UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

United States *ex rel.* Clarissa Zafirov,

Plaintiff/Relator,

v. CASE NO. 8:19-cv-01236-SDM-SPF

Florida Medical Associates, LLC d/b/a VIPcare; Physician Partners, LLC; Physician Partners Specialty Services, LLC; Sun Labs USA, INC.; Anion Technologies, LLC; Anthem, Inc.; Freedom Health, Inc.; Optimum Healthcare, Inc.; and Siddhartha Pagidipati,

Defendants.
_____/

PROVIDER DEFENDANTS' REPLY IN SUPPORT OF MOTION TO DISMISS

Defendants Florida Medical Associates, LLC, Physician Partners, LLC, Physician Partners Specialty Services, LLC, Sun Labs USA, Inc., and Anion Technologies, LLC (the "Provider Defendants") file this reply in support of their motion to dismiss Zafirov's complaint. The False Claims Act's statutory bars require dismissal of all Zafirov's claims—permanently.

ARGUMENT

I. The public disclosure bar forecloses Zafirov's efforts to relitigate *Sewell*.

For Zafirov's claims to survive the False Claims Act's public disclosure bar, she needs to show that (1) her claims were not already publicly disclosed, (2) her allegations are not "substantially similar" to prior public disclosures, and (3) she is an "original source" of the publicly

disclosed information. *See* Doc. 50 at 17–18.[1] She fails in all three respects. Because Zafirov, not the Provider Defendants, "bears the burden of proving that the public disclosure bar does not preclude h[er] FCA action," her claims should be dismissed with prejudice. *See U.S. ex rel Brown v. BankUnited Trust 2005-1*, 235 F. Supp. 3d 1343, 1354 (S.D. Fla. 2017) (quoting *U.S. ex rel. May v. Purdue Pharma. L.P.*, 811 F.3d 636, 640 (4th Cir. 2016)).

First, Zafirov's efforts to run from the prior public disclosures are unavailing. Zafirov's argument boils down to a single idea, namely, that because she alleges continued fraud, involving additional defendants, the public disclosure bar is inapplicable. *See* Doc. 56 at 22–23; Doc. 57 at 18. This argument is flawed in that it conflates the "public disclosure" prong with the "substantial similarity" prong. Under the first prong's "generally broad scope," the Provider Defendants' cited public disclosures readily satisfy this prong. *Schlinder Elevator Corp. v. U.S. ex rel. Kirk*, 563 U.S. 401, 404 (2011).

What is more, it is enough that the prior public disclosures generally overlap with what she alleges here. *See also U.S. ex rel. Boothe v. Sun Healthcare Grp., Inc.*, 496 F.3d 1169, 1174 (10th Cir. 2007) ("[n]ot a single circuit has held that a *complete* identity of allegations, even as to time, place and manner, is required to implicate the public disclosure bar.") (emphasis in original). The allegations featured in *Sewell* and its press coverage overlap significantly with those made by Zafirov. *See* Doc. 50 at 18–20 (describing *Sewell*'s same allegations concerning, and the press's focus on, "doctors" and "physicians"); *see also Sewell* Second Am. Compl. ¶¶ 109–113 (alleging "that the diagnosis codes submitted by certain *providers* are incorrect or even fraudulent.") (emphasis added).

[1] Docket 50 is the refiled version of Docket 44—the Provider Defendants' motion to dismiss—and citations across those documents are therefore the same.

Sewell also resulted in a Corporate Integrity Agreement ("CIA") requiring Freedom to submit its data to a third-party auditor "to determine whether Freedom properly submitted risk adjustment eligible diagnoses to CMS in accordance with CMS's rules and criteria under the Medicare Advantage Program."[2] Doc. 50, Ex. A, at App'x C. The *Sewell* CIA is publicly available on the government's website and is linked in a DOJ press release about the case.[3] The Sixth Circuit recently held that a publicly available CIA requiring a Medicare provider to submit its coding, billing, and claims submissions to a third-party auditor was a public disclosure under § 3730(e)(4)(A)(1). *See U.S. ex rel. Maur v. Hage-Korban*, --- F.3d ----, No. 20-5301, 2020 WL 7038408, at *3 (6th Cir. Dec. 1, 2020). The Sixth Circuit's decision is squarely on point. The Court should follow its analysis here.

Second, Zafirov's allegations are "substantially similar" to those earlier public disclosures. Here, Zafirov suggests that because she has sued more defendants than the *Sewell* relator, and spread her allegations over a different—but largely overlapping—time period, there is no substantial similarity. *See* Doc. 56 at 22-23; Doc. 57 at 18. This misapplies the law and misstates the facts.

