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IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

THE UNITED STATES OF AMERICA
Plaintiff,
ex. Relator Emily Roe., an individual;

vs.

STANFORD HEALTHCARE BILLING DEPARTMENT;

STANFORD HEALTH CARE (FORMERLY KNOWN AS STANFORD HOSPITALS AND CLINICS);

DR. FREDERICK DIRBAS;

DEBRA ZUMWALT;

THE BOARD OF DIRECTORS OF THE STANFORD HEALTH CARE;

THE BOARD OF DIRECTORS OF THE LUCILE SALTER PACKARD CHILDREN'S HOSPITAL AT STANFORD;

CASE NO.: CV17-08726-DSF

JUDGE: Hon. Dale S. Fischer
[FILED UNDER SEAL PURSUANT TO FALSE CLAIMS ACT, 31 U.S.C. §§ 3730(b)(2) AND (3)]

JURY TRIAL DEMANDED

Complaint Filed: Dec. 4, 2017

SECOND AMENDED COMPLAINT FOR VIOLATION OF 31 U.S.C. §§ 3729-33, "FALSE CLAIMS ACT"

1. **FRAUD: PRESENTATION OF FALSE CLAIMS FOR UNBUNDLED PRE-OPERATIVE VISITS**
2. **FRAUD: UPCODED MULTIPLE UNITS OF MEDICAL AND SURGICAL GOODS**

THE LELAND [STANFORD] JUNIOR UNIVERSITY;

THE BOARD OF TRUSTEES OF [LELAND] STANFORD [JUNIOR] UNIVERSITY;

STANFORD HEALTH CARE ADVANTAGE ("SHCA"); and

DOES 1-10, inclusive,
Defendants.

3. **FRAUD: UPCODED OFFICE VISITS TO THE HIGHEST PAYING CODES**
4. **FRAUD: FALSIFIED BILLED SERVICES PROVIDED BY NON-PHYSICIANS**
5. **FRAUD: UPCODED LAB AND PATHOLOGY SERVICES**
6. **FRAUD: UPCODED ANESTHESIA, OPERATING ROOM, AND RECOVERY-ROOM TIME BLOCK FRAUD**
7. **FRAUD: PRESENTATION OF FALSE RECORDS MATERIAL TO OBLIGATION TO PAY**

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Plaintiff the United States of America ("United States") by and through Relator Emily Roe ("Relator"), alleges as follows:

SUMMARY OF ACTION

1. This Second Amended Complaint ("SAC") for violations of the False Claims Act, 31 U.S.C. § 3729, et seq. ("FCA") is filed on behalf of Plaintiff United States, pursuant to 31 U.S.C. §3730.

2. This FCA also known as a *qui tam* action is based upon the "upcoding" and "unbundling" healthcare billing practices engaged in by STANFORD HEALTH CARE *et al.,* and its subsidiaries and affiliates.

3. This action is based on STANFORD's identified billing schemes and habitual submissions of false, fraudulent and/or misleading healthcare bills, retention of payment received for fraudulent claims, and false appeals of denied

claims to commercial payors and insurers, whereas STANFORD did the following with knowledge of the falsity from at least January 1, 2010 through present date:

(1) *Unbundled* and billed pre- and post-operative visits *and* facility fees in violation of global surgery fee rules;

(2) *Upcoded* units of exorbitant surgical supplies and medical goods like breast implants or artificial skin substitute- i.e. whereby STANFORD billed *double* or a greater number of *units* than the actual units used, and billed units were contradictory to units recorded in the surgeon's reports;

(3) U*nbundled* and *upcoded* tissue pathology exam codes in violation of the "1 tissue, 1 code [CPT]" rule- i.e. a single surgical pathology specimen was charged as two or three pathology codes and stacked with multiple facility or technical charges;

(4) Habitually *upcoded* physician office visits and time codes to the highest paying level codes (CPT 99205 and 99215) without documentary support, and in contradiction to the medical records;

(5) Freely *upcoded* unlicensed staff services and mid-level providers' (physician assistants and nurse practitioners) visits to the highest paying physician codes in violation of "incident to" guidelines- thereby also fraudulently misreporting the actual provider of services;

(6) Unlawfully billed for unsupervised and *unlicensed practice of medicine*, and diagnostic testing and procedures by unlicensed personnel; and

(7) Egregiously instructed and *required* that its medical billers and coders *always bill at the maximum level and fees,* regardless of the

lack of medical necessity, lack of substantiating medical records, and failure to adhere to national Correct Coding Initiatives ("CCI").

JURISDICTION AND VENUE

4. This Court has original jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732, which specifically confer jurisdiction on this Court for actions brought pursuant to 31 U.S.C. § 3730.

5. Under 31 U.S.C. § 3730(e)(4)(A), there has been no statutorily relevant public disclosure of "substantially the same allegations or transactions" alleged in this Complaint.

6. To the extent there has been any such public disclosure, Relator meets the definition of an "original source," as that term is defined under 31 U.S.C. § 3730(e)(4)(B).

7. Specifically, on or about December 4, 2017 Relator voluntarily disclosed to the United States the information upon which allegations or transactions at issue in this Complaint are based prior to any purported public disclosure under 31 U.S.C. § 3730(e)(4)(A).

8. Alternatively, Relator has knowledge that is independent of and materially adds to any purported publicly disclosed allegations or transactions, and Relator voluntarily provided the information to the United States before filing her complaint. Relator therefore qualifies as an "original source" of the allegations in this Complaint such that the so-called public disclosure bar set forth at 31 U.S.C. § 3730(e)(4) is *inapplicable*.

9. Relator has served upon the Attorney General of the United States, the United States Attorney for the Central District of California, the Attorney General of the State of California, the California Department of Insurance, and the Los Angeles County District Attorney's Office the original Complaint and

the written "Disclosure Statement" summarizing the known material evidence and information in the possession of Relator related to the original Complaint, in accordance with the provisions of 31 U.S.C. § 3730(b)(2).

10. The "Disclosure Statement" is supported by material evidence, and documentary evidence has been produced with the disclosure. The documents referenced in the Disclosure Statement, and those produced in connection therewith or subsequently, are incorporated herein by reference.

11. Relator shall serve upon the Attorney General of the United States, the United States Attorney for the Central District of California, the Attorney General of the State of California, the California Department of Insurance, and the Los Angeles County District Attorney's Office Commissioner or their respective designees a copy of this Second Amended Complaint ("SAC") and any subsequent amended complaints.

12. This Court has personal jurisdiction over Defendants and venue is proper in this District pursuant to 31 U.S.C. § 3732(a), because Defendants can be found in, reside, and/or transact business in this District, and because acts proscribed by 31 U.S.C. § 3729 occurred in this District.

13. Venue is also proper pursuant to 28 U.S.C. § 1391(b) because one or more Defendants reside in this District and many Defendants are residents of the State of California, and because a substantial part of the events or omissions giving rise to the claims alleged occurred in this District.

INTRADISTRICT ASSIGNMENT

14. Assignment to this Division is proper because a substantial part of the events or omissions which give rise to the claims alleged occurred in this district, as more particularly set forth below.

PARTIES

I. DEFENDANTS

15. STANFORD HEALTHCARE BILLING DEPARTMENT, ("SHC BILLING") entity form unknown (may also be known as UNIVERSITY HEALTHCARE ALLIANCE ("UHA") is a business having its principal place of business in Los Angeles, California. SHC BILLING conducts business and receives the its payments at P.O. box 743447 in Los Angeles, CA 90074-3447. SHC BILLING also conducts business through the state of Texas with a division of its billing and collection service there, while maintaining one of its primary bank accounts at Bank of America located in Illinois.

16. Defendant STANFORD HEALTH CARE ("SHC") a.k.a. STANFORD HEALTHCARE (formerly known as STANFORD HOSPITALS AND CLINICS, STANFORD MEDICINE, and STANFORD HOSPITAL) is a nonprofit public benefit corporation organized and existing under the laws of the State of California, having its principal place of business in Stanford, California and operating satellite and health services throughout the United States. SHC is designated as a tax-exempt, non-profit organization under section 501(c)(3) of the Internal Revenue Code ("IRC").

17. Defendant STANFORD HEALTH CARE ADVANTAGE ("SHCA") is an entity form unknown, having its principal place of business in California.

18. Defendant FREDERICK DIRBAS, M.D., a.k.a FRED DIRBAS, FRED DIRKAS, doing business as "SOFTWARE FOR SURGEONS" ("DIRBAS") is an individual and surgeon having his principal place of business and residence in Menlo Park, California.

19. Defendant DEBRA ZUMWALT a.k.a. DEBRA L. ZUMWALT, DEBRA ZUMWALT HARMON, and DEBRA HARMON, ("ZUMWALT") is an individual having her principal place of residence in Menlo Park, California.

20. Defendant THE BOARD OF DIRECTORS OF STANFORD HEALTH CARE ("BOARD") is an entity form unknown, having its principal place of business in California.

21. Defendant THE BOARD OF DIRECTORS OF THE LUCILE SALTER PACKARD CHILDREN'S HOSPITAL AT STANFORD ("CHILDREN'S BOARD") is an entity form unknown, having its principal place of business in California.

22. Defendant THE LELAND [STANFORD] JUNIOR UNIVERSITY ("UNIVERSITY") is a nonprofit public benefit corporation organized and existing under the laws of the State of California, having its principal place of business in Stanford, California. UNIVERSITY is designated as a tax-exempt, non-profit organization under section 501(c)(3) of the Internal Revenue Code.

23. Defendant THE BOARD OF TRUSTEES OF [LELAND] STANFORD [JUNIOR] UNIVERSITY is an entity form unknown, having its principal place of business in California.

24. Relator is ignorant of the true names and capacities of the defendants sued herein under the fictitious names DOES 1 through 10. Each of the fictitiously named defendants is responsible in some manner for the acts and violations herein alleged. Relator will seek leave to amend this complaint to allege said defendants' true names and capacities as soon as Relator ascertains them.

25. At all times mentioned herein, each defendant was the agent for each other defendant, was acting in the course and scope of such agency, and was engaged in a conspiracy to do the things herein alleged.

26. Plaintiff is informed and believes and thereon alleges, that all times relevant herein, each of the Defendants was the agent, employee, partners, joint venturer, or co-conspirator of the remaining Defendants, and in doing the things alleged herein was acting within the scope of such agency, employment, partnership,

joint venture, or conspiracy. Plaintiff is informed and believes, and thereon alleges, that the conduct of each Defendant as alleged herein was known to and ratified by each of the other Defendants, and that the benefits thereof were accepted by each of the Defendants.

27. Plaintiff is informed and believes and on that basis alleges that at all times relevant herein, Defendants, and each of them, were and remain the alter-egos of each other, that they did and still do dominate, influence and control each other, that there existed and still exists a unity of ownership between them, that the individuality and separateness of each entity was and remains non-existent, that each such entity was and remains a mere shell, conduit and/or naked framework which the other defendants used and still use to conduct their business affairs, that each such entity was and remains inadequately capitalized, and that an injustice and fraud upon Plaintiff will result if the theoretical separateness of the defendant entities is not disregarded and each such defendant held liable for all relief being sought herein.

28. Plaintiff is informed and believes and on that basis alleges that at all times , Defendants, and each of them, knowingly and willfully conspired, joined and participated with each other in the conduct alleged in furtherance of a conspiracy between and among Defendants to enrich themselves at Plaintiff's expense, and that each such defendant is therefore liable with each other defendant for the conduct herein alleged, for the damages suffered by Plaintiff and for the relief being sought herein.

29. There exists, and at all times herein mentioned has existed, a unity of interest and ownership between SHC on the one hand, and University Healthcare Alliance, Stanford Medicine, University Medical Group, Stanford Express Care, Stanford Health Care Alliance Network, Stanford University School of Medicine, Stanford Health Plan, Lucille Packard Children's Hospital, The

Leland Stanford Junior University, The Board of Directors of Stanford Health Care, The Board of Trustees of Leland Stanford Junior University, The Board of Directors of the Lucile Salter Packard Children's Hospital at Stanford, and Stanford Healthcare Advantage ("SHCA"), and Stanford StartX Fund, on the other, such that any individuality and separateness among these Defendants, and each of them, have ceased, and these additional entities are the alter egos of SHC. Plaintiff is informed and believes, and thereon alleges, that:

a. SHC has completely controlled, dominated, managed and operated the other entities for its sole and exclusive benefit;
b. SHC has commingled the assets of the additional entities and has commingled its own revenues and assets with those of these corporations, to suit SHC's needs and convenience;
c. SHC has failed to maintain any degree of separateness with the additional entities;
d. As to the additional entities, SHC has failed to observe corporate formalities. The activities of the additional entities have been carried out without the separate holding of directors' or shareholders' meetings, and proper records or minutes of corporate proceedings have not been maintained
e. SHC at all times herein mentioned, has controlled and operated these additional entities as devices to avoid individual, agency and respondent superior liability, and for the purpose of mingling non-profit and for-profit funds, and substituting financially insolvent partnerships, corporations and/or corporations with limited financial resources, in the place of SHC ; and
f. SHC has so inadequately capitalized several of the additional entities and or drained assets, compared with the business to be done by these entities

and the risks of loss attendant thereto, that their capitalization is trifling and/or illusory.

30. Plaintiff is informed and believes, and thereon alleges, that SHC has committed additional acts and omissions sufficient to impose alter ego liability of which Plaintiff is presently unaware. Additional acts and omissions on the part of SHC, consistent with those factors listed in *Associated Vendors, Inc. v. Oakland Meat Co.* (1962) 210 Cal.App.2d 825, 838- 840, and subsequent cases, will be further developed during discovery in this litigation.

