IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF ALABAMA
NORTHEASTERN DIVISION

UNITED STATES ex rel ANITA C.SALTERS, BRINGING THIS ACTION ON BEHALF OF THE UNITED STATES OF AMERICA C/O JOYCE WHITE VANCE U.S. Attorney Northern District of Alabama 1801 Fourth Avenue North Birmingham, AL 35203 and C/O Eric Holder Attorney General of the United States Department of Justice 10th & Constitution Aves. N.E. Washington, D.C. 20530 Plaintiff and Relator, vs. AMERICAN FAMILY CARE, INC. Defendant.	Civil Action No. Date Received: _____ Complaint **Filed** **IN CAMERA** **SEALED**, Pursuant to 31 U.S.C. § 3730(b) _____ United States District Court Judge **FALSE CLAIMS ACT COMPLAINT AND DEMAND FOR JURY TRIAL**

COMPLAINT

COMES NOW Relator, Anita C. Salters, on behalf of herself and the United States of America and alleges as follows:

INTRODUCTION

1. Relator brings this action on behalf of herself and the United States of America to recover statutory damages and civil penalties under the False Claims Act, 31 U.S.C. §§ 3729-33.

2. These claims are based upon Defendant's submission of false and fraudulent patient claims for payment to the United States, and its fiscal intermediaries, in order to obtain millions of dollars in payments from Medicare, Medicaid, Tricare and Champus from 2003 to the present. Defendant's false and fraudulent claims to the United States took various forms including: upcoding of patient visits; unbundling of claims; billing for after-hours service during normal business hours; submitting false claims for payment during the global period of a surgical procedure; charging for a Level 1 office visit when a patient saw a nurse or nurse's aide for an injection; billing for non-qualified ultrasounds; billing a surgical code for an "ear popper"; abuse of the locum tenens process; and violating the Stark and Anti-Kickback laws in relation to laboratory referrals, physical therapy referrals and surgical referrals.

3. Relator also makes a claim for violation of the Whistleblower Protection Laws as she was discharged for attempting to report and stop one or more false claims to the United States.

4. Relator has complied with the requirement of the False Claims Act to provide all of her material evidence to the United States prior to filing suit.

JURISDICTION AND VENUE

5. This action arises under the False Claims Act, as amended, 31 U.S.C. §§3729-33. This Court has jurisdiction over this action under 31 U.S.C. §3730 and 28 U.S.C. §§ 1345 and 1367 (a).

6. The Court has personal jurisdiction over the Defendant, because the Defendant is an Alabama corporation and can be found in, is authorized to transact business in, and is transacting business in the Northern District of Alabama, and because the Defendant committed acts within this district and division that violated 31 U.S.C. §3729.

PARTIES

7. Relator, Anita Salters, worked for American Family Care as its director of the claims processing center from January 10, 2007 to June 30, 2010. As director of claims processing, Ms. Salters' duties included: supervising daily processing of insurance claims (including Medicare and Medicaid); supervising payment processing; supervising insurance reimbursement; supervising patient account balances; and, supervising workers' compensation claims and occupational medicine claims. Ms. Salters has intimate knowledge of Defendant's billing practices and procedures, including billing to Medicare, Medicaid, Tricare and Champus.

8. Relator Salters is a resident of Alabama. She has worked in the medical field since 1973. Relator is also a certified coder.

9. While working with American Family Care, Relator gained her direct and independent knowledge of Defendant's fraudulent conduct by personally dealing with Defendant's management and physicians and through her personal observations and experiences as a certified coder. Relator had daily contact and work in the Defendant's billing process.

10. In March of 2010, Relator began reporting the issues complained of herein to management. In June of 2010, she was terminated for obtuse reasons of management style after having a stellar record of reducing Defendant's accounts receivable for more than 90 days to 29 days.

11. Defendant, American Family Care, Inc., is a privately owned and operated Alabama corporation. American Family Care provides medical services at 23 locations throughout Alabama and has recently expanded into Nashville, Tennessee. American Family Care has Huntsville locations in: Madison on Hwy. 72 West; University Drive; Whitesburg, Decatur; and, Hampton Cove.

THE LAW

12. Except as specifically noted in the Complaint, the allegations herein apply to the time period of 2003 through the present.

The False Claims Act

13. The False Claims Act provides in pertinent part that:

> (a) 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; (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 $5,000.00 and not

more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note; Public Law 104-410), plus three times the amount of damages which the Government sustains because of the act of that person. (b) For purposes of this section(1) the terms “knowing” and “knowingly” (A) means that a person, with respect to information (i) has actual knowledge of the information; (ii) acts and deliberate ignorance of the truth or falsity of the information, or (iii) acts in reckless disregard of the truth or falsity of the information; and, (B) require no proof of specific intent to defraud; (2) the term “claim” (A) means any request or demand, whether under contract or otherwise, for money or property and whether or not the United States has title to the money or property that (i) is presented to an officer, employee or agent of the United States, or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested and demanded and (3) the term “obligation” means an established duty, whether or not fixed, arising from an expressed or implied contractual, grantee-grantor, or license-licensee relationship, from a fee-based or similar relationship, from a statute or regulation, or from the retention of any over-payment; and (4) the term “material” means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property. 31 U.S.C. §3729

* * * *

31 U.S.C. §3730 (h) relief from retaliatory

> actions (1) in general. Any employee, contractor, or agent shall be entitled to all relief necessary to make that employee contractor, or agent whole, if that employee contractor, or agent is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee, contractor, or agent on behalf of the employee, contractor, or agent or associated others in furtherance of an action under this sub-section or other efforts to stop one or more violations of this sub-chapter. (2) Relief. Relief under paragraph (1) shall include reinstatement with the same seniority status that employee, contractor, or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees. An action under this sub-section may be brought in the appropriate district court of the United States for the relief provided in this sub-section.