As to the law, the Eleventh Circuit has held that later cases based in "*any part*" on prior public disclosures are substantially similar. *See* Doc. 50 at 20-21 (quoting *Battle v. Bd. of Regents*

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[2] Separately, Zafirov argues that industry and government CMS reports detailing this fraud do not qualify as public disclosures. *See* Doc. 56 at 22. That is incorrect: regardless of the identities of doctors who wrote down the allegedly incorrect codes, the underlying conduct has also been publicly disclosed in a government report.

[3] *See* DOJ, *Medicare Advantage Organization and Former Chief Operating Officer to Pay $32.5 Million to Settle False Claims Act Allegations* (May 30, 2017), https://www.justice.gov/opa/pr/medicare-advantage-organization-and-former-chief-operating-officer-pay-325-million-settle; HHS OIG, *Corporate Integrity Agreement Between the Office of Inspector General of the Department of Health and Human Services and Freedom Health Inc. and Optimum Healthcare, Inc.*, https://oig.hhs.gov/fraud/cia/agreements/Freedom_Health_Inc_and_Optimum_Healthcare_Inc_05112017.pdf (last visited Dec. 8, 2020).

for Ga., 468 F.3d 755, 762 (11th Cir. 2006) (emphasis in original). By openly admitting to "recycling" from *Sewell*, Zafirov essentially concedes substantial similarity. *See* Doc. 57 at 19. Moreover, she does much more than merely "recycle some applicable language" from *Sewell*: she lifts her whole theory of the case from *Sewell*. A side-by-side comparison of the two complaints is telling:

Sewell Second Amended Complaint	**Zafirov's Current Complaint**
Defendants "submit as many diagnosis codes as possible . . . look[ing] for any hint of medical conditions that correspond to HCC codes that substantially increase CMS payments, and then claim that the patient was treated for that condition – regardless of whether the patient actually has the condition or was treated for it in the year in question, by a qualified provider [] in a face-to-face visit." (¶ 121)	Defendants "submit as many [] diagnosis codes as possible . . . look[ing] for any hint of medical conditions that correspond to HCC codes that substantially increase CMS payments, and then claim that the patient was treated for that condition – regardless of whether the patient actually has the condition or was treated for it in the year in question by a qualified provider in a face-to-face visit." (¶ 49.b)
"Relator identified flagrant coding violations . . . f[inding] that Freedom had coded every condition it could find, consistently assigning the highest possible value code to each condition, regardless of whether those codes violated CMS rules." (¶ 124)	"Relator identified flagrant coding violations . . . f[inding] that physicians routinely coded, and Freedom accepted, every condition the doctor could conceivably find and then assigned the highest possible code to those conditions, regardless of whether . . . the coding violated CMS rules." (¶ 50)

See Doc. 50 at 20–21 (additional side-by-side comparisons of the *Sewell* and Zafirov complaints); *see also Hage-Korban*, 2020 WL 7038408, at *4 (affirming substantial similarity where the relator "copie[d] much of the [earlier] complaint verbatim"). That easily activates this prong's "quick trigger." *U.S. ex rel. Osheroff v. Humana, Inc.*, 776 F.3d 805, 814 (11th Cir. 2015).

Layering new patient examples and additional defendants onto the *Sewell* allegations cannot save this complaint. Adding "new [d]efendants, and describ[ing] different specific patient examples," the crux of what Zafirov pretends to "add" to *Sewell*, does not dilute substantial

similarity. *See Hage-Korban*, 2020 WL 7038408, at *2 (affirming a district court's application of the public disclosure bar on those grounds).

Zafirov's effort to recast her claims as something new because they relate in part to actions taken after the *Sewell* settlement is likewise unavailing. *See* Doc. 57 at 19–20. Federal courts "consistently f[ind] that a continuing fraud in a new time period is not a new fraud, but is, instead, substantially similar to prior public disclosures." *U.S. v. Medco Health Solutions, Inc.*, No. 11-684-RGA, 2017 WL 63006, at *8 (D. Del. Jan. 5, 2017); *see also U.S. ex rel. Galmines v. Novartis Pharmaceuticals Corp.*, 88 F. Supp. 3d 447, 450 (E.D. Pa. 2015) ("new allegations" against similar defendants "are substantially similar, [because] they allege the same underlying scheme, but as applied to a new time period."). Zafirov alleges the same conduct (inflated capitation payments), by the same individuals (insurers, physicians, and their bosses), under the same legal theories (indistinguishable FCA claims). Because Relator at best "allege[s] the same fraud continued in a new time period, h[er] complaint is substantially similar to . . . public disclosures." *Medco Health*, 2017 WL 63006, at *8

Third, Zafirov is not an original source, much less a "consummate" one. For the first time, and in a single sentence, she suggests that she "voluntarily provided her information to the Government before filing this case." *See* Doc. 57 at 20. Even assuming that is true, it is not enough. As an initial matter, Zafirov's bald conclusion—absent from her complaint—fails to provide any "specific facts" establishing her "original source status knowledge": the who, what, where, and when of what she learned and how she informed the government. *BankUnited Trust*, 235 F. Supp. 3d at 1358. This independently dooms her original source status.

