ROBBINS ARROYO LLP
KEVIN A. SEELY (199982)
600 B Street, Suite 1900
San Diego, CA 92101
Telephone: (619) 525-3990
Facsimile: (619) 525-3991
kseely@robbinsarroyo.com

Attorneys for Qui Tam Plaintiff

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SAN FRANCISCO DIVISION

KAW

CV 15 5631

UNITED STATES OF AMERICA EX REL TOMIYA GAINES, Plaintiff, v. STANFORD HEALTH CARE and UNIVERSITY HEALTHCARE ALLIANCE, Defendants.	Case No. **FILED UNDER SEAL PURSUANT TO 31 U.S.C. §3730(b)(2)** **DO NOT PLACE IN PRESS BOX** **DO NOT ENTER ON PACER** COMPLAINT FOR DAMAGES UNDER THE FEDERAL FALSE CLAIMS ACT DEMAND FOR JURY TRIAL

TABLE OF CONTENTS

Qui Tam plaintiff Tomiya Gaines ("Relator"), through her attorneys, Robbins Arroyo LLP, brings this action on behalf of the United States of America, under the False Claims Act, 31 U.S.C. §3729, *et seq*. ("FCA"), based upon personal knowledge, relevant documents, and information and belief, and in support thereof, states and alleges as follows:

I. NATURE OF THIS ACTION

1. This action is based on false claims being submitted by defendants University HealthCare Alliance ("UHA") and its greater than 50% owner, Stanford Health Care ("SHC") (collectively, "Defendants"). The false claims were submitted by Defendants to the United States of America, through Medicare, for undocumented medical procedures and services, resulting in substantial damages to the United States of America.

2. More specifically, UHA habitually submits bills to Medicare for various procedures and services, despite a gross lack of ***required*** documentation evincing that that such billed procedures and services were actually rendered. UHA's improper billing has caused Medicare to wrongfully pay UHA and SHC millions of dollars in Medicare payments.

3. But for Defendants' false billing, UHA and SHC would have never received the millions of dollars in payments that they did from the government.

4. Defendants, by their unlawful conduct of knowingly submitting false claims to the government, for payment of government funds, have violated the FCA, and are liable to the government for treble damages and penalties associated with the false claims alleged herein.

II. JURISDICTION AND VENUE

5. This is an action to recover damages and civil penalties on behalf of the United States of America arising out of false claims, transactions, and other related acts of Defendants, and is brought pursuant to 31 U.S.C. §§3729-3733, more popularly known as the FCA, through Relator, pursuant to 31 U.S.C. §3730(b), for and on behalf of the United States of America.

6. Jurisdiction of the Court is founded upon 28 U.S.C. §§1331 and 1345. The claims set forth herein arise under and are founded upon federal law. Relator is aware of no jurisdictional bars to this action.

7. Personal jurisdiction over Defendants is proper in this Court pursuant to 31 U.S.C.

§3732(a), which provides that any action under 31 U.S.C. §3730 may be brought in any district in which the defendants can be found, reside, transact business, or in which any act proscribed by 31 U.S.C. §3729 occurred.

8. Venue is proper in this District pursuant to 31 U.S.C. §3732(a) and 28 U.S.C. §1391(b). Defendant UHA is headquartered in this District and both Defendants transact business in this District, including the conduct which gives rise to the fraudulent claims set forth herein.

III. INTRADISTRICT ASSIGNMENT

9. Pursuant to Civil Local Rule 3-2(c) and (d), assignment of this case to the San Francisco Division of the United States District Court for the Northern District of California is proper because a substantial part of the events and omissions giving rise to Relator's claims occurred within the San Francisco Division.

IV. PARTIES

10. ***The United States of America*** is the real plaintiff in interest with respect to the claims asserted herein. The Medicare program is administered and supervised by the Centers for Medicare & Medicaid Services ("CMS"), a division of the U.S. Department of Health & Human Services ("HHS").

11. ***Relator*** is currently employed by UHA as a Coding Quality Coordinator, and has been employed in that position since about April 2015. Relator's personal knowledge, beliefs, and experiences, based mainly on her employment at UHA, are consistent with the allegations discussed herein.

12. ***Defendant SHC***, formerly known as Stanford Hospital and Clinics, is a non-profit public benefit California corporation and more than 50% owner of defendant UHA. Defendant SHC has administrative offices located at 300 Pasteur Drive, Stanford, California.

13. ***Defendant UHA*** is a non-profit public benefit California corporation with administrative offices located at 855 Oak Grove Avenue, Suite 100, Menlo Park, California. It is primarily owned and controlled by defendant SHC. Defendant UHA owns and operates the administrative and logistical aspects of a network of board-certified primary care and specialty physicians, including insurance, human resources, payroll, and appointment scheduling. Each year,

defendant UHA submits more than $30 million worth of claims to Medicare on behalf of its network of clients.

V. BACKGROUND ALLEGATIONS

A. The FCA—Generally

14. The FCA prohibits several variations of fraud on the government.

15. Among other things, the FCA prohibits knowingly presenting, or causing to be presented, to the federal government a false or fraudulent claim for payment or approval, and conspiring to defraud the government by getting a false or fraudulent claim allowed or paid. 31 U.S.C. §§3729(a)(1)(A).

