**UNITED STATES DISTRICT COURT**
**FOR THE MIDDLE DISTRICT OF FLORIDA**
**ORLANDO DIVISION**

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| UNITED STATES OF AMERICA and STATE OF FLORIDA ex rel. AMANDA DITTMAN and CHARLOTTE ELENBERGER M.D.,<br><br>Plaintiffs/Relators,<br><br>vs.<br><br>ADVENTIST HEALTH SYSTEM/SUNBELT, INC. d/b/a FLORIDA HOSPITAL, also d/b/a FLORIDA HOSPITAL ORLANDO, also d/b/a FLORIDA HOSPITAL ALTAMONTE, also d/b/a FLORIDA HOSPITAL APOPKA, also d/b/a FLORIDA HOSPITAL EAST ORLANDO, also d/b/a FLORIDA HOSPITAL CELEBRATION HEALTH, also d/b/a FLORIDA HOSPITAL KISSIMMEE, also d/b/a WINTER PARK MEMORIAL HOSPITAL,<br><br>Defendants. | 6-10-CV-1062-ORL-28KRS<br><br>CIVIL ACTION FILE NO. _____<br><br>**FILED UNDER SEAL**<br><br>**[FALSE CLAIMS ACT –QUI TAM]**<br><br>**JURY DEMAND** |

**COMPLAINT**

**COME NOW**, AMANDA DITTMAN and CHARLOTTE ELENBERGER, M.D. ("Relators") in the above-styled action, by and through their counsel of record, WILBANKS & BRIDGES, LLP, and JAMES, HOYER, NEWCOMER, SMILJANICH & YANCHUNIS P.A., and state that this is an action brought on behalf of the United States of America and the State of Florida by Relators against ADVENTIST HEALTH SYSTEM/SUNBELT, INC. d/b/a Florida Hospital, also d/b/a FLORIDA HOSPITAL ORLANDO, also d/b/a FLORIDA HOSPITAL ALTAMONTE, also d/b/a FLORIDA HOSPITAL APOPKA, also d/b/a FLORIDA HOSPITAL EAST ORLANDO, also d/b/a FLORIDA HOSPITAL CELEBRATION HEALTH, also d/b/a FLORIDA HOSPITAL KISSIMMEE, also d/b/a WINTER PARK MEMORIAL HOSPITAL (hereinafter sometimes collectively referred to as " FLORIDA HEALTH SYSTEM" or as "Defendants") pursuant to the

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Qui Tam provisions of the Civil False Claims Act, 31 U.S.C. § 3729-33 and pursuant to pendente jurisdiction, the state false claims act of the State of Florida, Fla. Stat. § 68.082(2)(a)-(c) and (g).

## JURISDICTION AND VENUE

1. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a) and 3730(b). This Court has jurisdiction to entertain a qui tam action. Relators are "original sources" and otherwise authorized to maintain this action in the name of the United States as contemplated by the Civil False Claims Act, 31 U.S.C. § 3729-33 and the Florida False Claims Act, Fla. Stat. § 68.082(2)(a)-(c) and (g).

2. Venue is appropriate as to each Defendant, in that one or more of Defendants can be found in, reside in, and/or transact business in this judicial district. Additionally, acts proscribed by 31 U.S.C. § 3729 have been committed by one or more of the Defendants in this judicial district. Within the meaning of 28 U.S.C. § 1391(c) and 31 U.S.C. § 3732(a), venue is proper.

3. Relators have made voluntary disclosures to the United States Government prior to the filing of this lawsuit as required by 31 U.S.C. § 3730(b)(2). Appropriate disclosures are also being made to the State of Florida.

4. This court has pendente jurisdiction as to claims asserted by Relators on behalf of the State of Florida to 28 U.S.C. § 1367.

## THE PARTIES

5. Plaintiff AMANDA DITTMAN is a citizen of the United States of America. Relator DITTMAN is currently a resident of the State of California. She brings this *qui tam* action based upon direct and unique information obtained during Relator's employment with Florida Hospital Orlando, located in Orlando, Florida. Plaintiff AMANDA DITTMAN is a Health Information

Management ("HIM") coding professional, and has substantial experience with coding and reimbursement compliance.

