

1 J. Bernard Alexander III (State Bar No. 128307)  
2 ALEXANDER MORRISON + FEHR LLP  
3 1900 Avenue of the Stars, Suite 900  
4 Los Angeles, California 90067  
5 (310) 394-0888  
6 (310) 394-0811 (facsimile)  
7 balexander@amflp.com  
8 *Counsel for Plaintiff-Relator Bicocca*

9 R. Scott Oswald (admitted *pro hac vice*)  
10 soswald@employmentlawgroup.com  
11 Janel Quinn (admitted *pro hac vice*)  
12 jqinn@employmentlawgroup.com  
13 The Employment Law Group, P.C.  
14 1717 K Street NW, Suite 1110  
15 Washington, D.C. 20006  
16 (202) 261-2813  
17 (202) 261-2835 (facsimile)  
18 *Counsel for Plaintiff-Relator Bicocca*

19 **IN THE UNITED STATES DISTRICT COURT**  
20 **FOR THE NORTHERN DISTRICT OF CALIFORNIA**  
21 **San Francisco Division**

22 UNITED STATES OF AMERICA and  
23 STATE OF CALIFORNIA, *ex rel.*  
24 MICHAEL BICOCCA,

25 *Plaintiffs,*

26 v.

27 KAISER PERMANENTE, *et al.*,

28 *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, 17<sup>th</sup> Floor

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**TABLE OF CONTENTS**

	<b>Page</b>
I. INTRODUCTION.....	1
II. BACKGROUND.....	2
III. ARGUMENT .....	5
A. Bicocca’s Amended Complaint is the Operative Complaint in this Matter. ....	5
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. ....	6
C. Bicocca Alleges a Distinct, Separate Theory of Fraud from the Material Elements of the Other Relators that Filed Before Bicocca. ....	9
IV. CONCLUSION .....	11

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
27  
28

**TABLE OF AUTHORITIES**

**Page**

**CASES**

*Loux v. Rhay*,  
375 F.2d 55 (9th Cir. 1967)..... 5

*Morongo Band of Mission Indians v. California State Bd. of Equalization*,  
858 F.2d 1376 (1988)..... 6

*Rhodes v. Robinson*,  
621 F.3d 1002 (9th Cir. 2010)..... 5

*United States. ex rel. Kurnik v. PharMerica Corp.*,  
2015 WL 1524402 (D.S.C. Apr. 2, 2015)..... 5

*United States ex rel. Lujan v. Hughes Aircraft Co.*,  
243 F.3d 1181 (9th Cir. 2001)..... 6, 7, 8

*United States ex rel. Palmieri v. Alpharma, Inc.*,  
928 F. Supp. 2d 840 (D. Md 2013)..... 5

*United States ex rel. Savage v. CH2M Hill Plateau Remediation Co.*,  
2015 WL 5794357 (E.D. Wash. Oct. 1, 2015)..... 7

*United States ex rel. Branch Consultants v. Allstate Ins. Co.*,  
560 F.3d 371 (5th Cir. 2009)..... 8

*United States ex rel. Carter v. Halliburton Co.*,  
144 F. Supp. 3d 869 (E.D. Va. 2015) ..... 5

*United States ex rel. Chin v. CVS Pharmacy, Inc.*,  
2017 WL 4174416 (C.D. Cal. Aug. 15, 2017)..... 6

*United States ex rel. Hartpence v. Kinetic Concepts, Inc.*,  
792 F.3d 1121 (9th Cir. 2015) ..... 6, 7, 8, 9

*United States ex rel. Heath v. AT&T, Inc.*,  
791 F.3d 112 (D.C. Cir. 2015)..... 7, 8

*United States ex rel. Marion v. Heald Coll., LLC*,  
2015 WL 4512843 (N.D. Cal. July 24, 2015)..... 8

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**STATUTES**

31 U.S.C. § 3729..... 1  
31 U.S.C. § 3730(b)(5)..... 2  
42 U.S.C. § 1395w-23(a)(1)(C)(i), (a)(3) ..... 3

**REGULATIONS**

42 C.F.R. § 422.308(c)(2) ..... 3

**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<sup>1</sup>. 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

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<sup>1</sup> 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.

1 first-to-file bar provision of the False Claims Act, 31 U.S.C. § 3730(b)(5). *Osinek*  
2 Dkt. No. 141.

