3:13-cv-03891-EMC
Billable Pages:	30	**Cost:**	3.00

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TAB 40

ADRMOP,APPEAL,CLOSED,RELATE

U.S. District Court
California Northern District (San Francisco)
CIVIL DOCKET FOR CASE #: 3:16-cv-05337-EMC

Stein, et al v. Kaiser Foundation Health Plan, Inc., et al
Assigned to: Edward M. Chen
Lead case: 3:13-cv-03891-EMC
Member case: (View Member Case)
Case in other court: California Central, 2:16-cv-03331
22-15862
Cause: 31:3729 False Claims Act

Date Filed: 09/19/2016
Date Terminated: 05/05/2022
Jury Demand: None
Nature of Suit: 375 Other Statutes: False Claims Act
Jurisdiction: Federal Question

Plaintiff

United States of America
ex rel Marcia Stein and Rodolfo Bone

represented by **Arthur Di Dio**
United States Department of Justice
Ben Franklin Station
P. O. Box 261
Washington, DC 20044
202-307-0275
Fax: 202-307-3852
Email: Arthur.Di.Dio@usdoj.gov
LEAD ATTORNEY
ATTORNEY TO BE NOTICED

Benjamin Joseph Wolinsky
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ER-1963

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Fax: 415-436-6927
Email: erica.hitchings@usdoj.gov
TERMINATED: 05/21/2021

Plaintiff

Marcia Stein
ex rel.

represented by **Abram Zinberg**
The Zinberg Law Firm, APC
412 Olive Ave., Suite 528
Huntington Beach, CA 92648
714-374-9802
Fax: 714-698-4048
Email: AbramJ@ZinbergLaw.com
ATTORNEY TO BE NOTICED

William Kioki Hanagami
The Hanagami Law Firm, A.P.C.
5950 Canoga Avenue, Suite 130
Woodland Hills, CA 91367-5035
818-716-8570
Fax: 818-716-8569
Email: BillHanagami@esquire.la
ATTORNEY TO BE NOTICED

Plaintiff

Rodolfo Bone
ex rel.

represented by **Abram Zinberg**
(See above for address)
ATTORNEY TO BE NOTICED

William Kioki Hanagami
(See above for address)
ATTORNEY TO BE NOTICED

V.

Defendant

Kaiser Foundation Health Plan Inc.
a California corporation

represented by **David J. Leviss**
O'Melveny and Myers LLP
1625 Eye Street, NW
Washington, DC 20006
(202) 383-5282
Email: dleviss@omm.com

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PRO HAC VICE
ATTORNEY TO BE NOTICED

K. Lee Blalack , II
O'Melveny and Myers LLP
1625 Eye Street, NW
Washington, DC 20006
(202) 383-5374
Email: lblalack@omm.com
PRO HAC VICE
ATTORNEY TO BE NOTICED

Defendant

Kaiser Foundation Hospitals
a California corporation

Defendant

Kaiser Foundation Health Plan of Colorado
a Colorado corporaton

represented by **David J. Leviss**
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

K. Lee Blalack , II
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Defendant

Kaiser Foundation Health Plan of Georgia, Inc.
a Georgia corporation

Defendant

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
a Maryland corporation

Defendant

Kaiser Foundation Health Plan of The Northwest
an Oregon corporation

Defendant

Kaiser Foundation Health Plan of Washington
a Washington corporation

Defendant

The Permanente Medical Group, Inc.
a California corporation

represented by **David J. Leviss**
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

K. Lee Blalack , II
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Defendant

Southern California Permanente Medical Group
a business entity, form unknown

represented by **David J. Leviss**
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

K. Lee Blalack , II
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Defendant

Colorado Permanente Medical Group
a Colorado corporation

represented by **David J. Leviss**
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

K. Lee Blalack , II
(See above for address)
PRO HAC VICE
ATTORNEY TO BE NOTICED

Defendant

The Southeast Permanente Medical Group
a Georgia corporation, Hawaii

Defendant

Hawaii Permante Medical Group

Defendant

Mid-Atlantic Permanente Medical Group

Defendant

Northwest Permanente, P.C.