6. Plaintiff CHARLOTTE ELENBERGER, MD. is a citizen of the United States of America. Relator ELENBERGER is a resident of the State of Florida. She brings this *qui tam* action based upon direct and unique information obtained by Relator ELENBERGER while employed by Florida Radiology Associates ("FRA") from July 1995 until June 2008. In addition, she obtained information while exercising her staff privileges at Defendant Florida Hospital from July 1995 until November 2009. As characterized by the False Claims Act, Plaintiffs will be referred to collectively as "Relators" hereafter.

7. Defendant ADVENTIST HEALTH SYSTEM/SUNBELT, INC., a Florida non-profit corporation, owns and/or operates the following hospitals in the State of Florida: FLORIDA HOSPITAL ORLANDO, also d/b/a FLORIDA HOSPITAL ALTAMONTE, also d/b/a FLORIDA HOSPITAL APOPKA, also d/b/a FLORIDA HOSPITAL EAST ORLANDO, also d/b/a FLORIDA HOSPITAL CELEBRATION HEALTH, also d/b/a FLORIDA HOSPITAL KISSIMMEE, also d/b/a WINTER PARK MEMORIAL HOSPITAL. The principal address of said Defendant is 111 N. Orlando Avenue, Winter Park, Florida 32789. The registered agent of said Defendant is Tamara L. Trimble, 111 N. Orlando Avenue, Winter Park, Florida 32789.

## STATUTORY BACKGROUND OF GOVERNMENTAL HEALTH PROGRAMS

8. The Medicare Program (hereinafter "Medicare") is a Health Insurance Program administered by the Government of the United States that is funded by taxpayer revenue. The Medicare Program is directed by the United States Health and Human Services Department. Medicare was designed to assist participating states in providing medical services and durable

medical equipment to persons over sixty-five (65) years of age and certain others that qualify for Medicare.

9. The Medicaid Program ("Medicaid") is a Health Insurance Program administered by the Government of the United States that is funded by State and Federal taxpayer revenue. It is overseen by the United States Health and Human Services Department. Medicaid was designed to assist participating states in providing medical services, durable medical equipment and prescription drugs to financially-needy individuals that qualify for Medicaid.

10. TRICARE/CHAMPUS is a federally-funded program that provides medical benefits, including hospital services, to (a) the spouses and unmarried children of (1) active duty and retired service members, and (2) reservists who were ordered to active duty for thirty days or longer; (b) the unmarried spouses and children of deceased service members; and (c) retirees.

11. Wherever appropriate, Medicare, Medicaid and TriCare/Champus and all other Federal and State payors will be collectively referred to as "Government Payors."

## APPLICABLE FEDERAL AND STATE FRAUD STATUTES

FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729-33 *et. seq.*;

*Title 31 USCA Section 3729 of the Federal False Claims Act provides as follows:*

*(a) Liability for Certain Acts-*

*(1) IN GENERAL- Subject to paragraph (2), any person who—*

*(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;*

*(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim;*

*(C) conspires to commit a violation of subparagraph (A), (B), (D), (E), (F), or (G);*

*(D) has possession, custody, or control of property or money used, or to be used, by the Government and knowingly delivers, or causes to be delivered, less than all of that money or property;*

*(E) is authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;*

*(F) knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge property; or*

*(G) 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 or property 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 (28 U.S.C. 2461 note; Public Law 104-410), plus 3 times the amount of damages which the Government sustains because of the act of that person.*

The FLORIDA FALSE CLAIMS ACT, Fla. Stat. § 68.082(2), specifically provides, in part, that

*Any person who:*

*(a) Knowingly presents or causes to be presented to an officer or employee of an agency a false or fraudulent claim for payment or approval;*

*(b) Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by an agency;*

*(c) Conspires to submit a false or fraudulent claim to an agency or to deceive an agency for the purpose of getting a false or fraudulent claim allowed or paid;*

*(d) Has possession, custody, or control of property or money used or to be used by an agency and, intending to deceive the agency or knowingly conceal the property, delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt;*

*(e) Is authorized to make or deliver a document certifying receipt of property used or to be used by an agency and, intending to deceive the agency, makes or delivers the receipt without knowing that the information on the receipt is true;*

*(f) Knowingly buys or receives, as a pledge of an obligation or a debt, public property from an officer or employee of an agency who may not sell or pledge the property lawfully; or*

*(g) Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to an agency,*

*is liable to the state for a civil penalty of not less than $5,500 and not more than $11,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.*

**REGULATIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) RELEVANT TO THE FRAUDULENT SCHEMES**

12. USE OF -59 MODIFIERS: In January 1996, the Centers for Medicare & Medicaid Services began the National Correct Coding Initiative (NCCI) edits. This initiative was developed to promote the correct coding by providers and to prevent Medicare payment for improperly coded services. The initiative consists of automated edits that are part of the fiscal intermediary's claims processing systems.