31. Adherence to the fiction of the separate existence of these additional entities as entities distinct from SHC would permit an abuse of the corporate privilege, sanction fraud and promote injustice.

32. Plaintiff is informed and believes, and thereon alleges, that at all times herein mentioned, and continuing to the present, that the additional entities have operated, and currently operate, as a single business enterprise. Such Defendants have but one enterprise, and this enterprise has been so handled that it should respond, as a whole, for the acts committed by SHC as alleged herein. Each corporation, individual and entity has been, and is, merely an instrument and conduit for the others in the prosecution of a single business venture.

33. There is such a unity of interest and ownership among these Defendants that the separate personalities of the corporations, individuals and entities no longer exist. If the acts of SHC. and the additional defendants are treated as those of one or any of these corporations alone, an inequitable result will follow in that these defendant(s) may have insufficient assets to respond to the ultimate award of compensatory damages, costs, attorney's fees and punitive damages entered in this case. Further, an award of punitive damages against one or more of the defendants alone will not accurately reflect the amount necessary for punishment of the entire business enterprise conducted by SHC.

II. RELATOR

34. Relator is a board-certified physician and surgeon, licensed by the Medical Board of California, in good standing.

35. Relator is also a highly-trained and certified professional medical coder and biller, as credentialed by the American Academy of Professional Coders ("AAPC"). As such, Relator has specialized training and expertise in CPT coding guidelines and as an auditor for insurance billing.

36. Relator is a designated expert for the California Department of Consumer Affairs, and is currently a designated expert for multiple State agencies. In the capacity as a retained expert, Relator has testified on behalf of the State in matters involving medical coding, unbundling, upcoding, chart cloning, medical record alteration, and codified procedural services. Hence, Relator has special knowledge, skills, and a surgical background which are relevant to this action.

37. In mid-November 2012 and early December 2012, Relator had a pre-operative visit and underwent a major surgery with DIRBAS at SHC, respectively.

38. In or about November 2016, while reviewing the medical and billing records for these services, Relator first observed certain billing irregularities which were then confirmed by SHC, ZUMWALT, and DIRBAS. As a result of Realtor's audit, STANFORD in fact conceded in writing that more than 15-18% of the total $153,000 charges for Relator's surgery were improper and were thus subject to refund. This caused Relator to undertake an extensive investigation into STANFORD healthcare revenue schemes, uncovering the triggering fraudulent billing practices described below.

39. Relator has filed this action anonymously, under the pseudonym "Emily Roe," for two separate and legally sufficient reasons. First, to protect Relator's and her family's medical privacy. Second, as a practicing physician and

surgeon, Relator relies on referrals from other medical professionals. Stanford has become a dominant force in healthcare in California. Accordingly, if her identity were to become publicly known, Relator's pursuit of a false claims action against Stanford and an entire cadre of its referring physicians could adversely impact both her health, finances and her career.

III. RELATOR'S INVESTIGATION

40. Relator underwent a major surgery at STANFORD on 12/12/12 which was reimbursed by ABC as CPT 19304 for approximately $1600. On 12/11/12 STANFORD and DIRBAS improperly billed for a "pre-operative" visit (non-billable) as CPT 99215 for $494 the day prior to surgery. The visit was provided by DIRBAS'S PA, Candace Schulz, and the note was never signed by DIRBAS although the service was improperly billed under DIRBAS's NPI. STANFORD was paid on both codes, rendering nearly 40% in unjust enrichment to SHC. Despite receiving payment from ABC, SHC also billed the patient for the 99215 improper code, was double paid, and retained the additional 99215 payment for more than 5 years.

41. On or about November 2016, while reviewing the medical and billing records for Relator's 2012 STANFORD surgery, Relator noticed certain billing irregularities.

42. On or before December 2017, Relator filed a first wrongful billing grievance with STANFORD as to the unbundled and improperly charged pre-operative visit and was only then refunded $341.97 on demand. (Exh. "A")

43. On February 7, 2018 STANFORD, DIRBAS, and DOES 1-10 conceded in writing they improperly billed the pre-operative visit, and that they had failed to timely refund the fees. (Exh. "B")

44. On or about mid-January 2018 , Relator filed a 2nd wrongful billing grievance with STANFORD as to the unbundled and improperly upcoded 2 units of surgical Alloderm, whereas the surgeon's operative report stated only 1 unit was used.

45. On or about March 8, 2018 STANFORD, DIRBAS, and DOES 1-10 conceded in writing they improperly billed 2 units of surgical supplies "Alloderm" for $34,000 when in fact they should have billed only 1 unit at $17,400, and that they had failed to timely refund the fees. (Exh. "B")

46. On or about mid-January 2018, Relator filed a 3rd wrongful billing grievance with STANFORD as to the unbundled and improperly upcoded 6 units of pathology for roughly $6700, whereas the surgeon's operative report stated only 2 specimens were collected and sent to the lab for approximately $800, and upcoded time units of the recovery room for 295 minutes at roughly $14,000, whereas recovery room time was under 120 minutes.

Medicare (CMS) Records

47. Given the magnitude of SHC's billing conduct and institutional "high rates of coding", accordingly, Relator submitted a Freedom of Information Act ("FOIA") request to CMS to further investigate the "high rates of coding" and payment records for DIRBAS and SHC. (*See United States ex rel. Integra Med Analytics LLC v. Providence Health and Services,* No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

48. CMS provided Relator with responsive coding, billing, and payment records for DIRBAS and SHC, a true and correct copy of which, with minor highlighting and redaction, are attached hereto as Exhibit "Q". These records show that from 2010 to 2016, DIRBAS billed CMS countless times with high level 99215 codes for non-billable pre-operative visit codes, and many dates on

which he neither personally rendered the billed services, nor did he sign the medical records. DIRBAS and SHC knew that these visits were non-chargeable.

49. The CMS reports obtained by Relator conflicted sharply with CMS guidelines for proper billing, and the deposition testimony given by DIRBAS in another matter, in which he testified that he had not signed off many pre-operative notes and had his PA or unlicensed interns see the patients. (*See* Exh. "I") The CMS reports obtained by Relator show that DIRBAS in fact billed Medicare (and Medi-Gap commercial carriers) and received payment for CPT Code 99215 innumerable times for pre-operative visits, in advance of surgery.

50. These highly conflicting reports caused Relator concern for STANFORD's global improper utilization of government and private health care dollars in upcoding and presenting false claims for reimbursement.

51. Upon information that STANFORD "harassed" and pushed its doctors to generate larger billings than they were capable of doing through lawful means, and that other STANFORD doctors and surgeons had a custom and practice of similar unbundled billing for federally-funded patients, Relator submitted a FOIA request to CMS for Medicare billing and payment data for other STANFORD doctors from January 2007 through October 23, 2017, including Drs. Gurtner, Wapnir, Amanda Wheeler, Dung Nguyen, chief of breast surgery, Nazerali, Jeffrey, and Gordon Lee. Relator received the first of these reports in or about March 2017, and the last of the reports on or about March 2018.

52. Attached hereto as Exhibit "AA" and "BB" are true and correct copies of the CMS billing ledgers of Dr. Gurtner, a plastic surgeon at SHC, and Dr. Wheeler, respectively. Stanford Healthcare has NPI 1437292927, Dr. Gurtner NPI 1891830881, and Dr. Wheeler NPI 1477749752. Dr. Wheeler had countless charges of 99214 and 99215 for pre-operative office visits. Dr. Gurtner billed

CMS $961,810 from 2010 to 2017, and 95% of his office visits were upcoded 99204 as 99205 and 99215 (124 patients), which are the highest paying codes.

53. Analyzing the data using expertise as a certified medical coder and biller, as well as a practicing surgeon, Relator determined that STANFORD had pattern billed and received federal and State funds for claims which did not appear to conform to CCI, were incompatible code combinations, and failed to adhere to CMS mandates.

54. For example, SHC and Gurtner upcoded CPT code 19340 (which codifies a single stage "one-and-done" mastectomy reconstruction with an immediate prosthesis) for 2 and 3 stage breast reconstruction codes (CPT 19342), which pay 10-15% *less* than a one stage surgery (CPT 19340). Gurtner billed 19340 more than 17 times, although DIRBAS testified under oath that none of the SHC surgeons were doing "one and done" reconstruction, and he had never seen it performed at SHC. (Exhibit I- Dirbas Depo)

55. A "one-and-done" breast reconstruction at time of mastectomy pays more because it has the advantages of significant cost savings to Medicare and commercial insurance carriers, as there is the expectation of only one hospitalization, one recovery room charge, one anesthesia charge, etc.

56. As another example, STANFORD had a demonstrable course of conduct of unlawful upcoding of surgical supply units and medical goods used during surgery. Thus, rather than billing for the correct units, STANFORD would upcode and bill multiple units. This upcoding practice was most lucrative for surgeries using artificial tissue and biologic implants, where each unit costs upwards of tens of thousand of dollars. Dr. Gurtner billed CPT 15777 ($767) for the work of implanting the tissue in 9 patients, but billed multiple units as high as $5192 rather than one. SHC upcoded and billed $17,400 per unit of biologic tissue, even if none were used.

57. The surgeon fees for services have been reduced dramatically whereas a major surgery typically reimburses $1000-$1500 in professional fees, however the real profits for STANFORD were charging supplies, surgical goods, and operating room and recovery room time which run in the tens of thousands of dollars per hour.

Other Stanford Patient Investigations

58. SHC a purported "non-profit", is not only one of the top 3 most profitable hospitals in the U.S., but SHC employs an entire army of (excess of 300) billing staff for the 613-bed hospital. (See Exh. F: letter from SHC attorneys)

59. SHC is in fact very expensive, particularly for women's health. In other words, when national benchmarks for a "one-and-done" single-stage mastectomy cost an average of $34,839-$78,000, SHC easily charges double.

60. Where national benchmarks for a breast biopsy with sentinel lymph node exam costs an average of $6,700 -$15,870, on 1/15/2020 STANFORD billed patient Ms. Perla Ni and HealthNet of California a staggering $143,396.66 for the same simple procedure. (See Exh. "J": STANFORD bill Perla Ni)

61. Where national benchmarks for skin patch testing are $10-$35 per unit, on or October 4, 2018 STANFORD charged Professor Janet Winston and ABC a mouth dropping $43,385 for 119 units of a simple skin test. ABC negotiated the rate to $14,000, of which $3000 was assigned as a deductible to be paid by Winston. Winston filed a grievance and STANFORD negotiated for her to pay just half, instead of the full $3000 due STANFORD.

62. On December 2012 STANFORD billed Anthem Blue Cross ("ABC") a staggering $153,488.68 for a 1-day surgery and observation. (See Exh. "A": STANFORD bill) In 2018 and 2019, STANFORD ended up having to refund

$17,000 for fraudulently upcharged 2 units of surgical supply "Alloderm" at $34,000, and $341.97 for a fraudulently upcoded pre-operative visit.

63. According to the California Attorney General Xavier Becerra, the same medical service in STANFORD's area (Northern California) is nearly double the fee at comparable Southern California hospitals. (See Exh. "K", and https://www.sacbee.com/news/local/health-and-medicine/article238596833.html) https://www.sacbee.com/news/local/health-and-medicine/article238596833.html) (See http://petris.org/wp-content/uploads/2018/03/CA-Consolidation-Full-Report_03.26.18.pdf)

64. STANFORD provides health services and bills consumers throughout California through its telemedicine portals, in particular using its "MyHealth" portals which also push video platforms for patients outside of the SHC area and to many parts of the United States. According to advisory.com in 2015 STANFORD Medicine Clinic provided 60% of its visits as "virtual visits". In 2015 only 40% of STANFORD's more than 6500 visits were "in-person visits".

65. Of STANFORD's total annual healthcare billings from at least January 1, 2010 through present, it is demonstrated herein that at minimum no less than 11-15% (and up to 50%) of all its billed CPT codes are habitually and fraudulently manufactured through institution wide schemes including pattern upcoding and unbundling, and "cheat sheets".

66. Defendants institutionally trained coders using distributed billing "cheat sheets" and instructed their army of medical billers and coders to always bill at the maximum level, regardless of the lack of substantiating medical record, or medical necessity". (See Exh. "C" Decl. Gaines ¶10)

67. Defendants also instructed and required their billers and coders to improperly and aggressively "scrub" healthcare claims with false and fraudulent codes which were unsupported and contradictory to the medical records. In doing so,

Defendants circulated "cheat sheets" to billers and new hires. Doctors were not only harassed and told their volume of billings was low, but they were prevented from checking their billing records, and their billing reports were concealed from most STANFORD physicians and providers. (Exh. "C", Decl. Gaines ¶10)

68. Defendants also used pressure tactics and a high pressure work environments to force doctors and billers to upcode and increase their "volume of billing". Defendants stated the same and used institution-wide mandates directing billers to appeal and re-appeal claims which were properly denied by the carriers, knowing of the falsity and fraud of their conduct. In doing so, Defendants often created, edited, and schematically presented multiple altered versions of the true medical records, sometimes with 3 or more "versions" of the same operative report to obtain unjust payment from insurers. Defendants adulterated electronic medical records and used unsigned and unauthenticated physician records in order to obtain higher billing. (See Exh. "I", Deposition DIRBAS)

69. When Defendants fraudulently billed payors for upcoded and unbundled services they did so with blatant disregard for the truth and with intent to obtain unjust enrichment *inter alia* falsified healthcare claims. (See Exh. C: Decl. Gaines generally)

70. Each false health care claims authorized by the STANFORD medical provider and scrubbed and transmitted by the STANFORD medical coder thus by definition has the requisite elements stated of fraud. Each exemplar healthcare claim in Exhibits Q, AA, and BB are thus *prima facie* evidence of the fraud, and have the required element- the what (claim for payment), who (rendering provider NPI, rendering institution NPI, and the biller who scrubs and transmits the claims), the when (all claims are date stamped for transmission), and the why (increased revenue). Thus, every incident of a false healthcare claim being tendered to the carrier with either knowing falsity, or a

blatant disregard for the truth, by the rendering provider, the coder, and the billing compliance officer, collectively meets the elements of fraudulent claim.