In any event, Zafirov further fails to prove, as she must to establish herself as an original source, that she satisfies one of two prerequisites: that she either (a) voluntarily disclosed

everything in her complaint to the government before the *original* public disclosure (e.g., *Sewell*) or (b) had "independent" knowledge which "materially added" to the public disclosures *and* that she has voluntarily provided ***all*** such information to the government before filing this action. 31 U.S.C. § 3730(e)(4)(B). As to the first prerequisite, it is irrelevant that she may have "provided her information to the Government before filing this case," because that is not the inquiry. Doc. 57 at 20. Instead, the first prerequisite asks whether the relator disclosed her information "*prior to [the] public disclosure*." 31 U.S.C. § 3730(e)(4)(B) (emphasis added). Here, the *Sewell* case was settled over a year before Zafirov began working at Physician Partners. She obviously did not disclose her allegations to the government before the *Sewell* case was filed.

As for the second prerequisite, "independent" knowledge means "direct knowledge"; information "derived from secondhand sources" does not count. *See U.S. ex rel. Saldivar v. Fresenius Med. Care Holdings, Inc.*, 841 F.3d 927, 936-37 (11th Cir. 2016). Zafirov's copied-and-pasted complaint betrays any claim that her knowledge is legitimately independent of what *Sewell* revealed. Throughout her complaint, Zafirov levels her weightiest allegations "on information and belief," which is "categorically insufficient for original source status." *Medco Health*, 2017 WL 63006, at *9; *see, e.g.,* Compl. ¶¶ 11-14, 66, 72, 73, 76, 80 (offering dozens of allegations on "information and belief").

Moreover, when Zafirov is not relying upon "information and belief," she bases her claims on secondhand—rather than "independent"—knowledge. She repeatedly refers to other physicians' care notes, hearsay passed on from other physicians and staff, and her guesses about what Defendants did (or did not) do billing- and submission-wise. *See, e.g.,*¶ 50 (relying on hearsay); ¶ 73 (alleging submissions "on information and belief"). This sort of "second-hand knowledge derived from evidence . . . in [a] prior case and conversations with doctors, other

providers, and [defendants'] officials" does not qualify as "independent" original source information. *See Wilheim v. Molina Healthcare of Fla.*, 674 F. App'x 960, 961 (11th Cir. 2017) (per curiam). In short, Zafirov's "background information" and "secondhand information . . . fails . . . the original source requirement." *See Fresenius Med. Care*, 841 F.3d at 937.

Moreover, any "independent" knowledge underlying Zafirov's allegations does not "materially add to" the prior public disclosures. "Materiality" means "information of 'such a nature that knowledge' of it 'would affect' the 'government's decision-making.'" *Hage-Korban*, 2020 WL 7038408, at *8. (quoting *U.S. ex rel. Advocates for Basic Legal Equality, Inc. v. U.S Bank*, 816 F.3d 428, 432 (6th Cir. 2016) [hereinafter *ABLE*]). New complaints which "merely add[] details to what is already known in outline" do not "materially add" anything. *See ABLE*, 816 F.3d at 432 (internal quotation marks and citations omitted). As discussed throughout, everything in Zafirov's complaint merely adds detail to what previously has been alleged and would not have—and has not—affected the government's decision-making.

Simply put, the public disclosure bar permanently blocks Zafirov's case. Because no amount of amendment can undo *Sewell*'s public disclosures, the Complaint should be dismissed with prejudice. *See Osheroff*, 776 F.3d at 816 (affirming dismissal with prejudice under the public disclosure bar); *see also U.S. ex rel. Barber v. Paychex, Inc.*, No. No. 09-20990-CIV, 2010 WL 2836333, at *1 (S.D. Fla. July 15, 2010) (dismissing a relator's first complaint with prejudice under the public disclosure bar).

