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9 Attorneys for Relator
KARIN BERNTSEN

10 UNITED STATES DISTRICT COURT
11 CENTRAL DISTRICT OF CALIFORNIA

12
13 UNITED STATES OF AMERICA, *ex rel*
KARIN BERNTSEN,

14 Plaintiffs,

15 v.

16 PRIME HEALTHCARE SERVICES, INC.;
17 PRIME HEALTHCARE SERVICES
ALVARADO, LLC; PRIME
18 HEALTHCARE SERVICES GARDEN
GROVE, LLC; PRIME HEALTHCARE
19 HUNTINGTON BEACH, LLC; PRIME
HEALTHCARE LA PALMA, LLC;
20 DESERT VALLEY HOSPITAL, INC.;
PRIME HEALTHCARE SERVICES
21 FOUNDATION, INC.; PRIME
HEALTHCARE SERVICES ENCINO,
22 LLC; VERITAS HEALTH SERVICES,
INC.; PRIME HEALTHCARE SERVICES
23 MONTCLAIR LLC; PRIME
HEALTHCARE PARADISE VALLEY,
24 LLC; PRIME HEALTHCARE SERVICES
SAN DIMAS, LLC; PRIME
25 HEALTHCARE SERVICES SHASTA,
LLC; PRIME HEALTHCARE SERVICES
26 II, LLC; PRIME HEALTHCARE
ANAHEIM, LLC; DR. PREM REDDY, and
27 DR. LUIS LEON,

28 Defendants.

Case No.: CV 11-08214 FMO(MANx)

FOURTH AMENDED
COMPLAINT

BROWN, WHITE & NEWHOUSE^{LLP}
ATTORNEYS



1 This is an action brought by Plaintiff/Relator Karin Berntsen on behalf of the
2 United States of America pursuant to the Federal False Claims Act, 31 U.S.C. §
3 3729, *et seq.* In support thereof, Relator alleges as follows:

4 **I.**

5 **INTRODUCTION**

6 1. Defendant Prime Healthcare Services, Inc. and the hospitals which it
7 owns and operates through its subsidiaries (collectively referred to as “PHS”) have
8 defrauded the federal government of millions of dollars by billing for medically
9 unnecessary inpatient short stay admissions which should have been classified as
10 outpatient/observation cases. PHS’s behavior is particularly egregious because in an
11 effort to receive greater reimbursement from Medicare and other government
12 healthcare programs, PHS has explicitly instructed its physicians and hospital staff
13 to disregard the Medicare guidelines and to choose inpatient admission over
14 outpatient/observation status in almost every instance, regardless of whether the
15 criteria for inpatient admission has been satisfied.

16 2. PHS also wrongfully increases the MS-DRG payments it receives from
17 Medicare through upcoding by falsifying information concerning the complications
18 and comorbidities associated with patients’ diagnoses.

19 3. In addition, PHS unlawfully refuses to discharge patients who are
20 eligible to be transferred for post-acute care.

21 4. As a result, PHS compromises the well-being of its patients and
22 fraudulently increases its payments from Medicare and other government healthcare
23 programs.

24 **II.**

25 **JURISDICTION AND VENUE**

26 5. This action arises under the False Claims Act, 31 U.S.C. §§ 3729 –
27 3732. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1331, 28
28 U.S.C. § 1345 and 31 U.S.C. § 3732(a), which specifically confers jurisdiction on

1 this Court for actions brought under 31 U.S.C. § 3730.

2 6. This Court has personal jurisdiction over Defendants pursuant to 31
3 U.S.C. § 3732(a), which authorizes nationwide service of process, because at least
4 one of the Defendants can be found in, resides in, transacts business in and has
5 committed the alleged acts in the Central District of California.

6 7. Venue is proper in this District pursuant to 28 U.S.C. § 1391(b)-(c) and
7 31 U.S.C. § 3732(a) because at least one of the Defendants can be found in, resides
8 in and transacts business in the Central District of California, and many of the
9 alleged acts occurred in this District.

10 8. Relator is an original source as defined by the False Claims Act in 31
11 U.S.C. § 3730(e)(4)(B) and Relator has made voluntary disclosures to the United
12 States prior to the filing of this lawsuit.

13 **III.**

14 **PARTIES**

15 9. Relator Karin Berntsen has been employed at Defendant Alvarado
16 Hospital—first as the Director of Quality and Risk Management and then as the
17 Director of Case Management. In February 2013, she became the Director of
18 Performance Improvement (PI). Relator is a registered nurse with more than
19 twenty-years of experience in healthcare leadership and patient care positions. She
20 has published two books regarding patient safety matters. From 2003 to 2005, she
21 was the Director of Nursing for the County of San Diego, CA.

22 10. Defendant Prime Healthcare Services, Inc. (“PHS”) is a Delaware
23 corporation with its primary place of business at 3300 East Guasti Road, Ontario,
24 San Bernardino County, California 91761. PHS was founded by Dr. Prem Reddy in
25 2001. PHS began its strategy of acquiring hospitals in financial distress with its
26 2004 purchase of Chino Valley Medical Center, which was in Chapter 11
27 bankruptcy. PHS incorporates a model of educating doctors in the financial aspects
28 of medicine to change distressed hospitals into financially stable businesses.



1 Through its wholly-owned subsidiaries, PHS now owns and operates fourteen
2 hospitals in the state of California. The Defendant hospitals, and their corresponding
3 subsidiaries, are:

- 4 a. Alvarado Hospital Medical Center, located in San Diego, CA – Prime
5 Healthcare Services Alvarado, LLC
- 6 b. Centinela Hospital Medical Center, located in Inglewood, CA – Prime
7 Healthcare Centinela, LLC
- 8 c. Chino Valley Medical Center, located in Chino, CA – Veritas Health
9 Services, Inc.
- 10 d. Desert Valley Hospital, located in Victorville, CA – Desert Valley
11 Hospital, Inc.
- 12 e. Encino Hospital Medical Center, located in Encino, CA – Prime
13 Healthcare Services Foundation, Inc. and Prime Healthcare Services
14 Encino, LLC
- 15 f. Garden Grove Hospital Medical Center, located in Garden Grove, CA –
16 Prime Healthcare Services Garden Grove, LLC
- 17 g. Huntington Beach Hospital, located in Huntington Beach, CA – Prime
18 Healthcare Huntington Beach, LLC
- 19 h. La Palma Intercommunity Hospital, located in La Palma, CA – Prime
20 Healthcare La Palma, LLC
- 21 i. Montclair Hospital Medical Center, located in Montclair, CA –
22 formerly Prime Healthcare Services III, LLC; presently Prime
23 Healthcare Services Foundation, Inc. and Prime Healthcare Services
24 Montclair, LLC
- 25 j. Paradise Valley Hospital, located in National City, CA – Prime
26 Healthcare Paradise Valley, LLC
- 27 k. San Dimas Community Hospital, located in San Dimas, CA – Prime
28 Healthcare Services San Dimas, LLC

1 l. Shasta Regional Medical Center, located in Redding, CA – Prime
2 Healthcare Services Shasta, LLC

3 m. Sherman Oaks Hospital, located in Sherman Oaks, CA – Prime
4 Healthcare Services II, LLC

5 n. West Anaheim Medical Center, located in Anaheim, CA – Prime
6 Healthcare Anaheim, LLC

7 11. Prime Healthcare Services Foundation, Inc., d/b/a Encino Hospital
8 Medical Center and Montclair Hospital Medical Center, (“PHSF”) is a Delaware
9 corporation with its primary place of business at 3300 East Guasti Road, 2nd Floor,
10 Ontario, California, 91761. A wholly owned and operated subsidiary of PHS, PHSF
11 was founded by a \$1 million donation from Dr. Prem Reddy. Encino Hospital
12 Medical Center and Montclair Hospital Medical Center were donated to PHSF by
13 PHS in 2009 and 2011, respectively. PHSF is a 501(c)(3) charitable organization.

