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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
BALTIMORE DIVISION

UNITED STATES OF AMERICA, *ex rel.*
BARBARA MCHENRY
[redacted]

Plaintiffs,

v.

ANNE ARUNDEL MEDICAL CENTER
2001 Medical Parkway
Annapolis, Maryland 21401

Serve Registered Agent:
The Corporation Trust Incorporated
351 West Camden Street
Baltimore, Maryland 21201

Defendant.

Case No. 1:15-cv-01256-ELH

Complaint for Violations of the Federal False Claims Act, 31 U.S.C. §§ 3729 et seq. ; Age Discrimination in Employment Act

FILED UNDER SEAL

Jury Trial Demanded

Qui tam Relator Barbara McHenry ("Relator" or "McHenry"), by her attorneys, individually and on behalf of the United States of America, files this Complaint against Defendant Anne Arundel Medical Center ("Defendant" or "AAMC") to recover damages, penalties, and attorney's fees for violations of the federal False Claims Act, 31 U.S.C. §§ 3729 et seq. ("FCA") and violations of the Age Discrimination in Employment Act, 29 U.S.C. §§ 621 et seq.

JURISDICTION AND VENUE

1. This Court has subject matter jurisdiction over this action under 29 U.S.C. § 626(c), 28 U.S.C. § 1331 and 31 U.S.C. § 3732(a).

2. This Court has personal jurisdiction over Defendant pursuant to 31 U.S.C. § 3732(a) because Defendant transact business in this judicial district.

3. Venue is proper in this Court under 28 U.S.C. §1391(c) and 1395(a), and 31 U.S.C. § 3732(a) because the complained of illegal acts occurred within this judicial district, and because Defendant transacts business within this judicial district.

PARTIES

4. In or about June of 1982 Anne Arundel Medical Center hired McHenry as a full time clinical pharmacist.

5. Anne Arundel Medical Center is a non-profit regional health system headquartered in Annapolis, Maryland with outpatient pavilions in Bowie, Kent Island, Pasadena, Odenton, and Waugh Chapel.

6. AAMC opened an Anticoagulation Clinic ("the Clinic") in or about June of 2007.

7. The Clinic provides point of care testing for the monitoring of oral anticoagulation therapy in an outpatient setting.

8. Immediately after the Clinic opened, McHenry began working at the Clinic as a clinical pharmacist.

9. In or about July 2011, McHenry became the supervisor of the Clinic.

10. McHenry is sixty years old.

11. Approximately seventy-five to ninety percent of the Clinic's patients are Medicare beneficiaries.

12. Through her employment at AAMC, McHenry has firsthand knowledge of Defendant's fraudulent business practices.

FACTUAL ALLEGATIONS

AAMC Under-Bills Medicare for Visits that are Not Reimbursable

13. The Clinic provides point of care testing for monitoring of oral anticoagulation therapy in an outpatient setting.

14. The Clinic educates patients, monitors blood tests that measure the blood's clotting ability, reviews patients' current medications for interactions, and adjusts doses for patients who take Warfarin.

15. AAMC under-bills Medicare for visits that are not reimbursable per Center for Medicare and Medicaid Services ("CMS").

16. For the Clinic's services, AAMC bills Medicare of a 0-5 levels scale, depending on the duration of the visit and service provided.

17. Per CMS guidelines, the Clinic can bill a visit as a "level 1," using ICD-9 code 99211 when office or other outpatient visit for the evaluation and management of an established patient, which may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.

18. Per CMS guidelines, the Clinic can bill a visit as a "level 2," using ICD-9 code 99212 when office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a problem focused history; a problem focused examination; straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.

19. Per CMS guidelines, the Clinic can bill a visit as a "level 3," using ICD-9 code 99213 when office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.

20. Per CMS guidelines, the Clinic can bill a visit as a "level 4," using ICD-9 code 99214 when office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

21. Per CMS guidelines, the Clinic can bill a visit as a "level 5," using ICD-9 code 99215 when office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

22. AAMC requires the Clinic to bill Medicare for every single patient who walks through its doors for a visit as "level 1" regardless of the duration of the visit or the services provided to the patient.

