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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

UNITED STATES OF AMERICA	**Case No.** 15-cv-3132 SRN/BRT
Plaintiff-Relator,	**COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, 31 U.S.C §§ 3729, *ET SEQ.***
v.	
[UNDER SEAL]	**FILED UNDER SEAL**
[UNDER SEAL]	**JURY TRIAL DEMANDED**
[UNDER SEAL]	
[UNDER SEAL]	
Defendants.	

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MINNESOTA

UNITED STATES OF AMERICA, *ex rel.* JEFF SAMUELSON, M.D. **Plaintiff-Relator,** **v.** **SKIN CARE DOCTORS, P.A., a Minnesota Professional Association, and MICHAEL J. EBERTZ, M.D.,** **Defendants.** **Registered Agent for Skin Care Doctors, P.A.: None Listed** **Registered Office Address for Skin Care Doctors, P.A.: 14000 Nicollet Ave. S #304 Burnsville, MN 55337**	**Case No. _____** **COMPLAINT FOR VIOLATIONS OF THE FALSE CLAIMS ACT, 31 U.S.C §§ 3729, *ET SEQ.*** **FILED UNDER SEAL** **JURY TRIAL DEMANDED**

INTRODUCTION

1. Qui Tam Relator Jeff Samuelson, M.D. ("Relator" or "Samuelson"), by and through his attorneys, David L. Scher and R. Scott Oswald of The Employment Law Group, P.C., and Susan M. Coler of Halunen Law, files this Complaint against Defendants Skin Care Doctors, P.A. ("SCD") and Michael J. Ebertz, M.D. (Ebertz), (collectively "Defendants"), to recover all damages, penalties, and attorney's fees for violations of the False Claims Act, 31 U.S.C. §§3729, *et seq.* ("FCA").

2. Defendants have knowingly submitted false and/or fraudulent claims to Medicare for medically unnecessary services.

3. Defendants have knowingly caused in-house and outside pathology laboratories to submit false and/or fraudulent claims to Medicare for medically unnecessary services.

JURISDICTION

4. Jurisdiction over this action is conferred upon this Court by 28 U.S.C. §1331, 31 U.S.C. §3732(a).

5. Venue is proper in this district pursuant to 31 U.S.C. §3732(a), which provides that "any action under § 3730 may be brought in any judicial district in which the Defendant or, in the case of multiple Defendants, any one Defendant can be found, resides, transacts business, or in which any act proscribed by § 3729 occurred."

6. There are no bars to recovery under 31 U.S.C. §3730(e).

7. In the alternative, Relator Samuelson is an original source as defined in 31 U.S.C. §3730(e)(4)(B).

8. Further, this action is not based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing at the State or federal level, or in a congressional, legislative, administrative, General Accounting Office, or State Auditor's report, hearing, audit, or investigation, or from the news media.

PARTIES

The Relator

9. Relator Samuelson is a resident of Edina, Minnesota.

10. Samuelson is a trained dermatologist.

11. Samuelson earned his M.D. from the University of Health Sciences, The Chicago Medical School, in 1989.

12. Samuelson completed his residency in dermatology at Fitzsimons Army Medical Center in 1996.

13. Among other certifications, Samuelson is a Fellow in the American Academy of Dermatology.

14. Samuelson joined SCD in 2000, six months after Ebertz founded the practice.

15. Samuelson is now living and working part-time in Los Angeles, working with a few other doctors on a part-time basis. He still considers Minnesota his "permanent address," since the home he owns is there. He is working to transition his work and home to Los Angeles.

The Defendants

16. SCD is a very profitable dermatology practice, with four offices and a staff of more than 60, including six doctors.

17. As of July 6, 2015, SCD's website indicated six doctors were in the practice (Ebertz, Nancy Leitch, Heidi Foster, Kathryn Gehrig, Rehana Ahmed, and Wayne Freilich).

18. SCD has an in-house pathology laboratory.

19. SCD operates four locations, in Burnsville, Edina, Orono and St. Cloud Minnesota. SCD is listed as a domestic Professional Association by the Minnesota Secretary of State. The Principal Executive Office Address is listed as: 14000 Nicollet Ave S #304, Burnsville, MN 55337, USA.

20. Michael J. Ebertz, M.D. is the sole owner of SCD and a doctor in the practice.

FACTUAL ALLEGATIONS

21. Defendants are engaging in three types of fraudulent billing practices that have led to Medicare paying out false claims totaling more than $1,000,000, although Relator believes it could be significantly more.