Stanford Executives and Managers With Knowledge of the Billing Fraud

71. On or about March 8, 2017 and multiple times thereafter, Relator contacted STANFORD doctor DIRBAS, billing compliance officer and Vice President ZUMWALT, and multiple billing managers to discuss the billing noncompliance issues identified herein. On June 18, 2018, Relator sent detailed correspondence to STANFORD's Billing Department, with a copy to ZUMWALT and DIRBAS setting forth in detail the results of her investigation, including copies of the aforementioned CMS records. A copy of this correspondence, redacted to remove Relator's personal identifying information, is attached hereto as Exhibit DD.

72. On April 9, 2018, Relator also directly called ZUMWALT's office to speak with her and notified her by email at zumwalt@stanford.edu, and STANFORD executives as well as its attorneys Ms. Stoutenburg via email to and by danielastoutenburg@dbtlaw.org, of STANFORD's billing non-compliance.

73. In its posted public policies, STANFORD acknowledges that it is subject to federal, state and local reimbursement laws and regulations . . . and false claim prohibitions, and represents that it operates an Ethics and Compliance Program, which reviews STANFORD's compliance with government health care program requirements and investigates allegations of non-compliance received from internal and external sources," which "may result in repayment of monies previously received from government and other third-party payers and/or disclosure of such overpayments, including, but not limited to, disclosure to the Centers for Medicare & Medicaid Services (CMS) and its contracted agents, or the Office of Inspector General, Department of Health and Human Services.

74. Despite its purported compliance program, STANFORD did not respond to the multiple "allegations of non-compliance received from" Relator, an "external source", nor did STANFORD return or disclose these overpayments to CMS and other carriers.

75. Defendants conspired to violate the FCA by causing the submission of false or fraudulent claims; conspired to make and use, or cause to be made or used, false records material to false or fraudulent claims; and, once put on notice of the unlawful billing, conspired to not disclose or return the resulting overpayments to the U.S., the State, and private insurers.

76. The practices complained of herein are continuing, resulting in the submission of additional false or fraudulent claims to Medicare, Medi-Cal, and private insurers, including, without limitation, Medigap carriers.

COMMON FACTUAL ALLEGATIONS

IV. GOVERNING STATUTE

VIOLATIONS OF THE FALSE CLAIMS ACT: 31 U.S.C. § 3729, *et seq*.
(By Plaintiff United States Against All Defendants)

77. The allegations of the preceding paragraphs are incorporated by reference as if fully set forth herein.

78. This claim for violations of the False Claims Act, 31 U.S.C. § 3729, *et seq*., is brought by Relator in the name of the United States, pursuant to 31 U.S.C. § 3730(b). Relator is an "original source" of the information on which this claim is based, as that term is defined in 31 U.S.C. § 3730(e)(4)(B).

79. 31 U.S.C. § 3729(a)(1)(A) provides that any person who:

> knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval . . .

> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 . . . , plus 3 times the amount of damages which the Government sustains because of the act of that person.

80. 31 U.S.C. § 3729(b)(1) defines "knowingly" to "mean that a person, with respect to information – (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require[s] no proof of specific intent to defraud."

81. In relevant part, 31 U.S.C. § 3729(b)(2) defines "claim" as:

> any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that—
>
> (i) is presented to an officer, employee, or agent of the United States; or
>
> (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government's behalf or to advance a Government program or interest, and if the United States Government—
>
> (I) provides or has provided any portion of the money or property requested or demanded; or
>
> (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded . . . .

82. The Medicare and Medicaid claims submitted by Defendants to CMS and/or its Medicare Administrative Contractors and/or the MMIS Fiscal Intermediaries are "claims" within the meaning of the FCA.

83. By virtue of the acts described above, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval by regularly and freely unbundling and separately charging for surgeries and

procedures that were part of a global fee schedule, and thus not eligible for separate billing, in violation of 31 U.S.C. § 3729(a)(1)(A).

84. By virtue of the acts described above, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval for innumerable "single stage immediate mastectomy reconstructions" which were not performed as such, in violation of 31 U.S.C. § 3729(a)(1)(A).

85. 31 U.S.C. § 3729(a)(1)(B) provides that any person who:

> knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim . . . .
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 . . . , plus 3 times the amount of damages which the Government sustains because of the act of that person.

86. 31 U.S.C. § 3729(b)(4) defines "material" as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."

87. By virtue of the acts described above, Defendants knowingly made, used, or caused to be made or used, false records and statements material to the foregoing false or fraudulent claims, in violation of 31 U.S.C. § 3729(a)(1)(B). Specifically, Defendants knowingly submitted false or fraudulent claims using false CPT billing codes, which not only influenced, but determined, the amount they were paid.

88. The United States, unaware of the falsity or fraudulence of the claims presented by Defendants, or the falsity of the records and/or statements which the Defendants made or used, or caused doctors and other health care providers to make, and in reliance on the accuracy thereof, paid Defendants, doctors, and other health care providers for claims that would otherwise not have been allowed, suffering damages.

89. 31 U.S.C. § 3729(a)(1)(G) provides that any person who

> knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money to the Government . . .
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 . . . , plus 3 times the amount of damages which the Government sustains because of the act of that person.

90. 31 U.S.C. § 3729(b)(4) defines "obligation" to include "an established duty, whether or not fixed, arising from an express or implied contractual . . . relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment[.]"

91. By virtue of the acts described above, Defendants knowingly concealed and/or knowingly and improperly avoided an obligation to pay or transmit money to the Government resulting from Defendants' retention of the foregoing overpayments, in violation of 31 U.S.C. § 3729(a)(1)(G).

92. As a result of the above-described conduct, the United States is entitled to civil penalties and treble damages as provided by 31 U.S.C. § 3729(a)(1).

93. 31 U.S.C. § 3729(a)(1)(C) provides that any person who "conspires to commit" any of the foregoing violations is liable for the same civil penalties and treble damages. Defendants conspired to commit each the violations alleged, for which they are jointly and severally liable.

V. BACKGROUND FACTS

A. Medicare, Medi-Cal, and Medigap Insurance

94. The Health Insurance for the Aged and Disabled Program, 42 U.S.C. § 1395, *et seq*., popularly known as Medicare, is a health insurance program

administered by the United States that is funded by taxpayer revenue. Medicare is overseen by the U.S. Department of Health and Human Services through its Center for Medicare and Medicaid Services ("CMS").

95. Medicare was designed to be a health insurance program and to provide for the payment of, *inter alia*, hospital services, medical services and durable medical equipment to persons over sixty-five (65) years of age, and for certain others that qualify under the terms and conditions of Medicare. Individuals/patients who receive benefits under Medicare are commonly referred to as "beneficiaries."

96. Medicare consists of four distinct parts: Part A provides hospital insurance with coverage for inpatient hospital services, skilled nursing care, and home health and hospice care; Part B provides supplementary medical insurance for physician services, outpatient services, and certain home health and preventive services; Part C is a private plan option for beneficiaries that covers all Part A and B services, except hospice; and Part D covers prescription drug benefits.

97. A Medicare Supplement Insurance (Medigap) policy is health insurance sold by private insurance companies that pays some of the health care costs that Medicare doesn't cover, including 20% of most Part A and Part B charges. Each standardized Medigap policy must offer the same basic benefits, no matter which insurance company sells it.

98. In California, 27 private insurers offer Medigap policies, which are regulated by the California Department of Insurance. Commercial carriers receive government funds for administration of Medicare Advantage patients. Hence commercial carrier claims are relevant to Medicare and *vice versa*. *See* http://www.insurance.ca.gov/01-consumers/105-type/95-guides/05-health/03-medsup/upload/msrg2018consumerphonerpts.pdf In 2015, 475,741 California Medicare beneficiaries, constituting 14.1%, had Medigap

policies. *See* https://www.ahip.org/wp-content/uploads/2017/05/Medigap_Report_5.1.17.pdf.

99. The Medicaid program is a cooperative undertaking between the federal and state governments to help the states provide health care to low-income individuals. The Medicaid program pays for services pursuant to plans developed by the states and approved by the U.S. Department of Health and Human Services through CMS. *See* 42 U.S.C. §§ 1396a(a)-(b). States pay doctors, hospitals, pharmacies, and other providers and suppliers of medical items and services according to established rates. *See* 42 U.S.C. §§ 1396b(a)(1), 1903(a)(1). The federal government then pays each state a statutorily established share of "the total amount expended ... as medical assistance under the State plan[.]" *See* 42 U.S.C. § 1396b(a)(1).

100. In California, the Medicaid program is known as Medi-Cal. As of May 2018, 7,068,665 female California residents were covered by Medi-Cal. *See* https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_at_a_Glance_May2018_ADA.pdf

101. For the fiscal year 2017-18, approximately *$92.734 billion* in Medi-Cal program funds will be expended on medical care services, of which the State will pay approximately $18.994 billion, and the federal government will pay approximately $56.699 billion. *See* https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2018_May_Estimate/M1899_Medi-Cal_Local_Assistance_Estimate.pdf

B. Medicare, Medi-Cal, and Medigap Claims

102. Enrolled providers of medical services to Medicare beneficiaries are eligible for reimbursement for covered medical services. By becoming a participating provider in Medicare, enrolled providers agree to abide by the rules, regulations,

policies and procedures governing reimbursement, and to keep and allow access to records and information as required by Medicare.

103. The Medicare Enrollment Application form for Institutional Providers, CMS-855A, requires that an authorized official such as the chief executive officer execute a "Certification Statement" that "legally and financially binds this provider to the laws, regulations, and program instructions of the Medicare program." Through its authorized official, the Institutional Provider must also certify that:

- I have read and understand the Penalties for Falsifying Information . . . . I understand that any deliberate omission, misrepresentation, or falsification of any information . . . contained in any communication supplying information to Medicare . . . may be punished by criminal, civil or administrative penalties, including but not limited to the denial or revocation of Medicare billing privileges, and/or imposition of fines, civil damages, and/or imprisonment.
- I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.
- I agree that any existing or future overpayment made to the provider by the Medicare program may be recouped by Medicare through the withholding of future payments.
- I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

104. Medicare maintains a unique National Provider Identifier (NPI) system,[1] which assigns a unique, 10-digit numeric identifier to each institution, physician, non-physician practitioner, or medical group practice requesting or

[1] The system formerly known as Unique Physician Identification Number (UPIN) was discontinued in June 2007, and replaced by the NPI system.

receiving payment for services provided to beneficiaries. NPI's are assigned to institutions as well as individual health care providers. Billing CMS requires utilization of the NPI's of both the institution and the individual rendering provider.

105. CMS administers the Medicare program through its contractors. CMS contracts with Medicare Administrative Contractors to process Medicare claims and perform administrative functions. In California, CMS currently contracts with Noridian Healthcare Solutions, LLC ("Noridian"), which administers and pays Part A and Part B claims from the Medicare trust fund, a reserve of monies provided by the federal government.

106. To bill Medicare for services provided to beneficiaries in California, facility providers submit a claim on Form CMS-1450 to Noridian, usually in electronic form, certifying that the contents of the form are true, correct, complete and that the form was prepared in compliance with all Medicare laws and regulations.

107. To bill Medicare for services provided to beneficiaries in California, individual physicians and practices submit a claim electronically (837P) or on Form CMS-1500 to Noridian, containing certain required information pertaining to the Medicare beneficiary, including the beneficiary's name, health insurance claim number ("HIC"), the date the subject service was rendered, the location where the service was rendered, the type of services provided, the CPT code, the number of services rendered, an ICD-9 code reflecting the patient's diagnosis, the charges for each service provided, the provider's NPI, and a certification that the services were personally rendered by the provider.

108. If the Medicare beneficiary has a Medigap policy, Medicare will forward the processed claim to the private Medigap carrier to process accordingly (based on deductible, copays, and co-insurance for a given Medigap plan). The Medigap carrier generally looks exclusively to Medicare to determine the

validity and allowable amount of the provider's claim, however carriers like Blue Shield of California and others are now overriding Medicare allowables, and paying based on commercial carrier policies.

C. Medicare Contractors

109. Medicare has multiple national contractors that administer its plans. Noridian and Palmetto GBA are such contractors. Palmetto provides a simple tool for providers to lookup CMS global days. *See* https://www.palmettogba.com/palmetto/global90.nsf/Front?OpenForm#step1

110. For example, entering the CPT code "19302" into this search tool reflects that this is a major surgery code for mastectomy with a 90-day global period:

D. CPT Codes and Global Days

111. The American Medical Association ("AMA") has established certain codes to identify medical services and procedures performed by physicians, known as the Physicians Current Procedural Terminology ("CPT") system. CPT codes are widely used and accepted by health care providers and insurers, including Medicare, Medi-Cal, and other public and private insurers.

112. As CMS explains, it

> developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in [Medicare] Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). *See* https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

113. The amount allowed by Medicare/CMS for each CPT code, by year the services were rendered and by locality, is available at https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx. The amount allowed for each code varies by location, and generally varies over time. Many codes have been reduced in value over the prior 10 years.