The Stark Statute

14. Enacted as amendments to the Social Security Act, 42 U.S.C. § 1395nn (commonly known as the "Stark Statute") prohibits a hospital (or other entity providing designated healthcare items or services) from submitting Medicare claims for payment based on patient referrals from physicians having a "financial relationship" (as defined in the statute) with the service provider. The regulations implementing 42 U.S.C. § 1395nn expressly require that any entity collecting payment for a designated healthcare service "performed under a prohibited referral must refund all collected amounts on a timely basis." 42 C.F.R. § 411.353.

15. The Stark Statute establishes a clear rule that the government will not pay for designated healthcare items or services prescribed by physicians who have improper financial relationships with other providers. 42 U.S.C. § 1395nn(g)(1). In enacting the statute, Congress found that improper financial relationships between physicians and entities to whom they refer patients can compromise the physicians' judgment as to whether an item is medically necessary, safe, effective, and of good quality. Congress relied upon various academic studies consistently showing that physicians who had financial relationships with hospitals and other entities used more of those entities' services than similarly situated physicians who did not have such relationships. The statute was designed specifically to reduce the loss suffered by the Medicare and other Federal Healthcare programs due to such increased questionable utilization of services.

16. Congress enacted the Stark Statute in two parts, commonly known as Stark I and Stark II. Enacted in 1989, Stark I applies to referrals of Medicare patients for clinical laboratory services made on or after January 1, 1992 by physicians with a prohibited financial relationship with the clinical lab provider. *See* Omnibus Budget Reconciliation Act of 1989, P.L. 101-239 § 6204.

17. In 1993, Congress extended the Stark Statute ("Stark II") to referrals for ten additional designated health services. *See* Omnibus Reconciliation Act of 1993, P.L. 103-66, § 13562, Social Security Act Amendments of 1994, P.L. 103-432, § 152.

18. As of January 1, 1995, Stark II applied to patient referrals by physicians having a prohibited financial relationship for the following ten additional designated health services: (1) Inpatient and outpatient hospital services; (2) Physical therapy; (3) Occupational therapy; (4) Radiology; (5) Radiation therapy; (6) Durable medical

equipment and supplies; (7) Parenteral and enteral nutrients, equipment and supplies; (8) Prosthetics, orthotics and prosthetic devices and supplies; (9) Outpatient prescription drugs; and (10) Home health services. *See* 42 U.S.C. § 1395nn(h)(6).

19. In pertinent part, the Stark Statute provides:

> 1. Prohibition of certain referrals
>
> (1) In general
>
> Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then –
>
> (A) The physician may not make the referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this chapter, and
>
> (B) The entity may not present or cause to be presented a claim under this subchapter or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).42 U.S.C. § 1395nn (emphasis added).

20. The Stark Statute broadly defines prohibited financial relationship to include any "compensation" paid directly or indirectly to a referring physician. Violation of the statute may subject the physician and the billing entity to exclusion from participation in federal health care programs and various financial penalties, including (a) civil money penalty for each service included in a claim for which the entity knew or should have known that the payment should not have been made under Section 1395nn(g)(1); and

(b) an assessment of the amount claimed for a service rendered pursuant to a referral the entity knew or should have known was prohibited.

21. In sum, the Stark Statute prohibits healthcare providers from billing Medicare and other federal health care programs for certain designated services referred by physicians with whom the provider has a financial relationship not falling within the safe harbors. The statute specifically prohibits providers from billing for such services. The Stark Statute was applicable to the entire time period of this complaint.

The Anti-Kickback Statute

22. The Federal Anti-Kickback statute, contained at 42 U.S.C. §1320a-7b(b), prohibits the offer, solicitation, payment or receipt of anything of value which is intended to induce the referral of patients for items or services reimbursable in whole or in part under any federal health care program, or to induce the ordering, recommending or arranging of items or services reimbursable in whole or in part under any federal health care program. The Anti-Kickback Statute was enacted in 1972.

THE MEDICARE AND MEDICAID PROGRAMS

23. Title XVIII of the Social Security Act, 42 U.S.C. § 1395*, et seq.*, establishes the Health Insurance for the Aged and Disabled Program, popularly known as the Medicare program. The Secretary of HHS administers the Medicare Program through CMS, a component of HHS.

24. The Medicare program consists of two parts. Medicare Part A provides basic insurance for the costs of hospitalization and post hospitalization care. 42 U.S.C. §1395c-1395i-2 (1992).

25. Medicare Part B is a federally subsidized, voluntary insurance program that

covers a percentage (typically eighty percent) of the fee schedule amount for physician, laboratory and diagnostic services. 42 U. S.C. §§ 1395k, 13951, 1395x(s). Reimbursement for Medicare claims is made by the United States through CMS. CMS, in turn, contracts with private insurance carriers, known as fiscal intermediaries, to administer and pay Medicare Part B claims from the Medicare Trust Fund. 42 U.S.C. § 1395u.

26. Medicaid is a federally assisted grant program for the several states. Medicaid enables the States to provide medical assistance and related services to needy individuals. CMS administers Medicaid on the federal level. Within broad federal rules, each state decides who is eligible for Medicaid, the services covered, payment levels for services and administrative and operation procedures. The states directly pay physicians, with the states obtaining the federal share of the payment from accounts that draw on funds belonging to the United States Treasury. 42 C.F.R. § 430.0-430.30 (1994). The Federal share of each state's Medicaid program varies. In Alabama, the Federal share of Medicaid payments is 80%.