(1) Falsely billing for removal of supposedly pre-cancerous lesions
(2) Falsely billing for made-up office visits
(3) Fraudulently ordering unnecessary biopsies for diagnoses that should be easily diagnosed without them

22. When Samuelson joined the practice, he owned a 20-percent share of the business, with Ebertz holding 75 percent and, another physician then in the practice, Allison Hoffman, with five percent. Ebertz now has 100 percent ownership of SCD because Samuelson quit the practice in October 2014, and Hoffman recently left the practice and transferred her five-percent share to Ebertz.

23. Ebertz makes millions annually from his practice. Ebertz's contributed revenue to the practice is about $1.6 million.

Relator and other SCD physicians discover the fraud

24. Because Ebertz's fraudulent practices were long-standing, nurses and other doctors in the practices had suspicions about his billing and occasionally talked about it.

25. Ebertz went on a four-month vacation in the spring and summer of 2014 when his mother fell ill, leaving the other doctors to cover for him.

26. The other doctors, including Samuelson, saw Ebertz's patients during this time.

27. Ebertz saw around 45-50 total patients per day.

28. Samuelson and other doctors were therefore able to directly observe Ebertz's patients and their files and realized that Ebert had been engaging in fraudulent practices.

Pre-cancers vs. benign growths

29. Pre-cancers and benign growths are both lesions that occur on the skin.

30. A pre-cancer is a crusty spot, whereas a benign lesion is a brown barnacle-shaped growth; it should be immediately apparent to a dermatologist that a lesion is one or the other.

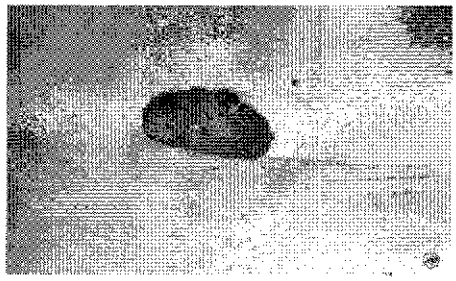
31. The process of removing lesions (whether benign or pre-cancerous) is quick and simple, although it results in significant discomfort for the patients. The doctor sprays liquid nitrogen from a canister onto the skin; it takes about three seconds to remove one growth.

32. Freezing off the lesions causes significant pain for the patients. It feels like a burn from a stove where the liquid nitrogen is sprayed.

33. Patients receive no anesthesia when lesions are frozen and removed.

Pre-cancer

Benign Growth



Ebertz falsely billed Medicare for removal of benign growths

34. Medicare reimburses for the removal of pre-cancers, but not the removal of benign growths.

35. If a patient says s/he is irritated by the growth, then a doctor might remove it and submit a claim.

36. It is unlikely Medicare would pay out that claim. If it did, the rate would be much lower than a pre-cancerous growth removal.

37. Ebertz "treated" conditions that were not covered by Medicare by mischaracterizing them.

38. Medicare reimburses around $120 for one lesion, progressively less for each additional removal up to 15, and then nothing for each lesion after the 15th.

39. Ebertz coded benign growths as pre-cancers in order to bill Medicare for their removal.

Number of Lesions Removed	Medicare Billing Code	Medicare Reimbursement
1	17000	$120
2-14	17002 or 17003	$120 + $15-20 for each to 14
15 or more	17004	~$350

40. Relator saw in Ebertz patients' files that Ebertz routinely removed 15 pre-cancers in a single visit, and thus billed under the 17004 billing code.

41. About 15 of the 20-25 Medicare patients Ebertz saw per day were found to have more than 15 AKs (pre-cancers) when they only had benign lesions.

42. The lesions, according to the patient files, were often in places that you rarely see pre-cancers (e.g. the chest and back).

43. The SCD doctors seeing Ebertz's patients realized that these patients did not have lesions previously removed in these places. They also observed that they did not have new pre-cancers.

44. The overwhelming majority of the removals performed by Ebertz were likely benign growths.

45. Relator noticed this with **virtually all** of Ebertz's patients that he saw during this period.

46. Ebertz performed far more removals than other doctors in the practice perform.

47. Patient files contained drawings of where the removed growths were but no photographs. Ebertz marked the growths with an X on a diagram and wrote AK, which stands for actinic keratosis, a type of pre-cancer.

48. Samuelson's observations that Ebertz was intentionally removing benign growths were corroborated by other doctors who saw Ebertz's patients.

49. Patients often asked why other doctors weren't removing as many lesions as Ebertz. Samuelson told many of Ebertz's patients that the growths he observed were benign, and removing them would not be covered by Medicare.

50. Some patients were annoyed by Samuelson telling them that their growths were benign. Most patients were ecstatic to learn they did not have any pre-cancers.

51. Very few patients wanted the growths removed after Samuelson told them the growths were benign (since they would have to pay out of pocket for that).