114. Medicare payment for a surgical procedure includes the pre-operative, intra-operative, and post-operative services routinely performed by the surgeon or by members of the same group with the same specialty. Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician.

115. The "global surgical package," also called global surgery fee, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. Attached hereto as Exhibit "Z" is a true and correct copy of CMS guidelines for global surgical codes. CMS assigns a fixed total or "global" fee for a codified surgery. The global fee payment for a code encompasses the work to perform the surgery as well as the before and after-care for the surgery.

116. The national global surgery policy became effective for surgeries performed on and after January 1, 1992. Medicare established a national definition of a "global surgical package" to ensure that Medicare Administrative Contractors (MACs) make payments for the same services consistently across all jurisdictions, thus preventing Medicare payments for services that are more or less comprehensive than intended. *See* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GloballSurgery-ICN907166.pdf

117. Global surgery applies in any setting, including an inpatient hospital, outpatient hospital, Ambulatory Surgical Center (ASC), and physician's office.

When a surgeon visits a patient in an intensive care or critical care unit, Medicare includes these visits in the global surgical package.

118. Physicians who furnish the surgery and all of the usual pre-and post-operative care may bill for the global package by entering the appropriate CPT code for the surgical procedure only. The Medicare approved amount for these procedures *includes* payment for services related to the surgery when furnished by the physician who performs the surgery. Separate billing is not allowed for visits or other services that are included in the global package. Thus, a surgeon cannot "unbundle" and bill separately for the pre-operative visit the day before surgery, or break components of a global surgery and bill into *"a la carte"* upcoded components. The following services are included and not separately billable for payment:

- Intra-operative services that are normally a usual and necessary part of a surgical procedure.
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room.
- For minor procedures, this includes pre-operative visits the day of surgery.
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery.
- Post-surgical pain management by the surgeon.

119. Evaluation and Management services ("E/M" or "visit") on the day before major surgery, or on the day of major surgery that result in the *initial decision to perform the surgery* are *not* included in the global surgery payment for the major surgery. Therefore, these services may be billed and paid separately.

120. Pursuant to CMS, codes with "090" are major surgeries which have a 90-day post-operative period which by definition includes one day pre-operative. Also, the day of the procedure is generally not payable as a separate service. Thus,

the total global period is 92 days, counting one day before the day of surgery, the day of surgery, and the 90 days immediately following the day of surgery.

FIRST CAUSE OF ACTION

"FALSE BILLING FOR NON-REIMBURSABLE SERVICES"
VIOLATION OF FCA: PRESENTATION OF FALSE CLAIMS FOR UNBUNDLED SURGICAL PRE-OPERATIVE VISITS
(Against Defendants SHC, DIRBAS, ZUMWALT, and DOES 1-10, and Each of Them)

121. Plaintiff repeats and reincorporates the allegations of all previous and subsequent paragraphs as if set forth in full at this point.

122. After the decision for surgery was made, Defendants institutionally and as a matter of routine policy required most patients to return a day or two before surgery for a "pre-operative" visit with the surgeon. Defendants then separately tacked on a charge for a "comprehensive return visit" (CPT 99214-99215) before surgery at $268-$491 per visit. STANFORD's *unbundling* scheme resulted in a globally higher professional fee of roughly $1268-$1491 for the same surgery, and a 26%-49% increase per professional services claim.

123. Moreover, in addition to professional fee upcoding, STANFORD upcoded and charged facility fees as well as the professional fees. Hence there was a compounding of the fraudulent fees, where a non-chargeable visit resulted not only in a false charge for the visit, but also stacked facility fees and supplies which otherwise were not chargeable during the global fee.

124. Defendants SHC, DIRBAS, ZUMWALT and DOES 1-10 (collectively "Defendants" as to this Count), knowingly unbundled and billed countless pre-operative visit codes (CPT 99213-99215) which they knew were not chargeable, in violation of global surgery rules, which specifically prohibit charging for a

visit after the decision for surgery has been made, and *before* surgery. (*See* Exh. Q, Dirbas billing ledgers, and Exh. "Z" Medicare Global Rules)

125. In the event the insurance carrier caught the false billing and demanded a refund, Defendants then surreptitiously "balance billed" the patient directly for the fraudulent charge. When Defendants' fraud went unnoticed for 365 days, per the insurance contracts and laches, Defendants were entitled to keep the entirety of the fraudulent funds. Despite knowledge of the overbilling, Defendants made no attempt to refund the patients or the carriers, as they were required to do.

Rule

126. The national global surgery policy became effective for surgeries performed on and after January 1, 1992. A national definition of a "global surgical package" has been established to ensure that payment is made consistently for the same services across all A/B MAC (B) jurisdictions, thus preventing Medicare payments for services that are more or less comprehensive than intended. (Accessed https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/GloballSurgery-ICN907166.pdf)

127. The "global surgical package", also called global fee, includes all the necessary services normally furnished by a surgeon before, during, and after a procedure. CMS assigns a fixed total or "global" fee for a codified surgery. The global fee payment for a code encompasses the work required to perform the surgery as well as the before and after-care for the surgery.

128. Major surgical codes like breast surgery have a fixed reimbursement fee to the surgeon. The surgical fee is coded using CPT codes. The CPT codes for many major surgeries have a "global fee" basis. That means that the surgeon is

paid for example $1000 dollars in total for that surgery including any office visits after the decision for surgery has been made, through 90 days after the surgery ("global period"). Therefore a "pre-surgery" visit is not separately chargeable to anyone, including the patient. Once the decision for surgery is made, another pre-operative visit cannot be stacked on top of the global surgery fee. (*See* Exh. "Z")

129. Under the global surgery fee program, a surgeon is not entitled to charge anything for the visit the day or days before surgery as "pre-op" nor is the surgeon permitted to charge for suture removal or wound checks for 90 days after the date of surgery. Physicians who furnish the surgery and furnish all usual pre-and post-operative care may bill for the global package by entering the appropriate CPT code for the surgical procedure only.

130. The Centers for Medicare Services ("CMS") and commercial carriers specifically prohibit providers for "unbundling" and charging for any visit that is subject to the global surgical fee. Such a practice would increase health care costs and expenditure by the carrier often 25-50% more per surgery, as was done in Relator's case.

Analysis

131. Relator's investigation demonstrated that on 12/11/12 SHC and DIRBAS fraudulently presented a healthcare claims to ABC for Relator by unbundling and billing a pre-operative visit as 99215 for $494 , despite that they had already charged a 99205 for a new patient visit for surgery on 11/9/12, and knew at the time of the claim submission that the 12/11/12 visit was "global" and not-reimbursable. On 12/12/12 SHC and DIRBAS also billed CPT code 19304 for a major surgery knowing that CPT code "19304" billed on 12/12/12 has a 1-day pre op global as well as 90-day post op global. CPT 19304, as with most major

surgery codes, is a global fee that includes the pre-operative and post-operative visits within its fee. (Exh. "A")

132. STANFORD therefore knowingly received and retained unjust enrichment for CPT code "99215" on 12/11/12, "comprehensive patient exam" as part of the pre-operative fee before a major surgery CPT code "19304" ($1600). The correct coding with the global codes would not have resulted in any more enrichment to STANFORD, other than the surgical fee for code 19304. STANFORD knowingly collected unjust enrichment of $341 for an included service, in combination form the patient and the insurance carrier, and failed to return the unearned funds despite knowledge of the falsity of their claim.

133. On 12/12/12 and on countless dates before and thereafter SHC,, DIRBAS, and Does 1-10 improperly unbundled and billed carriers for non-chargeable pre-operative visits, and also demanded their billers *appealed* improperly denied visits for further revenue. STANFORD actually submitted false claims to the commercial carrier and the government, whom in turn made payments to STANFORD based on the fraudulent activities.

134. Given the magnitude of SHC's billing conduct, accordingly, Relator submitted a Freedom of Information Act ("FOIA") request to CMS to establish foundational background for her claim and confirm the billing and coding allegations herein from more records for DIRBAS and SHC.

135. CMS provided Relator with responsive coding, billing, and payment records for DIRBAS and SHC, a true and correct copy of which, with minor highlighting and redaction, is attached hereto as Exhibit "Q". These records show that from 2010 to 2016, DIRBAS billed CMS countless times with high level 99215 codes for non-billable pre-operative visit codes, and many dates on which he neither personally rendered the billed services, nor did he sign the records.

136. Review of a large number (more than $3 million) of exemplar adjudicated government claims for STANFORD surgeons Dr. FRED DIRBAS, Dr. Amanda Wheeler, and others from 2010 to 2018 demonstrated that STANFORD surgeons routinely and improperly unbundled the "pre-operative" visit and billed the carriers and or patients for this impermissible fee as a separate service stacked onto the standard surgical fees more than 100 times and on multiple dates from 2010-2016, thereby constituting fraud.

137. For example, surgery code 19304 is billed at $1200. But the STANFORD surgeon gives himself an unearned raise (bonus) by unlawfully tacking on a code for an extra office visit as 99215 ($494). The surgeon therefore unlawfully has taken a true $1200 billable surgical service and inflated his fee to a $1694 billable service. STANFORD is thus reimbursed on the inflated $1694, as upcoded and billed, hence a fraudulent claim.

138. A typical SHC surgeon Dr. Amanda Wheeler billed just Medicare $1,494,584.50 or approximately $1.5 million over a four-year period from 2013 to 2017. $77,8103.5 which equates to 50% of that amount was breast surgery and included countless billings for non-reimbursable pre-operative visits. On information and belief, of Dr. Wheeler's subtotal, no less than 11-20% of claims were upcoded and/ or unbundled according to the schemes described herein.

139. In 3 of the years examined, STANFORD reported to the State that it performed 34,046 surgeries in 2016, which was up from 32,956 surgeries in 2015, and up from 30,751 surgeries in 2014. At a very conservative estimate that 13% of the total in 2016 surgeries were preceded by an unbundled pre- or post-op visit, that totals 4426 surgeries where typically a high complexity office visit code (CPT 99214 to 99215) was wrongly billed, and hence subject to FCA.

140. In simple calculation for 2016, extrapolating STANFORD's conservative number of unbundled pre-operative visits in 2016 multiplied by $341.97 per

captured pre-operative visit results in unjust enrichment to STANFORD of $1,513,559.22 in professional fees, plus doubled facility fees, in 2016 *alone*.

141. STANFORD executives with knowledge of the fraudulent billing activities alleged herein include Vice president Ms. Debra ZUMWALT, who is the head of billing compliance at SHC. From December 2014 through at least March 2018, ZUMWALT knew of and directed those under her to present false records material to obligation to pay and instructed those under her to conceal Defendants' demonstrated schemes and institution's billing noncompliance. ZUMWALT masterminded the upcoding and unbundling at SHC and ratified the fraud by her legal review of the SHC schemes and how to "game the system" without detection.

142. STANFORD billing compliance officer Ms. Chantel Susztar is the Director of Hospital Billing Integrity. She is another executive with knowledge of the fraudulent billing activities demonstrated herein. Ms. Susztar was under the direction of ZUMWALT and DIRBAS when she signed the correspondence dated "Feb. 7, 2018" which admitted to unbundling and improper billing of surgical preoperative visits on 12/11/12. (*See* Exh. B)

Foundational and Background Facts In support of the Cause of Action

143. On 06/29/16 SHC, DIRBAS, and DOES 1-10 tendered a false and fraudulent claim to Medicare for $3279 under penalty of perjury for two office visits (one a pre-operative visit) and a major surgery. SHC and DIRBAS violated global surgical fees because the pre-operative visits the day before surgery was *unbundled* and otherwise not billable. SHC and DIRBAS knew the pre-operative visit was not billable when they submitted the bill for payment. (Exh. "Q")

144. On 6/28/16 pursuant to FCA, $263 (7%) of just the professional fees was fraudulently collected. Incorporating the related fraudulent facility and operating room fees, STANFORD and DIRBAS received and retained at least 13-17% in unjust total enrichment from Medicare. (Billing National Provider Identification ("NPI") 1437292927, Rendering NPI 1154457091).

STANFORD'S CODING		*CORRECT* CODING	
CPT 99215 (pre-op visit)	$263	CPT No Charge Pre-op	$0
STANFORD Fee	$263	Correct Fee	$0

145. STANFORD freely and habitually unbundled pre-operative **visits** and collected unjust enrichment for "free- services". STANFORD did this through two separate unlawful charges, neither of which were allowed: (1) STANFORD billed a professional fee for the surgeon's pre-op visit , and (2) STANFORD additionally billed a facility fee[2] for the institution on each date of professional service.

Conclusion

146. According to sworn testimony of former STANFORD billing supervisor Ms. Gaines, STANFORD manager Terri Fischer and her associates at UHA told billers to disregard CCI, and supervisors guided coders by "cheat sheets" and directives to always bill high and maximal, regardless of documentation or necessity. Thus, STANFORD's conduct is demonstrative of fraud within the statutory definitions within false claims acts. (Exh. "C", Decl. Gaines, generally)

[2] Facility fees pay richly thousands of dollars for global surgery codes. STANFORD's pre-operative visit unbundling scheme added hundreds and thousands of dollars in *facility fees* in addition to the professional doctor fees per claim.

147. STANFORD's very high number of pre-operative CPT codes billed annually is achieved through "high rates of coding" and creative coding schemes and unbundling, of which *reasonable inferences* of fraud may be made. *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

148. Defendants knew of the falsity of their statements when they made them, and if they did not know of the falsity, they did not have any reasonable basis to believe the statements to be true. Defendants were told to upcode in order to obtain higher productions and revenues for expansion and promotion. Plaintiff(s) relied on Defendants' misrepresentations, and as a result was (were) damaged in amounts to be proven at trial.