3 As part of Defendants’ first-to-file analysis, Kaiser compares the later-filed  
4 relators’ original Complaints to Osinek’s original Complaint. Bicocca does not  
5 dispute that the claims alleged in his original Complaint are barred by Osinek’s  
6 original Complaint based on the first-to-file rule. However, Bicocca’s Amended  
7 Complaint supersedes the original Complaint and includes an additional, specific  
8 theory of False Claims Act liability that Osinek did not allege, and that the  
9 government did not intervene on, and is therefore not barred by the first-to file bar.  
10 As such, Bicocca respectfully requests the Court deny, in part, Kaiser’s Motion to  
11 Dismiss.

## 12 II. BACKGROUND

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

21 Nowhere in her Complaint does Osinek describe the latter source of diagnoses.  
22 Instead, she focuses on the former – describing addenda to capture “missed  
23 opportunities” that were “not addressed at the time of a [patient] encounter.” *Osinek*  
24 Dkt. 1 ¶¶ 24, 28. Osinek alleges that Kaiser directed physicians to add addenda to  
25 patient records “often many months after visits.” *Id.* at ¶ 28. Osinek provides  
26 examples of Kaiser instructing physicians to include addenda diagnoses two months,  
27 four months, seven months, and one year after the corresponding patient visits. *Id.* at  
28 ¶¶ 29–31.

1 As outlined in Kaiser’s Motion to Dismiss, all relators and the United States  
2 have alleged that Kaiser engaged in fraud against the Medicare Advantage program.  
3 Through the Medicare Advantage program, CMS authorizes certain private health  
4 insurance plans, like Kaiser, to provide Medicare benefits in exchange for a  
5 “capitated” monthly payment to the private health insurance plan. CMS determines  
6 the capitated rate through an annual bidding process and then CMS applies a risk-  
7 adjustment payment model, which adjusts the payment rate based on various factors  
8 including age, gender, and – notably – medical diagnoses. 42 U.S.C. § 1395w-  
9 23(a)(1)(C)(i), (a)(3); 42 C.F.R. § 422.308(c)(2). Medicare Advantage Organizations  
10 must ensure that diagnosis codes submitted for risk-adjustment payments are accurate,  
11 complete, and truthful. *Osinek* Dkt. No. 110 ¶ 79. The diagnosis codes submitted for  
12 risk-adjustment payments are valid only if they are documented in the medical record  
13 as a result of a face-to-face visit between a patient and physician, and in conformance  
14 with the International Classification of Diseases (“ICD”) Guidelines, which only  
15 permit the coding of documented conditions that both exist at the visit and that  
16 “require or affect patient care treatment or management.” *Id.* at ¶¶ 80-81 (internal  
17 citations omitted).

18 Bicocca’s allegation regarding Kaiser’s scheme to use an upfront list of past  
19 diagnoses for physicians to re-diagnose during a patient’s visit is a separate, distinct  
20 theory of False Claims Act liability that Bicocca illustrates in great detail in his First  
21 Amended Complaint. Bicocca describes these “hard copy” lists that are provided to  
22 physicians for their daily Medicare patients that include “the patient’s chronic  
23 conditions that [Kaiser] wanted the doctor to check off in the EMR.” *Bicocca* Dkt.  
24 No. 16 ¶ 94. Bicocca draws a distinction between these reports and the “addenda” for  
25 diagnoses “confirmed after the [patient visit].” *Id.* at ¶ 106. The upfront diagnoses list  
26 involves Kaiser requiring physicians “to go through the list of chronic conditions with  
27 every public benefits patient, check up on the status of those diagnoses, and confirm  
28 them, regardless of whether physicians have the time or qualifications to do so.” *Id.* at

1 ¶ 107. Bicocca even walks through an example of how a physician would be required  
2 to add a previously known diagnosis from the upfront list. *Id.* at ¶ 112.

3 Further, Bicocca also describes the underlying issues with Kaiser directing  
4 physicians to add previously known diagnoses from the upfront list. First, most  
5 physicians simply do not have the time necessary to properly diagnose and confirm all  
6 of the diagnoses from the list. *Id.* at ¶ 114. Bicocca explains that after his typical day's  
7 appointments, he is usually left with five minutes to "describe, discuss, and cover the  
8 nearly two dozen chronic conditions" on a patient's upfront list of diagnoses. *Id.* at ¶¶  
9 115–117. Second, a physician who is not a specialist in a certain area of medicine  
10 likely does not have the expertise or ability to manage and diagnose conditions  
11 involving that area of medicine. *Id.* at ¶¶ 112, 118. For example, Bicocca, an  
12 anesthesiologist who primarily focuses on pain management, does not have the  
13 expertise to properly review or manage a patient with heart failure or hypertension the  
14 way a cardiologist can. *Id.* at ¶ 120. Thus, the end result of Kaiser's upfront diagnoses  
15 list scheme is the creation of a false record in the patient's electronic medical records  
16 ("EMR") that these previous diagnoses were re-diagnosed, confirmed, and discussed  
17 with the patient during the visit.