Ebertz performed excessive biopsies

52. If a doctor freezes a pre-cancer and it doesn't go away, the doctor will typically do a biopsy to determine whether it is, in fact, cancerous.

53. A biopsy involves (1) a doctor shaving a growth off the skin, (2) processing the tissue to prepare it for pathology analysis, and (3) sending the tissue out to a lab for pathology analysis to see if it is cancerous.

54. Dermatologists should be able to determine visually whether something is potentially cancerous.

55. Ebertz biopsied spots or lesions that he knew to be benign.

56. He did this because biopsy fees are high, and the in-house laboratory allowed SCD to bill for processing the tissue and pathology analysis during the period in which the practice had an in-house pathologist.

57. Ebertz also often ordered two to five biopsies during one visit.

58. It is not standard practice to remove more than one biopsy per visit; most dermatologists would spot one problem growth and have it checked out.

59. In most cases the specimens Ebertz has biopsied could be identified by a first year medical student or an experienced nurse as benign.

60. Biopsies are billed under CPT codes 11100 and 11101.

61. Medicare reimburses $130 for a biopsy, plus ~$200 for processing the tissue (always done in-house at SCD) and an additional $100-150 for the pathology analysis.

62. SCD had a pathologist on staff for about 18 months, until she left last fall.

63. SCD now sends tissue out for pathology analysis.

64. SCD still has the laboratory. Biopsies are more profitable than removing pre-cancers because (1) Medicare pays more in reimbursement for biopsies and (2) SCD did the processing in-house, and, (3) for an 18-month period, SCD did the pathology analysis in-house as well.

65. Samuelson observed that Ebertz was performing many more biopsies than other doctors and he believes that a substantially higher percentage of Ebertz's biopsies came back as benign.

66. Samuelson believes Ebertz was ordering biopsies for growths he knew were benign/that are easily recognizable as benign.

67. Whether to do a biopsy is largely a judgment call, and some doctors may be more cautious than others. However, a significantly skewed percentage of biopsies that turn out to be benign, as seen here, indicates that Ebertz is doing biopsies that are not medically necessary.

Ebertz upcoded office visits

68. When patients come in for a specific procedures (e.g. to remove a pre-cancer), a doctor should bill for the procedure but not the office visit. The doctor simply submits the code for that procedure and Medicare reimburses accordingly.

69. When patients come in for reasons other than a procedure (e.g. acne), then it is appropriate to bill for the office visit (typically the doctor just talks to the patient and/or writes a prescription).

70. If patients come in for specific procedures and, during their appointments, complain about something else, then it is appropriate to bill for an office visit. For example, a patient might say "my elbow itches today," and the doctor would give her moisturizer to rub on it.

71. It is also appropriate to bill for an office visit with a new patient—even if the patient was there for a specific procedure.

72. Whenever patients came in for specific procedures, Ebertz falsely claimed that they also complained about xerosis (dry skin) and billed Medicare for the office visit in addition to billing for the specific procedures. Ebertz generally used code 99214 to bill for these office visits.

73. Billing for an office visit is only appropriate if the patient brings up another issue him/herself, even if the doctor and patient only talk about the other issue for a second.

74. Most of the time, the patient just had the procedure done and walks out.

75. Ebertz inserted another false diagnosis to charge for an office visit, essentially claiming a second condition was revealed by the patient during the treatment for something else. Usually, this additional condition was "xerosis," which means dry skin.

76. It is extremely unlikely that Ebertz's patients were complaining about dry skin at every office visit, which is what his bills to Medicare would suggest.

77. Samuelson has never billed for an office visit based on a xerosis diagnosis—it is very uncommon for a patient to complain about dry skin.

78. Patients don't know Ebertz is claiming they were treated for xerosis because all they see on the invoice is that Ebertz billed for an office visit.

79. The coding level for an office visit depends on several factors:

- 1 is for a nurse visit (nobody at SCD bills for that)
- 2 is the lowest code for an office visit with a doctor—a very simple visit (e.g. xerosis).
- 3 and 4 are for more complicated office visits.

Level	Medicare Billing Code	Medicare Reimbursement
1	99211	$20
2	99212	$44
3	99213	$73
4	99214	$108

80. For a new patient visit, doctors charge a 2 or 3 (some doctors might do 4 depending on the number and complexity of issues and the amount of time).

81. For an established patient visit, doctors charge a 3 or 4 (depending on the number and complexity of issues, number of body parts examined, and the patient's other health issues). SCD's billing software defaulted to a Level 4 for an office visit.

82. Samuelson believes that Ebertz rarely changed the level and almost always billed for a Level 4 visit. Samuelson and all other doctors manually changed to a lower level, where appropriate.