149. Had this State's carriers and the government have known of the concealed facts set forth herein, they would never have remitted payments to SHC for these false and fraudulent healthcare claims.

150. The actions of defendants herein were (l) fraudulent, meaning an intentional misrepresentation, deceit, or concealment of a material fact known to the defendants with the intention on the part of the defendant of thereby depriving a person of property or legal rights or otherwise causing injury; (2) malicious, meaning conduct which is intended by the defendants to cause injury to the PLAINTIFF or despicable conduct which is carried on by the defendants with a willful and conscious disregard of the rights or safety of others; (3) and/or oppressive, meaning despicable conduct that subjects a person to cruel and unjust hardship in conscious disregard of that person's rights; and done with the intention of depriving PLAINTIFF of substantial rights. PLAINTIFF is therefore entitled to punitive damages in a sufficient amount to make an example of, punish defendants, and deter future fraudulent, oppressive and malicious misconduct in an amount according to proof at trial.

151. The Defendants, and each of them, did the things described herein, among other things, fraudulently, maliciously, and oppressively. Their conduct was despicable, vile, base, contemptible, miserable, wretched and loathsome, and was carried on with a willful and conscious disregard of the rights of Plaintiff. That by reason of said conduct as described herein, Plaintiff is entitled to an award of exemplary damages pursuant to the FCA against the Defendants.

152. This action alleges that STANFORD's violation of FCA likely began prior to 2010 and is continuing. Hence the base damages for STANFORD's unbundling of professional fees as to this count *alone* for just pre-operative visits, extrapolated by the number of years, is easily *$15-50 million dollars*. STANFORD captured improper facility fees for unbundled pre-operative visits which are also subject to FCA. That figure can double once the technical or facility fees are added. Hence, FCA entitles Plaintiffs to *penalties* of $5000 to $10,000 per claim in addition to the base recovery.

153. Defendants' codes that should be reviewed are major surgery codes and improperly billed pre-operative visits (99213-99215) CPT charged within a few days to weeks before surgery.

SECOND CAUSE OF ACTION
"UPCODED UNITS FRAUD SCHEME"

VIOLATION OF "FCA": PRESENTATION OF FALSE RECORD FOR UPCODED UNITS OF MEDICAL SUPPLIES AND SURGICAL IMPLANTS

(Against Defendants SHC, DIRBAS, ZUMWALT and DOES 1-10 (herein collectively "Defendants" as to this Count) and Each of Them)

154. Plaintiff repeats and reincorporates the allegations of all previous and subsequent paragraphs as if set forth in full at this point.

155. STANFORD harassed its doctors and told them to bill 99205 and 99215 codes, and pushed its coders to bill always upcoded and multiple units of surgical goods, and intended to always report higher volume billing and revenues, when in fact one or no units were actually used for the patient.

156. Defendants SHC, DIRBAS, ZUMWALT, and each of them, and DOES 1-10 (collectively "Defendants" as to this Count) upcoded and billed higher units of expensive surgical supplies and medical goods than actually used, documented by the medical records, reasonable, or medically necessary. There were no demonstrable instances where Defendants in error *underbilled* the claims; rather Defendants' claims were always upcoded and the billing "high frequency of codes" and "upcoding" always in Defendants' favor.

157. STANFORD's very high number of upcoded multiple units billed annually is achieved through "high rates of coding" and creative coding schemes and unbundling, of which reasonable inferences of fraud may be made. *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

158. STANFORD exercised its billing schemes regularly in surgery, especially the expanding field of breast cancer surgery and mastectomy, where one implant costs several thousand dollars, and one artificial surgical tissue used is billed at $17,300 *per unit*. (*See* Exh. B: STANFORD letter 2018 and refund for false multiple units and services billed)

159. In the event the insurance carrier caught the false billing and demanded a refund, Defendants then surreptitiously "balance billed" the patient directly for the fraudulent charge. When Defendants' fraud went unnoticed for 365 days, per the insurance contracts, Defendants were entitled to keep the entirety of the fraudulent funds. (Exh. "E")

160. On 12/12/12 SHC and DIRBAS presented a false and fraudulent healthcare claim for payment to ABC for 2 units of Alloderm, when only 1unit was used, and only 1 unit was recorded in the surgeon's operative report. ABC paid SHC and DIRBAS for 2 units of Alloderm, whereas had Defendants billed properly, ABC would have never paid Defendants for 2 units. (Exh. "A")

161. SHC, ZUMWALT, DIRBAS, and DOES 1-10 knew that their claim to ABC was false, they were further notified in writing of the falsity of their claim on or about March 20, 2018, they conceded that their 2 units billed was upcoded, but they failed to refund the upcoded unit. the claims and ultimately retained. In 2018, STANFORD conceded in writing to ABC and the patient the overbilling for the surgical supply. Defendants' false claim on 12/12/12 resulted in a fraudulent payment of $17,300. (Exh. "B")

Rule

162. All medical and surgical supplies must be presented for claims to the carriers using CPT and HCPCS code, with accurate units. Rendering healthcare providers and facilities must only bill for units and supplies which are actually used, and which are "reasonable and medically necessary". Accurate surgical and nursing records must reflect the units and items used for each beneficiary. Surgeons' operative reports must support the number of surgical durable good billed, and the nursing records must support the surgeon's operative report on supplies used. In other words, the medical record evidence must not contradicts the billings, and the billings must not contradict the medical records.

163. Each facility is also required to have a billing compliance plan in place whereby there are adequate checks and balances to ensure upcoding and improper billing does not occur. Routine upcoding of units of good and supplies is healthcare fraud. Should an overage be billed, the payment should be promptly refunded to the carrier and/or the patient.

Analysis

164. STANFORD, ZUMWALT, DIRBAS, and DOES 1-10 failed to maintain such a billing compliance plan, or to adhere to correct coding in countless instances including on 12/12/12. (Exh. "B")

165. STANFORD typically bills multiple units of surgical goods, when in fact one or no unit was actually used. STANFORD's true usage of durable goods can be *reconciled* with the purchase orders, number of units purchased from the manufacturer(s) annually, and the number of units billed to patients. Upon information and belief, STANFORD's purchase of Alloderm was less than half the number of units STANFORD billed for that code per year, hence STANFORD's double and triple false billing per unit actually used.

166. STANFORD exercises its billing schemes regularly in the expanding field of breast cancer surgery and mastectomy, where one implant costs several thousand dollars, and one artificial surgical tissue used is billed at $17,300 *per unit*. (*See* Exh. B: STANFORD letter 2018 and refund for false multiple units and services billed)

167. In many cases, SHC surgeons' operative reports don't support the number of surgical durable good billed, and the nursing records don't support the surgeon's operative report. In other words, the evidence contradicts the billings, and the billings are contradictory to the medical records. Despite this, SHC and STANFORD billers and coders are instructed to upcode and overbill, regardless of the controverting medical records. (*See* Decl. Gaines ¶¶6-7)

168. On 12/12/12 and on countless dates before and thereafter from 2010 through present SHC, DIRBAS, ZUMWALT and DOES 1-10 improperly and knowingly unbundled and billed carriers for upcoded number of units of surgical goods and medical supplies, and billing managers like Jeanne Johnson

also appealed properly denied visits and charges, for additional unjust enrichment. (Exh. "E")

169. On or about March 10, 2018, STANFORD, DIRBAS, and ZUMWALT conceded in writing to having falsely billed ABC for the 2nd unit of Alloderm on 12/12/12, and admitted that 2 units were neither used, nor supported by the surgeon's operative report or nursing records.

170. On or about March 10, 2018 Chantel Susztar, SHC, DIRBAS, and ZUMWALT then misrepresented to Relator that they had timely refunded the 2nd unit of fraudulently billed Alloderm back to ABC, which was *untrue*. Defendants knew those statements as to making a refund to ABC] to be false when they made them to Relator on March 2018 because according to SHC's contract with ABC and general laches, the commercial claims are closed at 365 days. Hence Susztar, STANFORD, DIRBAS, and ZUMWALT never refunded the fraudulently billed 2nd unit of Alloderm to the carrier, or the Relator.

171. STANFORD executives with knowledge of the fraudulent billing activities alleged herein include General Counsel and Vice president Ms. Debra ZUMWALT, who is the head of billing compliance at STANFORD. From December 2014 through at least March 2018, ZUMWALT knew of and directed those under her to present false records material to obligation to pay and instructed those under her to conceal Defendants' demonstrated schemes and institution's billing noncompliance. ZUMWALT communicated with Relator multiple times by email as to the fraudulent charges and it was under ZUMWALT whereby the refund(s) to Relator was ordered.

172. SHC billing compliance officer Ms. Chantel Susztar is the Director of Hospital Billing Integrity. She is another executive with knowledge of the fraudulent billing activities demonstrated herein. Ms. Susztar was under the direction of ZUMWALT and DIRBAS when she signed the correspondence

dated "Feb. 7, 2018" which admitted to unbundling and improper billing of surgical preoperative visits on 12/11/12. (*See* Exh. B)

173. On or about February 7, 2018 ZUMWALT, SHC, and DIRBAS instructed Susztar to misrepresent to Relator that SHC had refunded the carrier for the upcoded units of Alloderm. ZUMWALT instructed Susztar to write to Relator and mislead Relator that the $15,300 refund for the upcoded unit of Alloderm had long prior been paid back to the carrier. When ZUMWALT, SHC, and DIRBAS caused to be misrepresented those facts to Relator, they knew those statements to be untrue because the laches on a claim close after 365 days, and they knew that ABC did not take a refund from SHC. Hence, STANFORD has retained the roughly $15,000 (allowed fee) for the fraudulently billed 2nd unit of Alloderm and has not refunded the amount to Relator, or the State.

Foundational and Background Facts In support of this Count

174. Proprietary data mining was undertaken of SHC adjudicated and paid Medicare claims[3] spanning 2010-2018 for representative providers at SHC to establish foundation, and buttress allegations herein of Defendants' false billing scheme. The examined data supported the aforementioned allegations.

175. A typical STANFORD surgeon Dr. Dung Nguyen billed Medicare alone $2,695,000.65 is a five-year span from 2012 to 2017. Dr. Nguyen is the Director of Breast Reconstruction at STANFORD Women's Cancer Center and she billed CPT 15777 (biologic or artificial tissue implant procedure) 23 times just to Medicare from 1/1/2013 to 12/31/2017; the majority of those were billed as bilateral procedures and at least 2 units of the artificial tissue were billed by STANFORD , regardless of how many units were used. Given that every

[3] Medicare beneficiaries have secondary plans which pay the 20% which Medicare does not cover. The secondary payments are covered by commercial carriers like Blue Shield and Anthem Blue Cross. Therefore Medicare claims are directly relevant to this commercial insurance False Claim Act.

healthcare claim submitted for payment must be transmitted with an "under penalty of perjury" affirmation, each dated false claim submitted by Nguyen was fraudulent within the meaning of FCA.

176. STANFORD freely and fraudulently upcoded billed quantities and units of exorbitant medical and surgical supplies. For example, throughout its hospitals and operating rooms, if one breast implant was used, STANFORD billed 2 units resulting in thousands of dollars of unjust enrichment. The surgeon's notes and operating room nurse notes showed one unit, but upcoding regularly resulted in billing more units than used. STANFORD then fraudulently double *billed another patient for the unused second implant* or surgical tissue that was already billed to another patient's carrier. (*See* Exh. MM- STANFORD admission)

177. STANFORD performed more than 220 mastectomies and hundreds more surgeries involving artificial tissue in one year alone. at an estimate that 100 of those cases had upcoded Alloderm units, where instead of 1 unit, 2 were fraudulently billed. That estimates to $1,700,000 per annum of false and fraudulent charges in just one medical supply code for mastectomy. Alloderm is also used in other surgeries and flaps and grafts, hence fraudulent billing for units of Alloderm is estimated in excess of $2.5 million dollars a year.

Conclusion

178. STANFORD actually submitted false claims to the commercial carriers and the government, whom in turn made payments to STANFORD based on the fraudulent billing activities based on upcoded number of units of surgical and medical goods used. The carriers justifiably relied on the false healthcare claims submitted by Defendants as being true. Had carriers not relied on Defendants' false statements, they would not have paid out on fraudulent claims. Hence, Plaintiff and its people have been damaged by Defendants' misrepresentations.

179. According to sworn testimony of former STANFORD biller Ms. Gaines, STANFORD billers are guided by "cheat sheets" and directives to always bill high and maximal, regardless of documentation or necessity. Thus, STANFORD's conduct is demonstrative of fraud within the statutory definitions within the FCA.

180. The CPT codes that should be reviewed are the volume and frequency of medical and surgical goods billed by Defendants, and high-end surgical supplies including artificial skin substitute (Alloderm) codes 15170-15171, 15777 and the total number of units billed per patient.

THIRD CAUSE OF ACTION
"MISREPRESENTATION OF RENDERING PROVIDER FRAUD SCHEME"

VIOLATION OF "FCA" FOR UPCODED SERVICES AND FALSIFIED RENDERING PROVIDERS, WHICH WERE IN FACT PROVIDED BY STUDENTS, NON-PHYSICIANS, INTERNS, AND UNLICENSED STAFF

(Against Defendants SHC, DIRBAS, ZUMWALT and DOES 1-10)

181. Plaintiff repeats and reincorporates the allegations of all previous and subsequent paragraphs as if set forth in full at this point.