27. At all times relevant to this Complaint, the United States provided funds to the State of Alabama in which Defendant conducted business through the Medicaid program, pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq*. Enrolled providers and suppliers of medical services to Medicaid recipients are eligible for reimbursement for covered medical services under the provisions of Title XIX of the 1965 Amendments to the Federal Social Security Act. By becoming a participating provider in Medicaid, enrolled providers and suppliers agree to abide by the rules, regulations, policies and procedures governing reimbursement, and to keep and allow access to records and information as required by Medicaid.

28. In order to receive Medicaid funds, enrolled providers and suppliers, together with their authorized agents, employees, and contractors, are required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and all applicable policies and procedures issued by the states.

29. As a condition of payment, the Defendant was required to expressly or impliedly certify compliance with the Medicare, Medicaid, and Social Security laws and regulations including the Stark and Anti-Kickback laws.

30. At all times relevant to the Complaint, Defendant was a Participating Medicare Part B provider. The Defendant submitted claims to Medicare and Medicaid for services that were tainted and false by the nature of the prohibited financial relationship between Defendant and its referring physicians.

31. At all times relevant to the complaint, the Medicare and Medicaid programs constituted a substantial source of revenue for the Defendant.

TRICARE

32. Tricare is a federal health insurance program for military personnel. It provides benefits similar to Medicare. The source of funding for Tricare is the federal government and payments are made for claims processed through fiscal intermediaries. Tricare is a federally funded health program that provides beneficiaries with medical care supplemental to that available in military and public health service facilities. All Tricare beneficiaries move over to Medicare at age 65. At all times relevant hereto, Defendant American Family Care, Inc. was a participating Tricare provider.

THE FRAUDULENT SCHEMES AND FALSE CLAIMS FOR PAYMENT

33. Defendant submitted false claims for payment or caused false claims for payment to be submitted. Defendant also created false records or statements in order to get false claims paid. Defendant also retained money it was obligated to return to the United States. Defendant's conduct consisted of upcoding of patient visits; unbundling of claims; billing for after-hours service during normal business hours; submitting false claims for payment during the global period of a surgical procedure; charging for a Level 1 office visit when a patient saw a nurse or nurse's aide for an injection; billing for non-qualified ultrasounds; billing a surgical code for an "ear popper"; abuse of the locum tenens process; and violating the Stark and Anti-Kickback laws in relation to laboratory referrals, physical therapy referrals, and surgical referrals.

Upcoding

34. The primary business of American Family Care is the out-patient clinical visit. Clinical visits are either for new patients or established patients. For new patients there are five levels of care that can be billed for a patient visit. The criteria for these levels of care and corresponding billing are outlined in the CPT Code book put out by the American Medical Association. There are also five levels of care for established patients outlined in the same book.

35. For new patients, the CPT Code book states normal time requirements under the Evaluation and Management Codes for each level of visit. A Level 1 visit (Code 99201) usually requires ten minutes of face-to-face time with the patient or family member. A Level 2 visit (Code 99202) usually requires twenty minutes of face-to-face time. A Level 3 visit (Code 99203) usually requires thirty minutes of face-to-face time. A Level 4 visit

(Code 99204) usually requires forty-five minutes of face-to-face time. A Level 5 visit (Code 99205) usually requires sixty minutes of face-to-face time.

36. For established patients, the CPT Code book states normal time requirements under the Evaluation and Management Codes for each level of visit. A Level 1 visit (Code 99211) usually requires five minutes of face-to-face time with the patient or family member. A Level 2 visit (Code 99212) usually requires ten minutes of face-to-face time. A Level 3 visit (Code 99213) usually requires fifteen minutes of face-to-face time. A Level 4 visit (Code 99214) usually requires twenty-five minutes of face-to-face time. A Level 5 visit (Code 99215) usually requires forty minutes of face-to-face time.

37. American Family Care routinely (and as a matter of corporate policy) upcoded patient visits to higher levels. The number of patient visits was so heavily upcoded that it is physically impossible for the physicians to have worked the amount of time they claim to have worked by the patient encounter codes they have billed. This is true even if the physicians worked 24 hours a day 7 days a week.

38. Shortly after beginning her employment at American Family Care, Relator realized that the physicians' documentation was not being reviewed for missing required elements according to federal guidelines.

39. Relator met with her direct supervisor, Joe Hawley, Vice President and CFO for American Family Care, Inc. Also, present was the co-founder, Chairman and CEO Dr. Bruce Irwin, along with Randy Johansen, President and COO. Relator requested the meeting to discuss the unbundling of codes and major concerns of lacking documentation to justify the level of service being billed. Relator was told at the meeting that she was not hired for her coding certification and that American Family

Care, Inc. would continue to unbundle codes and bill the level of service as it had been doing.

40. Relator had many meetings where she was instructed by Dr. Irwin, Joe Hawley, and Randy Johansen to teach the auditing staff to choose the level of care based on the services rendered and the diagnosis and not based on the documentation and actual time spent with the patient.