83. Ebertz was an outlier among Medicare doctors in charging for patient visits with this frequency and at this level.

84. Early on in Samuelson's tenure, Ebertz told him that he should think of a way to bill the insurer for every office visit. Specifically, he said that if Samuelson treated a patient for a wart, he should also write down that the patient had xerosis.

85. Ebertz said that he always noted that the patient complained of xerosis and that he recommended moisturizer because it allowed him to enter a billing code for the office visit.

86. Ebertz gave the same instruction to the other doctors when they joined the practice, but no one (including Relator) followed it.

87. Unearned office visits with made-up diagnoses such as "xerosis" bill at approximately $120 each.

88. Ebertz has done all of this consistently for the last 15 years.

Evidence that Ebertz's billing is anomalous

89. Ebertz's charges are far higher than those of others in similar practices, and far higher than the other doctors at SCD.

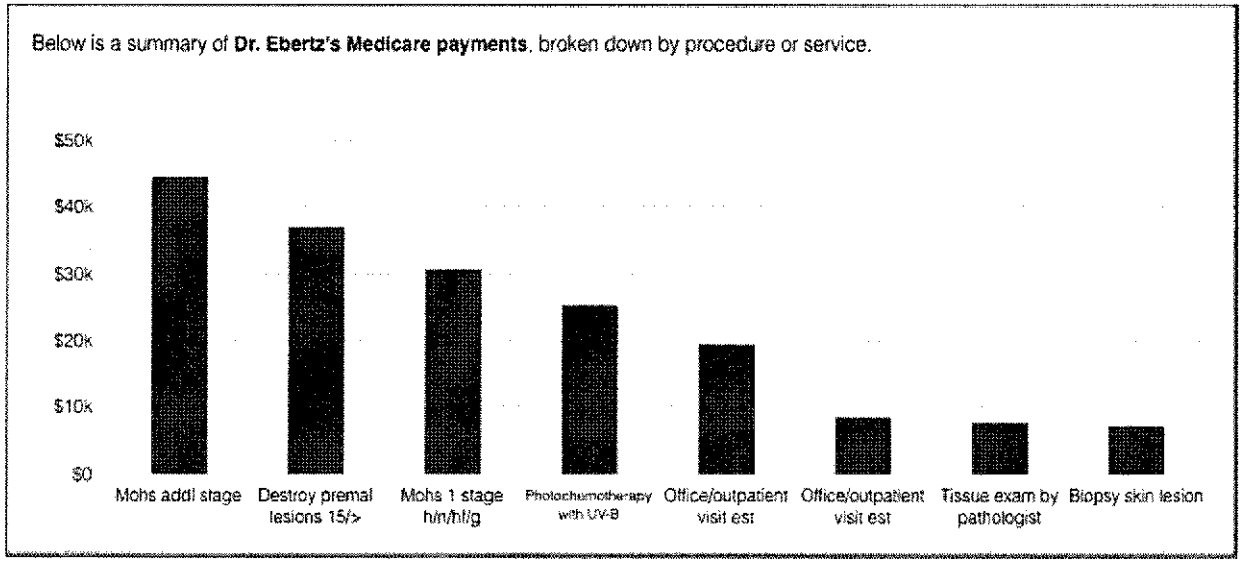
90. Ebertz claims to treat patients for conditions for which he does no treatment, (e.g., xerosis). He will charge a level 4 visit for xerosis, a condition that the patient usually did not mention and for which no treatment was provided.

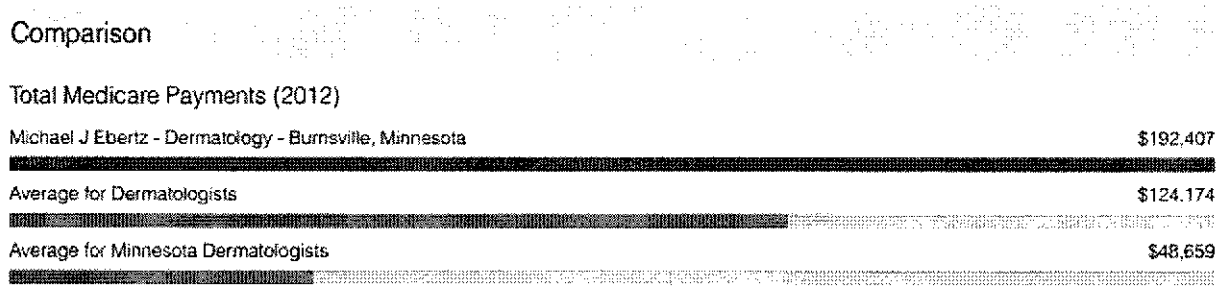
91. Ebertz does not try to justify his coding; he just claims it.