14 12. Prime Healthcare Services Alvarado, LLC d/b/a Alvarado Hospital
15 Medical Center (“Alvarado”) is a Delaware corporation with its primary place of
16 business at 6655 Alvarado Road, San Diego, California, 92120. Alvarado was
17 acquired by PHS in November 2010.

18 13. Dr. Prem Reddy is the founder and Chairman of the Board of Prime
19 Healthcare Services, Inc. Reddy actively oversees the acquisition and restructuring
20 of all new hospitals acquired by PHS, including implementing uniform protocols at
21 all PHS facilities.

22 14. Dr. Luis Leon is the regional CEO for Alvarado Hospital Medical
23 Center and Paradise Valley Hospital. Leon was made regional CEO after the former
24 CEO of Alvarado Hospital Medical Center resigned when the hospital was acquired
25 by PHS.

26 //

BROWN, WHITE & NEWHOUSE^{LLP}
ATTORNEYS

IV.

REGULATORY OVERVIEW

A. Inpatient Short Stay Hospital Admissions

15. In an effort to combat Medicare fraud and abuse, The Centers for Medicare and Medicaid Services (CMS) has increased scrutiny of the medical necessity for short-stay inpatient hospital admissions. Due to the greater reimbursement for inpatient services versus observation services, the Government requires strict adherence to inpatient admission rules.

16. Chapter 6, Section 6.5.2 of the Medicare Program Integrity Manual states that,

Inpatient hospital care must be medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

It further provides that “factors that may result in an inconvenience to a beneficiary or family do not, by themselves, justify inpatient admission.” *Id.* Inpatient care is only required if the beneficiary’s medical condition, safety, or health would be significantly and directly threatened if care were to be provided in a less intensive setting. *Id.*

17. Chapter 1, Section 10 of the Medicare Benefit Policy Manual sets forth the following factors that should be considered by the physician when deciding whether to admit a patient as an inpatient: the severity of the signs and symptoms exhibited by the patient; the medical predictability of something adverse happening to the patient; the need for diagnostic studies that appropriately are outpatient services; and the availability of diagnostic procedures at the time.

18. Short stay hospital stays have not only appeared on the OIG Work Plan but have also been a focus of Medicare’s Program for Evaluating Payment Patterns

1 Electronic Reports (PEPPER reports). Many hospitals use decision support system
2 tools such as InterQual to assist them in the inpatient admission versus
3 outpatient/observation status decision making process.

4 19. Hospitals are reimbursed by Medicare for the services they provide to
5 inpatients on the basis of diagnosis related groups (DRGs) and to outpatients on the
6 basis of Ambulatory Payment Classifications (APCs). On average, Medicare pays
7 approximately \$4,500 to \$5,000 more for a DRG than for an APC with its bundled
8 observation fee.

9 **B. Utilization Review is a Federally Mandated Requirement for Hospitals**

10 20. Hospitals must have in effect a Utilization Review (UR) plan that
11 provides for review of services furnished by the institution and by members of the
12 medical staff to patients entitled to benefits under the Medicare and Medicaid
13 programs. The UR plan must provide for review for Medicare and Medicaid
14 patients with respect to the medical necessity of (i) admissions to the institution; (ii)
15 the duration of stays; and (iii) professional services furnished, including drugs and
16 biological. 42 CFR § 482.30.

17 **C. Medical Severity – Diagnostic Related Groups under the Medicare**
18 **Inpatient Prospective Payment System**

19 21. Hospitals such as the PHS Defendants are reimbursed for their inpatient
20 services under the Medicare Inpatient Prospective Payment System (IPPS). Under
21 this system, the ICD-9 Procedure Code and the ICD-9 Diagnostic Code (and in some
22 cases age, sex and demographics) determine the appropriate MS-DRG classification.
23 ICD-9 procedures will typically be grouped to a MS-DRG classification which
24 indicates: with major complications and comorbidities (MCC); with complications
25 and comorbidities (CC); or without complications and comorbidities (without
26 CC/MCC).

27 22. Complications and Comorbidities typically increase the reimbursement
28 rate for an MS-DRG. Thus, patients' complications and comorbidities must be

1 accurately recorded in order to ensure that the hospital is appropriately reimbursed
2 by Medicare.

3 **D. Duty to Report and Return Overpayments from Medicare**

4 23. The Medicare and Medicaid program integrity provisions, 42 U.S.C. §
5 1320a-7k(d), state as follows:

6 **(d) Reporting and returning of overpayments**

7 **(1) In general**

8 If a person has received an overpayment, the person shall –

9 (A) report and return the overpayment to the Secretary, the State, an
10 intermediary, a carrier, or a contractor, as appropriate, at the correct address;
11 and

12 (B) notify the Secretary, State, intermediary, carrier, or contractor to
13 whom the overpayment was returned in writing of the reason for the
14 overpayment.

15 **(2) Deadline for reporting and returning overpayments**

16 An overpayment must be reported and returned under paragraph (1) by
17 the later of --

18 (A) the date which is 60 days after the date on which the overpayment
19 was identified; or

20 (B) the date any corresponding cost report is due, if applicable.

21 **(3) Enforcement**

22 Any overpayment retained by a person after the deadline for reporting
23 and returning the overpayment under paragraph (2) is an obligation (as
24 defined in section 3729(b)(3) of title 31) for purposes of section 3729 of such
25 title.

26 //



V.

FACTUAL ALLEGATIONS

A. False Claims Act violations resulting from improper inpatient hospital admissions and fraudulent claims for DRG payments based on upcoding

24. In November 2010, Defendant Prime Healthcare Services purchased Alvarado Hospital. Subsequent to the purchase, Alvarado's entire executive team, including the CEO Harris Koenig, resigned and Dr. Luis Leon was installed as the Regional CEO overseeing Alvarado Hospital. PHS's Chairman of the Board is Dr. Prem Reddy whose medical specialties are internal medicine and cardiology.