23. Most patient visits to the Clinic are level one, as they take roughly ten minutes.

24. A number of patient visits can take fifteen to eighteen minutes and should be billed as "level 2."

25. All new patient visits take roughly forty-five minutes to one hour and should be billed as "level 3" but AAMC bills these visits as "level 2."

26. AAMC uses an internal electronic records database to maintain its patient records. AAMC used MediTech through approximately 2009 or early 2010, and then it purchased a database from Electronic Patient Records System ("EPIC"), and AAMC's Information Technology department partnered with EPIC to create ALEC, an electronic records database specific to outpatient ambulatory care.

27. For each patient visit, the pharmacist has to input his or her notes from the visit and then enter a billing code for the visit. The pharmacist cannot close a patient visit page, referred to as a "patient encounter," without entering a billing code.

28. With both MediTech and ALEC, the pharmacists have to bill every patient visit as a "level 1" or "level 2" visit and did not have the option to bill at a higher level or not to bill at all.

29. The patient visit charge is in addition to the charge for the INR (blood test) for each patient.

30. AAMC's billing is processed by the finance department, not the pharmacy.

31. At the end of a patient encounter, the pharmacist enters the patient visit information into MediTech/ALEC and for the duration of the visit, the pharmacists have to choose level 1 or level 2 from a drop down menu.

32. Then the charge is submitted to the finance department, which then bills Medicare for the visit.

33. Medicare pays out eighty percent of the cost of the patient visit.

34. For patients with a secondary payer, the finance department then submitted the charge to the secondary payer for payment.

35. In meetings, McHenry learned that AAMC under-bills its patient visits to avoid a Medicare audit due to the fact that it bills many visits for which it should not bill at all.

36. AAMC bills every patient who walks in its doors as for a "level 1" visit, regardless of whether or not it is appropriate for AAMC to bill for the visit at all. This charge is in addition to the INR charge.

37. MediTech and ALEC have a field for the pharmacist to enter the amount of time they spent with each patient.

38. McHenry avoided entering her time spent with each patient in her notes because of the disconnect between the time spent with a patient and the billing level. McHenry did not want to lie.

39. However, AAMC management instructed McHenry to include her time spent in her notes, but that she should not put in more than 10 minutes.

AAMC's Billing Practices Violate CMS Guidelines

40. In about 2009, AAMC received a memo from CMC, indicating that AAMC should not bill for an E&M visit if the pharmacist does not make a dose adjustment or if there is no patient complication. The memo stated in part:

> Novitas Solutions continues to experience both questions and confusion regarding the billing of 99211, (office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician), in addition to the laboratory blood draws for warfarin management.
>
> An evaluation and management (E/M) service (99211) would be allowable if it is determined that the patient's medication needs adjustment, the INR is not therapeutic, or if the patient has symptoms that need to be addressed.

The billing of an E/M service in addition to obtaining the clinical specimen (phlebotomy or finger stick) is not medically reasonable and necessary if the following conditions are met:

If the INR is within the therapeutic range, and

1. the documentation does not support a need for adjustment of warfarin dosage, or
2. the documentation does not support that the patient is symptomatic, or
3. the documentation does not support the presence of a new medical co-morbidity or dietary change.

41. Per CMS guidelines, AAMC can bill for an evaluation and management service ("E&M"), using the code 99211 (level 1), if the patient's medication needs adjustment, the INR is not therapeutic, or if the patient has symptoms that need to be addressed.

42. An E&M visit is an office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician.

43. An INR is a laboratory blood draw for warfarin management.

44. An INR is within the therapeutic range and cannot be billed for under three conditions spelled out in the CMS memorandum:

1. the documentation does not support a need for adjustment of warfarin dose, or
2. the documentation does not support that the patient is symptomatic, or
3. the documentation does not support the presence of a new medical co-morbidity or dietary change.