41. The upcoding problems were widely known at American Family Care. Dr. Steven Hefter lost his Blue Cross/Blue Shield of Alabama privileges in November 2008 due to upcoding his visits. Dr. Bruce Irwin, at that time, tried to force Relator to audit behind the Blue Cross/Blue Shield auditor in an attempt to use her certifications to prove that Relator disagreed with Blue Cross/Blue Shield's findings. Relator re-audited over 40 charts and in fact agreed with Blue Cross/Blue Shield's findings that the visits had been upcoded. Relator was then fired and re-hired, but told that she was to follow the instructions given by management from that point forward. Nothing was ever done to go back and refund the upcoding problems with Dr. Hefter's patients with other insurance companies, Medicare, Medicaid, Tricare or Champus.

42. After Dr. Hefter had his privileges pulled by Blue Cross/Blue Shield of Alabama, other American Family Care physicians became concerned about the upcoding that was happening in the home office. To try and prevent the upcoding, some physicians began writing the level of service in the patient medical record. Relator was then required by management to show the home office auditing staff how to change the level of care in the electronic medical records so it would match the level of care that was processed to the insurance carrier.

43. Upcoding visits to levels 3, 4, and 5 was a practice across the board at American Family Care. It happened on the front end in the individual practice offices, and it happened in the home office if the codes were not high enough to meet the bench marks set by the company. Physicians were pressured by management to upcode at the monthly physicians' meeting. The auditing staff members have never received training on current coding practices, how to properly determine the level of care or the required elements of documentation.

44. From her direct experience with billing at American Family Care, Relator reliably estimates that more than 70% of the level of cares at American Family Care are upcoded resulting in a significant increase in billing and false claims to Medicare, Medicaid, Tricare and Champus.

45. In January 2010, Relator was directly ordered to meet with auditing once again, because the company was below the corporate bench mark goal totals for level of care billings. Relator told Dr. Irwin that she would try to meet the billing bench marks set by management. Dr. Irwin replied "No, you will!" The Relator did meet with the staff and remind them that according to top management they should change level of care based on the bench mark curve set by the company and the services rendered are not billed strictly based on documentation and time spent with the patient.

46. At one point during Relator's employment, Dr. Irwin instructed the entire auditing team at the home office to bill all new patient visits as Level 5 visits regardless of what the local physician and office had indicated for the level of service. That order remained in effect for October and November of 2009. Dr. Irwin later changed this order, after Relator told Joe Hawley that there was no way all new patient visits could be Level 5

visits and that AFC was going to be sending up a red flag. But upcoding of visits did not stop. They were just not automatically changed to all Level 5s.

47. Relator also met with Dr. Michael Chandler about the number of Level 4 and 5 visits he was charging. Relator told him that it was impossible for him to have all 4s and 5s like he was charging. Dr. Chandler's response was that his years of experience justified the charges. Obviously, this is not correct according to the AMA guidelines and Relator told him so. Nothing changed, because Dr. Chandler talked with Dr. Irwin about the matter and Dr. Irwin told Dr. Chandler that there was nothing wrong with his billing.

48. The company, American Family Care, keeps physician stat sheets on each physician and it also keeps sign-in sheets at each office location. These documents, which are in the exclusive control of the company, can be used to prove that American Family Care is systematically upcoding its office visits and overcharging Medicare, Medicaid, Tricare and Champus.

49. Relator's allegations are corroborated by the fact that while she was employed by American Family Care, Blue Cross/Blue Shield also audited the physicians at American Family Care Trussville location and found that they were upcoding and billing for unnecessary tests. This audit took place in the first part of 2010.

Charging A Visit With A Nurse Or Nurse's Aide For An Injection As A Level 1 Office Visit

50. American Family Care had a policy of charging a Level 1 office visit, Code 99211, when a patient came in for just a shot or vaccination and saw only a nurse or nurse assistant. The correct charge should only be the less expensive injection code. By charging an office visit code, American Family Care systematically overbilled Medicare, Medicaid, Tricare and Champus.

Unbundling

51. American Family Care had a practice of unbundling the lab draw fee and the injection administration codes 36415 and 90772 (2008 and before) and 96372 (2009). These codes should simply be billed as part of the office visit.

52. American Family Care also systematically unbundled pulse oxitmetry tests (Code 94760) from the regular office visit. Pulse oxitmetry tests should be billed as part of the office visit.

53. AFC also unbundled vaccination injections from office visits that should have been billed simply as part of the office visit. The codes for vaccinations are 90471 and 90472.

54. Relator discussed the unbundling with Dr. Irwin. He clearly knew it was improper and would often be called by insurance companies about unbundling. However, Dr. Irwin's position was that the people who review claims are human too and might not catch the unbundling. Therefore, Dr. Irwin's position as the Head of AFC was that AFC was going to unbundle, and write-off what the insurance companies, including Medicare, Medicaid, Tricare and Champus (caught).

55. Relator has seen the write-off reports that American Family Care keeps for unbundling of codes. She was actually bringing the May 2010 unbundling write-off report to Joe Hawley when he fired her.

After-Hours Billing

56. The normal office hours for American Family clinics are 7 days a week-8:00 a.m. to 6:00 p.m. as advertised to the general public on the AFC website. When Relator arrived at American Family Care, the company was billing all weekend visits as after-

hours visits-Code 99050. This is an improper charge, because the regular office hours for the offices (as advertised to the public and written to all insurance companies) includes being open on the weekends. It took Relator two years after she arrived to get this stopped. No money was ever refunded by American Family Care to Medicare, Medicaid, Tricare, or Champus. Therefore, Defendant has knowingly concealed or improperly avoided an obligation to pay or transmit money or property back to the Government.