Defendant

Group Health Permanente

Defendant

Kaiser Permanente

Date Filed	#	Docket Text
05/16/2016	1	COMPLAINT filed by United States of America, ex rel. against Defendants Kaiser Foundation Health Plan Inc. Case assigned to Judge Manuel L. Real for all further proceedings. Discovery referred to Magistrate Judge Suzanne H. Segal. (Filing fee $ 400 Paid) (Attachments: # 1 CV-71) (jtil) (Entered: 05/18/2016)
11/03/2016	27	AMENDED COMPLAINT against Colorado Permanente Medical Group, Group Health Permanente, Hawaii Permante Medical Group, Kaiser Foundation Health Plan Inc, Kaiser Foundation Health Plan of Colorado, Kaiser Foundation Health Plan of Georgia, Inc., Kaiser Foundation Health Plan of The Northwest, Kaiser Foundation Health Plan of Washington, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., Kaiser Foundation Hospitals, Kaiser Permanente, Mid-Atlantic Permanente Medical Group, Northwest Permanente, P.C., Southern California Permanente Medical Group, The Permanente Medical Group, Inc., The Southeast Permanente Medical Group. Filed byRodolfo Bone, Marcia Stein. (vlkS, COURT STAFF) (Filed on 11/3/2016) (Entered: 11/03/2016)
06/25/2021	54	**ORDER by Judge Edward M. Chen granting (57) Motion to Consolidate Cases in case 3:13-cv-03891-EMC *SEALED*. (Manual service sent to parties listed in certificate of service on motion). (afmS, COURT STAFF) (Filed on 6/25/2021) (Entered: 06/27/2021)**
07/27/2021	56	Notice of Election to Intervene in part and to decline to Intervene in part ; [Proposed] Order to unseal by United States of America. (mclS, COURT STAFF) (Filed on 7/27/2021) (Entered: 07/28/2021)
08/25/2021	57	MOTION for leave to appear in Pro Hac Vice *for K. Lee Blalack, II* (Filing fee $ 317, receipt number 0971-16321912.) filed by Colorado Permanente Medical Group, Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado, Southern California Permanente Medical Group, The Permanente Medical Group, Inc.. (Blalack II, K. Lee) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/25/2021	58	MOTION for leave to appear in Pro Hac Vice *for David J. Leviss* (Filing fee $ 317, receipt number 0971-16322037.) filed by Colorado Permanente Medical Group, Kaiser Foundation Health Plan Inc., Kaiser Foundation Health Plan of Colorado, Southern California Permanente Medical Group, The Permanente Medical Group, Inc.. (Leviss, David) (Filed on 8/25/2021) (Entered: 08/25/2021)
08/27/2021	59	**ORDER by Judge Edward M. Chen granting 57 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**
08/27/2021	60	**ORDER by Judge Edward M. Chen granting 58 Motion for Pro Hac Vice. (afmS, COURT STAFF) (Filed on 8/27/2021) (Entered: 08/27/2021)**

12/18/2021	61	Transcript of Proceedings held on 11/16/21, before Judge Edward M. Chen. Court Reporter Belle Ball, CSR, telephone number (415)373-2529, belle_ball@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (120 in 3:13-cv-03891-EMC) Transcript Order) Redaction Request due 1/10/2022. Redacted Transcript Deadline set for 1/18/2022. Release of Transcript Restriction set for 3/18/2022. (Ball, Belle) (Filed on 12/18/2021) (Entered: 12/18/2021)
02/07/2022	62	**ORDER by Judge Edward M. Chen Granting 144 UNITED STATES' NOTICE OF WITHDRAWAL OF COUNSEL VANESSA I. REED (vla, COURT STAFF) (Filed on 2/7/2022) (Entered: 02/07/2022)**
02/28/2022	63	**Order by Judge Edward M. Chen Granting as to 160 STIPULATION TO EXTEND DEFENDANTS' FIRST-TO-FILE REPLY BRIEF PAGE LIMITATION (Filed in case 3:13-cv-03891-EMC). Associated Cases: 3:16-cv-05337-EMC, 3:18-cv-01347-EMC, 3:21-cv-03124-EMC, 3:21-cv-03894-EMC (vla, COURT STAFF) (Filed on 2/28/2022) (Entered: 02/28/2022)**
05/30/2022	64	Transcript of Remote Zoom Video Conference Proceedings held on April 21, 2022, before Judge Edward M. Chen. Court Reporter Ana Dub, CSR 7445, RDR, RMR, CRR, CCRR, CRG, CCG, telephone number 415-290-1651; ana_dub@cand.uscourts.gov. Per General Order No. 59 and Judicial Conference policy, this transcript may be viewed only at the Clerk's Office public terminal or may be purchased through the Court Reporter until the deadline for the Release of Transcript Restriction. After that date, it may be obtained through PACER. Any Notice of Intent to Request Redaction, if required, is due no later than 5 business days from date of this filing. (Re (168 in 3:13-cv-03891-EMC) Transcript Order,,,) Release of Transcript Restriction set for 8/29/2022. (amd, COURT STAFF) (Filed on 5/30/2022) (Entered: 05/30/2022)
06/03/2022	65	NOTICE OF APPEAL to the 9th Circuit Court of Appeals filed by Rodolfo Bone, Marcia Stein. (Appeal fee of $505 receipt number ACANDC-17235401 paid.) (Attachments: # 1 Exhibit 1 05/05/2022 Order, # 2 Exhibit 2 Representation Statement) (Hanagami, William) (Filed on 6/3/2022) Modified on 6/6/2022 (kmg, COURT STAFF). (Entered: 06/03/2022)
06/13/2022	66	USCA Case Number **22-15862** for 65 Notice of Appeal to the Ninth Circuit, filed by Rodolfo Bone, Marcia Stein. (gba, COURT STAFF) (Filed on 6/13/2022) (Entered: 06/13/2022)
06/27/2022	67	TRANSCRIPT ORDER for proceedings held on 04/21/2022 before Judge Edward M Chen by Rodolfo Bone, Marcia Stein, for Court Reporter Ana Dub. (Hanagami, William) (Filed on 6/27/2022) (Entered: 06/27/2022)
07/07/2022	68	Transcript Designation Form for proceedings held on 04/21/2022 before Judge Edward M. Chen, re 65 Notice of Appeal to the Ninth Circuit, 66 USCA Case Number *22-15862* Transcript due by 8/8/2022. (Hanagami, William) (Filed on 7/7/2022) (Entered: 07/07/2022)

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