92. A Medicare audit could reveal the fraud by reviewing patients' histories and treatments, and by analyzing his billing practices and his stated justifications for the billing.

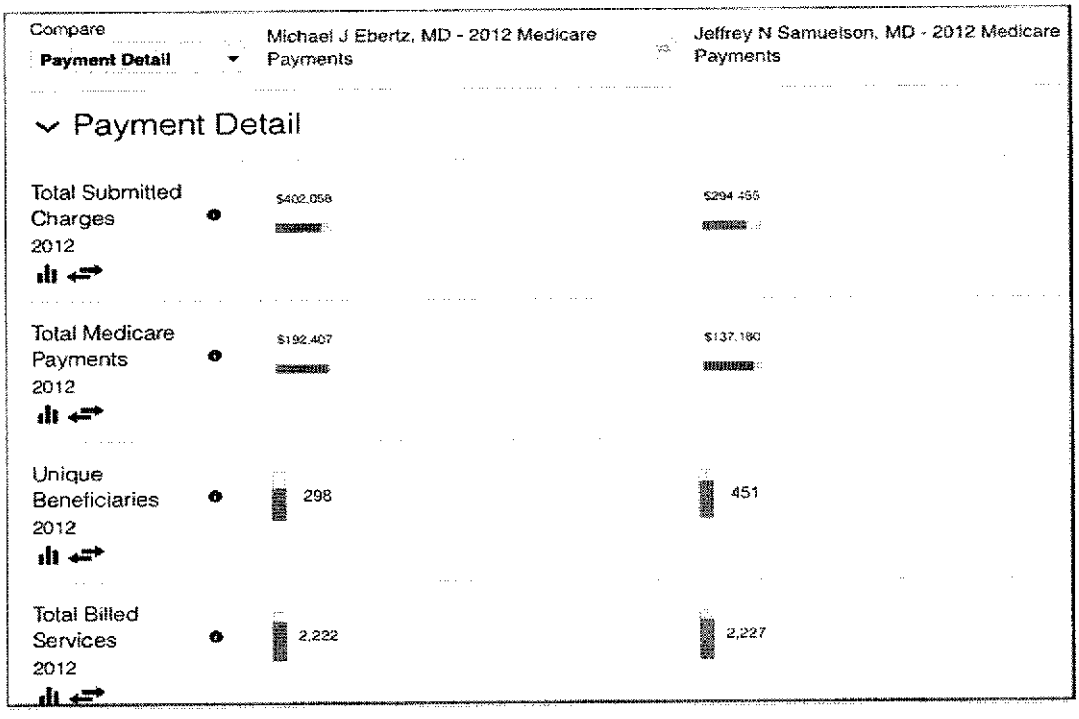
Dr. Ebertz's Medicare payments by procedure from 2012

93. Dr. Ebertz's Medicare billing is significantly higher than the average for other Minnesota dermatologists in 2012. Information *available at* http://medicare-payments.findthebest.com/l/130144/Michael-Ebertz-Burnsville-Minnesota.

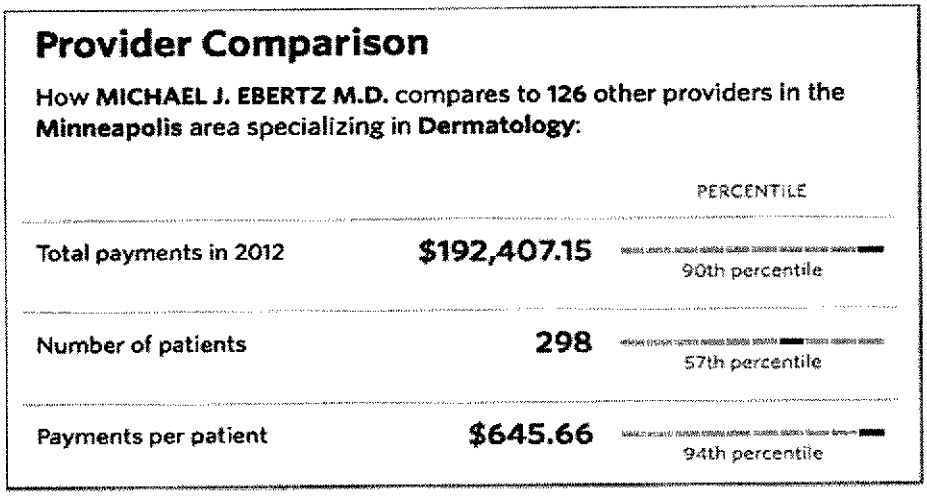




A comparison of Samuelson's and Ebertz's billing (ca 2012)



94. Notably, Ebertz is in the 57th percentile of patients, but the 90th percentile in payments. Information *available at* http://projects.wsj.com/medicarebilling/#/1144386392



Samuelson leaves the practice

95. Samuelson left the practice because tensions between him and Ebertz had increased in recent years.

96. Ebertz treats staff badly, reducing nurses to tears on many occasions.

97. As the tension worsened, there was an incident when the assistant office manager (Ebertz's nephew, Ben) claimed that Samuelson had yelled at a nurse.