18 Kaiser made it very clear to Bicocca that he was expected to re-diagnose the  
19 previous diagnoses from the upfront list. Bicocca recalls Kaiser's trainers in 2015  
20 telling physicians that "these diagnoses are vital to [the physicians'] paychecks." *Id.* at  
21 ¶ 144. The trainers told Bicocca that "each of the chronic conditions" from a patient's  
22 upfront diagnoses list had to be checked off "every year" in order for Kaiser to be  
23 reimbursed for its services for the patient. *Id.* In or around 2015, Kaiser's Assistant  
24 Physicians in Charge ("APIC") and Chief of Gastroenterology, Jason Guardino, gave  
25 Bicocca and other physicians a directive to the effect of, "you must check and discuss  
26 every chronic condition, and then you're done." *Id.* at ¶ 147. Furthermore, Dr. Steve  
27 Olson, Kaiser's Regional Physician Director of Clinical Documentation and Coding,  
28 instructed Bicocca to merely ask the patient if they still had the previous diagnosis,

1 and to use a patient’s “yes” response as a green light to include the diagnosis once  
2 more in the patient’s EMR – falsely certifying that the physician had properly  
3 diagnosed, discussed, and confirmed the diagnosis with the patient. *Id.* at ¶¶ 166–169.

### 4 **III. ARGUMENT**

#### 5 **A. Bicocca’s Amended Complaint is the Operative Complaint in this** 6 **Matter.**

7 As part of Defendants’ first-to-file analysis, Kaiser compares the later-filed  
8 relators’ original Complaints to Osinek’s original Complaint. However, Bicocca’s  
9 Amended Complaint supersedes the original Complaint, and therefore is the operative  
10 Complaint in this matter. *Rhodes v. Robinson*, 621 F.3d 1002, 1005 (9th Cir. 2010)  
11 (holding that an amended complaint supersedes the original complaint, and the  
12 original complaint is then treated as non-existent) (citing *Loux v. Rhay*, 375 F.2d 55,  
13 57 (9th Cir. 1967)).

14 Kaiser’s discussion regarding amended complaints is without merit. *Osinek* Dkt.  
15 141 at 17. First, *United States ex rel. Carter v. Halliburton Co* is an Eastern District of  
16 Virginia case and thus not binding on this Court, and *Carter* itself recognizes that “at least  
17 two [other] district courts [have concluded] that a relator may avoid the first-to-file bar by  
18 amending.” 144 F. Supp. 3d 869, 882 (E.D. Va. 2015); *see also U.S. ex rel. Kurnik v.*  
19 *PharMerica Corp.*, 2015 WL 1524402, at \*6 (D.S.C. Apr. 2, 2015) (holding that the  
20 “operative complaint” for the Court’s first-to-file analysis was plaintiff-relator’s amended,  
21 not original, complaint); *U.S. ex rel. Palmieri v. Alpharma, Inc.*, 928 F. Supp. 2d 840, 851  
22 (D. Md 2013) (“first-to-file rule does not bar [plaintiff-relator’s] Amended Complaint”  
23 because if the Court “were to dismiss the Amended Complaint, it would do so without  
24 prejudice, and the first-to-file rule would not preclude [plaintiff-relator] from filing an  
25 identical pleading under a new case number tomorrow.”).

26 Second, the Court in *Carter* only addressed plaintiff-relator’s amended complaint  
27 in the context of determining whether another action was pending such that the plaintiff’s  
28

1 claim would be barred by first-to-file and did not conduct any comparison regarding the  
2 similarity of the elements of fraud alleged, which is the very issue here.

3 Third, *U.S. ex rel. Lujan v. Hughes Aircraft Co.* does not concern any issue  
4 pertaining to an amended complaint whatsoever. 243 F.3d 1181 (9th Cir. 2001). The  
5 words “amended” and “original” in relation to a complaint appear nowhere in the opinion,  
6 making Kaiser’s citation to *Lujan* confusing and inappropriate.