II. Zafirov's copycat case is also barred by the first-to-file rule.

Zafirov's claims are also barred by the FCA's first-to-file rule. Zafirov and the Provider Defendants apparently agree on two things: the first-to-file analysis is "simple" and Zafirov generally alleges the same fraud as the *Fernandez* relator. *See* Doc. 56 at 18–20 (conceding that

"both complaints allege schemes to increase risk scores in order to secure higher payments from Medicare"); Doc. 50 at 16-17. Yet, Zafirov urges the Court to ignore the first-to-file rule because, in her view, she alleges more than the *Fernandez* relator.[4] *See* Doc. 56 at 19. Not only is that the wrong inquiry, it also isn't true.

As Zafirov admits, the first-to-file rule asks only whether the later complaint "alleges a fraudulent scheme the government already would be equipped to investigate based on the first complaint." *U.S. ex rel. Bernier v. Infilaw Corp.*, 347 F. Supp. 3d 1075, 1083 (M.D. Fla. 2018) (internal quotation marks and citations omitted). Thus, "even if the [later] allegations incorporate additional or somewhat different facts or information," the bar blocks the later-filed case, so long as the fraud alleged is generally the same. *Id; see also U.S. ex rel. Cho v. HIG Capital,* No. 2020 WL 5076712, at *11 (M.D. Fla. Aug. 26, 2020) ("[t]he fact that the later action names different or additional defendants is not dispositive as long as the two complaints identify the same general fraudulent scheme").

As a comparison of the *Fernandez* and Zafirov complaints reveals, that is precisely the case here. Indeed, Zafirov alleges the same fraud (upcoding to secure higher capitated payments), based on the same conduct (billing for medically unnecessary care and pressuring physicians to upcode), by the many of the same defendants (including, for example, Physician Partners), in an effort to recover for the *same three claims*.[5] *See U.S. ex rel. Fernandez v. Physician Partners, et al.*, No.

[4] *Fernandez* is moving forward: the relator secured new counsel and the Clerk recently issued summons to the Provider Defendants.

[5] For these reasons, *Fernandez* readily equipped the Government to investigate Zafirov's allegations too. *Fernandez* alleges more than "unnecessary diagnostic scans": it alleges physician pressuring, corporate (i.e., non-physician) upcoding, false submissions, and more. *See* Doc. 56 at 20; Ex. A ¶¶ 21–28. In short, *Fernandez* gave the government more than "enough information to discover the fraud alleged in the second-filed complaint." *HIG Capital*, 2020 WL 5076712, at *11 (internal quotation marks and citation omitted)).

8:18-cv-1959-T-35-JSS (M.D. Fla.), Compl. ¶¶ 17, 20–24, 34–44 (a true and correct copy of the *Fernandez* complaint is attached as **Exhibit A)**. Zafirov and Fernandez even poach from the same public disclosure: *Sewell*. *See id.* ¶ 6. So, although Zafirov's "complaint contains slightly different details," both complaints allege the same general scheme, triggering the first-to-file bar. *See HIG Capital*, 2020 WL 5076712, at *9; *see also Cooper v. Blue Cross & Blue Shield of Fla.*, 19 F.3d 562, 567 (11th Cir. 1994) ("once one suit has been filed . . . all other suits … based on the same kind of conduct [are] barred.")

III. Because the government already settled the claims Zafirov repackages here, the government action bar also blocks this case.

The government action bar, too, forecloses Zafirov's complaint. Her only arguments otherwise—that she is allowed to steal from *Sewell* and, disingenuously, that she is *not* stealing from *Sewell*—fail. *See* Doc. 56 at 23-24. Because her allegations parrot *Sewell*, because *Sewell* was indisputably a civil suit, and because the government was a party to *Sewell*, her complaint triggers the government action bar. *See* Doc. 50 at 22 (quoting 31 U.S.C. § 3730(e)(3)).

Zafirov takes more than "three similar sentences" from *Sewell*: she pilfers entire paragraph's worth of allegations, verbatim, *and* her whole theory of fraud. *See* supra at 3–5 (assessing substantial similarity); *see also Sturgeon v. Pharmerica Corp.*, 438 F. Supp. 3d 256, 262 (E.D. Pa. 2020) (observing that the "inquiry is essentially a test of factual similarity"). In fact, Zafirov pulls her whole theory of the case right out of *Sewell*: arguing that "[d]espite [Defendants'] previous lawsuit and settlement, the Defendants violated the FCA *again.*" Compl. ¶ 47 (emphasis in original). It is difficult to imagine a clearer case of a later, "parasite" case "receiving support, advantage, or the like" from an earlier, "host case": Zafirov outright admits the connection. *Sturgeon*, 438 F. Supp. 3d at 262.