25. Approximately seventy-percent of Alvarado Hospital's patients are covered by Medicare and other federal healthcare programs. Approximately twenty-percent are covered by Medicaid. The vast majority of Alvarado's patients are initially treated at the hospital's emergency room where a determination is made by attending physicians as to whether the patient should be placed under observation or admitted as an inpatient.

26. Prior to PHS's takeover of Alvarado, Relator, as the Director of Quality and Risk Management, in conjunction with the then in-place executive team, implemented a number of controls to preclude abuse of Medicare regulations regarding short stay inpatient hospital stays. These controls augmented the McKesson Company, InterQual decision support computer program then in use at Alvarado. Statistical reviews conducted subsequent to the implementation of Relator's procedures confirmed Alvarado's one-day stay admissions were well within accepted norms.

27. In December 2010, after the takeover by PHS, a meeting was held during which the former Chief Operating Officer, Darlene Wetton, informed the Medical Staff Department of Medicine Committee that PHS does not do observation, but admits all patients as inpatients. Thomas Young, MD the immediate past chief of the Department of Medicine conveyed to Ms. Wetton that he

1 strongly disagreed with PHS's directive not to use observation status and that he
2 personally would continue to identify observation patients when appropriate. Ms.
3 Wetton resigned before the end of January 2011.

4 28. Also discussed at the December 2010 meeting were the new chest pain
5 pre-printed order sets. After the takeover, PHS replaced the chest pain order forms
6 currently in use at Alvarado with new forms that no longer included a check-off to
7 select observation status as an option for site of service. The Medical Executive
8 Committee in a memo dated December 8, 2010 to the Alvarado Hospital Governing
9 Board (of which Dr. Prem Reddy was the Chairman) made a formal request to
10 restore a check-off for observation to the new order sets. Despite this request, the
11 check-off for observation was not added back on to the forms. The memo also
12 stated that these "new order sets are used throughout the Prime Healthcare system."
13 The "Forms Fast" system is the name of the computer system used by PHS to
14 generate forms for all of the hospitals it owns and operates.

15 29. In January 2011, more than 250 employees, including most of Alvarado
16 Hospital's Quality and Risk Management Department staff were dismissed by PHS.
17 At about the same time, Dr. Reddy implemented a monthly Hospitalist Meeting
18 attended by the senior and high-volume admitting physicians as well as key
19 administrators. The first such meeting was convened on February 1, 2011 at which
20 time Dr. Reddy startled those present by stating, "We don't do observation. All
21 patients should be inpatient. You can always find a reason to make the patient an
22 inpatient."

23 30. Dr. Reddy reiterated his instructions concerning inpatient admissions at
24 subsequent Hospitalist meetings attended by Relator, including a meeting on May 3,
25 2011 at which he also encouraged those present to upcode by adding complications
26 or comorbidities such as encephalopathy and fecal impaction to a diagnosis in order
27 to increase the DRG reimbursement rate. For example, he stated:
28

1 “If the patient is elderly, you should add encephalopathy for a higher payment.
2 You are missing some of these elderly patients. But, be careful . . . I don’t
3 want to go to jail, ha, ha, ha.”

4 “If you code fecal impaction in GI bleed diagnoses, I can get \$3,000 more per
5 case.”

6 “If the patient leaves against medical advice you are free to document
7 whatever conditions you want.”

8 31. Dr. Reddy’s instructions to upcode by exaggerating complications or
9 comorbidities (CCs or MCCs) also resulted in increases in improper diagnoses of
10 conditions including, but not limited to, septicemia, malnutrition, acute heart failure,
11 and autonomic nerve disorders. At a December 13, 2013 meeting, detailed *infra*,
12 Reddy instructed Prime physicians and administrators to diagnose heart failure as
13 “acute” rather than “chronic” so that hospitals could receive higher reimbursement
14 amounts. Reddy specifically told Dr. Larry Emdur that “you cannot admit a patient
15 for chronic systolic heart failure. It has to be acute.”

16 32. Within weeks of Alvarado’s purchase, the coding manager, Joseph
17 Ingranda resigned. Subsequent to the February 1, 2011 meeting, Relator was told by
18 a hospital coder, that the coder was instructed to make no coding distinction between
19 atrial fibrillation and atrial flutter, but rather to code at the highest paying DRG.
20 That coder resigned shortly thereafter as did her supervisor, Lori Cardle, vice-
21 president of Revenue Cycle.

22 33. At the August 23, 2011 Case Management meeting, Dr. Leon
23 confirmed the previous statements regarding patient observation status and
24 specifically instructed that the Case Management Department no longer be involved
25 in the process of assisting with the identification of observation status and that the
26 use of the InterQual system to evaluate observation status be discontinued.

27 34. By prohibiting the Case Managers from being involved in and from
28 reviewing the decisions regarding inpatient admissions, PHS was in direct violation

1 of the CMS requirement that a hospital must have in effect a utilization review (UR)
2 plan that must provide for review of Medicare and Medicaid patients with respect to
3 the medical necessity of admissions to the institution. 42 CFR § 482.30. Prohibition
4 of effective utilization review with regard to inpatient admissions was one of the
5 ways in which PHS was able to carry out and intentionally disguise its fraudulent
6 scheme of improperly admitting individuals as inpatients who did not meet medical
7 necessity for inpatient admission as opposed to placing them in observation.

8 35. Prior to the August 23, 2011 Case Management meeting, Dr. Leon
9 instructed Dr. Larry Emdur, a lead physician, to designate one out of five chest pain
10 patients for observation status in an apparent effort to make it more difficult for
11 auditors to detect PHS's deliberate practice of under-identifying observation status.
12 Nevertheless, the Program for Evaluating Payment Pattern Electronic Report
13 (PEPPER) for Alvarado began to reflect an inordinate increase in one-day stays,
14 respiratory infection diagnoses, septicemia infection diagnoses and other anomalies.

15 36. When Relator discussed her concerns regarding the observation status
16 changes with Dr. Leon, he informed her that observation billing was his
17 responsibility and if Medicare comes after him, he will "throw his group of lawyers
18 at them."

19 37. At a September 2, 2011 meeting called by Dr. Leon, he instructed the
20 Emergency Department manager, Tammy Russell, to eliminate references to
21 observation status on hospital admission forms. Later in that meeting, Ms. Russell
22 mentioned that a new ER doctor, Donald R. Sallee identified six observation status
23 patients on the night of September 1-2, provoking Dr. Leon to comment: "Six! Six
24 observation patients in one night! That is not right. We should do six observation
25 patients in one year!" He then instructed Ms. Russell to provide him the medical
26 files of those patients and, after commenting, "These new ER doctors need to be
27 trained," instructed Ms. Russell to summon Dr. Sallee to a subsequent private
28 meeting.

1 38. Relator was present at several hospitalist meetings where Reddy
2 directly and clearly instructed internal medicine physicians, known as the
3 Emergency Associate (EA) group, to not admit chest pain patients as outpatients, but
4 instead to find a reason to admit them as inpatients because the Medicare payments
5 are much higher for inpatients.