13. The NCCI edits contain pairs of Healthcare Common Procedure Coding System codes (HCPCs) that generally should not be billed together by a provider for a patient on the same date of service. Under certain circumstances, a provider may bill for two HCPCs services in a NCCI code pair and include a modifier on the claim that would bypass the edit and allow both services to be paid. A modifier is a two digit code that further describes the service performed. Thirty-five modifiers can be used to bypass the NCCI edits. Modifier -59 is one of these thirty-five modifiers.

14. Medicare strictly limits a healthcare provider's use of the -59 modifier. The prohibitions against indiscriminate use of the -59 modifier are very clear and specific. The -59 modifier should only be utilized when there is a distinct procedural service provided. It may represent a different session, different procedure or surgery, different anatomical site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries).

15. The -59 modifier is used to identify procedures/services that are not normally reported together, but which might be appropriate under unusual circumstances. The unusual circumstance which would allow the billers to use a -59 modifier may involve a different session or patient encounter, a different procedure or surgery, a different site or organ system, a separate incision/excision, a separate lesion or a separate injury not encountered or performed on the same day by the same physician.

16. When a service or procedure is coded with the -59 modifier, a bypass of the NCCI edits occurs. Because of the very specific criteria established for the use of the -59 modifier, it should only be used as a last resort. However, Defendant did not use the -59 modifier as a rare or "last resort" modifier. To the contrary, this -59 modifier was routinely and intentionally utilized by Defendant in order to disguise the systemic upcoding and unbundling of procedural codes in Defendant's hospitals. This fraudulent scheme resulted in overpayments being made by Government Payors to Defendants.

17. Use of MODIFIER -91: This modifier should be appended to laboratory procedure(s) or service(s) to indicate a repeat test or procedure on the same day. This modifier indicates to the carriers or fiscal intermediaries that the physician had to perform a repeat clinical diagnostic

laboratory test that was distinct or separate from a lab panel or other lab services performed on the same day, and was performed to obtain medically necessary subsequent reportable test values. This modifier should not be used to report repeat laboratory testing due to laboratory errors, quality control, or confirmation of results. The Defendants routinely and improperly added MODIFIER -91 to by pass edits to secure reimbursements for bundled laboratory procedures. This scheme resulted in overpayments being made by Government Payors to Defendants.

18. Use of MODIFIER -25: This modifier was established to facilitate the reporting of E/M services on the same day as a procedure for which separate payment may be made. The separate service must be significant enough to require a separate service, i.e., address a new or distinct problem. The need to perform an independent E/M service may be prompted by a complaint, symptom, condition, problem, or circumstance which may or may not be related to the procedure (or other service) provided. When modifier -25 is used on an E/M service of the same day as a procedure, the E/M service must have the key elements (history, examination, and medical decision-making) well documented. Defendants misused modifier -25 in order to improperly bypass edits to secure reimbursements for bundled emergency room procedures. This scheme resulted in overpayments being made by Government Payors to Defendants.

## SUMMARY OF FRAUDULENT ACTS OF DEFENDANTS

19. The purpose of the fraudulent actions described in this Complaint was to obtain unlawful and excessive reimbursement from Medicare, Medicaid and TriCare/Champus as well as other private insurers. Defendants have submitted fraudulent claims for reimbursement in express violation of federal and state statutes as well as the rules and regulations described hereafter. The Defendants have engaged in the following intentional, unlawful and fraudulent activities:

I. Failure to maintain any legitimate compliance protocols or corporate oversight needed to ensure the accuracy of billings presented to Government Payors;

II. Unlawful misuse of -59, -91 and -25 modifiers in order to facilitate the intentional unbundling and upcoding of procedural codes in order to obtain unlawful reimbursements;

III. Failure to make self disclosures in the time and manner required by law;

IV. Failure to return overpayments and/or make adjustments for improper payments received from Government Payors;

V. Overcharging Government Payors for the use of the drug Octreotide/Sandostatin; and

VI. The submission of false billings and fraudulent claims in connection with Computer Aided Detection (CAD) services.

## BACKGROUND INFORMATION REGARDING RELATORS

### AMANDA DITTMAN

20. Relator DITTMAN was employed by Florida Radiology Associates ("FRA") as a compliance officer from 1996 until 2001. From 2001 until 2008, Relator was employed by Defendant Florida Hospital Orlando. Because Relator served as a liaison between FRA and Defendant Florida Hospital, she acquired direct and specific knowledge regarding the coding and billing practices of Defendant Florida Hospital from 1996 until 2008.