16. Additionally, the FCA prohibits knowingly making or using, or causing to be made or used, a false or fraudulent record or statement to get a false or fraudulent claim paid or approved by the federal government. 31 U.S.C. §3729(a)(1)(B).

17. The FCA defines "knowing" as acting with a deliberate ignorance of, or reckless disregard of, the truth or falsity of the information. 31 U.S.C. §3729(b).

18. The statute allows any person having information about an FCA violation to bring an action on behalf of the United States of America and to share in any recovery obtained. It requires that the complaint be filed under seal for a minimum of sixty days (without service on the defendants during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

19. Any person who violates the FCA is liable for a civil penalty of not less than $5,000, up to $11,000, for each violation, plus three times the loss sustained by the United States of America. 31 U.S.C. §3729(a).

B. Medicare and Current Procedural Terminology Codes

20. The current procedural terminology ("CPT") code set is a medical code maintained by the American Medical Association ("AMA") through the CPT Editorial Panel. The CPT code set describes medical, surgical, and diagnostic services, and is designed to communicate uniform information about medical services and procedures among physicians, coders, patients, accreditation organizations, and payers for administrative, financial, and analytical purposes.

21. Each year Medicare publishes a Physician's Fee Schedule in which all of the CPT codes are listed, together with the reimbursement Medicare allows for each code. CPT codes are billed to Medicare by entering the code number on a claim form.

22. As stated in the Medicare Claims Processing Manual, "[p]roper coding is necessary on Medicare claims because codes are generally used in determining coverage and payment amounts."

C. Documentation Requirements for Medicare Billing

23. As noted in CMS, Medicare Learning Network, Evaluation and Management Services Guide, Providers that submit bills to Medicare for payment "must ensure that medical record documentation supports the level of service reported." As CMS succinctly states, "[i]f it isn't documented, it hasn't been done."

24. Providers cannot submit bills to Medicare for services when there is no record that such services were actually rendered.

D. The FCA Prohibits Improper Medicare Billing

25. Medicare analyzes whether the disease or symptoms warrant the test or procedures billed, as Medicare has found that some providers and billing companies bill for services which were not medically necessary or never actually rendered in order to illegally maximize reimbursement.

26. In connection with Medicare billing, the FCA expressly prohibits knowingly submitting false or fraudulent claims for payment or approval.

VI. RELEVANT FACTUAL BACKGROUND

27. UHA is a company that owns and operates the administrative and logistical aspects of a network of board-certified primary care and specialty physicians, including insurance, human resources, payroll, and appointment scheduling.

28. During Relator's short tenure as Coding Quality Coordinator at UHA (hired since about April 2015), she was exposed to multiple improper UHA billing practices with respect to several of the primary medical groups at UHA.

A. UHA's Improper Stress Echo Cardiogram Test Billing

29. UHA is systematically wrongfully billing Medicare for complete stress echocardiogram tests (CPT code 93351) when the lack of documentation only supports a limited Stress Echocardiogram test (CPT code 93308).

30. Stress echocardiography is a test that uses ultrasound imaging to show how well a heart muscle is working to pump blood to the body. It is mainly used to detect a decrease in blood flow to the heart from narrowing in the coronary arteries.

31. ***CPT Code 93351*** is reserved for a stress echocardiogram which is performed with a ***complete cardiovascular stress test.*** A complete cardiovascular stress test requires continuous electrocardiographic monitoring, supervision, interpretation, and report by a physician or other qualified health care professional, and must include examination of the left and right atria, left and right ventricles, the aortic, mitral, and tricuspid valves, the pericardium, and adjacent portions of the aorta. The charge for CPT code 93351 is $330.18.

32. ***CPT Code 93308*** is reserved for a follow-up *or* ***limited echocardiographic study***, an examination that does not evaluate or document the attempt to evaluate all the structures that comprise the complete echocardiographic exam. This is typically limited to, or performed in follow-up of, a focused clinical concern. The charge for CPT code 93308 is $154.26.

33. During Relator's tenure at UHA, she discovered that UHA regularly bills for complete stress tests when documents only support that limited testing was performed. Specifically, UHA regularly bills for stress tests under CPT code 93351, representing that a complete stress test was performed, when documentation ***does not*** support that a complete stress test was actually completed. In particular, documentation does not support that there was an evaluation of the left and right atria, left and right ventricles, the aortic, mitral, and tricuspid valves, the pericardium, and adjacent portions of the aorta.

34. These improper CPT code 93351 charges were billed to Medicare at the rate of $330.18 for each test, or $175.92 more than the charge for CPT code 93308 (limited echocardiographic study).

B. UHA's Improper Critical Care Billing

35. UHA regularly submits false bills to Medicare for critical care visits.

36. The AMA requires that "[t]ime spent with the individual patient [for critical services] should be recorded in the patient's record."

37. CPT codes 99291 and 99292 are used to report the total duration of time spent in provision of critical care services to a critically ill or critically injured patient.