6 39. In addition to the ER physicians, hospitalists, and case managers,
7 Reddy also pressured the clinical documentation information specialists (CDIs) to
8 engage in fraudulent conduct in order to increase inpatient admissions and DRG
9 reimbursements. For example, the CDIs were trained to exaggerate patients'
10 conditions on the query form in order to justify admitting them as inpatients or to
11 increase the DRG reimbursements even though the information on the query form
12 was not supported by the patients' medical records. Due to time constraints, many
13 physicians, especially the hospitalists, do not independently verify that the
14 conditions on the query forms are accurate and supported by the medical records.
15 Thus, the false information intentionally supplied by the CDIs in many instances
16 results in medically unnecessary inpatient admissions and/or upcoding because the
17 complications and comorbidities associated with patients' diagnoses have been
18 falsified.

19 40. As an instructional exercise regarding enhanced reimbursement coding
20 at the September 6, 2011 Hospitalist Meeting, Dr. Reddy personally reviewed and
21 manually altered patient records without consulting treating physicians. He
22 thereafter handed the records to Dr. Leon who reviewed the changes. In turn, Dr.
23 Leon handed them to Marianna Martinez, Director of Health Information Systems to
24 effect the changes. At this same meeting, Dr. Manorama Reddy said to Dr. Prem
25 Reddy, "We are not using observation like you told us, and almost all patients are
26 admitted as inpatients." Dr. Reddy nodded affirmatively to Dr. Manorama Reddy
27 when she made this statement.
28

1 41. On November 14, 2011 at 12:30 p.m., Relator attended a hospitalist
2 meeting conducted by Reddy. During the meeting, Reddy reviewed patient specific
3 information and identified numerous examples in which he thought a CC
4 (complication or comorbidity) or an MCC (major complication or comorbidity)
5 should have been added (even though Reddy had never seen or treated these
6 patients). One of the cases Reddy discussed involved a patient treated by Dr.
7 Fredrick Howden, a cardio-thoracic surgeon who was not present at the meeting.
8 Reddy stated that “he could get \$25,000 without a CC or MCC, but he could get
9 \$50,000 with a CC or MCC.” Reddy commented that due to the length of time the
10 patient had been in the hospital “there must be a CC or MCC.” Relator was
11 concerned by the fact that Reddy was instructing that a CC or MCC be added to
12 increase reimbursement even though he had never identified a basis in the medical
13 record to support the addition of a CC or MCC.

14 42. Also at this November meeting, Reddy told the physicians present that
15 they “should not use syncope because it is not enough to get a DRG.” He explained
16 that they should use another diagnosis so that the more lucrative DRG
17 reimbursement for an inpatient admission could be received as opposed to the lesser
18 observation outpatient reimbursement rate. He then stated that complications (CCs
19 or MCCs) needed to be added for chest pain patients as well. Dr. Reddy continued to
20 review records with Dr. Emdur denoting changes that could be made to those
21 records.

22 43. On April 23, 2012, Relator reported her concerns about PHS’s improper
23 practices to CFO Brian Kleven. Mr. Kleven stated that he had been at the meetings
24 in which Reddy told the doctors not to do observation. Mr. Kleven also stated he and
25 Relator had to support Reddy and Prime, and help cover for Dr. Reddy. Relator was
26 dismayed at Mr. Kleven’s response to her concerns and that he had suggested
27 helping to “cover up” Reddy’s improper practices.
28



1 44. PHS’s fraudulent activities described above are ongoing. PHS
2 continues to engage in upcoding, falsifying diagnoses, and improper inpatient
3 admissions.

4 45. Relator estimates that PHS Alvarado’s fraudulent short-stay inpatient
5 admission billings to government healthcare programs exceed \$8 million.
6 Considering Alvarado is a typical hospital within the PHS system and that some of
7 those hospitals have been within the PHS system for at least six years, Relator
8 conservatively estimates that PHS’s false billings just with regard to improper short-
9 stay inpatient admissions alone exceeds \$50 million.

10 46. In addition to the damages described above due to PHS’s inpatient
11 admissions which did not meet inpatient criteria, PHS is also liable for damages due
12 to Medicare payments it received for inpatient admissions made during the time
13 period during which it was refusing to perform its federally mandated utilization
14 review functions. PHS’s decision to not have an effective utilization review process
15 as required by law tainted all of its hospitals’ inpatient admission decisions because
16 these admissions were not subject to any form of review to ensure the medical
17 necessity of admissions to the institution. John Marino, M.D., the Medical Director
18 of Utilization Review, complained to hospital management regarding PHS’s
19 practices with regard to improper inpatient admissions.

20 47. Alvarado Hospital continued the practice of prohibiting UR until
21 approximately May of 2012 when CFO Brian Kleven decided that failing to perform
22 UR functions was too risky for the hospital from a liability standpoint. Mr. Kleven
23 was also concerned that Medicare would cease to reimburse Alvarado for inpatient
24 admissions if Medicare learned that Alvarado was in violation of its obligation to
25 implement an effective UR. Even though Alvarado Hospital eventually resumed UR,
26 other PHS hospitals have continued to prohibit UR with regard to inpatient
27 admissions. Furthermore, despite the reimplementation of UR at Alvarado, the
28 billing for fraudulent short-stay inpatient admissions at Alvarado continued.

1 48. Defendants' fraudulent activities described above have caused the
2 submission of false or fraudulent claims for payment which have caused monetary
3 damages to the government. In addition, the fraudulent conduct has resulted in
4 Defendants knowingly concealing or knowingly and improperly avoiding or
5 decreasing an obligation to pay or transmit money or property to the Government.
6 Defendants, due to fraudulent activities such as improper inpatient admissions,
7 upcoding, and falsifying complications, have received overpayments from Medicare
8 and have failed to report and return them within the time periods specified in 42
9 U.S.C. § 1320a-7k(d)(2).

10 **B. Evidence of Fraud throughout Prime Healthcare System**

11 49. Relator has specific evidence that the fraudulent activities alleged in the
12 Complaint are occurring throughout the Prime Healthcare system, including each of
13 the Defendant PHS hospitals.

14 50. As identified in this Complaint, Relator has attended numerous
15 meetings in which Defendant Reddy has issued system-wide instructions to engage
16 in improprieties which result in upcoding and medically unnecessary inpatient
17 admissions. Almost every time Reddy has issued these instructions or addressed
18 these issues, he has spoken in terms of the entire Prime healthcare system. Even
19 when these meetings took place at Alvarado hospital, Reddy's comments would
20 almost never be limited to Alvarado; rather, he would emphasize that the procedures
21 he was encouraging should be, and were being, used at the other PHS hospitals.