45. Services AAMC bills to Medicare as a level 1 must be appropriate to bill for anticoagulation management. The following are several instances when billing a visit as level 1 for anticoagulation management is appropriate:

- A new anticoagulant patient where education is required regarding dietary modifications, medicine restrictions, bleeding/trauma precautions, etc. This type of education would not be medically necessary every visit especially if the patient has been on anticoagulant therapy for an extended time. A periodic educational update

(i.e. every 3-6 months) maybe medically necessary, for example when a patient's therapy target has been difficult to optimize.
- A patient who presents with a history of a bleeding or adverse effect from anticoagulant therapy.
- A new caregiver presents with the patient to ensure compliance and needed education as noted above.

46. Conservatively, fifty-percent of the Clinic's patients' visits are purely therapeutic or otherwise should not be billed to Medicare at all under 99211 CPT code for E&M because they fall under a non-billable visit.

47. The following are instances when billing a 99211 at all is illegal:

- The 'in-person' encounter with the patient was only for the Point of Service Diagnostic Test
- Telephone management
- When the patient presents with no complaints and the service rendered is documenting current and future dose of anticoagulant, refilling current prescription, or when lab work is to be repeated
- Direct supervision not met
- Part of another E/M service

Conservatively, fifty-percent of the Clinic's patients' visits fall into one of these categories.

48. Relator has personal knowledge that AAMC bills most, if not all, of its patients for a 99211 CPT code for E&M, regardless of whether the billing is legal or not.

McHenry Complained about AAMC's Fraudulent Billing Practices

49. At the time McHenry joined the Clinic, AAMC's finance department instructed her to include the time of her visits.

50. McHenry avoided recording her time on her charts because it was not a mandatory practice, and she did not want to lie about the time she spent with a patient and to bill for ineligible visits.

51. In 2012 and early 2013, McHenry expressed her concern about AAMC's billing practices to James Caldwell, Director of Pharmacy Services since 2007, explaining that she did not want to put AAMC back in corporate compliance.

52. McHenry explained to Caldwell that she believed she was lying on her paperwork by billing for ineligible visits.

53. McHenry also had discussions with Amy Biddinger, AAMC' Patient Financial Services Specialist, about matching the time she recorded on the patient encounter with the "level 1" patient visit AAMC billed for.

AAMC has knowledge of its fraudulent billing

54. AAMC officials are aware of the Clinic's fraudulent billing scheme, but have indicated that they are afraid to fix the problem, since significant changes in their billing could raise a red flag and show that the Clinic engaged in fraudulent billing for a long time.

55. Bob Reilly, AAMC's Chief Financial Officer, had told his staff that AAMC will continue to bill every visit as a level 1 visit.

AAMC terminated McHenry's Employment

56. On or about October 3, 2014, AAMC terminated McHenry's employment for alleged "failure to successfully improve in several areas" relating to her interactions with her employees.

Estimated Damages

57. The majority of the Clinic's patients are Medicare beneficiaries, as the estimated average age of patients is seventy-two.

58. Approximately seventy-five to ninety percent of the Clinic's patients are Medicare or Tricare beneficiaries.

59. The Clinic sees about thirty-five patients per day, and an average of 1,150 visits per month.

60. As of October 3, 2014, the date of McHenry's termination, the Clinic had over 1,200 patients and performed over 1,800 patient visits per month.

61. As part of her duties as a supervisor McHenry prepared and delivered quarterly reports of the Clinic to the pharmacy therapeutics committee, and is therefore intimately familiar with the Clinic's statistics.

62. A level 1 visit varies in billing from $80-90 and a level 2 visit falls in the range of $170-190.

63. The anticoagulation clinic averaged 1,200 patients per month and 1,800 visits per month. Roughly 500 patients had repeat visits, and many reported to the Clinic for weekly visits.

64. Conservatively, 600 visits were for stable patients who had no complications and should not have been billed 99211 for E&M services, because they were within the therapeutic range, which is conservatively about 55% of patients.