182. SHC, DIRBAS, ZUMWALT and each of them, and DOES 1-10 (collectively "Defendants" as to this Count) and each of them upcoded or caused to be upcoded and improperly billed physician assistants ("PA") and unlicensed services as rendered by the attending doctors (misrepresented billing true rendering providers as billed).

183. Defendants using an army of unlicensed staff including interns and students billed for services by unlicensed staff which are non-billable, while misrepresenting to the carriers that services were provided by the attending physician, which was untrue. The attending physician in many hospital consults had never seen the patients, despite billing under their NPI for the care.

184. STANFORD's very high number of upcoded services and falsified rendering provider billed annually is achieved through "high rates of coding" and creative coding schemes and unbundling, of which reasonable inferences of fraud may be made. *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

Rule

185. Services rendered by unlicensed staff including students and interns not only constitute the unlawful unlicensed practice of medicine but are also entirely non-billable and non-reimbursable. All rendered care billed for healthcare reimbursement must be by a licensed provider who bills under his/her own NPI and name. All healthcare claims must therefore reflect under oath the true rendering provider of services. In other words, billing for services under another provider's name and NPI is prohibited and fraudulent.

186. Many payors according to national CMS guidelines for "incident to" services reimburse non-physician extenders or "mid-level providers" such as a nurse practitioners or PAs often at a lower percentage of fees (15-20% less) than would be paid to a physician. Unlicensed providers like medical students and medical assistants are ineligible to bill for services rendered. Procedures which are performed by unlicensed personnel without a medical doctor on site are typically also not chargeable.

187. The "incident-to" rules prohibit the doctor from billing for new patient visits provided by the PA, under the doctor's NPI. The doctor would sign off a note that he reviewed the chart without ever being involved in the direct care of the patient. "I have reviewed the Physician Assistant's note and agree with..." This

is incorrect use of the non-physician practitioner and incorrect billing under the "incident to" guidelines.

Analysis

188. In Relator's case, SHC and DIRBAS billed for a PA to provide services on 12/11/12 but falsely billed those under DIRBAS's NPI resulting in higher reimbursement. DIRBAS admitted he never signed the 12/11/12 medical record. (Exh. "I") DIRBAS's full-time PA (Candace Schulz) billed a little over $200 in one year in total under her own NPI, and less than 20 total visits per annum, whereas nearly all of her visits were incorrectly reported under DIRBAS's NPI.

189. Certain PA and intern services at STANFORD are not incident to and are solely provided by the PA or intern while the physician is not on premises or is on vacation or away at another facility. STANFORD often uses a nurse practitioner or physician assistant to provide the "pre-operative" visit or return visit. However, STANFORD fraudulently bills the service under the physician who did not render services, and/or was not present.

190. For example, in Relator's account, on date of service 12/11/12 STANFORD billed and received full enrichment for CPT code "99215", "comprehensive patient exam" as part of the pre-operative fee before a double mastectomy, where the services were provided by PA Candace Schulz but billed under Dr. Fred DIRBAS. Thus, the visit on the day before the surgery (pre-op) was *unbundled* for $494, whereas that should have never been billed, and been part of the "global fee" for the surgery. The correct coding within the global caps would not have resulted in any enrichment to STANFORD for the 12/11/12 visit.

191. Thus, STANFORD is receiving unjust enrichment for these services on 2 counts. Not only are the pre-op services unbundled as in the First Cause of

Action, they are also often up-coded and up-charged for the higher-level provider (M.D.) who did not render any services.

192. STANFORD also improperly billed for services rendered by unlicensed personnel without onsite physician supervision. There are countless STANFORD billing records where there is no attending signature for unlicensed medical assistants and students rendering and billing services. These improper acts result in STANFORD's exorbitant healthcare earnings and ability to "game the system" by falsifying the true rendering provider services. On November 12, 2014, Dr. DIRBAS testified under oath that he had not signed for unlicensed practice of medicine by medical student notes and he had billed for those medical services, when he knew that his signature was required to affirm that he did in fact see the patient and render care or under his direct supervision.

193. Division Chiefs of each medical department at STANFORD regularly held revenue "training sessions" with doctors, and new interns and residents matriculating in July of each year on how to comply fully with STANFORD's maximal billing directives, and achieve the highest revenues regardless of unlawful use of upcoding and unbundling. After a training session on "enhanced" coding practices, the STANFORD Division Chief instructed the session "It's easy to code high and get the 99205's and 99215's (highest paying CPT codes) JUST CLICK, CLICK, CLICK, CLICK", referring to STANFORD's exploitation of its "Epic" electronic medical records. The Division Chiefs directed the ability to clone and replicate electronic medical records easily with "CLICK, CLICK, CLICK, CLICK" to upcode claims to commercial *and* government carriers alike. Division Chief Singh held these "revenue" meetings on or about September 2015 and August 2016 with SHC and Stanford University employees and facility, and instructed her subordinates

to maximize revenues through "CLICK, CLICK, CLICK, CLICK" and direct that " the key thing that we need is more revenue and we are a low income specialty. On those meetings, Singh said "We need you [residents, interns, coders, and faculty] to do coding at the highest level." Singh also needed the "dean's tax" to be paid from the SHC revenues to fund Stanford University.

194. Using its cadre of unlicensed students, interns, and staff which rendered direct patient services, STANFORD also falsely billed all claims under the attending doctor's name and "NPI" regardless of the fact that the attending *never* saw the patient, and *never* participated in the patient care, hence fraudulent billing. STANFORD UNIVERSITY would also "cattle prod" the doctors (clinical professors) with their job security as instructors to upcode from low paying codes to the highest paying codes regardless of what services were provided and despite disagreement from the doctor because the UNIVERSITY had a fee-sharing agreement with STANFORD HOSPITAL called the "Dean's Tax". This policy where received a large percentage of the fees STANFORD doctors generated at STANFORD HOSPITAL through a 20-30 % "Dean's Tax" which allows the UNIVERSITY to share in the fraudulent profits of STANFORD HEALTHCARE.

195. If the doctors did not effectively upcode services as directed, STANFORD billers under the directives of revenue mastermind and Vice President ZUMWALT, who would have the final say by "scrubbing" all claims with upcoding prior to transmission to insurance carriers according to coding "cheatsheets".

196. On or about September 10, 2015 and September 18, 2018 STANFORD Division Chief Singh used the "revenue training sessions" attended by STANFORD coding managers and the division faculty and staff with examples of potential coding "opportunities" to increase the Division's revenues which

were scrutinized by STANFORD as subpar because the department lacked procedures and relied solely on upcoded office visits to meet its production quotas.

Foundational and Background Facts In support of the Cause of Action

197. Proprietary data mining was undertaken of SHC adjudicated and paid Medicare claims[4] spanning 2010-2018 for representative providers at SHC to establish foundational support of Defendants' false billing scheme. The data supported the aforementioned allegations.

198. STANFORD upcoded and falsified the identity of rendering providers of the majority if not all of midlevel provider office visits. Care was routinely provided by mid-level providers like physician assistants ("PA") without the supervising doctor but STANFORD falsely and knowingly billed exclusively under the physician National Provider Identification ("NPI"). STANFORD know or should STANFORD's misrepresentation of the rendering provider was fraud within the FCA.

Conclusion

199. According to sworn testimony of former STANFORD biller Ms. Gaines, STANFORD billers are guided by "cheat sheets" and directives to always bill high and maximal, regardless of documentation or necessity. Thus, STANFORD's conduct is demonstrative of fraud within the statutory definitions within false claims acts.

200. STANFORD uses many unlicensed staff and students, and otherwise mid-level providers throughout its surgical departments but billed exclusively under

[4] Medicare beneficiaries have secondary plans which pay the 20% which Medicare does not cover. The secondary payments are covered by commercial carriers like Blue Shield and Anthem Blue Cross. Therefore Medicare claims are directly relevant to this commercial insurance False Claim Act.

the surgeons' NPI even when the surgeon was on vacation. STANFORD also violated "incident-to" rules by freely billing new patient visits provided entirely by the PA, under the doctor's NPI. The doctor often would not even sign off a note that he reviewed the chart or did so without ever being involved in the direct care of the patient. This is incorrect use of the non-physician practitioner and incorrect billing under the "incident to" guidelines.

201. The CPT codes that should be reviewed are total billings by STANFORD surgical and medical PAs using their own NPI, which are negligible, as well as bills for SHC attendings on days they were out of state and or on vacation, yet continued to bill carriers and the government for services under their name.

FOURTH CAUSE OF ACTION
"OFFICE VISIT FRAUD SCHEME"

VIOLATION OF "FCA" FOR UPCODING OFFICE VISITS TO THE HIGHEST PAYING CPT CODES (99204, 99205, 99214, AND 99215) WITHOUT MEDICAL NECESSITY OR SUPPORTIVE MEDICAL DOCUMENTATION.

(Against All Defendants and Each of Them)

202. Plaintiff repeats and reincorporates the allegations of all previous and subsequent paragraphs as if set forth in full at this point.

203. Defendants, and each of them, and DOES 1-10 (collectively "Defendants" as to this Count) upcoded office visits to the highest-level paying CPT codes 99214-992215 and 99204-99205 (without medical necessity or reasonableness), and in disregard for lack of supporting medical services.

204. STANFORD's very high number of upcoded level of high office visits billed annually is achieved through "high rates of coding" and creative coding schemes and unbundling, of which reasonable inferences of fraud may be made. *United States ex rel. Integra Med Analytics LLC v. Providence Health and*

Services, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

205. Defendant DIRBAS in this action coded nearly all visits as 99205 or 99215, which demanded the highest payments. From 2010 to 2016, Defendants billed Medicare from $379 to $653 for a new patient CPT code 99205 visit. They billed Medicare $263 to $458 for a return patient, CPT code 99215 visit.

206. In comparison, from 2010-2016 Defendant DIRBAS billed Medicare CPT code 99211 (the lowest service) only once. The charge for CPT 99211 was $23.

207. Division Chiefs of each medical department at STANFORD regularly held revenue "training sessions" with doctors, and new interns and residents matriculating in July of each year on how to comply fully with STANFORD's maximal billing directives, and achieve the highest revenues regardless of unlawful use of upcoding and unbundling. After a training session on "enhanced" coding practices, the STANFORD Division Chief instructed the session "It's easy to code high and get the 99205's and 99215's (highest paying CPT codes) "*JUST CLICK, CLICK, CLICK, CLICK*", referring to STANFORD's exploitation of its "Epic" electronic medical records. Division Chief Singh told doctors and directed the ability to clone and replicate electronic medical records easily with "*CLICK, CLICK, CLICK, CLICK*" to upcode claims to commercial and government carriers.

208. Using its cadre of unlicensed students, interns, and staff which rendered direct patient services, STANFORD also falsely billed all claims under the attending doctor's name and "NPI" regardless of the fact that the attending never saw the patient, and never participated in the patient care, hence fraudulent billing resulting in exorbitant revenues and low overhead.

209. Stanford University would also harass and "cattle prod" the doctors (clinical professors) with their job security as instructors to upcode from low paying

codes to the highest paying codes regardless of what services were provided and despite disagreement from the doctor because the University had a fee-sharing agreement with STANFORD HOSPITAL called the "Dean's Tax". This policy where the University Dean received a large percentage of the tax advantaged dollars which STANFORD doctors generated at SHC through a 20-30 % "Dean's Tax", allowed the University to share in the fraudulent profits of SHC and its subsidiaries.

210. If the doctors did not effectively upcode services as directed, SHC and STANFORD billers would have the final say by "scrubbing" all claims with upcoding prior to transmission to insurance carriers according to coding "cheatsheets" and under imperative directives of STANFORD billing managers and executives including Chantel Susztar and DEBRA ZUMWALT.

211. On or about September 10, 2015 and September 2018 STANFORD Division Chief Singh used the "revenue training sessions" attended by STANFORD coding managers and the division faculty and staff with examples of potential coding "opportunities" to increase the Division's revenues which were scrutinized by STANFORD as "subpar" because the division lacked procedures and relied solely on upcoded office visits to meet its tight production quotas.

Rule

212. Outpatient office visits with a doctor are codified as CPT 99201-99205 for new patients, and 99211 to 99215 for return visits. The higher the code, the higher the fee and greater enrichment to the medical provider and institution.

213. A new patient visit would be codified as 99201 for a very short, limited problem. A new patient 99205 codifies a very extensive complex problem, typically 60-minute appointment. A return patient visit would be 99211 for a very short, limited problem. A return patient 99215 codifies a very extensive

complex problem, typically 40-minute appointment. These codes require the time to be face to face time with the billing doctor. Billing for services by unlicensed staff like a medical assistant or medical student do not count toward the face to face time with the physician and are ineligible for any code other than 99211.

214. Carriers and the government require that in addition to the facility NPI, that all claims include the true rendering health care provider. Falsifying the rendering provider is healthcare fraud.

Analysis

215. Relator's visits at STANFORD were charged always at the maximum and highest paying code. On 11/9/12 STANFORD billed 99205 for Relator, and on 12/11/12 billed 99215. These codes intimate the highest level of complexity and time required (60 minutes for 99205).

216. STANFORD surgeons including DR. FRED DIRBAS and Dr. Amanda Wheeler billed for far more than 7 patients per day, hence there is an impossibility that they could substantiate the time required for the number of 99205 and 99215 they fraudulently billed per day. In other words, there are no more than 7 or 8 hours in a workday. When a SHC doctors billed CPT 99205 code 15 times in one day, that calculates to 15 hours of face to face contact time, and it would be impossible for 1 doctor to achieve in a typical 7- 8 hour workday.