22 51. When discussing coding, billing, and other hospital procedures in the
23 context of inpatient admissions and/or increased DRG payments, including during
24 the meetings identified in the Complaint, Reddy has made numerous comments, in
25 the presence of Relator, indicating that the practices are system-wide including:
26 "This is the way we do things at **Prime**" and "**We** don't do observation . . . you can
27 always find a reason to make the patient an inpatient." Furthermore, Reddy is
28 conducting these same meetings (especially hospitalist meetings) at the other

1 Defendant PHS hospitals in which he specifically directs individuals to engage in
2 conduct which causes upcoding and medically unnecessary inpatient admissions. At
3 hospitals, such as Defendant Paradise Valley Hospital, Reddy for several years even
4 conducted the hospitalist meetings on a weekly basis.

5 52. At a December 13, 2013 meeting conducted by Reddy, Relator heard
6 Reddy state “We have in every hospital the same thing . . . We have now twenty-five
7 hospitals testing it . . . that’s what the advantage of having that kind of information
8 from various hospitals so somebody’s not in silo in one hospital.”

9 53. Relator has direct knowledge that other Prime hospitals are engaging in
10 the same fraudulent behavior as Alvarado, not only because she has personally heard
11 Reddy’s statements about the commonality of the practices throughout the Prime
12 Healthcare system, but also because of her interactions (during the course of her
13 professional responsibilities) with employees from other Prime hospitals. For
14 example, on October 10, 2012, Relator as well as Prime case managers, clinical
15 documentation improvement specialists (CDIs), and social workers, participated in
16 an on-line training webinar conducted by Milliman dealing with medical necessity
17 guidelines. Two of the participants, (Ann Davis, a social worker, and Desiree
18 Hawkins, Director of Case Management) were representatives of the Defendant PHS
19 hospital known as San Dimas Hospital; during the webinar, one of these individuals
20 stated: “We don’t do observation. The higher-ups want us to admit all patients as
21 inpatients.” None of the participants contradicted this statement.

22 54. Relator has also had conversations with representatives from Defendant
23 Paradise Valley Hospital. Janice Bowman, the Director of Case Management at
24 Paradise Valley, specifically told relator “we don’t do observation.” Neerav Jadeja, a
25 Paradise Valley Administrator, was present at the December 13, 2013 meeting
26 (discussed below in Section E of the Complaint) during which Reddy encouraged
27 upcoding in order to increase MS-DRG reimbursements received by Prime.
28

1 55. Defendant Dr. Luis Leon, who is Reddy’s “right hand man,” is the CEO
2 of both PHS’s Alvarado and Paradise Valley hospitals. Dr. Leon, as described in
3 detail herein, has been instrumental in ensuring that Reddy’s directives are
4 implemented in these hospitals. Dr. Leon attended the hospitalist meetings directed
5 by Reddy himself. Dr. Leon also regularly attended the case management meetings.

6 56. During the course of her professional duties, Relator has also reviewed
7 Program for Evaluating Payment Patterns Electronic Reports (PEPPER reports) for
8 at least four Defendant PHS hospitals, including Alvarado and Paradise Valley
9 hospitals. These PEPPER reports all demonstrated a similar trend, specifically a
10 significant increase in one-day stay inpatient admissions after PHS took over the
11 hospitals. These reports were also discussed at a case management committee
12 meeting which Relator attended.

13 57. Evidence of Prime’s system-wide fraud also stems from the fact that
14 several PHS hospitals contract with Emergency Medical Associates (EMA) to
15 provide ER physicians to service Prime Healthcare’s Emergency Departments. Thus,
16 Alvarado shares its ER doctors with other PHS hospitals including Centinela
17 Hospital Medical Center, Chino Valley Medical Center, Encino Hospital Medical
18 Center, Huntington Beach Hospital, La Palma Intercommunity Hospital, Montclair
19 Hospital Medical Center, Sherman Oaks Hospital and San Dimas Community
20 Hospital.

21 58. Therefore, when Relator, at several of the meetings she attended,
22 witnessed Reddy issue instructions for ER doctors regarding the prohibition against
23 observation services, those instructions pertained to ER doctors who practice at all
24 of the hospitals listed above – not just Alvarado Hospital. For example, at a
25 September 2011 meeting, Dr. Reddy instructed Dr. Leon to inform Dr. Mark Bell
26 (the medical director of EMA for all of the PHS hospitals contracted with EMA) that
27 “Prime does not do observation” and that Dr. Bell should train his ER doctors to
28 avoid observation at Prime hospitals.

1 59. In addition, Dr. Kevin Kelly, the medical director of EMA for Alvarado
2 hospital, was in attendance at most of the meetings in which Dr. Reddy and/or Dr.
3 Leon encouraged upcoding and prohibited observation. Dr. Kelly complained to
4 Relator about Dr. Reddy's directives to avoid using observation. At a case
5 management committee meeting on January 24, 2012, Dr. Kelly acknowledged that
6 "Prime corporate" had ordered him to remove "observation" from the Emergency
7 Services-Holding Orders and that observation was no longer an option on these
8 orders.

9 60. As part of her job responsibilities, Relator reviews claims before and
10 after they are submitted and reimbursed by Medicare. The billings that she has
11 reviewed from Alvarado are typical of billings submitted and reimbursed by the
12 other Defendant Prime hospitals because billing for all PHS hospitals is centralized
13 at PHS's Ontario headquarters. In addition, Dr. Reddy personally reviews and, if
14 necessary, modifies Medicare billings prior to submission to government healthcare
15 programs for all of the Defendant hospitals.

16 61. The billing system is not the only system that is standardized
17 throughout PHS. PHS also uses mostly the same forms for all of its hospitals. For
18 example, the December 8, 2010 memo from the Medical Executive Committee to
19 the Alvarado Hospital Governing Board stated that the new order sets (without the
20 observation check-off) are "used throughout the Prime Healthcare system." The
21 "Forms Fast" system is the name of the computer system used by PHS to generate
22 forms for the hospitals it owns and operates. Using forms without the observation
23 check-off option is another method by which PHS advanced its fraudulent scheme of
24 admitting patients when they should have been placed in observation. Furthermore,
25 a PHS corporate representative named Ann Abe, who was the Systems Director for
26 the entire Prime Healthcare system, indicated that she was aware that the
27 observation option had been eliminated from the PHS forms.
28

1 62. Another example of Prime’s use of standardized practices is evidenced
2 in an email dated October 13, 2011 from Shirlee Meadows, Director of Admitting,
3 which describes how earlier that year she had been instructed by April Jones, a
4 representative from Prime corporate management, to stop presenting the Medicare
5 Outpatient Observation Status form (OBS letter) to patients since “this is not a prime
6 standard.” Ms. Meadows also stated, “When we went live on Forms Fast we
7 requested that the OBS letter be put in but we were told no.”

8 63. Dr. Krishna P. Surapaneni, a vendor with MedWrite Biz for Defendant
9 PHS’ hospitals, commented to Relator, “PHS does not do observations” Dr.
10 Krishna’s comment is further evidence that Reddy has ensured that the Defendant
11 PHS hospitals are engaging in a system-wide scheme to increase Medicare
12 reimbursements through upcoding and fraudulent inpatient admissions.