Submitting False Claims For Payment During The Global Period Of a Surgical Procedure

57. Each surgical procedure has a period of time (such as 10 days for a laceration repair) called the global period during which follow-up and re-check visits are covered by the original CPT Code and charge. In other words, if a patient needs to get a hand stitched up at AFC and the doctor says he wants to see it in three days, that visit is covered by the original CPT Code charge global period and should not result in a separate office visit charge. Yet, AFC routinely bills the follow-up visit as a separate office visit.

58. Dr. Park, AFC's only surgeon, does general surgeries such as appendectomies at hospitals. The patient follow-up visits (both in hospitals and office visits) are covered by the surgical charge for 90 days and should not be charged as separate office visits. Prior to Relator arriving at AFC, Dr. Park routinely charged additional office visits for follow-ups and in hospital visits, which were covered by the original surgical charge. After Relator started noticing and objecting to Dr. Park's practice, he began falsifying records to justify the charges, such as adding a 24 modifier and making up an additional diagnosis such as hypertension.

Stark and Anti-Kickback Violations Regarding Laboratory Referrals

59. Dr. Ronald W. McCoy has his own private practice as an Otolaryngologist in Birmingham and Bessemer. His offices are located at 1201 11th Avenue South, Suite 520, Birmingham, Alabama 35201 and 1601 2nd Avenue North, Bessemer, Alabama 35020.

60. Dr. McCoy sends patients to American Family Care for blood allergy testing at their central laboratory in the Vestavia clinic. Prior to sending them to the Vestavia clinic he sent them to the Mountain Brook clinic before it closed.

61. In exchange for all these blood allergy testing laboratory referrals, AFC agreed to bill for the allergy and other lab testing under Dr. McCoy's provider number, as if Dr. McCoy were rendering the service. AFC then sends Dr. McCoy a check for a percentage of the charges collected. However, Dr. McCoy was not in the laboratory facility and was not rendering the service. He simply referred the patient to American Family Care. The payments to Dr. McCoy are an improper kickback in violation of the Stark and Anti-Kickback laws. The practice with Dr. McCoy was in place before Relator was ever employed by American Family Care.

62. Relator refused to bill these laboratory tests under McCoy's provider number, because he only sent an order over with the patient and was not present in the facility. Because of Relator's refusal, the claims were properly processed with the provider on duty as the rendering provider. After properly processing the claims, Relator received a phone call from Bonnie Leavins in Physicians Services that Mrs. Peggy McCoy (who runs her husband's office billing) had called, because Dr. McCoy had not received

compensation from American Family Care for sending a patient to obtain laboratory services at American Family Care.

63. Relator explained to Peggy McCoy that Relator believed this to be against the law. Relator was instructed by Bonnie Leavins and Randy Johansen of American Family Care to change the billing to Dr. McCoy and it would be discussed with her later, but in the meantime physicians' payroll needed to be completed. Relator met with Randy Johansen, Joe Hawley, and Kay Park (AFC's Vice President of Clinical Operations). Relator was told that she was wrong, because Dr. McCoy was employed by American Family Care even though he has his own practice. Relator told them that she only remembered two consultations where Dr. McCoy actually saw the patients since her employment. She was told that if she could prove that it was against the law to allow Dr. McCoy to send patients to American Family Care and for him to receive a percentage of the charges, then it would be discussed further.

64. Relator emailed Randy Johansen and Joe Hawley a copy of the Federal Registrar Stark-Anti-Kickback ruling and they never discussed it with her again, or even acknowledged her email.

65. The arrangement with Dr. McCoy is a clear payment for referrals in violation of the Stark and Anti-Kickback laws. Making the claims for payment for the patients referred by Dr. McCoy are false claims for payment.

66. The American Family Care physicians were also paid on a per-patient basis for referrals of their patients to American Family Care's physical therapy location called NexStep (in the Hoover location basement). The referrals to NexStep were tracked by American Family Care. Relator learned of the payments for referrals when Bonnie

Leavins from Physicians' Services called her about two incidences where AFC physicians were upset, because they did not receive their referral payment for referring a patient to physical therapy. Relator was asked to research what happened.

67. AFC physicians are also paid on a per-patient basis for referrals to American Family Care's only physician surgeon, Dr. Paul Park. American Family Care tracked the referrals to Dr. Park the same way it tracked referrals to physical therapy.

Non-Qualified Ultrasounds

68. To Relator's knowledge, American Family Care does not own a FDA approved Ultrasound Scanner. AFC has a small hand-held device at the Vestavia clinic, which was previously at the former Mountain Brook clinic. This device produces no films or recorded digital images.

69. When Relator questioned where the film (digital images) and/or reports were from the scans, and if it was a FDA approved device for the ultrasounds that American Family Care was billing, she was told by Kay Park (VP of Clinical Operations), Dr. Park's wife, that this was something that had been done for years and Relator did not need to worry about.

70. Relator tried to explain that even the Dexa Scans AFC was billing were not the procedure the CPT code called for. Relator even explained that years ago a sales representative had given an incorrect CPT code to one of her previous employer physicians and they charged out over $100,000.00 worth of Dexa Scans and had to refund the monies and sue the manufacturer of the device.

71. Again, no one at American Family Care listened to Relator's concerns or objections, or her warning that American Family Care was billing out fraudulent codes.

Because there was no approved ultrasound machine, all ultrasound billing by American Family Care is fraudulent. Ultrasound billing was done under Dr. Park's provider number.

Billing the "Ear Popper" As A Surgical Procedure

72. American Family Care has a device named the Ear Popper in each clinic. The device is made by Micro Medics. The device can be viewed online at www.earpopper.com. Patients can use this device at home.

73. American Family Care used the Ear Popper if a patient had a stopped up ear from sinusitis. The device shoots a puff air into the patient's nose to open up the congestion.