217. Counting the average work hours in a day as 7 for a provider, they would only be able to render 99205 to a maximum of 7 patients for an entire day. However, SHC doctors schedule and then bill far more than 7 patients in a day as codes 99205 and 99215.

Conclusion

218. On 12/12/12 and on countless dates before and thereafter STANFORD, DIRBAS, and DOES 1-10 improperly unbundled and billed carriers for upcoded office visits and services, and also appealed improperly denied visits for further revenue. STANFORD actually submitted false claims to the commercial carriers and the government, whom in turn made payments to STANFORD based on the fraudulent billing activities.

219. According to sworn testimony of former STANFORD biller Ms. Gaines, STANFORD billers are guided by "cheat sheets" and directives to always bill high and maximal, regardless of documentation or necessity. Thus, STANFORD's conduct is demonstrative of fraud within the statutory definitions within false claims acts.

220. Defendants' billed codes that were reviewed were physician office visit codes (99204-99205 and 99214-99215) and the total number of these CPT codes billed per provider per day. That showed the time billed per day exceeded 7-8 hours of office visits per day per physician and demonstrates that Defendants and their billers knew their billing was false and misreported the true rendering provider.

FIFTH CAUSE OF ACTION
LABORATORY AND "TISSUE FRAUD" SCHEME

VIOLATION OF "FCA" FOR UNBUNDLING AND UPCODING PATHOLOGY AND LAB CODES
(Against Defendants SHC, DIRBAS, ZUMWALT and DOES 1-10)

221. Plaintiff repeats and reincorporates the allegations of all previous and subsequent paragraphs as if set forth in full at this point.

222. Defendants SHC, DIRBAS, ZUMWALT and DOES 1-10, and each of them (collectively "Defendants" as to this Count) unbundled and upcoded pathology

codes (CPT 88302-88309 and 88312-88313, and 88341 and 88344) where they billed multiple units in excess of number of surgical tissues, and far greater complexity than actually "medically necessary or reasonable". Defendants also upcoded and unbundled laboratory services, whereby they billed for lab tests that were cancelled or not performed by the lab.

223. STANFORD's very high number of upcoded and unbundled lab and pathology services billed annually is achieved through "high rates of coding" and creative coding schemes and unbundling, of which reasonable inferences of fraud may be made. *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

Rule

224. Pathology codes are some of the simplest CPT in all of medicine to understand, encompassing from codes 88300-88399, and just 4 pages of the American Medical Association ("AMA") national coding reference book.

225. The rules are simple: 1 tissue, 1 jar, 1 CPT code. There are very few exceptions to this rule, which include instances where a tissue requires a special stain for diagnosis. Special stains are only required in 5-10% of cases, if even that. Accordingly, one tissue from 1 surgery can be usually billed as CPT code 88305, 88307, or 88309, depending on complexity.

226. A well-known and simple pathology income scheme is to circumvent proper billing, and unlawfully churn 1 tissue into multiple CPT codes, and to use multiple add-on special stain codes to obtain multiples of the allowed fee per specimen.

227. According to the AMA coding manual, CPT in surgical pathology codes (88300 through 88309) represent services. The higher the code, the greater the

fee. The code "reflects the physician work involved." The unit of service is the specimen. The CPT coding manual defines a specimen "as tissue or tissues that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."

228. CPT 88305 is the proper code for a reduction mammoplasty/ biopsy not requiring evaluation of margins. CPT 88307 is a breast excision with evaluation of margins as in a partial or simple mastectomy. CPT 88309 is a radical or modified radical mastectomy with regional nodes.

229. It is well known that National fee schedules in surgical pathology have been slashed since on or about 2011. The national reimbursement per CPT code "88307" for tissue pathology was $292.61 in 2013, was reduced to $288.50 in 2016, and reduced again to $240.71 in 2018.[5] The gradual decline in pathology CPT reimbursement would in effect deduce lower earnings and *higher overhead* since there is an expected reciprocal increase in costs of supplies, staffing, and the like.

Analysis

230. The known decline in laboratory and pathology reimbursement reasonably infers *higher overhead* calculations and lower profits. While there are expected reciprocal increases in costs of supplies, staffing, facilities, and the like, STANFORD shows "high rates of coding" and posts astonishing revenues amidst very low overheads, that are neither in line with community standards nor with lawful billing practices. (*See United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

[5] Referenced Medicare fee lookup at https://www.cms.gov/apps/physician-fee-schedule/search/search-results.aspx?Y=0&T=0&HT=0&CT=1&H1=88307&C=2&M=4

231. As a result of the reduced fee schedules, labs *and* pathology doctor's incomes have also been reduced, except at such institutions like STANFORD, and its affiliates like Lucille Packard Children's Hospital who have employed creating upcoding to actually increase their incomes despite the reduced per specimen fees.[6].

232. SHC and DIRBAS billing records for 12/12/12 show that 6 units of pathology codes were billed to ABC for Relator, but the surgeon's (Defendant DIRBAS) record showed that only 2 specimens were generated. (Exh. "A" and "I") On 12/12/12 SHC employees, billing staff, and SHC pathologist (Dr. Jensen) knew of the falsity of their claim for 6 units of high-level pathology codes when they tendered the upcoded claim to ABC.

233. Hence, there was no reasonable basis why STANFORD billed for 6 tissues where there were only 2 surgical tissues generated according to DIRBAS's signed operative record. SHC should have billed CPT 88307 or 88305 two units based on the surgical records, but instead SHC upcoded and billed additional units of pathology, resulting in more than $5800 of improper billing.

STANFORD'S CODING		*CORRECT* CODING	
CPT 88305 Level IV (2 units) CPT 88307 Level V (2 units) CPT 88303 Level II (2 units)	$1700 $3306 $1678	CPT 88307(2units) $827.52	
Stanford Billed	$6684	Correct Revenue	$827.52

Foundational and Background Facts in Support of This Count

234. As foundational facts, STANFORD's laboratory services including the pathology lab generates over $1 billion dollars of STANFORD's annual total $4.5 billion dollar revenue. Hence the lab and pathology department is a substantial (*vs*. trivial) source of Defendant's revenues.

[6] Sutter has been the subject of multiple successful false claims act actions from 2015 forward for its billing fraud and schemes. CV14-4100 San Francisco District Court

235. STANFORD's "Anatomical Pathology and Clinical Laboratories" is *abnormally* profitable (very high number of CPT codes billed annually) and has outrageously low reported overhead as discussed below. This type of reported margin is achieved through "high rates of coding" and creative coding schemes and unbundling, of which reasonable inferences of fraud may be made. *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

236. Bundling in pathology means that the provider is allowed 1 code per tissue or jar for pathology. Unbundling is a way to unlawfully charge more than 1 code per tissue by either dividing up the tissue, counting one specimen as 2, or otherwise billing higher units of pathology.

237. SHC pathology was unbundled because instead of charging for 1 tissue- they "cut" the tissue into 3 pieces so they could charge 3 times and triple the revenue. In other cases, SHC upcoded pathology by charging much higher level of services than was actually rendered.

238. In 2012 alone, STANFORD labs billed out charges of $1.0 billion gross billings for over 5.3 million billable tests. [7]Of the 1 billion dollars, 41% of the fees were generated from SHC inpatient fees, such as the pathology schemes described here. Remarkably, STANFORD reported that expenses were a fraction of the billables at $142 million dollars. Simply calculating STANFORD's percent overhead in billings versus expenses, that places STANFORD's lab overhead at astonishingly low 14% overhead. Such incredible billing is virtually unheard of in the medical space where overheads as a practical matter range from 35% to 75% of billings. STANFORD's "superhero" low overhead supports *creative billing schemes*. (*See* ¶241 Inset STANFORD posting)

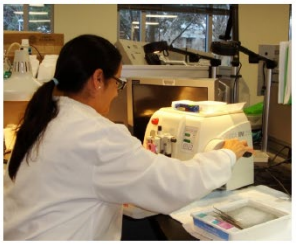
[7] (Ref. Dr. Brent Tan , MD, PhD Director of Laboratory Informatics, Stanford Department of Pathology 2015- accessed at http://www.executivewarcollege.com/wp-content/ uploads/TAN.tue_ .7am.Final_.pdf)

239. According to STANFORD, "At the STANFORD University Medical Center, approximately *31,000 surgical specimens* originating from the STANFORD Health Services Operating Rooms, STANFORD University Clinics, other area clinics, or from the private and independent Palo Alto Surgicenter are accessioned yearly." "Another *13,000 cases* are reviewed either when patients, whose pathology specimens were originally examined elsewhere [throughout California and other states], are referred to for treatment or when other pathologists refer difficult cases for second opinions." (Accessed at http://surgicalpathology.STANFORD.edu/ (*See* Exh. P)

Anatomic Pathology and Clinical Laboratories Statistics

Stanford HEALTH CARE

- Shared service: Stanford Health Care, Stanford Children's Health, Clinics, and Referred Clients
- Over 5.3 Million Billable Tests in FY2012
- Locations
  - Core Laboratory (SHC)
  - Transfusion Service (SHC)
  - Anatomic Pathology (SHC & Hillview)
  - Specialty Laboratories (Hillview)
  - 12 Patient Service Centers
- Over $1.0 Billion Gross Charges in FY2012
  - 41% SHC Inpatient
  - 59% LPCH, SHC Outpatient & Referral Testing
- $142 Million Expenses
- 22 sections
- 544 Paid FTE's
- 53 Faculty, 17 Clinical Fellows, 36 Residents



240. STANFORD pathology also bills both a technical component (tissue requisition and preparation) and a professional component (physician interpretation service) for pathology, generating even more revenue for SHC. Through an imperfect payment system, the reimbursable technical component is often 3 to 4 times the professional component. For example, in 2016,

according to CMS the technical component (or facility fee) for tissue was a whopping $288.50 and the professional component was $98.27.

241. SHCs' pathologist Kristen Jensen, M.D. who read and billed for Relator's 2 pathology specimens on 12/12/12 signed out only 4 specimens on her report, whereas DIRBAS had collected only 2 specimens, and Defendants fraudulently billed ABC for 6 specimens. (*See* Exhibit "A")

242. As foundational information of Defendants' pathology fraud, in 2014 Dr. Jensen ranked as a massive 92nd percentile statewide in California for the highest "payments per patients" in pathology that year, while ranking a very low "number of patients" in the 7th percentile. Surreptitiously, in 2015 Dr. Jensen disappeared from CMS billing altogether. (*See* http://graphics.wsj.com/medicare-billing/#/1932158334)

243. SHC's "Tissue Fraud" Scheme is described as follows: SHC upcoded units and improperly billed pathology laboratory tests including:

- Upcoded and unbundled surgery specimens as multiple separate pathology services;
- Failed to correctly bill the number of specimens per the surgeon's operative report;
- Habitually billed the maximum level and highest codes possible per encounter, thereby "high rates of coding";
- Freely violated the "1 specimen, one 1 pathology" rule; and
- Received unjust enrichment of 45-76% per specimen by the described tissue fraud schemes.

244. On 12/12/12 the surgeon's operative report stated only one (1) specimen was sent to the lab for each breast, hence only 2 total pathology CPT codes could be billed. STANFORD upcoded and billed for 6 pathology codes. (*See* Exh. "G", and "A")

245. Nothing in the STANFORD surgeon's report or his testimony under oath supported the total number of pathology specimens billed. (*See* Exh. G, and I Deposition Dr. DIRBAS p.154-159). Four of the codes in the pathology billing

were not supported by the operative reports, and 2 of the codes were unsupported by any record or nursing notes.

246. On 12/12/12 STANFORD's fraud schemes involved upcoding a single (1) surgical specimen as three (3) pathology codes, which is false and fraudulent upcoding *and* unbundling.

STANFORD coding: 1 specimen  = 3 pathology codes

Correct Coding: 1 surgical specimen = 1 pathology code

247. Even the STANFORD pathologist's report dated 12/12/12 (if to be believed) reflected a total of four (4) specimens, but STANFORD billed for (6) specimens for a total of $6600. It is clearly illegitimate and fraudulent for STANFORD billers and coders to have billed for phantom "surgical specimens" which have no accounting in the surgeon's operative reports or surgical nursing records.

248. In many cases, STANFORD unbundled and upcoded billed out three levels of pathology including 88305, 88307, and a "breast biopsy code" for one *contiguous* mastectomy surgical tissue removed together which when billed correctly results in mandatory *bundling* into one code. Moreover, any "biopsy" performed on the same day and the same tissue as the mastectomy would be bundled into the larger mastectomy code.

249. STANFORD surgeon DIRBAS testified in deposition that his operative report stated only 2 pathology specimens. His surgical report specifically listed only 2 tissues. (Exh. I Dr. DIRBAS Depo p.154-159)

250. DIRBAS testified under oath that STANFORD nurses filled out the pathology slips but did not disclose who at STANFORD scrubbed the claim and billed 6 units of pathology. (*See* Exh. I, Depo DIRBAS p. 171)

251. STANFORD's upcoded pathology charges resulted in $6684 of technical fees ("HC" Hospital charges) for SHC whereas SHC was entitled to only bill

for 2 units of pathology according to the surgeon's report, totaling approximately $827.52 per the benchmark fee schedule.

Conclusion

252. Defendants knew of the falsity of their statements when they made them, and if they did not know of the falsity, they did not have any reasonable basis to believe the statements to be true. Plaintiff relied on Defendants' misrepresentations, and as a result was damaged in amounts to be proven at trial.