98. Samuelson disputed this, and the nurse denied it, but on October 28, 2014, Ebertz ordered Samuelson to be suspended without pay for one month. Ben had cancelled all of Samuelson's appointments for the next day without telling him, a sign that Ebertz had planned to force Samuelson out.

99. Samuelson did not return to work after that, and negotiated a separation agreement with Ebertz, which became effective December 12, 2014.

100. The separation was made effective back to October 28, 2014.

101. Ebertz essentially pushed Samuelson out of the practice.

102. Officially, Samuelson reached a buy-out agreement with the practice, but, in fact, Ebertz falsely claimed as a justification for pressuring him to leave that Samuelson was abusive to nurses and other doctors and needed anger management (this is pretext).

103. At the time, he was pushed out, Samuelson had a 20 percent stake in the practice, and Ebertz was uncomfortable with anyone else having such a large share (when Samuelson left, Ebertz's stake rose to 95 percent).

Staff rally around Samuelson

104. After Samuelson left SCD, the office staff rallied around him.

105. Some nurses came to his home the next day to ask what happened. Samuelson went out to dinner with a group of them the following week.

106. Though he could not speak about his opinion of Ebertz because of the non-disparagement clause in his separation agreement, the staff spoke on their own initiative about how much fraud Ebertz was committing.

107. Staff enjoyed working with Samuelson and expressed fear of being left with Ebertz.

COUNT I

Defendant SCD Knowingly Presented, or Caused to be Presented False or Fraudulent Claims for Payment or Approval in Violation of 31 U.S.C. §3729(a)(1)(A)

108. The allegations of all paragraphs in this Complaint are incorporated by reference.

109. 31 U.S.C. § 3729(a)(1)(A) subjects to liability any person or entity that "knowingly presents, uses, or causes to be presented, a false or fraudulent claim for payment or approval."

110. Under 42 U.S.C. § 1395y Medicare excludes payment for services that are deemed medically unnecessary, including "items and services...[that] are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

111. Medicare claims may be false if they claim reimbursement for services or costs that either are not reimbursable or were not rendered as claimed. *See United States v. R&F Props. of Lake Cnty., Inc.*, 433 F.3d 1349, 1356 (11th Cir. 2005) (*citing United States v. Calhoon*, 97 F.3d 518, 524 (11th Cir.1996); *Peterson v. Weinberger*, 508 F.2d 45, 52 (5th Cir.1975)).

112. A Medicare provider becomes eligible to provide services and receive payments under Medicare after completing the enrollment process and agreeing to comply with the

provisions laid out in 42 U.S.C. § 1395cc, which include making adequate provisions for returns of moneys incorrectly collected.

113. SCD knowingly submitted false claims for payment for treatment that was medically unnecessary when:

a. SCD unnecessarily removed benign growths and billed Medicare as if it performed medically necessary removals of pre-cancers.

b. SCD used billing code 17004 to bill for removal of 15 or more pre-cancers.

c. SCD ordered unnecessary biopsies of lesions that Ebertz should have been able to see were benign.

d. SCD used CPT codes 11100 and 11101 to bill for unnecessary biopsies.

e. SCD billed for in-house processing of tissue collected in unnecessary biopsies.

114. SCD knowingly caused outside pathology labs to submit false claims for payment when:

a. SCD sent tissue samples from unnecessary biopsies to outside pathology labs for pathology analysis.

b. The outside pathology labs submitted claims to Medicare for analyzing tissue resulting from unnecessary biopsies.

115. SCD submitted false claims for payment to Medicare based on treatment not rendered as claimed when:

a. SCD routinely billed for office visits when it should not have done so (e.g. when it was already billing for an underlying procedure).

b. SCD used the higher level billing code 79214 when it should have used lower level codes 79212, 79213, or should not have billed at all for an office visit.

c. SCD billed at the highest office visit rate as a matter of course without respect to the nature of the visit.

116. SCD violated the FCA when it submitted false claims for payment to the Government, when it billed for services that were medically unnecessary (removal of benign growths, biopsies) and/or were not rendered as claimed (up-coded office visits).