74. AFC fraudulent billed the use of the Ear Popper under the surgical code 69401 Eustachian tube inflation, transnasal, without catherization, to bill for using this device in the office. The Ear Popper should not be billed as a surgical code. It is not a surgery. The Ear Popper should be billed as part of the overall office visit. AFC billed for this procedure very often.

75. American Family Care patients actually called and complained frequently, because this improper billing code is a surgical procedure code that the patient would see on their bill. The patients complained because the device only puffed air into the nasal cavity. Blue Cross Blue Shield of Alabama investigated the many patient complaints and in 2008 found the device inappropriate and not FDA approved for this procedure code and demanded thousands of dollars be refunded back to Blue Cross Blue Shield of Alabama.

76. American Family Care had to refund the money billed for this procedure to Blue Cross Blue Shield of Alabama. Relator told management (Joe Hawley and Randy Johansen) that AFC needed to notify all other payors that they had been improperly charged for the Ear Popper. Management refused to let her do so and AFC has wrongfully withheld money it owes to the Government.

Abuse Of The Locum Tenens Process

77. American Family Care, during Relator's entire employment, misused and abused the Locum Tenens Process. It is supposed to be used for physicians to fill in for the place of a physician who is sick, or on vacation, or short staffed. The Latin phrase Locum Tenens means "in place of another."

78. At American Family Care, the company allowed new physicians to work for months as Locum Tenens while waiting for their application paperwork to be completed and signed by the physicians. AFC would go ahead and work them as Locum Tenens sometimes for months while getting the credentials and application completed. During this time, AFC billed for these doctors under other physician provider numbers.

79. Even after Dr. Steven Hefter lost his Blue Cross Blue Shield of Alabama privileges, AFC worked him as Locum Tenens. Even today, American Family Care works Dr. Hefter as Locum Tenens about every weekend without provider numbers. Dr. Hefter is actually employed somewhere else.

80. Dr. Eugene Evans, Dr. Charles Buckmaster, and Dr. Syed Hasan have been used long term as Locum Tenens physicians, because they there were problems with their provider approval process.

81. Many patients would call and complain to American Family Care, because American Family Care billed under a physician they did not see and they were simply told that the physician was on call for the billing physician.

82. American Family Care is improperly billing for these long term Locum Tenens physicians under provider numbers for physicians who were not present in the facility and often unaware that charges were being submitted under their provider number.

RELATOR'S DIRECT AND INDEPENDENT KNOWLEDGE OF THE FRAUD

83. Relator had three years of direct contact with daily operations and claims processing in the home office of American Family Care. Relator also audited thousands of claims. Relator also handled thousands patient complaints regarding the fact that they thought fraudulent billing practices were occurring.

Relator's Efforts To Report The Fraud

84. As described in the preceding paragraphs, Relator attempted to convince management to stop the fraud only to be repeatedly rebuffed and ultimately terminated. Relator had many executive meetings and discussions only to be told to do what she was told to do if she wanted to remain gainfully employed. Ultimately, Relator was terminated for her efforts to report and stop the fraud and false claims for payment.

Billing

85. The billing process at American Family Care is as follows: A patient signs in to be seen and the front office staff enters them into the Centricity Practice Management system; the computer then generates an internal charge ticket and sends the information to the Electronic Medical Records (Aprima) for medical record documentation; the patient visit is recorded either on an electronic record or paper

encounter sheet; all material that is hand written is scanned into the system using Hot Keys (SSI) software; The physician or medical staff enters the charges either in the electronic medical record or they are handwritten on the paper chart; the AFC auditors are assigned duties for particular clinics; the auditors are rotated every month, so they do not audit the same clinics all the time; the auditor views all documents and enters any incorrect information and missed charges, they also change the evaluation and management code based on services rendered and not based on documentation (this is where the home office upcoding happens); this information is entered onto an electronic form HCFA 1500 which contains certifications as to the accuracy and truthfulness of the claim and that it complies with all Medicare rules, laws and regulations; the charges are approved by the home office auditors and set to go via electronic filing to the fiscal intermediary; At least twice a day the claims are sent to the clearinghouse/fiscal intermediary IDX-Centricity; the claim is either accepted or denied for additional information; if the claim is denied the auditing staff is responsible to correct or add information to get the claim paid and re-send it to the clearinghouse/fiscal intermediary. Claims are typically submitted to Medicare within seven to ten days after a patient visit. Claims are paid by Medicare and other federal payors 14 days after submission by AFC.

86. The following is a list of the American Family Care Physicians and their Federal Provider Numbers under which American Family Care billed Medicare, Medicaid, Tricare and Champus. The first three numbers of the physician provider number have been redacted for privacy concerns. Relator and her counsel, as well as the United States have these numbers.