7 Finally, Kaiser also cites *Morongo Band of Mission Indians v. California State Bd.*  
8 *of Equalization* – a non-FCA-related case discussing jurisdiction and an amended  
9 complaint in the context of an interpleader claim. 858 F.2d 1376, 1381 (1988). As such,  
10 Kaiser’s discussion regarding amended complaints is without merit and Bicocca’s  
11 Amended Complaint should be considered the operative Complaint in this matter.

12 **B. Bicocca Alleges a Distinct, Separate Theory of Fraud from the**  
13 **Material Elements of Osinek’s Earlier-Filed Fraud Allegations, and**  
14 **Thus is Not Barred by the First-to-File Rule.**

15 In its Motion to Dismiss, Kaiser acknowledges that the first-to-file rule may  
16 bar “portions” of a later-filed complaint, rather than the entirety of the complaint.  
17 *Osinek* Dkt. 141 at 18. To the extent that some of Bicocca’s allegations overlap with  
18 the same essential elements of the fraud scheme Osinek alleges – specifically the  
19 addenda claims – Bicocca does not dispute that these allegations are barred by the  
20 first-to-file rule. However, Bicocca’s Amended Complaint includes a separate,  
21 distinct FCA fraud scheme – Kaiser’s use of upfront diagnoses lists to re-diagnose  
22 patients – which is not discussed anywhere in Osinek’s Complaint. Because  
23 Bicocca’s Complaint includes an entirely new fraud scheme, Bicocca is not barred by  
24 the FCA’s first-to-file rule.

25 Two competing *qui tam* complaints can “allege a similar fraudulent scheme”  
26 and still contain distinct material elements that overcome the first-to-file bar as to the  
27 later-filed complaint. *United States ex rel. Chin v. CVS Pharmacy, Inc.*, 2017 WL  
28 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

1 later-filed Medicare fraud *qui tam* complaint, even though the later-filed complaint  
2 named the same defendants and involved the same fraudulent billing practices over  
3 the same time period, because the two complaints alleged separate, distinct fraud  
4 schemes that differed as to the applicable rules for the use of billing codes. 792 F.3d  
5 1121, 1131–32 (9th Cir. 2015). The *Hartpence* Court noted that the later relator’s  
6 action *did* provide an additional benefit to the government because it alerted the  
7 government of a wholly different, additional type of fraud that it might not have  
8 otherwise discovered. *Id.* at 1131 (“[Later-relator] provided information about a  
9 different form of fraud, and without that information the government might not have  
10 investigated beyond [Defendant’s additional fraudulent practices].”).

11 Likewise, the D.C. Circuit in *United States ex rel. Heath v. AT&T, Inc.*, held  
12 that two competing *qui tam* complaints were distinct enough to overcome the first-to-  
13 file bar as to the later-filed complaint because although both complaints centered on  
14 an alleged AT&T price manipulation fraud scheme, the scheme “manifested itself in  
15 sufficiently distinct ways” such that “the material elements of the fraud scheme  
16 differ[ed]” between them. 791 F.3d 112, 122–23 (D.C. Cir. 2015).

17 Kaiser argues that once the government is on “notice of the essential facts of an  
18 alleged fraud,” then the first-to-file bar “stops repetitive claims.” *Osinek* Dkt. 141 at  
19 14–15, citing *United States ex rel. Lujan v. Hughes Aircraft Co.*, 243 F.3d 1181,  
20 1186–87 (9th Cir. 2001). However, the Eastern District of Washington held that the  
21 government notice analysis “does not serve the FCA’s purpose of providing private  
22 parties the opportunity to pursue actions alleging fraud,” – in other words, fraud  
23 schemes with similar, yet distinct material elements of fraud should be considered as  
24 separate claims under the first-to-file bar. *U.S. ex rel. Savage v. CH2M Hill Plateau  
25 Remediation Co.*, 2015 WL 5794357 at \*8–9 (E.D. Wash. Oct. 1, 2015).