117. SCD violated the FCA when it caused outside pathology labs to submit false claims arising from medically unnecessary treatment.

118. Samuelson knows that rampant violations have occurred because he has seen Ebertz's patients and their patient files.

119. SCD knew it was falsely billing Medicare for unnecessary treatment because Ebertz knew that he was removing benign growths and billing for removal of pre-cancers.

120. SCD knew it was falsely billing Medicare for unnecessary biopsies on growths that Ebertz knew were benign.

121. SCD knew it was causing outside pathology labs to falsely bill Medicare for pathology analysis of tissue samples from unnecessary biopsies.

122. SCD knowingly miscoded the treatment that Ebertz performed by billing for office visits even when it was not appropriate to do so (e.g., even when also billing for a procedure) and by almost always billing at the highest level for those office visits.

123. The repeated nature of Ebertz's billing practices and their departure from the standard billing practices observed in the rest of the practice, suggest that these activities were

not "negligence." *See United States ex rel. Miller v. Weston Educ., Inc.*, 784 F.3d 1198, 1204 (8th Cir. 2015).

124. At the very least SCD showed a reckless disregard of the truth, which the FCA treats as fulfilling the scienter requirement. *See id.* SCD's false claims to Medicare are therefore knowingly false.

125. SCD's false statements that treatment provided was medically necessary are material because they were submitted to Medicare for payment.

126. SCD's false statements that treatment was rendered as claimed were material because Medicare would not have reimbursed SCD for office visits in addition to underlying procedures if it knew Ebertz was making up diagnoses.

127. SCD's false statements that treatment was rendered as claimed were material because Medicare would not have reimbursed at the highest office visit rate for visits with underlying procedures if it knew Ebertz was making up diagnoses.

128. Without SCD's false statements that treatment provided was medically necessary, Medicare would not have paid SCD for these claims.

129. Without SCD performing unnecessary biopsies, the outside pathology labs would not have billed Medicare for pathology analysis and Medicare would not have paid claims for payment based on that analysis.

130. Without SCD's false statements that his patients were complaining of dry skin, Medicare would not have paid for office visits on top of procedures.

131. Even in cases in which Medicare might have paid for an office visit, without SCD falsely billing at the highest office visit code, Medicare would not have paid out as much.

132. The United States of America has been damaged by all of the above misrepresentations and failures to comply with requisite laws and regulations in an as of yet undetermined amount.

COUNT II

Defendant Ebertz Knowingly Presented, or Caused to be Presented False or Fraudulent Claims for Payment or Approval in Violation of 31 U.S.C. §3729(a)(1)(A)

133. The allegations of all paragraphs in this Complaint are incorporated by reference.

134. 31 U.S.C. § 3729(a)(1)(A) subjects to liability any person or entity that "knowingly presents, uses, or causes to be presented, a false or fraudulent claim for payment or approval."

135. Under 42 U.S.C. § 1395y Medicare excludes payment for services that are deemed medically unnecessary, including "items and services…[that] are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

136. Medicare claims may be false if they claim reimbursement for services or costs that either are not reimbursable or were not rendered as claimed. *See United States v. R&F Props. of Lake Cnty., Inc.*, 433 F.3d 1349, 1356 (11th Cir. 2005) (*citing United States v. Calhoon*, 97 F.3d 518, 524 (11th Cir.1996); *Peterson v. Weinberger*, 508 F.2d 45, 52 (5th Cir.1975)).

137. A Medicare provider becomes eligible to provide services and receive payments under Medicare after completing the enrollment process and agreeing to comply with the provisions laid out in 42 U.S.C. § 1395cc, which include making adequate provisions for returns of moneys incorrectly collected.

138. Ebertz knowingly submitted false claims for payment for treatment that was medically unnecessary when:

a. Ebertz unnecessarily removed benign growths and billed Medicare as if he performed medically necessary removals of pre-cancers.

b. Ebertz used billing code 17004 to bill for removal of 15 or more pre-cancers.

c. Ebertz ordered unnecessary biopsies of lesions that he should have been able to see were benign.

d. Ebertz used CPT codes 11100 and 11101 for unnecessary biopsies.

e. Ebertz caused SCD to bill Medicare for in-house processing of tissue collected in unnecessary biopsies.

139. Ebertz knowingly caused outside pathology labs to submit false claims for payment when:

a. Ebertz sent tissue samples from unnecessary biopsies to outside pathology labs for pathology analysis.

b. The outside pathology labs submitted claims to Medicare for analyzing tissue resulting from unnecessary biopsies.