21. When Relator Dittman began her employment with Defendant Florida Hospital, she worked in the Radiology Department. She was supervised by the Directors of the Revenue Management Department, Lynne Criswell and Daniel Myers, who were supervised by the Vice Presidents of Defendant Florida Hospital, Bonnie Bradley and Jeff Hurst.

22. In 2006, Defendant Florida Hospital began a reorganization process in anticipation of

Medicare payment cuts. Defendant hired a new Director for the Radiology Department, Roland Rhynus. Mr. Rhynus repeatedly told Relator DITTMAN that he wanted to move her out of the Radiology Department because of her constant objections to billing issues. Relator DITTMAN continued to voice her concerns about improper billing of multiple CT abdomen and pelvic scans on the same date of service. She also complained about the billing processes regarding CT Colonography and 3D reconstruction. Mr. Rhynus told the CT Modality Manager, Jan Clemmons that Relator was a problem for the Radiology Department, and as a result, Relator was transferred to the Revenue Management Department in March 2008.

23. Despite her transfer to the Revenue Management Department, Relator DITTMAN retained her Radiology Department responsibilities. She also accepted new job responsibilities for all seven of Defendant's Orlando-area campuses. Relator immediately became aware of a multitude of compliance issues outside of the Radiology Department. She discovered compliance problems that were occurring daily throughout the Adventist Hospital System. Relator DITTMAN was not allowed to take corrective actions, and she was admonished by her superiors to "do what she was told."

24. After Defendant's reorganization in 2006, an accounting staff with no billing or coding background was appointed to direct the Revenue Management Department. Relator DITTMAN was the only employee in the Revenue Management Department with coding training and certifications. Despite that fact and Relator Dittman's capabilities, only clinical staff members were asked to audit accounts. Relator believes this happened because the clinical staff, who did not have coding training or credentials, did not have sufficient training or coding education to question Defendant's illegal practices.

25. Defendant's administrative staff was rewarded quarterly with financial bonuses for

meeting their budget. There was a direct correlation between meeting the budget and maximizing reimbursement from Government Payors. The administrative staff made it clear that Relator should not do anything that would cause them to miss their projected budget.

26. Relator DITTMAN repeatedly informed her superiors of Defendant Florida Hospital's illegal billing practices. Additionally, Defendant was advised by an outside audit firm to stop its illegal unbundling and overcharging practices.

**CHARLOTTE ELENBERGER**

27. Relator ELENBERGER was employed by Florida Radiology Associates ("FRA") from July 1995 until June 2008. In addition, she had active staff privileges at Defendant Florida Hospital from July 1995 until November 2009. On many occasions, Relator was asked to act as a liaison between FRA and Defendant Florida Hospital.

28. Defendant Florida Hospital electronically downloaded all billing information regarding imaging studies directly to FRA's billing computer. It was because of this process, that Relator became aware of billing discrepancies existing between Defendant Florida Hospital and FRA. Relator brought this issue to the attention of Defendant's staff, but nothing was corrected.

29. The issues of fraudulent billing, the non-disclosure of overpayments and refusal to return money from overpayments were discussed at numerous meetings held between members of FRA and Defendant Florida Hospital. Relator ELENBERGER was present at these meetings, along with Defendant Florida Hospital's business manager, billing personnel, compliance committee members, the Defendant's Vice President in charge of outpatient registration, Radiology Department Director and Lori Sommerfeld, who was in charge of inputting price file changes into Defendant's computer system.

**DEFENDANTS ILLEGALLY USED CPT CODE MODIFIERS TO BYPASS NCCI EDITS IN ORDER TO RECEIVE ADDITIONAL AND UNLAWFUL REIMBURSEMENTS FOR OTHERWISE BUNDLED PROCEDURES**

30. Defendant Florida Hospital's executives used specific modifiers to circumvent billing rules in order to obtain Medicare payments. This was done by using the CPT Code modifiers -59, -91, and -25 to bypass NCCI edits. The effect of this practice was to overbill Government Payors by unbundling charges.