The mere fact that some of the defendants here were not named defendants in *Sewell* does not change the analysis. *See* Doc. 56 at 23. Physician Partners had its contracts with Freedom and Optimum before they settled *Sewell* in May 2017. Moreover, the *Sewell* relator alleged that Physician Partners' predecessor-in-interest, FIPA, LLC, was incentivized to make inaccurate diagnoses and that it submitted false codes. *See Sewell* Second Am. Compl. ¶¶ 160-167. Therefore, even before it settled *Sewell*, the government was well equipped to proceed against Physician Partners, as well as against the other Provider Defendants whom Zafirov alleges Pagidipati owned and controlled. It chose not to do so. Similarly, the government has chosen not to intervene in the instant case. By definition, then, there is "no useful return to the government" from this follow-on case. *See U.S. ex rel. Batty v. Amerigroup Ill., Inc.*, 528 F. Supp. 2d 861, 876 (N.D. Ill. 2007) (noting there is "no useful return to the government . . . where [the] government decline[s] to intervene in [a] second *qui tam* action") (quotation omitted).

At bottom, the government knew before, during, and after *Sewell* that the Provider Defendants allegedly played a role in that case. Yet the government declined to go after them—twice. Because the government action bar applies "to the [initial] suit as a whole," not merely "a particular claim or number of claims," Zafirov's entire case should be dismissed. *U.S. ex rel. Bennett v. Biotronik, Inc,* 876 F.3d 1011, 1021 (9th Cir. 2017); *see also Amerigroup*, 528 F. Supp. 2d at 873 ("once the government knows the essential facts of a fraudulent scheme, it has enough information to discover related frauds").

CONCLUSION

For all of the foregoing reasons, as well as the co-defendants' arguments, the Provider Defendants request that the Complaint be dismissed with prejudice.

Dated: December 16, 2020

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on December 16, 2020, I filed the foregoing with the Court's electronic filing system, which will cause a copy to be served upon all counsel of record.

A. Lee Bentley III
Attorney for the Provider Defendants

Exhibit A

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA ex rel. KEITH FERNANDEZ Plaintiffs, v. FREEDOM HEALTH, INC., OPTIMUM HEALTHCARE, INC., and PHYSICIAN PARTNERS, LLC., Defendants.	)

FILED UNDER SEAL
JURY TRIAL DEMANDED

8:18-CV-01959-T-35-JSS

COMPLAINT

1. This is an action to recover damages and civil penalties on behalf of the United States of America under the False Claims Act ("FCA"), 31 U.S.C. §§ 3729 et seq.

2. This action arises from false statements, false records, and false claims submitted to the United States by Defendants to get these false claims paid.

3. Relator Keith Fernandez ("Relator") alleges that Defendants have violated the FCA by systematically submitting false risk adjustment data to Medicare in order to receive enhanced payment from the government.

I. Parties

4. **Relator Keith Fernandez** is a resident of the State of New York. In 2015 he was the CEO of National Diagnostic Systems ("NDS" or "Diagnostic Systems"), a radiology physician service business. NDS is now dissolved. Relator is currently an MBA candidate at The Wharton School at the University of Pennsylvania.

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$400.00

5. **Defendants Freedom Health, Inc., and Optimum Healthcare, Inc.**, both Medicare Advantage insurance programs, are Florida corporations with a principal places of business in Tampa, Florida.

6. Freedom and Optimum previously settled a case alleging similar violations and entered into a Corporate Integrity Agreement with the United States Department of Health and Human Services. *United States ex rel. Sewell v Freedom Health, Inc. Optimum Healthcare, Inc., et al.*, 8:09-cv-1625-T-35TGW (M.D. Fla).[1]

7. **Defendant Physician Partners LLC** ("Physician Partners"), located in Tampa, Florida, is a Management Service Organization serving approximately 22,000 Medicare Advantage patients.

8. Physician Partners, Freedom Health ("Freedom"), and Optimum Healthcare ("Optimum") are affiliated companies and have overlapping ownership.

II. Jurisdiction and Venue

9. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. §1331 and 31 U.S.C. § 3732, which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730.

10. Venue is proper in this district pursuant to 31 U.S.C. § 3732(a), and 28 U.S.C. §1391(b) and (c), in that all defendants can be found in, reside in, and transact business in the Middle District of Florida.

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1 https://www.justice.gov/opa/pr/medicare-advantage-organization-and-former-chief-operating-officer-pay-325-million-settle.

11. Relator is an original source of the allegation contained herein, and has voluntarily disclosed such to the United States Attorney's Office for the Middle District of Florida before filing his complaint.