38. CPT code 99291 is used to report the first thirty to seventy-four minutes of critical care on a given date, and is billed at a non-facility price of $308.08.

39. CPT code 99292 is used to report additional block(s) of time, of up to thirty minutes each beyond the first seventy-four minutes, and is billed at a non-facility price of $135.08 per additional thirty minutes.

40. UHA regularly submits bills to Medicare under both of the above codes despite a gross lack of documentation in the patients' records concerning the patients' time spent in critical care. Specifically, the patients' records often contain ***no documentation whatsoever*** concerning the patients' purported time spent in critical care.

41. Instead, UHA simply receives a list of billing codes from its members, and UHA coders are instructed to submit the codes for Medicare billing without verifying the services (which would be impossible in any event given the lack of supporting documentation).

42. Thus, UHA knowingly bills false claims for critical care. As a result, UHA has wrongfully collected countless charges from Medicare billed under CPT codes 99291 and 99292, with fees of $308.08 and $135.08, respectively.

C. Additional Concerns

43. The above examples merely highlight what Relator believes to be a pattern and practice of improper billing at UHA.

44. During Relator's tenure, she witnessed multiple additional questionable billing examples suggesting that UHA's primary focus is on creating a system to ensure Medicare payment, rather than on properly coding per AMA guidelines.

45. As an initial matter, UHA's coding department was understaffed when Relator began

working at UHA, and staffing problems dramatically increased during Relator's tenure. Although UHA took on numerous additional clients shortly after Relator was hired, UHA refused to hire additional coders to adequately handle the skyrocketing workload. Instead management pressured coders to speed up the coding process at the expense of accuracy, and further specifically instructed coders to ignore serious billing concerns.

46. Whenever lack of documentation to support billing was brought to managements' attention, the response was almost always along the lines of "just bill it."

47. When patient service orders lacked required physician signatures to authenticate the document, in clear violation of billing requirements, coders were instructed to bill it anyway.

48. When procedures did not fit into billable Medicare categories, coders were instructed to change the codes to ensure Medicare payment.

VII. DAMAGES CAUSED BY DEFENDANTS' FALSE CLAIMS

49. As detailed above, although UHA has never publicly disclosed how much of its revenue is derived from Medicare, conservative estimates suggest that UHA earns well over $30 million a year in revenue from Medicare.

50. Relator believes that UHA's billing violations are habitual and rampant throughout UHA, comprising a substantial portion of the tens of millions of dollars that UHA bills Medicare each year.

VIII. COUNT I - FCA 31 U.S.C. §3729(a)(1)(A)

51. Relator incorporates by reference and realleges each and every allegation contained above, as though fully set forth herein.

52. This is a claim for treble damages and penalties under the FCA, 31 U.S.C. §§3729, *et seq.*, as amended.

53. By virtue of the acts set forth above, Defendants presented or caused to be presented, false or fraudulent claims for payment or approval to the U.S. government in violation of 31 U.S.C. §3729(a)(1).

54. The United States, unaware of the falsity of the claims, paid and continues to pay claims that would not be paid but for Defendants' unlawful conduct.

55. As a result of the Defendants' acts, the United States of America has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

IX. COUNT II - FCA 31 U.S.C. §3729(a)(1)(B)

56. Relator incorporates by reference and realleges each and every allegation contained above, as though fully set forth herein.

57. This is a claim for treble damages and penalties under the FCA, 31 U.S.C. §§3729, *et seq.*, as amended.

58. By virtue of the acts set forth above, Defendants have knowingly made, used, or caused to be made or used, false or fraudulent records and statements, and omitted material facts, to get false and fraudulent claims paid or approved, within the meaning of 31 U.S.C. §3729(a)(1)(B).

59. The United States of America, unaware of the falsity of the records, statements, and claims made or caused to be made by the Defendants, paid and continues to pay claims that would not be paid but for Defendants' unlawful conduct.

60. As a result of the Defendants' acts, the United States of America has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

X. PRAYER FOR RELIEF

WHEREFORE, Relator, on behalf of the United States of America, respectfully requests this Court to enter judgment for Relator, and on behalf of the United States of America, and against Defendants, on each Count of this Complaint, and to impose judgment against the Defendants and in favor of Relator, on behalf of the United States of America, as follows:

(a) for the United States of America to be awarded damages in an amount equal to three times the loss sustained by the United States of America because of false claims and fraud alleged herein, as the FCA provides;

(b) for civil penalties of statutorily-determined amounts for each and every false claim that Defendants presented to the United States of America and/or its representatives;

(c) for an award to Relator for reasonable expenses, attorneys' fees, and costs incurred in connection with this action;

(d) for Relator to be awarded the maximum amount allowed, pursuant to the FCA; and

(e) that this Court award such other and further relief as it deemed proper.

XI. DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands a trial by jury.

Dated: December 9, 2015

ROBBINS ARROYO LLP
KEVIN A. SEELY

KEVIN A. SEELY

600 B Street, Suite 1900
San Diego, CA 92101
Telephone: (619) 525-3990
Facsimile: (619) 525-3991
E-mail: kseely@robbinsarroyo.com

Attorneys for Qui Tam Plaintiff

1069923