13 64. As described above, Reddy has created a corporate-wide culture of
14 fraudulent behavior which permeates all of the Defendant PHS hospitals at all levels.
15 Reddy has pressured and trained individuals, including corporate administrators, ER
16 physicians, hospitalist physicians, case managers, and CDIs to engage in fraud in
17 order to increase the payments PHS receives from Medicare. Furthermore, Relator
18 has personally witnessed Reddy engage in this behavior and has seen first-hand the
19 harmful consequences to patients and to the Medicare program as a result of this
20 fraud.

21 **C. Relator is an original source under 31 U.S.C. § 3730(e)**

22 65. Relator is an “original source” under 31 U.S.C. § 3730(e). Before the
23 filing of this action, Relator made voluntary disclosures to the government.

24 66. Relator has independent, first-hand knowledge of the fraud she has
25 alleged against all of the Defendant PHS Hospitals. As specifically addressed
26 throughout the Complaint and in detail in paragraphs 49-64, Relator’s personal
27 knowledge and evidence of upcoding and fraudulent inpatient admissions is not just
28 limited to Alvarado Hospital. Rather, she has evidence that the fraudulent conduct is

1 occurring throughout the Prime Healthcare System. In addition, Relator, due to her
2 professional responsibilities, has specific knowledge that PHS is submitting and
3 causing to be submitted to Medicare false claims for payment due to upcoding and
4 medically unnecessary inpatient admissions, and that Medicare, unaware of the
5 fraud, has reimbursed PHS for these claims.

6 67. A substantial portion of Relator's knowledge comes from meetings
7 identified herein that she personally attended, including those in which Defendant
8 Reddy discussed the improper protocol for inpatient admission versus observation
9 status and methods to increase DRG reimbursements within the Prime hospital
10 system. The information from these meetings that Relator has provided to the
11 government was not publically disclosed at the time Relator provided the
12 information to the government or at the time she filed her complaint.

13 68. In addition, in the course of her professional responsibilities, Relator
14 has access to PHS's billing information and daily patient census, which allows her to
15 view patient-specific information concerning dates of admission, diagnoses, names
16 of treating physicians, and DRG billing and reimbursement data. Furthermore, as
17 explained above, the billing for Alvarado hospital, as well as all PHS hospitals, is
18 uniform and centralized at PHS's Ontario, California headquarters.

19 69. Relator, as detailed above, as part of her job responsibilities personally
20 attends PHS meetings and interacts with PHS employees outside of Alvarado
21 hospital, including PHS corporate officials. For example, on July 6, 2012, Relator
22 traveled to PHS headquarters in Ontario, California for a corporate meeting attended
23 by PHS corporate representatives, including Suzanne Richards (Vice-president of
24 clinical operations) and Ann Abe (Systems Director for Prime).

25 70. Relator's personal knowledge is not limited to her experiences at
26 Alvarado hospital. Relator is an "original source" with regard to her allegations
27 against all of the Defendants.
28

1 **D. Specific Instances of Fraudulent Inpatient Hospital Admissions**

2 71. Relator has evidence of specific instances in which PHS has wrongfully
3 admitted Medicare patients to the hospital as inpatients when they should have been
4 placed under observation instead. The patients in the chart below were admitted to
5 Alvarado Hospital as inpatients even though the medical necessity for an inpatient
6 admission had not been satisfied. In each of these patient-specific examples, PHS
7 unlawfully submitted claims to Medicare, which the government reimbursed. Had
8 CMS known of the falsity of these claims, it would not have paid them.

Patient	Date	Inpatient Diagnosis	Findings	DRGs Submitted and Reimbursed	Physician's Initials
A	9/11/2011	Chest Pain	12 lead ECG normal Troponins normal	392 Esoph, Gast & Misc Dig Disorder	LP
B	9/16/2011	Chest Pain	12 lead ECG normal Troponins normal	313 Chest Pain	HT
C	9/11/2011	Dizziness	12 lead ECG normal CBC/Chemistry normal	074 Cran & oerif Nerv Dis	RE
D	8/1/2011	Chest Pain	12 lead ECG normal Troponins normal	313 Chest Pain	RE

22 72. Relator has evidence of several additional instances of fraudulent
23 inpatient admissions which are not represented in the above chart but have been
24 provided to the government in the disclosure materials.

25 **E. Additional examples of fraudulent claims for DRG payments resulting**
26 **from unlawful upcoding**

27 73. On December 13, 2013, Relator attended a meeting conducted by
28 Defendant Reddy where Reddy instructed Prime physicians and administrators on

1 how to unlawfully upcode certain medical diagnoses in order to maximize Medicare
2 reimbursement. At this meeting, Reddy explained how to change medical records of
3 patients after the attending physicians complete their diagnoses. At no time did
4 Defendant Reddy personally provide clinical evaluation of any of these patients. In
5 fact, most of these patients already had been discharged from the hospital at the time
6 their medical records were being altered.

7 74. At this meeting, Defendant Reddy repeatedly stated that the policy of
8 intentionally misrepresenting diagnoses is implemented throughout all hospitals
9 within PHS. As a result of this widespread practice of upcoding, Reddy is
10 orchestrating the inflation of the MS-DRG weight from Non-Complicating or
11 Comorbid Conditions to Major Complicating or Comorbid Conditions, resulting in
12 higher weighted payments from Medicare. This illegal and systemic practice also
13 compromises patient safety by causing unnecessary and inappropriate medical
14 services to be performed on patients.

15 75. For example, Defendant Reddy instructed Prime physicians and
16 administrators to diagnose patients with aspiration pneumonia even though a much
17 higher percentage of pneumonia cases are healthcare acquired pneumonia.
18 Specifically, while examining a patient's record, Reddy stated "[T]his patient is a
19 pneumonia patient, but when they have pneumonia in elderly, write 'possible
20 aspiration pneumonia.' That is a higher weight." Reddy then went on to criticize
21 the treating physicians for prescribing drugs such as Vancomycin (even though
22 Vancomycin is the proper drug for treatment of healthcare acquired pneumonia – the
23 condition with which most of these patients were originally diagnosed by their
24 treating physicians). Reddy further suggested that with regard to a specific
25 pneumonia patient, additional descriptions and conditions including "confused,
26 elderly, ischemia, and failure to thrive" should be added to the patient's records even
27 though he had never seen the patient.
28

1 76. During this meeting, Reddy was critical of certain doctors who were
2 correctly diagnosing patients. Reddy attempted to intimidate those doctors into
3 following his directives by belittling them as “dwarves.” At one point, Reddy
4 referred to a well-respected physician, Alvarado’s Infectious Disease Specialist, Dr.
5 Butera, as “old fashioned” for prescribing Vancomycin and directed other physicians
6 to “educate” Dr. Butera.