140. Ebertz submitted false claims for payment to Medicare based on treatment not rendered as claimed when:

a. Ebertz routinely billed for office visits when he should not have done so (e.g. when he was already billing for an underlying procedure).

b. Ebertz billed at the highest office visit rate as a matter of course without respect to the nature of the visit.

c. Ebertz used billing code 79214 when he should have used codes 79212, 79213, or should not have billed at all for an office visit.

141. Ebertz violated the FCA when he submitted false claims for payment to the Government, when he billed for services that were medically unnecessary (removal of benign growths, biopsies) and/or were not rendered as claimed (up-coded office visits).

142. Ebertz violated the FCA when he caused outside pathology labs to submit false claims arising from medically unnecessary treatment.

143. Samuelson knows that rampant violations have occurred because he has seen Ebertz's patients and their patient files.

144. Ebertz knew he was falsely billing Medicare for unnecessary treatment because he knew that he was removing benign growths and billing for removal of pre-cancers.

145. Ebertz knew he was falsely billing Medicare for unnecessary biopsies on growths that he knew were benign.

146. Ebertz knew he was causing outside pathology labs to falsely bill Medicare for pathology analysis arising out of unnecessary biopsies.

147. Ebertz knowingly miscoded the treatment that he performed by billing for office visits even when it was not appropriate to do so (e.g., even when also billing for a procedure) and by almost always billing at the highest level for those office visits.

148. The repeated nature of Ebertz's billing practices and their departure from the standard billing practices observed in the rest of the practice, suggest that these activities were not "negligence." *See United States ex rel. Miller v. Weston Educ., Inc.*, 784 F.3d 1198, 1204 (8th Cir. 2015).

149. At the very least, Ebertz showed a reckless disregard of the truth, which the FCA treats as fulfilling the scienter requirement. *See id.* Ebertz's false claims to Medicare are therefore knowingly false.

150. Ebertz's false statements that treatment provided was medically necessary are material because they were submitted to Medicare for payment.

151. Ebertz's false statements that treatment was rendered as claimed were material because Medicare would not have reimbursed Ebertz for office visits in addition to underlying procedures if it knew Ebertz was making up diagnoses.

152. Ebertz's false statements that treatment was rendered as claimed were material because Medicare would not have reimbursed at the highest office visit rate for visits with underlying procedures if it knew Ebertz was making up diagnoses.

153. Without Ebertz's false statements that treatment provided was medically necessary, Medicare would not have paid these claims.

154. Without Ebertz performing unnecessary biopsies, the outside pathology labs would not have billed Medicare for pathology analysis and Medicare would not have paid claims for payment based on that analysis.

155. Without Ebertz's false statements that his patients were complaining of dry skin, Medicare would not have paid for office visits on top of procedures.

156. Even in cases in which Medicare might have paid for an office visit, without Ebertz falsely billing at the highest office visit code, Medicare would not have paid out as much.

157. The United States of America has been damaged by all of the aforementioned misrepresentations and failures to comply with requisite laws and regulations in an as of yet undetermined amount.

PRAYER FOR RELIEF

WHEREFORE, Relator Samuelson, on behalf of himself and the United States Government, prays as follows:

1. That, for violations of the False Claims Act, 31 U.S.C. §3729, *et seq.*, this Court enter Judgment against the Defendants jointly and severally in an amount equal to three times the amount of damages the United States Government has sustained because of the Defendants' actions, plus a civil penalty of $11,000 for each action in violation of 31 U.S.C. §3729;

2. That this Court award prejudgment interest;

3. That this Court award the Plaintiff/Relator the maximum "relator's share" allowed pursuant to 31 U.S.C. § 3730(d), as well as reasonable expenses, attorney fees, and costs incurred by the Relator;

3. That the United States Government and Relator Samuelson receive all other relief, both in law and equity, to which they reasonably are entitled.

DEMAND FOR A JURY TRIAL

Relator, on behalf of himself and the United States, demands a jury trial on all claims alleged herein.

Dated: July 24, 2015

Respectfully submitted,

Susan M. Coler, # 217621
Halunen Law
1650 IDS Center
80 South Eighth Street
Minneapolis, MN 55402
Telephone: (612) 650-4098
Facsimile: (612) 605-4099
coler@halunenlaw.com
Local Counsel for Plaintiff-Relator

R. Scott Oswald, *to be admitted pro hac vice*
David L. Scher *to be admitted pro hac vice*
The Employment Law Group, P.C.
888 17th Street, N.W., 9th Floor
Washington, D.C. 20006
Telephone: (202) 261- 2810
Facsimile: (202) 261- 2835
soswald@employmentlawgroup.com
dscher@employmentlawgroup.com
Counsel for Plaintiff-Relator