26 Bicocca’s Amended Complaint carves out a separate, materially different claim  
27 that *Osinek* did not originally put the government on notice of. Like in *Hartpence*,  
28 Bicocca and *Osinek*’s complaints are centered around, essentially, the same group of

1 defendants, over the same general period of time, for generally similar fraud schemes.  
2 *Hartpence* at 1131–32. Both complaints allege a fraud scheme involving inaccurate  
3 and manipulated patient diagnoses to obtain increased reimbursements from the  
4 government. But mere similarity alone does not trigger the first-to-file bar. This case  
5 is akin to *Heath*, where the fraud schemes, which had a similar foundation, diverged  
6 in the material, essential elements of fraud. *Heath* at 122–123. Here, whereas Osinek  
7 alleged that Kaiser used addenda lists provided *after* a patient visit to increase a  
8 patient’s total diagnoses, Bicocca presented the government with a wholly distinct  
9 fraud scheme – Kaiser’s use of an upfront diagnoses list given to a physician *before*  
10 visiting with a patient, rather than the use of addenda *after* the physician had already  
11 met with the patient. Thus, Bicocca presents a separate and distinct method by which  
12 Kaiser is defrauding the government, which indicates that Osinek’s Complaint did not  
13 have the requisite “essential facts” to discover the entirety of Defendants’ “fraudulent  
14 scheme.” *Osinek* Dkt. 141 at 16, citing *Lujan*, 243 F.3d at 1189.

15 Further, Bicocca’s identification of a completely different fraudulent scheme  
16 does not constitute a mere addition of “factual details” to an already existing fraud  
17 claim. *Id.*, citing *United States ex rel. Branch Consultants v. Allstate Ins. Co.*, 560  
18 F.3d 371, 378 (5th Cir. 2009). Unlike *Marion*, which Kaiser cites to, Bicocca is not  
19 simply presenting a “factual variation” of the same scheme, but rather a completely  
20 different and separate scheme altogether. *Id.* at 16-17, citing *United States ex rel.*  
21 *Marion v. Heald Coll., LLC*, 2015 WL 4512843, at \*3 (N.D. Cal. July 24, 2015). The  
22 explicit difference between the two fraud schemes illustrates that Osinek and  
23 Bicocca’s complaints do not allege the same material elements of fraud, thereby  
24 supporting the argument that Bicocca’s Amended Complaint, in part, is not barred by  
25 Osinek’s first-filed Complaint.

26 Finally, dismissal of Bicocca’s Complaint would not serve the purpose of the  
27 first-to-file bar, which seeks to “promote incentives for whistle-blowing insiders.”  
28 *Hartpence* at 1131 (citing *Lujan* at 1187). As *Hartpence* emphasized, even if

1 “increasing the class of potential qui tam claimants reduces the potential incentive for  
 2 any individual plaintiff to bring suit... allowing claims for related but distinct fraud  
 3 claims encourages broader investigation and increases the total potential for  
 4 recovery.” *Id.* Thus, here, Bicocca’s identification of an additional fraud scheme  
 5 encourages the government to examine Kaiser’s diagnosing practices and  
 6 reimbursement fraud more widely and deeply, and adds to the total amount the  
 7 government can recover.

8 **C. Bicocca Alleges a Distinct, Separate Theory of Fraud from the**  
 9 **Material Elements of the Other Relators that Filed Before Bicocca.**

10 Relators (1) Taylor; (2) Arefi, Kumar, and Prime Healthcare Service (“Arefi”);  
 11 (3) Stein and Bone (“Stein”); and (4) Bryant and Hernandez (“Bryant”) all filed  
 12 complaints after *Osinek*, and before Bicocca in time. Relator Arefi filed a Non-  
 13 Opposition to Kaiser’s Motion to Dismiss on January 24, 2022. *Osinek* Dkt. No 143.  
 14 As such, to the extent that the Court sees the first-to-file bar as jurisdictional, Bicocca  
 15 does not need to compare his Amended Complaint to Arefi’s Complaint, but may  
 16 compare his Amended Complaint with Taylor, Stein, and Bryant’s Complaints. Such  
 17 comparison shows that Bicocca should still be regarded as first-to-file with respect to  
 18 his sole remaining claim, the upfront diagnoses list fraud scheme.

19 Relator Taylor filed a Complaint on October 22, 2014, and a First Amended  
 20 Complaint immediately after on November 3, 2014. *Taylor* Dkt. No. 1, 4. Nowhere in  
 21 his Amended Complaint does Taylor allege that before a physician meets with a  
 22 patient, Kaiser provides the physician with a list of the patient’s previous diagnoses to  
 23 re-diagnose during the visit. Instead, Taylor alleges numerous other sources of  
 24 diagnoses that Kaiser used to add to a patient’s EMR, including diagnoses from  
 25 external providers (*Taylor* Dkt. No. 4 ¶¶ 78–93), diagnoses identified in probe audits  
 26 (*Id.* at ¶¶ 94–154), diagnoses identified through high risk filters (*Id.* at ¶¶ 155–161),  
 27 and invalid diagnoses that should never have been included in a patient’s chart in the  
 28 first place (*Id.* at ¶¶ 162–164). None of these liability theories are the same as

1 Bicocca’s allegation regarding the upfront diagnoses lists. Thus, Taylor’s Complaint  
2 does not bar Bicocca’s Complaint as to Bicocca’s sole remaining claim.