65. For the 100,550 visits handled by the clinic up to two weeks before AAMC terminated McHenry's employment on October 3, 2014, approximately 50% (50,275 visits) were therapeutic and should not have been billed for under the CMS memo.

66. A conservative estimate of the amount the hospital received per visit is $80.

67. A conservative estimate of patient visits and billing amounts comes to just over $4 million that should not have been billed at all.

68. The national average for therapeutic range is 62%, and AAMC was generally greater than the national average, so the improper billing number is potentially in the $5 million range.

McHenry Begins Supervising at the Clinic

69. During the time McHenry supervised the Clinic, starting around 2011 or 2012, the Clinic's average patient satisfaction scores were 92%, and in fiscal year 2014 it was the only department at AAMC to earn a 97% patient satisfaction rate for two of the four quarters.

70. By comparison, the emergency department's patient satisfaction scores were about 65%.

71. Recently, changes in CMS rules have begun to tie Medicare reimbursement rates to patient satisfaction surveys, so the high satisfaction scores could improve AAMC's bottom line.

72. In 2013, McHenry's department passed The Joint Committee (JCAHO) standards evaluations with flying colors, even earning the honor of being a "best practice model." Only two other areas of the hospital earned this distinction.

The LEAN Process

73. AAMC repeatedly used the "LEAN" process to revamp its departments. The LEAN process is a management tool designed to make processes more efficient and cost effective.

74. As part of this, AAMC brought in consultants to help rebuild departments. Most departments of the hospital's pharmacy went through two or three of these processes, but the Clinic was only subject to it once.

75. Although McHenry did not need to bring anyone else from her department into the LEAN process, she nevertheless asked Linda Alwan ("Alwan") to be a part of the process since it was possible that the LEAN process would affect her operation area in the Clinic.

76. The LEAN process for the Clinic was a week long. On day two, McHenry learned that Alwan was lobbying AAMC LEAN members for stricter controls on non-compliant patients and other changes, behind McHenry's back. Alwan did so despite the fact that employees were strictly prohibited from lobbying for any changes.

77. Alwan made recommendations to the LEAN committee, which the committee accepted.

78. After three months of the new stricter model that Alwan advocated for, staff did not like it, patients hated it, and McHenry was forced to tweak the process, which was allowed if done through proper channels, as McHenry did.

79. As McHenry started making these changes, Alwan completely turned against her.

80. Around the time Alwan became upset with McHenry, AAMC was also implementing a new evaluation process in which employees evaluated their supervisors.

Poor Staff Evaluations Begin

81. In or about October 2012, McHenry received poor evaluations from her staff on the employee evaluations of supervisors.

82. Caldwell told McHenry that her staff had complained in the evaluations that McHenry was disrespectful to them, created a stressful work environment, and brought stress from home into the work place. Her staff had gone to Caldwell with similar complaints.

83. In October 2012, McHenry met with Caldwell regarding these complaints, Caldwell would not give McHenry any feedback more specific than this, and would not tell her who was complaining to him.

84. Caldwell said that he advised the employees to come to McHenry with any issues and not to him, but they never did that. Instead, they continued to complain to him.

85. On or about April 24, 2013, AAMC presented McHenry with a formal development plan.

86. The development plan was a result of employees allegedly expressing concerns to Caldwell about McHenry's performance.

87. As part of the April 2013 development plan, Caldwell and McHenry were supposed to meet weekly so that he could mentor McHenry through the improvement process.

88. After several months, the meetings with Caldwell stopped.

89. Since the meetings with Caldwell had stopped, McHenry assumed her performance must have been improving, and by early September 2013 she had even contemplated going to Caldwell and asking him to close out the growth plan since there had been no further discussion on the subject.

McHenry's Final Written Warning

90. On or about December 30, 2013, AAMC gave McHenry a final written warning in lieu of suspension because of poor evaluations from her employees. AAMC's reasoning for the final written warning was an alleged failure to meet expectations outlined in her formal growth plan of April 24, 2013.