31. The unlawful use of modifier -59 to bypass NCCI edits allowed Defendants to receive reimbursement for bundled procedures. This unbundling occurred on a systemic basis in Defendants' hospitals. This practice was used to unbundle urology procedures in the Kidney Stone Center, GI procedures performed outside of the Radiology Department, lung bronchoscopy and endoscopy procedures as well as spinal surgery and spinal pain management procedures. (See Florida Hospital System Chart, attached as Exhibit 1).

32. Defendants were aware of these improper and illegal practices in violation of Government billing requirements, but decided not to correct them. Many of the inappropriate charging practices stemmed from inaccurate chargemaster items, which were used on a daily basis.

33. Defendants systematically misused the -59 modifier by adding it to specific CPT codes in order to bypass the Government's NCCI edits. For example, Defendants obtained illegal payments for fluoroscopic and x-ray procedures that should have been "bundled" with other primary procedures provided to the patient rather than reimbursed separately. This type of illegal use of the -59 modifier typically involved urology, GI, lung, spinal and VAD procedures in the

operating room.

34. Relator ELENBERGER has personal knowledge that unbundling for fluoroscopy procedures occurred many times in surgical procedures outside of the Radiology Department. In order to accomplish this, Defendant created an internal edit within its own billing system that identified specific patients whose fluoroscopy and x-ray procedures had been improperly unbundled. Defendant's system then generated reports on the flagged patients and sent them to staff members. Defendant's staff members, including Relator DITTMAN, were instructed to modify the billing codes and add -59 modifiers to the patients' billing data even though the legal criteria for addition of the modifier had not been met. After the -59 modifier was manually added to the billing data, the bill was electronically submitted to the Government. The Government, in reliance on the -59 modifier, would reimburse Defendant for the fluoroscopy and x-ray procedures. (See Exhibit 1). In these instances, the fraudulent scheme required the affirmative taking of specific steps by Defendants to cover-up the actual services rendered in order to get paid for two separate claims that should have been bundled into one claim.

35. For example, when a patient went to the Kidney Stone Center for lithotripsy of a kidney stone and retrograde urography, the Center charged for the lithotripsy with CPT code 50590, the urography with CPT code 74420, the fluoroscopy with CPT code 76000, and the abdomen film with CTP code 74000. Both CPT codes 76000 and 74000 are bundled procedures and should not be separately billable. However, for many years, Defendant Florida Hospital charged the Government for both procedures by using a -59 modifier to bypass NCCI edits for payment. The edits would not have allowed the procedures to be billed separately.

36. Relator DITTMAN witnessed other examples of the unbundling and improper use

of the -59 modifier. When charging for a cholangiogram in the operating room, Defendants would add an additional fluoroscopy charge using CPT code 76000 with an attached -59 modifier.

37. Defendants would also use the -59 modifier in the angiogram and cardiac catheterization labs to bill for fluoroscopy and multiple injections, which were charges that should have been bundled into the primary procedure. In these instances, there was no evidence in the medical record that separate procedures or encounters occurred which would justify the use of the -59 modifier.

38. Additionally, when patients receiving venous access devices in Defendant's operating rooms were charged under surgical CPT codes 36555-36571, 36575-36576, 36578-36585, and 36589-36590, Defendant was able to receive reimbursement for fluoroscopic guidance for needle placement under CPT code 77000, 77001 or 77001. However, it was improper for Defendant to receive reimbursement for both the fluoroscopy guidance and the confirmatory chest x-ray. Defendants were aware of the reimbursement regulations, but used the -59 modifier to receive reimbursement for both charges. Additionally, Defendant overrode NCCI edits by adding the -59 modifier to the codes reflecting the chest x-rays performed to check the position of line placements or for pneumothorax for surgical procedures.

39. Also, when providing lung procedures such as bronchoscopy (CPT 31622-31656) in its Operating or Endoscopy rooms, Defendant is allowed reimbursement for fluoroscopic guidance under CPT code 77002, but is not allowed separate reimbursement for CPT codes 76000 or 76001. By adding the -59 modifier, Defendant was able to override the NCCI edit that bundled CPT codes 76000 or 76001 with CPT code 77002 and the bronchoscopy surgical codes.

40. In the Kidney Stone Center, urology procedures involving urethral catheters, stone extractions, etc., included fluoroscopy, and were bundled into CPT codes 50382-50389 and 74420-74430. Defendant added the -59 modifier to bypass the NCCI edits and receive reimbursement to which it was not entitled.