3 The Stein Relators filed a Complaint on May 16, 2016. *Stein* Dkt. No. 1.  
4 Stein’s Complaint discusses upcoding the severity of high value codes such as sepsis  
5 and malnutrition diagnoses (*Id.* at ¶¶ 50–79) and refreshing missing diagnoses from a  
6 patient’s medical record (*Id.* at ¶¶ 80–103) but does not discuss the introduction of a  
7 patient’s complete diagnoses list before a patient’s visit, with the understanding that  
8 the physician was expected to re-diagnose all of the patient’s previous conditions  
9 during the visit. Thus, Stein’s Complaint does not bar Bicocca’s Complaint as to  
10 Bicocca’s sole remaining claim.

11 Finally, the Bryant Relators filed a Complaint on March 1, 2018. *Bryant* Dkt.  
12 No. 1. Bryant alleges an upcoding scheme for “missed opportunity” high value codes  
13 (*Id.* at ¶¶ 54–82), upcoding for ventilator-dependent patients (*Id.* at ¶¶ 83–106),  
14 sepsis-specific upcoding (*Id.* at ¶¶ 107–128), additional high value condition-specific  
15 upcoding schemes (*Id.* at ¶¶ 129–149), query templates used to add additional  
16 diagnoses to a patient’s EMR (*Id.* at ¶¶ 155–164), and additional upcoding schemes  
17 including data-mining, computer assisted coding, clinical documentation  
18 improvement programs, and related schemes (*Id.* at ¶¶ 165–202). Bryant does not  
19 allege the same material fraud scheme as Bicocca – the use of upfront diagnoses lists.  
20 As such, Bryant’s Complaint does not bar Bicocca’s Complaint as to Bicocca’s sole  
21 remaining claim.

22 In sum, although the remainder of Bicocca’s Complaint is precluded by the first  
23 to file rule as to Osinek’s Complaint – and as to Taylor, Stein, and Bryant’s  
24 Complaints – none of the preceding complaints alleged the same material fraud  
25 scheme as Bicocca with regard to the upfront diagnosis lists, and therefore Kaiser’s  
26 Motion to Dismiss Bicocca’s Amended Complaint based on first-to-file grounds  
27 should be denied as to that specific allegation.  
28

1 **IV. CONCLUSION**

2 Relator Bicocca’s Amended Complaint put the government on notice of an  
3 entirely new and materially distinct fraud scheme. While Osinek’s original Complaint  
4 precludes most of Bicocca’s allegations under the FCA’s first-to-file bar, Bicocca’s  
5 Amended Complaint should not be dismissed in its entirety. Bicocca’s claim as to  
6 Kaiser’s creation and presentation of falsified patient electronic medical records  
7 through the use of an upfront diagnoses list given to physicians, all for the sake of  
8 obtaining higher reimbursements from the government through Medicare, should be  
9 preserved. Bicocca respectfully requests that the Court deny Kaiser’s Motion to  
10 Dismiss as to this theory of fraud and allow Bicocca to proceed with discovery.

11  
12 February 15, 2022

Respectfully submitted,

13  
14 /s/ Janel Quinn

15 R. Scott Oswald (admitted *pro hac vice*)  
16 soswald@employmentlawgroup.com  
17 Janel Quinn (admitted *pro hac vice*)  
18 jquinn@employmentlawgroup.com  
19 The Employment Law Group, P.C.  
20 1717 K Street NW, Suite 1110  
21 Washington, D.C. 20006  
22 (202) 261-2813  
23 (202) 261-2835 (facsimile)

24 J. Bernard Alexander III (State Bar No. 128307)  
25 ALEXANDER MORRISON + FEHR LLP  
26 1900 Avenue of the Stars, Suite 900  
27 Los Angeles, California 90067  
28 (310) 394-0888  
(310) 394-0811 (facsimile)  
balexander@amflp.com

*Counsel for Plaintiff-Relator Bicocca*

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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  
Janel Quinn