III. The Law

12. **The False Claims Act** provides in pertinent part that any person who: (A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval; (B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; (C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G), is liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000, plus 3 times the amount of damages which the Government sustains because of the act of that person. 31 U.S.C. § 3729(a)(l) *et seq*.

13. **The Medicare program** was enacted under Title XVIII of the Social Security Act in 1965, to pay for certain healthcare services based primarily on age. The Department of Health and Human Services ("HHS") administers the Medicare Program, as promulgated by 42 U.S.C.§§ 1395 *et seq*. The Center for Medicare and Medicaid Services ("CMS") is the agency of HHS directly responsible for the administration of the Medicare Program. The Medicare program provides for the payment of claims submitted to it by healthcare providers for services rendered to its beneficiaries.

14. **Medicare Advantage programs** are an alternative to the traditional fee-for-service program. In the Medicare Advantage program private insurers agree to pay all the medical claims for a pool of beneficiaries in exchange for a monthly capitation payment

per enrollee. This capitation payment is adjustable based upon the severity of illness of the patient, known as the risk score.

15. Certain diagnosed illnesses are entitled to enhanced reimbursement, which must be based upon face-to-face encounters with providers. In seeking enhanced capitation payments, insurers must provide accurate and sufficient evidence, known as risk adjustment data.

16. Because submitting incorrect diagnosis codes increases risk adjustment payments, CMS requires MA plans to follow strict guidelines when submitting codes. See, e.g., *2008 Risk Adjustment Training for Medicare Advantage Organizations Participant Guide*. First, CMS requires that the patient must have been treated for the relevant diagnoses during a face-to-face encounter with a physician or a hospital during the year in question. The treating provider must document the facts supporting the diagnosis code in the medical records and sign and date the record. CMS expressly prohibits MA plans from submitting "risk adjustment diagnoses based upon any diagnostic radiology service" *Participant Guide* at 4-3.

IV. Defendants' Misconduct

17. Defendants have defrauded CMS by knowingly submitting incorrect and/or unsubstantiated risk adjustment data to CMS. Under the MA payment system, CMS adjusts the monthly capitation rate it pays MA plans for each member to account for the member's health risk. CMS pays MA plans more if the plans' members have certain diseases or illnesses that routinely require more expensive care. CMS makes these enhanced payments

in reliance on data-known as "Risk Adjustment" data-submitted by the plans about the health status of their members.

18. In September 2015, National Diagnostic Systems ("NDS") contracted with Physician Partners, a Management Service Organization serving 22,000 Medicare Advantage patients, to provide ultrasound screening exams to its Medicare Advantage patients within Physician Partners's network of primary care physicians ("PCPs") in Florida.

19. Physician Partners first solicited NDS on May 5, 2015 by email. After preliminary talks, Physician Partners hired NDS to perform ultrasound screening exams of the lower arteries of the legs and echocardiograms for Physician Partners' patients. Physician Partners agreed to pay NDS a flat fee of $70 for each screening exam furnished. Physician Partners executives told Relator, who was then CEO of NDS, that these tests were limited screening exams only, and that the program did not directly generate revenue for their companies. Over the course of the next 2 months, NDS and its physicians performed 1,748 screening exams for Physician Partners' patients.

20. Relator soon observed that Physician Partners was routinely *forging* primary care physician prescriptions for leg and cardiac scans. The scripts for these tests were not generated by the patient's physician. Instead, Physician Partners was using its own stationery envelopes, mass mailed instructions (purporting to be from the patients' primary care doctors) to Physician Partners patients imploring them to call a toll-free phone number and schedule leg ultrasounds and echocardiograms. Of note is the harsh and deceptive language used in the letters:

IMPORTANT LETTER / ORDER FROM YOUR DOCTOR / OPEN IMMEDIATELY
NO CHARGE TO YOU!
VERY IMPORTANT / ABOUT YOUR GOOD HEALTH / AN OUNCE OF PREVENTION IS WORTH A POUND OF CURE
IN REVIEWING YOUR MEDICAL HISTORY, I HAVE IDENTIFIED THE DIAGNOSTIC TESTS TO BE PERFORMED

21. The phone number reached a Physician Partners call center, not a doctor's office, where operators were instructed via a written script to tell patients that they could not refuse the tests, and that their health was at risk even though this was not the case. The doctors' electronic signatures' were copied and pasted on the prescriptions.