7 77. Generally, about 3% of pneumonias are aspiration, and according to the
8 2013 coding data, the reimbursement rate for aspiration pneumonia (MS-DRG 177)
9 is \$11,302, while the reimbursement rate of simple healthcare acquired pneumonia
10 (MS-DRG 179) is only \$5,389. Additionally, Defendants’ practice endangers
11 pneumonia patients because they are treated with inappropriate and medically
12 unnecessary drugs, rather than with the medications normally used to treat simple
13 pneumonia, such as Vancomycin.

14 78. At this meeting, Defendant Reddy further directed physicians to upcode
15 “pre-renal” conditions as Vasomotor Nephropathy (“VMN”). Current Medicare
16 coding guidelines state that VMN is renal failure, and not a “pre-renal” condition.
17 Defendant Reddy further instructed PHS’s Emergency Department physicians to
18 diagnose all elderly patients with any evidence of dehydration or confusion as
19 suffering from encephalopathy or possible encephalopathy.

20 79. As a result of these practices, Reddy is elevating the MS-DRG weight
21 from Non-Complicating or Comorbid Conditions to Major Complicating or
22 Comorbid Conditions, resulting in the submission of fraudulent claims for the
23 purpose of generating excessive Medicare reimbursements and overpayments.

24 80. Also during the December 13, 2013 meeting, Defendant Reddy
25 repeatedly instructed physicians to insert the word “possible” before several
26 diagnoses in order to receive a higher reimbursement. According to the ICD-10-CM
27 Official Guidelines for Coding and Reporting (2013) “If the diagnosis documented
28 at the time of discharge is qualified as ‘probable’, ‘suspected’, ‘likely’,

1 ‘questionable’, ‘possible’ or ‘still to be ruled out’, or other similar terms indicating
2 uncertainty, code the condition as if it existed or was established.”

3 81. Defendant Reddy instructed Emergency Room physicians to “set the
4 stage for other doctors” knowing that the “possible” diagnosis was unlikely to be
5 eliminated by a subsequent physician. Defendant Reddy repeatedly stated “possible
6 this, possible that, possible this” as the Prime method for describing patient
7 diagnoses, even when there was no medical basis for doing so, thereby allowing the
8 coders to use a higher weight MS-DRG.

9 82. Throughout the meeting, Reddy made several statements indicating that
10 the methods he was describing to increase DRG reimbursements were being used at
11 all the Prime hospitals.

12 **F. False Claims resulting from refusal to transfer or discharge patients**

13 83. Hospitals are ordinarily entitled to full DRG payment when patients are
14 discharged to their home following a covered inpatient stay. However, in certain
15 circumstances involving acute care hospitals, CMS has instituted modified DRG
16 payment policies which result in reduced DRG payments based on length of stay and
17 discharge setting criteria. CMS instituted these payment policies so that acute care
18 hospitals do not receive full DRG payments for Medicare patients that are
19 discharged early and then admitted for additional medical care in other clinical
20 settings. These DRGs are referred to as “Transfer DRGs.”

21 84. Transfer DRGs include a reimbursement rate that is lower than full
22 DRG payments, because the acute care hospital is required to split the DRG payment
23 with the provider that treats the patient after discharge. The reduction in payment
24 follows a formula that depends on the patient’s actual length of stay (“LOS”) and the
25 geometric mean LOS for that DRG.

26 85. CMS defines a “transfer” as a discharge of a Medicare eligible hospital
27 inpatient to (a) a non-IPPS hospital or a distinct non-IPPS unit, long-term care
28 hospitals, psychiatric hospitals, and cancer hospitals; (b) a skilled nursing facility; or

1 (c) to a home under a written plan for home health services beginning within three
2 days of discharge.

3 86. Hospitals are responsible for identifying those discharges to which the
4 post-acute transfer rules apply by reporting the appropriate patient discharge status
5 code.

6 87. Refusing to discharge patients when appropriate raises numerous
7 patient safety concerns. Increasing a patient's length of stay, while under certain
8 circumstances medically necessary, nevertheless exposes the patient to a greater risk
9 of experiencing complications such as hospital acquired infections, medical errors
10 and falls. For this reason, it is not in the patient's best interest to unnecessarily
11 extend his/her length of stay, especially when the treating physician has determined
12 that treatment in an acute care hospital is no longer medically necessary.
13 Unfortunately, improperly extending patients' lengths of stay is the practice that
14 Defendants engaged in for the sole purpose of fraudulently increasing the
15 reimbursements received from government healthcare programs.

16 88. Relator is aware that from at least January 2012 through the present,
17 Defendants have routinely and intentionally circumvented CMS's transfer DRG
18 policies by forcing patients who are ready to be discharged to remain at the hospitals
19 for longer than medically necessary, rather than having the patients transferred to
20 another appropriate health care facility. As a result, Defendants qualify for the
21 higher reimbursement rate normally reserved for standard DRGs and can avoid the
22 lower reimbursement rates associated with Transfer DRGs.

23 89. Two forms were circulated by Prime Corporation showing handwritten
24 notes by non-treating Prime Staff, suggesting that certain patients had been
25 discharged too soon and how increasing those patients' lengths of stay could avoid
26 the fee splitting resulting from transfer DRGs.

27 90. On November 15, 2012, Relator attended a meeting with various case
28 managers, including Mohammed Ibrahim, a Clinical Documentation Information

1 Specialist (CDI) at Alvarado Hospital. Ibrahim informed Relator that, at least twice
2 a week, Defendant Reddy provides Ibrahim with multiple case reviews of Medicare
3 patients that Reddy believes were discharged too soon. At no time has Defendant
4 Reddy been the treating physician for these patients.

5 91. Additionally, Defendant Reddy instructed Ibrahim and other CDIs to
6 begin taking steps to avoid the Transfer DRG classification by finding ways to
7 influence the treating physicians to increase individual patients' LOS, thereby
8 maximizing the hospitals' reimbursement rate.

9 92. For example, Patient AA was admitted to Alvarado Hospital on
10 November 7, 2012 and was administered services that have a geometric mean LOS
11 of 5.1 days. The initial DRG was coded as 208, Respiratory System Diagnosis with
12 Ventilator Support less than 96 hours. Because of the patient's condition, the DRG
13 was changed to 207, Respiratory System Diagnosis with Ventilator Support greater
14 than 96 hours. The patient had a progressive course of medical issues that was
15 treated and the patient's DRG was finalized as 4 TRACH w/ MV 96+ hrs. OR PDX
16 EX FACE, MOUTH, NECK W/O MAJ OR. However, when Patient AA was going
17 to be discharged, Defendant Reddy circulated the medical billing paperwork among
18 Ibrahim and other CDIs with handwritten notes alerting the CDIs that they should
19 not allow Patient AA to be discharged more than three days before the target
20 geometric LOS.

