William K. Hanagami
HANAGAMI LAW
A PROFESSIONAL CORPORATION
913 TAHOE BOULEVARD, SUITE 5
INCLINE VILLAGE, NV 89451-7414
(833) 716-8570 / (833) 716-8569 *FAX*
Bill@Hanagami.com

Abram J. Zinberg
THE ZINBERG LAW FIRM
A PROFESSIONAL CORPORATION
412 OLIVE AVENUE, SUITE 528
HUNTINGTON BEACH, CA 92648-5142
(714) 374-9802 / (714) 698-4048 *FAX*
AbramJ@Zinberglaw.com

Attorneys for Plaintiffs and *Qui Tam* Relators,
Marcia Stein and Rodolfo Bone

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. <u>THE FIRST-TO-FILE BAR DOES NOT BAR FACTUALLY DIFFERENT RISK ADJUSTMENT FRAUD SCHEMES</u>.

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

1 coding occurred contemporaneously with the MA enrollees' and Medicare patients' hospital
2 encounters and were carried out by KFH coders. The frauds do not directly involve Kaiser
3 Health Plan personnel nor rely on data mining, HCC refreshing, probe audits, leading queries,
4 physician manipulation via NLP or CMT mis-mapping , nor other tactics that required medical
5 records to be improperly subsequently amended.
6
7 F. IN THE ALTERNATIVE, RELATORS SHOULD BE GRANTED
8 LEAVE TO AMEND THEIR COMPLAINT.
9 Leave to amend a complaint "shall be freely given when justice so requires."
10 Fed.R.Civ.P. 15(a). "The standard for granting leave to amend is generous." *Balistreri v.*
11 *Pacifica Police Dept*., 901 F.2d 696, 701 (9th Cir. 1990). "The court considers five factors in
12 assessing the propriety of leave to amend—bad faith, undue delay, prejudice to the opposing
13 party, futility of amendment, and whether the plaintiff has previously amended the complaint."
14 *United States v. Corinthian Colleges,* 655 F.3d 984, 995 (9th Cir. 2011).
15 Here, there is no evidence of bad faith, undue delay, prejudice to the opposing parties,
16 nor futility of amendment. Although Relators filed their first and second amended complaints,
17 they were filed to clarify or add allegations. Those amended complaints were NOT filed in
18 response to pleading motions. Leave to amend should be denied only if the Court determines
19 that "allegation(s) of other facts consistent with the challenged pleading could not possibly
20 cure the deficiency." *Schreiber Distributing Co. v. Serv-Well Furniture Co.*, 806 F.2d 1393,
21 1401 (9th Cir. 1986). In the event the Court grants any portion of the motion to dismiss the
22 Sepsis, Malnutrition or AA claims, Relators request leave to file a further amended complaint
23 to correct any deficiency in the pending SAC.
24 / / /
25 / / /
26
27
28

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,

THE ZINBERG LAW FIRM
A Professional Corporation

HANAGAMI LAW
A Professional Corporation

Dated: February 15, 2022

By: */s/William K. Hanagami*
William K. Hanagami
Attorneys for Plaintiffs and *Qui Tam* Relators, Marcia Stein and Rodolfo Bone

William K. Hanagami
HANAGAMI LAW
A PROFESSIONAL CORPORATION
913 TAHOE BOULEVARD, SUITE 5
INCLINE VILLAGE, NV 89451-7414
(833) 716-8570 / (833) 716-8569 *FAX*
Bill@Hanagami.com

Abram J. Zinberg
THE ZINBERG LAW FIRM
A PROFESSIONAL CORPORATION
412 OLIVE AVENUE, SUITE 528
HUNTINGTON BEACH, CA 92648-5142
(714) 374-9802 / (714) 698-4048 *FAX*
AbramJ@Zinberglaw.com

Attorneys for Plaintiffs and *Qui Tam* Relators,
Marcia Stein and Rodolfo Bone

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 [PROPOSED] ORDER
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 [PROPOSED] ORDER DATE: March 31, 2022 TIME: 1:30 p.m. JUDGE: Edward M. Chen CRTRM: 5, 17th Floor

ORDER

This matter coming to be heard on March 31, 2022, upon consideration of Defendants' Motion to Dismiss Pursuant to 31 U.S.C. § 3730(b)(5), and the Court being fully advised in

the premises;

IT IS HEREBY ORDERED that Defendants' Motion is DENIED as to Relators Marcia Stein and Rodolfo Bone.

Dated:

____
Hon. Edward M. Chen
United States District Judge