22. There was no medical necessity for any of these tests. These tests were actually "ordered" by defendants, not by the primary care physicians. There was no face-to-face examination by the physicians. In addition, echocardiograms are never in ordered by primary care physicians and even cardiologists will only order such based upon a precipitating examination and medical necessity. Defendants "ordered" these tests only to increase the risk score for their Medicare Advantage members in order to received enhanced payments from Medicare.

23. Some Physician Partners primary care physicians became so suspicious of the testing program, with an insurance company ordering indiscriminate testing on their patients, that they instructed Physician Partners to cancel all of the screening tests. An example is Dr. Roque who protested, resulting in Physician Partners canceling all screening test patient appointments for him.

24. Relator also observed that Physician Partners demanded that NDS and its physicians use suggested diagnosis (ICD) codes that defendants referred to in phone calls to NDS as "weighted codes." NDS was given a list of such diagnosis codes relating to many serious diagnoses, which NDS radiologists were constantly badgered into using in their reports. The sole purpose of such a scheme was to increase risk score and reimbursement for defendants.

25. CMS regulations expressly prohibit Medicare Advantage plans from "submitting risk adjustment diagnoses based upon any diagnostic radiology services." See *2008 Risk Adjustment Training for Medicare Advantage Organizations Participant Guide*, at 4-3. This is because radiology alone, only suggests a possible diagnosis, which must be viewed in conjunction with a face-to-face examination, and review of the patient's medical record. Yet this is precisely what defendants did, submitting diagnoses based solely upon radiological screening tests.

26. Physician Partners executives went so far as asking NDS physicians to go back and amend final test reports to include certain ICD codes. Physician Partners even asked NDS to find and pay other doctors who would play ball. Despite this, NDS refused these requests and often got into heated arguments with Physician Partners management over their attempt to pressure them. After the first week of the testing program, Physician Partners COO Kollefrath refused to accept NDS test reports until certain "data needs" were fulfilled, a euphemism for false coding.

27. On November 2, 2015, Physician Partners's chief of staff sent an email to Relator requesting NDS doctors' NPI numbers, facility license numbers and state license

numbers) apparently to facilitate billing to the Medicare Part C program through their affiliated HMO Entities, Freedom and Optimum.

28. During a weekly conference call on November 4, 2015 between PP Executives and NDS, Kollefrath admitted to Relator that Physician Partners planned on having its affiliate HMO's Freedom and Optimum submit NDS encounter data to the Medicare Part C Program for reimbursement. Relator earlier had been told by Physician Partners that its diagnostic exams would not be reported to Medicare for reimbursement purposes. That same day Physician Partners sent an email to NDS and Physician Partners staff summarizing the key items from this conference call. This email suggests that Physician Partners and affiliate Freedom/Optimum intended to submit encounter data directly to the Medicare Part C program.

29. Relator also found it highly suspicious that Physician Partners began making payments to NDS from Physician Partners CEO Sidd Pagidipati's personal American Express credit card. Physician Partners would often brag to Relator that Sidd was very wealthy and had a million dollar limit on his card and they insisted on making payments this way.

30. On November 6 and 19, 2015 Relator sent emails to Physician Partners executives alerting them that they did not approve of the submission of NDS encounter data by Freedom/Optimum to Medicare due to concerns regarding compliance with Federal Laws.

31. In response to this email, Physician Partners's Kollefrath immediately sent an email to NDS stating that they would not submit the encounter/claims data until both parties

agreed explicitly on how to do so, a tacit admission of intent to do just so. With Physician Partners refusing to drop its demands for false additional diagnosis codes, among other things mentioned, NDS severed its relationship with Physician Partners in Novermber, 2015.

32. NDS was not the only company that did screening tests for Physician Partners. In a telephone conversation between Relator and Kollefrath on May 5, 2015, Kollefrath told Relator that Physician Partners had another diagnostic testing company, HealthFair, administer ultrasounds on HealthFair's mobile buses to over 12,000 patients within Physician Partners's network, starting in June of 2014. Kollerfrath stated that this screening program on the mobile buses, referred to it as "STEP 1", was a great success. He then told Relator that Physician Partners had requested that HealthFair perform another round of the screening program directly within the offices of Physician Partners's Primary Care Physicians, due to "compliance reasons." He called this next "in-office" program with HealthFair, "STEP 2". Kollerfrath stated that HealthFair struggled with "STEP 2" and that Physician Partners and its CEO, Sidd Pagidipati, wanted to hire another vendor for "STEP 3", hence the contract with NDS.

DAMAGES

33. Defendants have received millions of dollars of improper risk adjustment payments from Medicare. Medicare pays an increased capitation payment each month for patients with certain diagnoses. Defendants have received risk adjustment payments for thousands of patients, by submitting false diagnoses to Medicare.