41. Similarly, the single view abdomen procedure (CPT code 74000) is included and bundled into the lithotripsy surgical code (CPT code 5059). Defendant used the -59 modifier to override the NCCI edit and obtain unauthorized reimbursement.

42. Fluoroscopy codes 76000-76001 are normally bundled into ER radiology supervision interpretation codes (CPT codes 74328-74330) and surgical codes (CPT codes 43260-43272), but Defendant used the -59 modifier to bypass the NCCI edits to obtain separate reimbursement for fluoroscopy procedures.

43. Defendant also used the -59 modifier to bypass NCCI edits for fluoroscopy (CPT codes 76000, 76001, 76005, and 77003) in spinal procedures and pain management procedures with the following CPT codes: 62310-62319, 62263-62264, 62270-62273, 62280-62282, 22526-22527, 62263-62264, 62270-62282, and 62310-62319. The latter codes are injection codes used primarily in pain management procedures.

44. Additionally, Defendants utilized the -91 modifier to bypass edits in order to secure payments for bundled laboratory procedures, and the -25 modifier to bypass edits to secure payments for bundled emergency room procedures.

## OCTREOTIDE/SANDSTATIN OVERCHARGES

45. Octreotide (trade name Sandostatin) is a drug that is similar to a hormone called

somatostatin. Octreotide lowers substances in the body such as insulin, glucagons, growth hormone and chemicals that affect digestion. It is used to treat acromegaly and to relieve the symptoms caused by gastroenteropancreatic (GEP) tumors. Octreotide is given either intravenously or by injection.

46. In August 2008, Relator DITTMAN attended a Revenue Management Department meeting at Defendant's Florida Hospital Orlando regarding an internal hospital audit which had examined billings submitted for the drug Octreotide. The audit covered the time period from August 1, 2007 to July 31, 2008 and analyzed information in the Sunport and PharmNet computer systems.

47. The audit revealed that the Defendant had incorrectly associated the same price file number with two different doses of Octreotide. The price file number for 5000mcg of Octreotide is 7300005691 and represents a $3,109.96 charge. The Defendant incorrectly used this same price file number for the smaller 1000mcg dose of the drug. Each time this incorrect price file was used for the lower dose, the Defendant charged $3,109.96 instead of the correct charge for 1000mcg of the drug which is only $621.99.

48. For the time period covered by the audit alone, Defendant's pricing error involving Octreotide resulted in almost $2 million in overcharges. Approximately 24% of those overcharges were submitted to the Government Payors.

49. Despite the fact that Defendant had knowledge of its Octreotide pricing error, it made no effort to correct the overcharges or to issue refunds to the appropriate Government Payor. In addition, it is likely that the pricing error also may have been occurring prior to August 1, 2007, yet the Defendant made no attempt to review the Octreotide pricing information outside of the time period covered by the audit described herein.

## COMPUTER AIDED DETECTION ("CAD") FALSE BILLING

50. Computer Aided Detection ("CAD") software analyzes mammogram images and marks suspicious areas for radiologists to review in order to assist them in determining which images could lead to invasive tumors. CAD was approved by the U.S. Food and Drug Administration in 1998 and has been incorporated into many mammography imaging practices.

51. Defendant has had CAD capability at several of its Florida Hospital locations for the past several years. Even though CAD is used in connection with the majority of mammograms performed at these hospitals, there have always been instances in which CAD is not or cannot be performed in connection with the mammography procedures at Defendant's hospitals. Despite this fact, Defendant improperly created a price file for mammography billing which automatically associated CPT codes for CAD for all mammogram services performed at Defendant's hospitals regardless of whether CAD was actually used in connection with the mammograms. The OC system is the name of Defendant's computer system which was programmed to have the CAD charge automatically "explode" from the mammography price file. This CAD billing error was exacerbated by the fact that the OC system would not allow for reversal of the CAD charge once it exploded from the price file. Consequently, for several years, Defendant received unlawful overpayments from Government Payors for CAD services which were never performed.

52. Defendant's failure to correct the error in the OC system eventually led to a particularly flagrant example of fraudulent billing. For approximately three months at the beginning of 2006, CAD was not functioning at Defendant's Celebration Hospital. Nevertheless, Defendant continued to charge for CAD services at the Celebration Hospital during this time period even though the CAD equipment was not in working order. Several radiologists brought this issue to the

attention of the radiology supervisor at the Celebration hospital but it continued for approximately 90 days.