253. On 12/12/12 and on countless dates before and thereafter SHC and DOES 1-10 improperly upcoded and billed carriers for upcoded and unbundled pathology billing, and also appealed improperly denied pathology services for further revenue. STANFORD actually submitted false claims to the commercial carriers and the government, whom in turn made payments to STANFORD based on the fraudulent activities. Defendants knew of the falsity of these claims when they generated them, and tendered the false pathology claims to commercial payors for payment. (See Exh. A)

254. According to sworn testimony of former STANFORD and SHC biller Ms. Tomiya Gaines, STANFORD billers are guided by "cheat sheets" and directives to always bill high and maximal, regardless of documentation or necessity. Thus, STANFORD's "high rate of coding" conduct is plausibly demonstrative of fraud, and reasonable inferences may be made within the statutory definitions within the FCA. (*See United States ex rel. Integra Med Analytics LLC, supra.)*

255. SHC's codes that were reviewed were the number of pathology CPT 88305-88309 billed per patient, and CPT 88305-88309 billed per surgery code. More importantly, the number of units of surgical pathology CPT codes that were

billed per patient that Relator alleges are medically unlikely edits (MUE) are these:

256. Multiple units of 88305, 88306, 88307 that exceed the number of surgeries performed on any one patient.

257. If a single CPT 19304 mastectomy was billed, then that should result in one surgical pathology CPT code. Defendants' surgeries often resulted in more than 2 or more surgical pathology codes per surgery.

SIXTH CAUSE OF ACTION
"TIME UNIT FRAUD SCHEME"
VIOLATION OF "FCA" FOR FALSE AND UPCODED ANESTHESIA, OPERATING ROOM, AND RECOVERY ROOM TIME
(Against Defendants SHC, ZUMWALT, and DOES 1-10)

258. Plaintiff repeats and reincorporates the allegations of all previous and subsequent paragraphs as if set forth in full at this point.

259. SHC, ZUMWALT, and DOES 1-10, and each of them (herein collectively "Defendants" as to this Count) improperly billed or caused to be billed deliberately upcoded anesthesia time, operative room, and "recovery-room" time block billing. Overreaching and billing even one or a few extra units (15 minute increments) of these services costs thousands of dollars per unit, and results in hundreds of millions of dollars of unlawfully billed surgical and recovery room services.

260. STANFORD's very high number of upcoded time block units in these surgical and recovery room services billed annually is achieved through "high rates of coding" and creative coding schemes and unbundling, of which reasonable inferences of fraud may be made. *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

Rule

261. Hospitals and their billing services and departments are responsible for accurate and substantiated time billing for anesthesia services, operating room time, and "recovery-room" fees. These are generally billed in units or increments of 15 minutes and are several thousand dollars per unit. Overreaching and billing for more time than was rendered, or which is medically necessary or reasonable, is improper upcoding and considered fraud pursuant to the FCA.

262. Providers (like Defendants here) who always make "mistakes" in their favor for higher charges *and* time than actually rendered, are consistent with "high rates of coding". Reasonable inferences may therefore be made that STANFORD's demonstrated "high rates of coding" are fraud. *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

Analysis

263. Defendants codified disproportionate time block billing for anesthesia services and "post anesthesia care" in the recovery room for even young otherwise healthy patients undergoing surgery. Rather than billing the true time, billers and coders under the directives of revenue manager and Vice President ZUMWALT caused to be billed hundreds of millions of dollars of upcoded time units which were not consistent with the nursing or anesthesia records.

264. Defendants charged more than $1000 per 15 minutes of "post anesthesia care" and upcoded the units of time billed, which were not supported by the medical records (for example in Relator's claim Defendants reported an unsubstantiated 13 units of post anesthesia care on 12/12/12 which would

translate to 195 minutes or 3 ¼ hours spent in the recovery room). That simply was not true, and Relator spent far less than 195 minutes in recovery, despite Defendants billing an exorbitant "195 minutes" and retained payment for the same. In fact, national guidelines show that the average patient spends 45 minutes to 75 minutes in the recovery room where nurses watch the patient, not 195 minutes as Defendants falsely billed.

265. On 12/12/12/ Defendants also unbundled and charged tens of thousands of dollars for "anesthesia time" which was untrue. On 12/12/12 Defendants unbundled and charged nearly one hundred thousand dollars per 8 hours for "OR time"-operating room- (or roughly $10,000[8] per hour of operating room time), which was also untrue. Defendants failed to show supporting documentation to support the false and upcoded anesthesia and recovery coding.

266. For example, on 12/12/12 Defendants' unbundling of the "OR room" in Relator's case resulted in charges of $69,685 plus $16,848.00 plus $14,870 totaling $101,403.

267. As foundational and background facts, the STANFORD hospital generates an average of $7 million dollars per bed per annum. Much of these revenues result from the fraudulent and always upcoded time charges for anesthesia and recovery room, which accounted for 2/3 of Relator's total billing of $150,000 in a 1-day surgery.

Conclusion

268. On 12/12/12 and on countless dates before and thereafter SHC and DOES 1-10 improperly upcoded and billed carriers for false time block billing, and also appealed improperly denied time codes for further revenue. STANFORD

[8] In comparison, private jet travel for an executive light jet in the U.S. costs $4000-$8000 per hour.

actually submitted false claims to the commercial carriers and the government, whom in turn made payments to STANFORD based on the fraudulent activities.

269. According to sworn testimony of former STANFORD biller Ms. Gaines, STANFORD billers are guided by "cheat sheets" and directives to always bill high and maximal, regardless of documentation or necessity. Thus, STANFORD's conduct is plausibly demonstrative of fraud within the statutory definitions within the FCA. (*See* Exh. "C", Decl. Gaines, generally)

270. The codes that were reviewed were the number of recovery room fee units and anesthesia time units billed per patient and also per calendar year, and found impossibility that the exorbitant number of upcoded units Defendants billed annually could even fit into a calendar year.

271. Defendants' average amount of "recovery time" billed per patient exceeded the national average. Defendants' "High rates of coding" here combined with their known business practices as described herein, can be reasonably inferred as fraud. (*See* Exh. A: STANFORD invoice Recovery Time 13 units (1 unit is 15 minutes) billed for total of $14,846). (*See United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019))

SEVENTH CAUSE OF ACTION

"FALSE RECORDS"

VIOLATION OF "FCA": FALSE RECORD MATERIAL TO OBLIGATION TO PAY

(Against All Defendants and Each of Them)

272. Plaintiff repeats and reincorporates the allegations of all previous and subsequent paragraphs as if set forth in full at this point.

273. Defendants and each of them made and used or caused to be made or used false records or statements material to an obligation to pay or transmit money in the State, or knowingly concealed, avoided, or decreased an obligation to pay or transmit money in the State.

274. STANFORD's very high number of manufactured and false records presented for billing annually is achieved through "high rates of coding" and creative coding schemes and unbundling, of which reasonable inferences of fraud may be made. *United States ex rel. Integra Med Analytics LLC v. Providence Health and Services*, No. CV 17-1694 PSG (SSx), 2019 WL 3282619 (C.D. Cal. July 16, 2019)

275. Defendants violated the FCA from at least January 1, 2010 to the present by engaging in the fraudulent and illegal practices described herein. Said false records or statements were made with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

276. Compliance with applicable statutes including commercial carriers, Medicare, Medi-Cal and the various other federal and state laws cited herein was implied, and also was an express condition of payment of healthcare claims submitted in the State

277. Had the State known that Defendants were violating the federal and state laws cited herein, it would not have allowed to be paid the claims submitted by health care providers and third-party payers in connection with STANFORD's fraudulent and illegal practices.

278. Defendants and each of them conspired with one another to get false and fraudulent healthcare claims allowed and paid under the laws of this State. DEFENDANTS acted in a concerted fashion to defraud the commercial payors in the State and acted with others in keeping the facts necessary to investigate the fraud and the damages caused by the fraud away from the State of California.

279. Division Chiefs of each medical department at STANFORD regularly held revenue "training sessions" with doctors, and new interns and residents matriculating in July of each year on how to comply fully with STANFORD's maximal billing directives, and achieve the highest revenues regardless of unlawful use of upcoding and unbundling. After a training session on "enhanced" coding practices, the STANFORD Division Chief instructed the session "It's easy to code high and get the 99205's and 99215's (highest paying CPT codes)", "*JUST CLICK, CLICK, CLICK, CLICK*", referring to STANFORD's exploitation of its "Epic" electronic medical records to create false and misleading records.

280. The Division Chief directed the ability to clone and replicate electronic medical records easily with a resounding directive to the attending physicians to "*CLICK, CLICK, CLICK, CLICK"* to upcode claims and falsify that they had directly provided the patient care when they in fact had not, to commercial and government carriers alike.

281. Using its cadre of unlicensed students, interns, and staff which rendered direct patient services, STANFORD also falsely billed all claims under the attending doctor's name and "NPI" regardless of the fact that the attending never saw the patient, and never participated in the patient care, hence fraudulent billing. Stanford University would also "cattle prod" the doctors (clinical professors) with their job security as instructors to "*CLICK, CLICK, CLICK, CLICK*" into Epic EMR and create records to upcode from low paying codes to the highest paying codes regardless of what services were provided. Moreover, doctors were prodded despite disagreement because the University had a fee-sharing agreement with SHC called the "Dean's Tax". This policy allowed the University to receive a large percentage of the fees STANFORD doctors

generated at SHC through a 20-30 % "Dean's Tax" which allows the University to co-mingle tax advantaged funds with fraudulent profits of SHC.

282. On or about September 10, 2015 and September 18, 2018 STANFORD Division Chief used the "revenue training sessions" attended by STANFORD coding managers and the division faculty and staff with examples of coding "opportunities" to increase the Division's revenues which were scrutinized by STANFORD as subpar because the department lacked procedures and relied solely on false records to support upcoded office visits (CPT 99214-99215, 99204-99205) to meet its production quotas.

283. STANFORD executives with knowledge of the fraudulent billing activities alleged herein include General Counsel and Vice president Ms. Debra ZUMWALT, who is the head of billing compliance at STANFORD. From at least December 2014 through at least March 2018, ZUMWALT knew of and directed those under her to present false records material to obligation to pay and instructed those under her to conceal Defendants' demonstrated schemes and institution's billing noncompliance.

284. The government, by and through, the administration of its insurance programs and its carriers, unaware of STANFORD'S fraudulent and illegal practices, was damaged by carriers' payment of the claims submitted by health care providers. As a result of the actions of SHC and Defendants, Plaintiff and its people have been severely damaged in an amount to be proven at trial.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for relief as follows:

1. That the Court enter Judgment against Defendants and in favor of the United States for each Count in an amount equal to three times the amount of damages the United States has sustained as a result of

Defendants' actions, plus the maximum civil penalty for each violation of the False Claims Act, 31 U.S.C. § 3729, *et seq*.;

2. For Relator's reasonable attorney's fees, expenses, costs of suit, and maximal award of the recovery to Relator pursuant to 31 U.S.C. § 3730(d).

3. For orders preliminarily and permanently enjoining Defendants from continuing the fraudulent claims practices alleged herein; and

4. For such other and further relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

Realtor and Plaintiff demands a trial by jury on all claims so triable.

Respectfully submitted,

Dated: March 1, 2020

/S/ GJuarez

Gloria M. Juarez, Esq.
LAW OFFICE OF GLORIA JUAREZ
Attorneys for Relator, Emily Roe

CERTIFICATE OF SERVICE

STATE OF CALIFORNIA, COUNTY OF LOS ANGELES

I am over the age of 18 years. I have personal knowledge of the facts upon which I make this declaration, and if called upon to testify, under oath, I could and would competently testify thereto. On the date below I caused to be served the within **SECOND AMENDED COMPLAINT AND EXHIBITS** on the required parties in this action, as follows:

_X__(electronic service) By causing to be uploaded a true and correct copy thereof, and addressed as indicated on the attached service list on the parties electronically using the CM/ECF and Pacer system, and/or electronic mail for those parties not accessible by ECF.

___(service by U.S. mail) By placing a true and correct copy thereof and enclosing in a sealed envelope, addressed as indicated on the attached service list, with postage thereon fully paid, and depositing in the U.S. Mail.

Frank Sheeder Sean R. Crain (State Bar No. 291515) Alston & Bird LLP 2200 Ross Avenue, Suite 2300 Dallas, TX 75201 Telephone: 214-922-3400/ Facsimile: 214-922-3899 E-mail: sean.crain@alston.com Email: Frank.Sheeder@alston.com **Counsel for Defendants**	**United States Attorney General for the District of California** NICOLA T. HANNA United States Attorney Frank Kortum David K. Barrett (SBN 149882) Room 7516, Federal Building 300 N. Los Angeles Street Los Angeles, California 90012 Tel: (213) 894-0522 Email: David.Barrett@usdoj.gov Email: frank.kortum@usdoj.gov
Mr. Nicholas Campins, Esq. California Department of Insurance Fraud Liaison Bureau 45 Fremont Street, 21st Floor San Francisco, CA 94105 (415) 538-4149 Direct Telephone Nicholas.Campins@insurance.ca.gov **Counsel for the State of California**	**Attorney General of California** Mr. Xavier Becerra, Attorney Gen. Siobhan A. Franklin, Deputy Attorney General 1455 Frazee Rd. Suite 315 San Diego, CA 92108 Telephone (619) 688-6071 Email:Siobhan.Franklin@doj.ca.gov
Frederick Dirbas 1285 Valparaiso Ave. Menlo Park, CA Email: dirbas@stanford.edu	

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct. Dated: March 2, 2020

/s/Arthur Long
ARTHUR LONG
Assistant to Ms. Juarez, Counsel for Relator