V. Counts

A. Presenting or Causing False or Fraudulent Claims, § 3729(a)(1)(A)

Relator repeats and realleges the preceding paragraphs as if fully set forth herein.

34. All Defendants, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly presented or caused to be presented, and may still be presenting or causing to be presented, to the United States of America false or fraudulent claims for payment or approval, in violation of 31 U.S.C. § 3729(a)(1)(A).

35. All defendants also made or caused claims which include materially misleading omissions in violation.

As a result of Defendants' actions, as set forth above, the United States of America has been, and may continue to be, severely damaged.

B. All Defendants' False Records or Statements, § 3729(a)(1)(B)

Relator repeats and realleges the preceding paragraphs as if fully set forth herein.

36. All Defendants, in reckless disregard or deliberate ignorance of the truth or falsity of the information involved, or with actual knowledge of the falsity of the information, knowingly made, used, or caused to be made or used, and may still be making, using or causing to be made or used, false records or statements material to false or fraudulent claims, in violation of 31 U.S.C. § 3729(a)(1)(B).

37. The false records or statements were material to Defendants' claims for Medicare payment because Medicare would not have paid the claims absent the records or statements.

38. The United States, unaware of the falsity of the claims and/or statements

made by Defendants, and in reliance on the accuracy of these claims and/or statements, paid and may continue to be paying or reimbursing claims for services to patients enrolled in Federal Programs where said services are unnecessary, unreasonable and/or not provided.

As a result of Defendants' actions, as set forth above, the United States of America has been, and may continue to be, severely damaged.

C. Defendants Freedom and Optimum Avoided an Obligation to Refund, 31 U.S.C. § 3729(a)(1)(G)

Relator repeats and realleges the preceding paragraphs as if fully set forth herein and further alleges.

39. Freedom and Optimum entered into a Corporate Integrity Agreement with the United States Department of Health and Human Services. *United States ex rel. Sewell v Freedom Health, Inc. Optimum Healthcare, Inc., et al.* docket 8:09-cv-1625-T-35TGW (M.D. Fla). [2]

40. The Corporate Integrity Agreement specifically required defendants Freedom and Optimum "to identify and adjust any past charges or claims for unallowable costs."

41. On information and belief, neither Freedom nor Optimum have identified nor adjusted the claims Relator asserts in his instant complaint, relating to the screening exams NDS or HealthFair did for defendants.

42. Defendants Freedom and Optimum made reverse false claims in violation of § 3729(a)(1)(G)) by falsely certifying compliance with its CIA's reporting requirements in

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2 https://oig.hhs.gov/fraud/cia/agreements/Freedom_Health_Inc_and_Optimum_Healthcare_Inc_05112017.pdf

order to avoid their obligation to pay stipulated penalties under the CIA. 31 U.S.C. § 3729(a)(1)(G).

43. The claims submitted by Defendant Optimum are also false because it was in material breach of the CIA's compliance and reporting obligations at the time it submitted those claims.

44. The Defendant Optimum knowingly made, used or caused to be made or used false records or false statements – i.e., the false certifications made or caused to be made by it – material to an obligation to pay or transmit money to the Government or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government.

The false statements or records misleadingly omit critical facts which constitute material misrepresentations.

VI. **Prayer for Relief**

WHEREFORE, *Qui Tam* Plaintiff Fernandez, for the United States, and for himself, prays as follows and request:

A. That the Court enter judgment against the Defendants in an amount equal to three times the amount of damages the United States Government has sustained because of Defendants' actions, plus a civil penalty of $11,000 for each action in violation of 31 U.S.C. § 3729, and the costs of this action, with interest, including the costs to the United States Government for its expenses related to this action;

B. That in the event the United States Government intervenes, Mr. Fernandez be awarded 25% of the proceeds of the action or the settlement of any such claim;

C. That in the event the United States Government does not intervene, Mr. Fernandez be awarded 30% of the proceeds of this action or the settlement of any such claim;

D. That under the Florida False Claims Act, the Court enter judgment against the Defendants for the maximum amount of damages and civil penalties available under the Florida False Claims Act; and award the maximum share permitted by law of all amounts recognized by that Act as a consequence of this action;

E. That Mr. Fernandez be awarded all costs, attorneys' fees, and litigation expenses; and

F. That the United States Government and Mr. Fernandez receive any and all other relief, both at law and in equity, to which they may reasonably appear entitled.

JURY DEMAND: Plaintiff request trial by jury.

Respectfully submitted 8/8/18

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