21 93. As a consequence of the pressure by Defendant Reddy to avoid the
22 reimbursement fee-splitting associated with Transfer DRGs, physicians began
23 refusing to discharge patients. Patient AA was extubated on November 20, 2012 and
24 appeared ready for transfer to a post-acute facility. Relator is aware that on or about
25 November 20, 2012, Dr. Neelakatan Ramineni, a physician at Alvarado Hospital,
26 had written orders to transfer this patient to a post-acute care facility. However,
27 upon learning that the patient was going to be discharged several days before the
28 geometric LOS of 22.2 days, Dr. Ramineni canceled the transfer order and held the

1 patient in Alvarado Hospital's Advanced Care Unit (ICU step down unit) until the
2 full geometric LOS days were reached, thereby allowing Alvarado Hospital to
3 receive the full reimbursement rate. Notably, Defendant Reddy had been advising
4 Dr. Ramineni and his associate medical group members to attempt to meet the full
5 geometric LOS at Alvarado Hospital for the purpose of receiving higher
6 reimbursement from Medicare.

7 94. Dr. Richard A. Mayer, another physician at Alvarado Hospital,
8 discovered that the tracheostomy patient had been ready for transfer and voiced his
9 concerns regarding the obvious patient safety issues of keeping the patient longer
10 than what was medically necessary. In spite of these objections, Dr. Ramineni
11 refused to transfer the patient until the entire geometric LOS had been reached.

12 95. Relator is aware of additional fraudulent practices at Prime in order to
13 increase patients' LOS. Under certain limited conditions, Medicare will pay some
14 nursing home costs for Medicare beneficiaries who require skilled nursing or
15 rehabilitation services. To be covered, the patient must receive the services from a
16 Medicare certified skilled nursing home after a qualifying hospital stay. A qualifying
17 hospital stay is the amount of time spent in a hospital just prior to entering a nursing
18 home. This is at least three days.

19 96. At the December 13, 2013 meeting detailed in Paragraph 48, *supra*,
20 Defendant Reddy instructed hospital administrators and physicians to have the
21 nursing homes give the hospital administrators an internal sheet listing patients
22 whose Medicare days have expired so when one of the patients gets sick, the nursing
23 home sends the patient to the hospital. This hospital stay can then generate a three-
24 day qualifying stay in the hospital, extending a patient's Medicare benefit period or
25 beginning a new Medicare benefit period in the nursing home.

26 97. By promoting the transfer and admission between the nursing home and
27 the hospital, the process allows the nursing homes to avoid lower paying daily Medi-
28 Cal rates (~\$300 per day) and receive the higher Medicare daily rates (~\$600 per

1 day). Defendant Reddy promoted the use of the internal list and tracking the
 2 diagnoses explicitly to increase referrals to Alvarado Hospital and to allow the
 3 nursing homes to obtain maximum reimbursement amounts from Medicare.

4 98. Based on the fact that Reddy conducts similar meetings at all of the
 5 PHS hospitals, Relator believes that the same instructions have been issued and the
 6 same procedures regarding transfer DRGs and fraudulently increasing LOS have
 7 been implemented throughout the Prime healthcare system. In addition, when Reddy
 8 issues instructions or discusses hospital procedures, such as those involving LOS,
 9 Relator has observed that he routinely addresses these matters on a system-wide
 10 basis. Furthermore, as previously described, based on Relator's observations as an
 11 insider, PHS is centrally operated and routinely uses the same processes at all its
 12 hospitals.

13 99. Defendants' fraudulent activities described above (admitting patients
 14 when medically unnecessary, upcoding to increase MS-DRG reimbursements, and
 15 refusing to discharge patients) have caused the submission of false or fraudulent
 16 claims for payment which have caused monetary damages to the government. In
 17 addition, the fraudulent conduct has resulted in Defendants knowingly concealing or
 18 knowingly and improperly avoiding or decreasing an obligation to pay or transmit
 19 money or property to the Government. Defendants have received overpayments
 20 from Medicare and have failed to report and return them within the time periods
 21 specified in 42 U.S.C. § 1320a-7k(d)(2).

22 VI.

23 **FIRST CLAIM FOR RELIEF:**

24 **A. Violations of the Federal False Claims Act, 31 U.S.C. § 3729(a)**

25 100. Relator incorporates paragraphs 1 - 99 of this complaint as though fully
 26 set forth herein.

27 101. As described above, Defendants have submitted and/or caused to be
 28 submitted false or fraudulent claims to Medicare and other government healthcare

1 programs by billing for medically unnecessary inpatient short stay admissions which
2 should have been classified as outpatient/observation cases; by wrongfully
3 increasing their DRG payments from Medicare by falsifying information concerning
4 patients' diagnoses, complications, and comorbidities; by improperly increasing
5 patients' lengths of stay; and by failing to report and return overpayments from
6 Medicare within the required time period.

7 102. In doing so, Defendants have violated:

- 8 (1) 31 U.S.C. § 3729(a)(1)(A) by knowingly presenting, or causing to
9 be presented, false or fraudulent claims for payment or approval;
10 and/or
11 (2) 31 U.S.C. § 3729(a)(1)(B) by knowingly making, using or causing
12 to be made or used, a false record or statement material to a false
13 or fraudulent claim; and/or
14 (3) 31 U.S.C. § 3729(a)(1)(G) by knowingly making, using, or causing
15 to be made or used, a false record or statement material to an
16 obligation to pay or transit money or property to the Government,
17 or knowingly concealing or knowingly and improperly avoiding or
18 decreasing an obligation to pay or transmit money or property to
19 the Government.

20 103. To the extent any of the conduct alleged herein occurred on or before
21 May 20, 2009, Relator alleges that Defendants knowingly violated 31 U.S.C. §
22 3729(a)(1); 31 U.S.C. § 3729(a)(2); and 31 U.S.C. § 3729(a)(7) prior to amendment,
23 by engaging in the above-described conduct.

24 104. Because of the false or fraudulent claims made by Defendants, the
25 United States has suffered, and continues to suffer damages.

26 **PRAYER**

27 WHEREFORE, Relator requests that judgment be entered against Defendants
28 ordering that:

1 a. Defendants pay an amount equal to three times the amount of damages
2 the United States has sustained because of Defendants' actions, plus a civil penalty
3 against Defendants of not less than \$5,500 and not more than \$11,000 for each
4 violation of 31 U.S.C. § 3729;

5 b. Relator be awarded the maximum amount allowed pursuant to 31
6 U.S.C. § 3730(d);

7 c. Defendants cease and desist from violating the False Claims Act, 31
8 U.S.C. § 3729, *et seq.*;

9 d. Relator be awarded all costs of this action, including attorneys' fees,
10 expenses, and costs pursuant to 31 U.S.C. § 3730(d); and

11 e. The United States and Relator be granted all such other relief as the
12 Court deems just and proper.

13 **DEMAND FOR JURY TRIAL**

14 A jury trial is requested for all issues so triable.

15
16 DATED: August 8, 2014

Respectfully submitted,

BROWN WHITE & NEWHOUSE LLP

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18
19 By s/George B. Newhouse, Jr.
GEORGE B. NEWHOUSE, JR.
Attorneys for Relator
KARIN BERNTSEN

20
21
22 DATED: August 8, 2014

Respectfully submitted,

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24
25
26 By s/Elaine Stromgren
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