91. Erin Hachey ("Hachey") was a student in or about 2011 to complete her Pharm. D. degree. She asked to come to AAMC as a student.

92. In late 2011, AAMC hired her as a Pharmacist.

93. McHenry confided in Hachey that AAMC was counseling her on employee relations and asked Hachey to please come to McHenry if Hachey saw any issues.

94. Other than an occasional, "you were a little short" with someone, Hachey never spoke up about any major issues.

95. On August 29, 2014, Hachey tendered her resignation.

96. Hachey told McHenry emphatically to McHenry's face that McHenry had nothing to do with her leaving. Her new job at CVS featured four ten-hour days per week, and earned her $5 more per hour.

97. However, Caldwell later told McHenry that Hachey stated during her exit interview that McHenry was one of the factors that led her to leave AAMC.

98. Despite the feedback from her staff that McHenry received from Caldwell, McHenry generally gave her staff and supervisor good feedback on their evaluations.

99. McHenry was fair to staff in their evaluations, and even successfully lobbied for everyone to receive one percent raises when Caldwell said there was insufficient funding to do so.

100. McHenry was afraid that if she turned in a negative evaluation, it would be used against her in her employees' evaluations of her performance.

101. After McHenry's negative staff evaluations, Caldwell initially met with her to help her through the process, but the weekly/monthly meetings stopped by the summer.

102. Caldwell volunteered HR to meet with McHenry's team to work through the changes resulting from the LEAN process, but no meeting was ever held.

103. On several occasions, McHenry asked for a meeting with the staff and Caldwell and/or Human Resources to clear the air about staff complaints since she was still unsure what specific actions were allegedly upsetting the staff.

104. McHenry's mentoring sessions with Caldwell largely consisted of his asking "How are things going?" in the break room.

105. Again, in 2014, the employee evaluations regarding McHenry's performance with staff were poor. According to Caldwell, they were no better than the previous year, though McHenry was never allowed to see any of the comments or evaluations.

106. Caldwell stated that he would not allow McHenry to see the comments or evaluations because he was afraid she would retaliate, a theme he expressed several times, saying "make sure you don't come across as retaliating for employees' comments."

107. Caldwell has been accused of race discrimination by African-American pharmacists.

108. The turnover rate of pharmacists has been very high under Caldwell's leadership. He has undergone intense scrutiny under numerous LEAN processes.

109. As part of the Budgetary Planning, AAMC tasked Caldwell with reducing his budget by six percent.

110. By April 2014, McHenry stopped disciplining employees..

111. Some employees were doing their shopping online at work, some did homework for outside classes while at work, and one employee used work time to shop for dresses for her friends' weddings.

112. A number of employees would send and receive texts all day long.

113. One pharmacist was chronically late, and was on time only twice over a three-month period.

114. However, McHenry believed she could not discipline any of these individuals because they would retaliate against her with poor evaluations leading to further discipline or termination for her.

115. On or about September 26, 2014, Caldwell and McHenry had a meeting, during which he stated that he had just looked at the employee evaluations of McHenry again and there was no improvement.

116. At that meeting he admitted "I guess I dropped the ball."

117. He said he thought things were going all right since he had not heard anything until Kelly Slear ("Slear"), Clinical Pharmacist, left on September 12, 2014, and then the evaluations.

118. On or about September 26, 2014, Caldwell told McHenry that Slear made complaints about her. However, McHenry conducted Slear's exit interview, and Slear told McHenry that Caldwell and John Ness were the reasons she was leaving AAMC, and it had nothing to do with McHenry.

119. During McHenry's September 26, 2014 meeting with Caldwell, she again asked for specifics regarding employee evaluations of her performance, but Caldwell would not reveal any specifics.

120. He just gave the same general descriptions as before. McHenry again requested a meeting with the staff and Human Resources to clear the air, though Caldwell did not grant this request.