Provider Name	NPI /UPIN Number
Abele MD, Donald	xxx9420394
Ajamoughli MD, Ghaith	xxx1212974
Asuru MD, Agatha	xxx559
Bacgauddin MD, Aniqa	
Baldwin MD, Alicia	xxx0853280
Banks MD, Debra	
Bean MD, Stuart	xxx3287725
Bedsole MD, Donald	xxx2570042
Bentley MD, Amy	xxx539
Booker Graddick MD, Cynthia	
Campbell MD, Jonathan	xxx1065509
Chandler MD, Michael	xxx5168766
Chau MD, James	xxx5727784
Connolly DO, Randy	
Crescentini MD, Robert	xxx9079797
Currie MD, Bryan	xxx981
Custis MD, James	xxx8688873
Dang MD, Patrick	
Dannelly MD, Julia	
Davis MD, Lasan	xxx0726867
Dawodu MD, Oludayo	xxx4737397
Delong MD, James	xxx6814405
Doshi MD, Sangeeta	xxx7520153
Doss MD, Amy	xxx9574648
Drake MD, Holsey	xxx6016494
Dutton MD, Christina	
Eicher MD, Michael	xxx9349819
Elder MD, Jeffrey	xxx7569923
Evans MD, Eugene	xxx0879930
Fauci MD, Janelle	xxx4423542
Feist MD, Caroline	xxx8311020
Fellman MD, Kim Ngan P	
Fong MD, Jian Huai	xxx0491419
Fordham MD, Zackary	
Goodman MD, Thomas	xxx9874882
Grier MD, Raymond	xxx287
Haider MD, Zehra	xxx339
Hale MD, Bernard	xxx8338236
Hasan MD, Syed	xxx5534465
Hefter MD, Steven	xxx9840719
Holloway III MD, John	xxx8028875
Hwang MD, Edward	xxx8244098
Jiwani MD, Ali	xxx0542015
Kapoor MD, Bharat	xxx2772677
Keithley MD, Larry	xxx5341221
Ketchum MD, Carey	xxx8934140

Kidd MD, Dixie	xxx5427413
Lawrence MD, Sharon	xxx4674574
Maddox MD, Mikelle	xxx0578726
McCoy MD, Ronald	xxx717
Moore Jarmon MD Marquista	
Morris MD, Peter	xxx790
Moseley MD, Jonathan	
Nelson MD, Gina	xxx8473630
Pair MD, Frank	xxx2097211
Paquette MD, Brian	xxx2370397
Park MD, Paul F	xxx5186651
Paupoo MD, Arasen	
Petry MD, Cary	xxx7277439
Pike MD, Bob	xxx5702678
Pivovarov MD, Ivan	xxx7662148
Powell MD, Michael	xxx0358818
Pratt MD, Ebony	xxx765
Reese MD, Celeste	xxx4893809
Reynolds MD, Karen	
Richardson MD, James	xxx395
Roman MD, Deborah	xxx7227046
Roque MD, Elmer	xxx4141096
Russell MD, Joy	xxx6562900
Sachdev MD, Jatinder	xxx4893551
Scarborough MD, John	xxx032
Simmons MD, David	xxx4278379
Smith MD, Taniya	xxx9669550
Sterns MD, Albert	xxx2960917
Sunkavalli MD, Pallavi	xxx4878639
Taylor MD, Burnestine	xxx7655355
Thai MD, Phu	
Thomas MD, Michael	xxx5500340
Vinson MD, William P	xxx268
Welsh MD, Don	xxx2853260
Whitaker MD, LeeC	
Williams MD, Bruce	xxx5778615
Williams MD, Daniel	xxx2055284
Wynn MD, Andrew	xxx4793531

87. While Relator has intimate knowledge of Defendant's billing practices and billing system, she does not have possession of any individual false claims for payment, because Defendant terminated her and escorted her from the building without allowing any documents to leave with her. The actual documentation and the specifics of each false claim are within the exclusive control of the Defendant. However, Relator's

position as the director of claims processing for American Family Care provide an indicia of reliability to her claims.

COUNT I
VIOLATION OF 3729 (a)(1)(A)

88. Relator hereby incorporates and re-alleges all the preceding paragraphs as if set forth fully herein.

89. Defendant by and through its agents, officers, and employees, 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).

90. The United States has been damaged as a result of Defendant's violations of the False Claims Act in an amount to be proven at trial. The United States is entitled to this sum as reimbursement for monies obtained by the Defendant for false claims submitted to the United States.

91. The United States is entitled to three times the total damages sustained as a result of the Defendant's violations.

92. The United States is entitled to a civil penalty of not less than $5,000.00 and not more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note; Public Law 104-410) for each of Defendant's false claims.

93. Relator is entitled to reasonable attorney's fees and cost pursuant to 31 U.S.C. §3730(d)(1).

COUNT II
FALSE CLAIMS ACTS VIOLATIONS 3729(a)(1)(b)

94. Relator hereby incorporates and hereby re-alleges all of the preceding paragraphs as if fully set forth herein.

95. Defendant by and through its agents, officers, and employees, knowingly made, used, or caused to be made or used, a false record or statement material to a false or fraudulent claim in violation of 31 U.S.C. §3729 (a)(1)(b).

96. The United States has been damaged as a result of Defendant's violations of the False Claims Act in an amount to be proven at trial. The United States is entitled to this sum as reimbursement for monies obtained by the Defendant for false claims submitted to the United States.

97. The United States is entitled to three times the total of damages sustained as a result of the Defendant's violations of 31 U.S.C. §3729(a)(1)(b).

98. The United States is entitled to a civil penalty of not less than $5,000.00 and not more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note; Public Law 104-410) for each of Defendant's false claims.

99. The Relator is entitled to reasonable attorney's fees and cost pursuant to 31 U.S.C. §3730(d)(1).

COUNT III
THE FALSE CLAIMS ACT VIOLATIONS OF 3729(a)(1)(g)

100. Relator hereby incorporates and re-alleges all the preceding paragraphs as if set forth fully herein.

101. Defendant, by and through it agents, officers, and employees, knowingly made, used, or caused 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 concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government in violation of 31 U.S.C. §3729 (a)(1)(g).

102. The United States has been damaged as a result of Defendant's violations of the False Claims Act in an amount to be proven at trial. The United States is entitled to this sum as reimbursement for monies obtained by the Defendant for money improperly withheld from the United States.