53. Relator ELENBERGER learned of Defendant's fraudulent billing with regard to CAD in April of 2006 when her radiology practice, Florida Radiology Associates (FRA) realized not only that Defendant had received improper reimbursement for the technical component of the CAD services which were never performed, but also that Defendant's false billing had caused FRA to mistakenly receive reimbursement for the professional component of the CAD services. When FRA learned of this improper reimbursement, it promptly refunded the money for the CAD services at issue to all insurance carriers, including Medicare.

54. FRA informed Defendants of the fact that FRA and the hospital had been overpaid and that FRA had refunded the money it received for CAD services during the period of time when CAD was not working. However, Defendant refused to refund the portion of the funds which it had improperly received because it was concerned that a refund would "raise a red flag" and result in an audit of the hospital by the Government Payors. Defendant's refusal to refund the money received as a result of the false CAD billings was discussed at several meetings between FRA and Rholand Rhynus, the Radiology Director for all seven of Defendant's hospitals.

55. In late 2006, Relator Elenberger attended an information technology meeting at which the following individuals were present: Charles May, FRA business manager; Andy Crowder and his assistant Valerie McGibbon; Ed Majors; Max Grady and Rholand Rhynus. Relator Elenberger asked Mr. Rhynus at the meeting whether Defendant was going to refund the money for the fraudulent CAD charges. Mr. Rhynus reiterated that Defendant did not want to "bring attention" to itself by issuing a refund. After the meeting, Mr. Rhynus went to Relator DITTMAN'S office and informed

her as well that Defendant would not be returning the money for the false CAD charges which were submitted to Government Payors for services that were never rendered.

56. In 2007, Defendant finally attempted to correct the error in the OC system which led to the false CAD billing by modifying the price file to include a "mammogram without CAD" option. However, Defendant never refunded the overpayments which it received as a result of the false CAD charges. Defendant's fraudulent billings for CAD services constitute false and/or fraudulent claims in violation of the False Claims Act. The fact that Defendant continued to bill for CAD even when CAD was not operational and then intentionally tried to conceal the overpayments it received to avoid issuing a refund to Government Payors demonstrates the culture of fraud and deceit that Defendants promoted.

## COUNT I

## VIOLATION OF FEDERAL FALSE CLAIMS ACT - 31 U.S.C. § 3729-33

Paragraphs 1 through 56 are incorporated into Count I as if fully set forth herein.

57. This is a civil action brought by Relators on behalf of the United States against the Defendants under the Federal False Claims Act, 31 U.S.C. § 3729-33.

58. The Defendants knowingly, or with reckless disregard, or in deliberate ignorance of the truth or the falsity of the information involved, presented or caused to be presented, false or fraudulent claims for payment to federally-funded health insurance programs, in violation of, inter alia 31 U.S.C. § 3729(a)(1)(A).

59. Further, the Defendants in reckless disregard, or deliberate ignorance of the truth or the falsity of the information involved, made, used, caused to be made, or caused to be used, false or fraudulent records and statements to get false or fraudulent claims paid or approved, in violation of,

inter alia 31 U.S.C. § 3729(a)(1)(B).

60. The Government Payors, unaware of the falsity of the claims and/or statements made or caused to be made by the Defendants, and in reliance on the accuracy of these claims and/or statements, paid for purported medical procedures and services provided to individuals insured by federally-funded health insurance programs, including Medicare and other Government Payors. Had the United States known that the bills presented by Defendants for payment were false and misleading, payment would have not have been made for such claims.

61. Additionally, Defendants have violated 31 U.S.C. 3729(a)(1)(G) by knowingly making, using or caused to be made or used, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the Government.

62. As a result of Defendants' actions, the Government Payors have been severely damaged.

## COUNT II

## CONSPIRACY TO VIOLATE THE FALSE CLAIMS ACT - 31 U.S.C. § 3729(a)(1)(C)

Paragraphs 1 through 56 are incorporated into Count II as if fully set forth herein.

63. The Defendants conspired with one another to get false and fraudulent claims allowed and paid by the Government Payors.

64. The Defendants conspired together, and later withheld information specifically known to Defendants regarding the fraudulent billing of patients.