121. During McHenry's September 26, 2014 meeting with Caldwell, McHenry asked Caldwell why he thought Hachey had asked to come back to AAMC, if the staff had so many complaints about McHenry.

122. Caldwell did not answer her question.

Termination

123. On October 3, 2014, Caldwell called McHenry to a meeting, where AAMC terminated her employment. AAMC terminated her employment without severance pay.

124. During the October 3, 2014 meeting where Caldwell terminated McHenry employment, McHenry asked if she could step down from her supervisory role in the Clinic and take on a position in the pharmacy, in lieu of being terminated from AAMC and losing her livelihood.

125. AAMC terminated McHenry's employment for alleged "failure to successfully improve in several areas" relating to her interactions with her employees.

126. Caldwell told her she could not do so.

127. AAMC never complied with McHenry's requests for meetings with the staff to clear the air and determine from the staff their specific quibbles with her leadership.

128. She only received global comments from Caldwell.

129. McHenry had spoken with a few employees about their evaluations of her work. They swore that they were not giving McHenry bad reviews.

130. By the time she was terminated in 2014, McHenry had worked at AAMC for approximately twenty-five years total.

131. Prior to becoming the supervisor at the Clinic, she worked at AAMC, and was one of the highest-paid individuals at the pharmacy.

132. When McHenry began working at the Clinic, she received a seven percent raise to her annual salary, and continued to be one of the highest paid supervisors at AAMC.

133. At budgetary meetings, Caldwell repeatedly told his supervisors that he needed to cut six percent from the AAMC pharmacy budget.

134. Caldwell told McHenry that the biggest portion of the Clinic budget was salary, so his only options were to increase revenue or cut salaries.

Replacement

135. AAMC then hired Hachey to replace McHenry.

136. At the time, Hachey was approximately thirty-five years old.

137. AAMC did not give Hachey a supervisory title so that it could pay her a lower salary than it paid McHenry.

Administrative Exhaustion

138. McHenry filed a charge of discrimination with the Equal Employment Opportunity Commission in Baltimore on July 28, 2015.

139. McHenry received her Notice of Right to Sue letter on August 30, 2016.

140. McHenry timely amended her complaint on November 10, 2016, to include the new claim under the Age Discrimination in Employment Act.

COUNT ONE
Violations of the False Claims Act
31 U.S.C. § 3729(a)(1)(A)

141. Relator alleges and incorporated by reference the allegations made in all of the preceding paragraphs of this Complaint.

142. By virtue of the acts described in the preceding paragraphs, Defendant knowingly presented or caused to be presented, and continue to cause and present to the United States false or fraudulent claims for payment or approval in violation of the FCA.

143. AAMC bills every single patient that walks through its doors for a level 1 visit, regardless of whether or not the charge is appropriate.

144. To conceal its fraudulent and improper billing practices, AAMC bills every single patient for a level 1 visit despite the length of the visit.

145. The patient visit charge is in addition to the charge for the INR (blood test) for each patient.

146. AAMC and the Clinic's management are aware of the fraudulent billing practices, but have refused to correct their billing practices in order to avoid an audit.

147. Even though a relator is not required to identify every conceivable detail of a fraud to satisfy Rule 9(b) and then, even if specific false claims were not alleged, relator need only allege sufficient indicia of reliability, Relator in this case has in fact alleged the who, what, where, when and how of the fraud alleged in this Count:

a. Who – AAMC

b. What – Presents claims to Medicare for reimbursement for patient visits that are i) not qualified for Medicare reimbursement; and ii) billing every unqualified patient visit at a level 1 visit in order to avoid an audit.

c. Where – AAMC's Anticoagulation Clinic

d. When – From when the Anticoagulation Clinic opened through the present.

e. How – i) Billing Medicare for level 1 and level 2 patient visits when the patient visits do not qualify as level 1 or level 2 visits; ii) instructing the Clinic's pharmacists to continue to bill every visit as a level 1 or level 2; and iii) refusing to correct fraudulent billing practices in order to avoid detection and an audit.