103. The United States is entitled to three times the total damages sustained as a result of Defendant's violations of 31 U.S.C. §3729 (a)(1)(g).

104. The United States is entitled to a civil penalty of not less than $5,000.00 and not more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note; Public Law 104-410) for each of Defendant's false claims.

105. The Relator is entitled to reasonable attorney's fees and cost pursuant to 31 U.S.C. §3730(d)(1).

COUNT IV
FALSE BILLINGS INCIDENT TWO ANTI-BACK/STARK ACT VIOLATIONS

106. Relator hereby incorporates and re-alleges all preceding paragraphs as if set forth fully herein.

107. From 2003 to the present, Defendant violated the Anti-Kickback/Self-Referral Laws, 42 U.S.C. §1395nn (a)(1), (h)(6) and 42 U.S.C. §1320a-7b(b), by entering into

prohibited financial relationships with physicians in order to obtain referrals of their patients.

108. Defendant's violations of these laws rendered it statutory ineligible to receive payment for services rendered to patients referred pursuant to these prohibited relationships, under both the express terms of 42 U.S.C. §1395nn and by operation of the Medicaid/Medicare laws and regulations, including 42 C.F.R. §424.5 (a).

109. The United States conditions payment on Defendant's compliance with the Anti-Kickback/Self Referral laws, 42 U.S.C. §§1395nn (a)(1), (h)(6) and 1320a-7b (b).

110. Defendant submitted and continues to submit claims for payment rendered to Medicare and Medicaid patients while knowingly violating the Anti-Kickback/Self Referral laws and thereby statutorily ineligible to receive payment in violation of the False Claims Act, 31 U.S.C. §3729.

111. Defendant's actions also caused the submission of claims for payment for services rendered for Medicare, Medicaid, Tricare, and Champus patients while Defendant was knowingly violating the Anti-Kickback/Self Referral laws and statutorily ineligible to receive payment violating the False Claims Act 31 U.S.C. §3729.

112. Accordingly, Defendant, by and through its agents, officers, and employees, knowingly presented or caused to be presented false or fraudulent claims for payment or approval and knowingly made, used, caused to be made or used, false records or statements material to a false or fraudulent claim and/or knowingly made, used, or caused 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 concealed or knowingly

and improperly avoided or decreased an obligation to pay or transmit money or property to the Government in violation of 31 U.S.C. §3729.

113. The United States has been damaged as a result of Defendant's violations of the False Claims Act in an amount to be proven at trial. The United States is entitled to this sum as reimbursement for monies obtained by the Defendant for false claims submitted to the United States.

114. The United States is entitled to three times the total damages sustained as a result of Defendant's violations of the 31 U.S.C. §3729.

115. The United States is entitled to a civil penalty of not less than $5,000.00 and not more than $10,000.00, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 Note; Public Law 104-410) for each of Defendant's false claims.

116. The Relator is entitled to reasonable attorney's fees and cost pursuant to 31 U.S.C. §3730(d)(1).

COUNT V
VIOLATION OF THE WHISTLEBLOWER PROTECTION PROVISIONS OF THE FALSE CLAIMS ACT 31 U.S.C. §3730(h)

117. Relator hereby incorporates and re-alleges all preceding paragraphs as if set forth fully herein.

118. Defendant discharged and otherwise discriminated against Relator, Anita Salters, in the terms and conditions of her employment, because of the lawful acts done by Relator, Anita Salters in furtherance of her efforts to stop one or more violations of the False Claims Act by Defendant, American Family Care.

119. Pursuant to the False Claims Act, Relator is entitled to reinstatement with the same seniority status that she would have had but for the discrimination, two times the amount of back pay, interest on back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees.

PRAYER FOR RELIEF

WHEREFORE, Relator prays for judgment

(a) Ordering the Defendant to pay the United States Government three times its actual damages resulting from the Defendant's violations of the False Claims Act;

(b) Ordering Defendant to pay the United States Government a civil penalty for each false claim as set forth in the False Claims Act;

(c) Ordering Defendant to pay Relator monetary damages for its violation of 31 U.S.C. §3730 (h), the Whistleblower Protection Provision of the False Claims Act;

(d) Awarding Relator an amount the Court decides is reasonable for collecting the civil penalty and monetary damages by pursuing this matter, which award, by statute shall not be less than 15% nor more than 25% of the proceeds of this action or the settlement of any such claim, if the Government intervenes in the action and not less than 25% nor more than 30% if the Government declines to intervene in the action.

(e) Ordering the Defendant to pay Relator's attorney's fees and cost;

(f) Granting such other relief as the Court may deem just and proper.

RELATOR HEREBY DEMANDS TRIAL STRUCK JURY.

_____
DON MCKENNA ASB-6494-C66D
HARE, WYNN, NEWELL AND
NEWTON, LLP
The Historic Massey Building
Suite 800
2025 Third Avenue North
Birmingham, AL 35203
Tel: (205) 328-5330
Fax: (205) 324-2165
don@hwnn.com

CERTIFICATE OF SERVICE

I hereby certify that I have served a copy of the above and foregoing pleading upon the following attorneys of record, by placing a copy of same in the United States mail, postage prepaid, on this the 20th day of October 2010.

C/O JOYCE WHITE VANCE
U.S. Attorney
Northern District of Alabama
1801 Fourth Avenue North
Birmingham, AL 35203

C/O Eric Holder
Attorney General of the United States
Department of Justice
10th & Constitution Aves. N.E.
Washington, D.C. 20530

_____
Don McKenna