65. The Defendants acted in a concerted fashion to defraud the Government Payors, and the Defendants acted together in keeping the facts necessary to investigate the fraud and the damages caused by the fraud away from the United States. Accordingly, the Defendants violated 31 U.S.C. §

3729(a)(1)(C).

66. As a result of the Defendants' actions, the Government Payors have been severely damaged.

## COUNT III

## DEFENDANT HAS VIOLATED THE STATE OF FLORIDA FALSE CLAIMS ACT Fla. Stat. § 68.082(2)(a)-(c) and (g)

Relator restates and realleges the allegations contained in Paragraphs 1-56 above as if each were stated herein in their entirety and said allegations are incorporated by reference.

67. The FLORIDA FALSE CLAIMS ACT, Fla. Stat. § 68.082(2), specifically provides, in part, that:

*Any person who:*

*(a) Knowingly presents or causes to be presented to an officer or employee of an agency a false or fraudulent claim for payment or approval;*

*(b) Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by an agency;*

*(c) Conspires to submit a false or fraudulent claim to an agency or to deceive an agency for the purpose of getting a false or fraudulent claim allowed or paid;*

*(d) Has possession, custody, or control of property or money used or to be used by an agency and, intending to deceive the agency or knowingly conceal the property, delivers or causes to be delivered less property than the amount for which the person receives a certificate or receipt;*

*(e) Is authorized to make or deliver a document certifying receipt of property used or to be used by an agency and, intending to deceive the agency, makes or delivers the receipt without knowing that the information on the receipt is true;*

*(f) Knowingly buys or receives, as a pledge of an obligation or a debt, public property from an officer or employee of an agency who may not sell or pledge the property lawfully; or*

*(g) Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to an agency,*

*is liable to the state for a civil penalty of not less than $5,500 and not more than $11,000 and for treble the amount of damages the agency sustains because of the act or omission of that person.*

68. Defendant knowingly presented or caused to be presented to the Florida Medicaid program false claims for payment and approval, claims which failed to disclose the material violations of the law, and knowingly made, used and caused to be made and used, false records and statements to get false and fraudulent claims paid and approved by an agency of the State of Florida. Defendants conspired to submit false claims to Government Health Care Programs and to deceive Federal/Government Health Care Programs for the purpose of getting false and fraudulent claims allowed and paid, all in violation of Fla. Stat. § 68.082(2)(a)-(c).

69. The State of Florida paid said claims and has sustained damages, to the extent of its portion of Medicaid losses from Medicaid claims filed in Florida because of these acts by the Defendant.

WHEREFORE, Relators pray for judgment against Defendants as follows:

(a) That Defendants be ordered to cease and desist from submitting and/or causing the submission of additional false claims or otherwise violating 31 U.S.C. § 3729-33;

(b) That judgment be entered in favor of the United States and Relators, and against the Defendants, in the amount of each and every false or fraudulent claim multiplied as provided by 31 U.S.C. § 3729(a), plus a civil penalty of not less than Five Thousand Five Hundred and No/100 ($5,500.00) Dollars, and no more than Eleven Thousand and No/100 ($11,000.00) Dollars per claim, as provided by 31 U.S.C. § 3729(a), to the extent such multiplied penalties shall fairly compensate

the United States of America for losses resulting from the various schemes undertaken by Defendants, together with penalties for specific claims to be identified at trial after full discovery; and

(c) That judgment be entered in favor of the State of Florida and Relators, and against the Defendants, in the amount of each and every false or fraudulent claim multiplied as provided by 31 U.S.C. § 3729(a), plus a civil penalty per claim, as provided by Fla. Stat. 68.082, et. seq., to the extent such multiplied penalties shall fairly compensate the State of Florida of America for losses resulting from the various schemes undertaken by Defendants, together with penalties for specific claims to be identified at trial after full discovery; and

(d) That Relators be awarded the maximum amount permissible according to 31 U.S.C. § 3730(d) and Fla. Stat. 68.082, *et.seq.*; and

(e) That judgment be granted for the United States of America and Relators, and against Defendants, for any costs including, but not limited to, court costs, expert fees, and all attorneys' fees incurred by Relators in the prosecution of this suit;

(f) That judgment be granted in favor of the Relators and the State of Florida, and against Defendants, in an amount equal to three times the amount of damages that Florida has sustained as a result of the Defendants' actions, as well as a civil penalty for each violation of Florida's false claims act;

(g) That the United States and Relators be granted such other and further relief as the Court deems just and proper.

This 15th day of July, 2010.

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