COUNT TWO
Violations of the False Claims Act
31 U.S.C. § 3729(a)(1)(B)

148. Relator alleges and incorporated by reference the allegations made in all of the preceding paragraphs of this Complaint.

149. By virtue of the acts described in the preceding paragraphs, Defendant knowingly made and used, and continue to make and use, of false claims to submit to Medicare for reimbursement for visits that do not qualify as Medicare reimbursable visits.

150. With both MediTech and ALEC, AAMC's internal patient records management databases, AAMC pharmacists have to bill every patient visit as a level 1 or level 2 visit and did not have the option to bill at a higher level or not to bill at all.

151. Even though a relator is not required to identify every conceivable detail of a fraud to satisfy Rule 9(b) and then, even if specific false claims were not alleged, Relator need

only allege sufficient indicia of reliability, Relator in this case has in fact alleged the who, what, where, when and how of the fraud alleged in this Count:

a. Who – AAMC

b. What – Presents claims to Medicare for reimbursement for patient visits that are i) not qualified for Medicare reimbursement; and ii) billing every unqualified patient visit at a level 1 visit in order to avoid an audit.

c. Where – AAMC's Anticoagulation Clinic

d. When – From when the Anticoagulation Clinic opened through the present.

a. How – i) Billing Medicare for level 1 and level 2 patient visits when the patient visits do not qualify as level 1 or level 2 visits; and ii) forcing pharmacists to bill for every patient visit as a level 1 or a level 2, and not giving pharmacists the option to not bill for patient visits.

COUNT III
Violations of the Age Discrimination in Employment Act
29 U.S.C. § 621

152. Relator alleges and incorporates by reference the allegations made in all of the preceding paragraphs of this Complaint.

153. McHenry is an "employee" as defined by 29 U.S.C. § 630(f).

154. Defendant is an "employer" as defined by 29 U.S.C. § 630(b).

155. McHenry is over forty years old.

156. Defendant discriminated against McHenry because of her age when it:

a. Failed to help McHenry understand or improve based on her development plans;

b. Terminated her employment on or about October 3, 2014; and

c. Hired Hachey, a thirty-five year old, to replace McHenry at a much lower salary.

157. These adverse actions raise a reasonable inference of unlawful discrimination based on age because McHenry's replacement was much younger and much less senior in experience and salary.

158. AAMC has no legitimate business reasons for the adverse actions it took against McHenry and its stated reasons for its adverse actions against McHenry are pretext for age discrimination.

159. McHenry was among the most senior and most qualified of the staff.

160. McHenry has sustained damages as a result of AAMC's illegal discrimination in violation of the Age Discrimination in Employment Act including, but not limited to, lost wages; lost bonuses; damage to her career; and emotional, mental, and physical distress and anxiety.

161. McHenry is entitled to such legal or equitable relief as will effectuate the purpose of the Age Discrimination in Employment Act, including, but not limited to, economic damages, compensatory damages, and reasonable costs and attorneys' fees.

PRAYER FOR RELIEF

WHEREFORE, the Relator Barbara McHenry, acting on behalf of and in the name of the United States of America, and on her own behalf, prays that judgment be entered against Defendant for violation of the Age Discrimination in Employment Act and the False Claims Act as follows:

(a) In favor of the United States against the Defendants for treble damages to the federal government from the submission of false claims, and the maximum civil penalties for each violation of the False Claims Acts;

(b) In favor of the Relator for the maximum amount pursuant to 31 U.S.C. § 3730(d) to include reasonable expenses, attorney fees, and costs incurred by the Relator;

(c) In favor of Relator for economic damages, compensatory damages, and reasonable costs and attorneys' fees related to the Age Discrimination in Employment Act claims;

(d) For all costs of the False Claims Act civil action; and

(e) In favor of the Relator and the United States for further relief as this court deems just and equitable.

DATE: 10th day of November, 2016

Respectfully Submitted,

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JURY DEMAND

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