UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TENNESSEE
CHATTANOOGA DIVISION

UNITED STATES OF AMERICA and the **STATE OF TENNESSEE**

Plaintiffs, ex rel.

[UNDER SEAL]

Plaintiffs-Relators,

v.

[UNDER SEAL]

Defendants.

Case No. 1:21-CV-84
McDonough/Steger

COMPLAINT

FILED UNDER SEAL
Pursuant to 31 U.S.C. § 3730(b)(2)

JURY TRIAL DEMANDED

PLAINTIFFS-RELATORS' SEALED QUI TAM COMPLAINT

FILED UNDER SEAL PURSUANT TO
THE FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3730(b)

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TENNESSEE
CHATTANOOGA DIVISION

UNITED STATES OF AMERICA and the **STATE OF TENNESSEE**

Plaintiffs, ex rel.

JULIE ADAMS, M.D., STEPHEN ADAMS, M.D., and **SCOTT STEINMANN, M.D.**

Plaintiffs-Relators,

v.

CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY (d/b/a Erlanger Medical Center and Erlanger Health System), UT-ERLANGER MEDICAL GROUP, INC., THE PLASTIC SURGERY GROUP, UNIVERSITY SURGICAL ASSOCIATES, P.C., and **ANESTHESIOLOGY CONSULTANTS EXCHANGE, P.C.,**

Defendants.

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1. "No man can serve two masters."[1] Despite this age-old proscription, Defendant Chattanooga-Hamilton County Hospital Authority (d/b/a Erlanger Medical Center and Erlanger Health System) ("Erlanger"), together with Defendants UT-Erlanger Medical Group, The Plastic Surgery Group, University Surgical Associates, P.C., and Anesthesiology Consultants Exchange, P.C., have allowed surgeons to operate on as many as three patients at the very same time, leaving residents and interns alone with anesthetized patients without appropriate medical back-up or supervision. To maximize profits, Defendants have knowingly violated state and federal laws designed to protect patients and ensure the integrity of the bills Defendants seek to have the government pay. Further, Defendants did not disclose these practices to patients, in violation of the most fundamental rules of informed consent.

2. When Plaintiffs-Relators, among others, raised concerns about patient safety and compliance, the leadership of Erlanger deliberately turned a blind eye to the problems, deciding, instead, to focus negative attention upon those who dared to raise such issues. The Plaintiffs-Relators have been told to be quiet, shunned for even raising compliance problems, threatened and – when they persisted – punished, losing compensation, stature, and, ultimately, their jobs because they were – in the view of Erlanger's leadership – a "threat to the enterprise."

3. The Plaintiffs-Relators in this case, Doctors Stephen Adams, Julie Adams, and Scott Steinmann, are three highly respected senior physicians, including Erlanger's Chief Information Officer. This complaint is based on their personal experiences taking care of patients in the medical center, their review of records, and their insight into Erlanger's policies and practices.

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[1] Matthew 6:24.

4. Though Defendants' derelictions involved countless patients, this Complaint, brought under the federal False Claims Act and Tennessee Medicaid False Claims Act (collectively, "FCA"), is about those surgeries and procedures involving patients whose treatments were financed with Medicare and Medicaid dollars. Despite their knowledge that compliance with billing rules governing informed consent, overlapping surgeries, anesthesia, and recordkeeping is material to the receipt of those dollars – and even after Plaintiffs-Relators apprised them of the problems – Defendants billed the government payors and kept the money.

5. The surgeries were often scheduled to start within fifteen to thirty minutes of one another and, in the case of three overlapping bookings, two or more surgeries frequently occurred entirely within the duration of a third. This routine practice meant unwitting patients were subjected to longer-than-necessary operating-room times and charges, often under anesthesia, often in the care of trainees, and nearly always without the backup of a properly qualified surgeon, despite legal requirements.

6. Operating room records – the *sine qua non* of a submission for payment to federal and state payors – were laden with half-truths, omissions of critical qualifying information, and flat out lies. For example, teaching surgeons regularly attested to being present for the entire surgery for each of two surgeries occurring simultaneously. In instances where three surgeries occurred at the same time, as to which regulations relegate the teaching surgeon to a hospital supervisory role that may not be billed, surgeons nonetheless billed for services as the teaching physician.

7. As Defendants were well aware, these derelictions and others violate standards established as conditions of payment by the federal government and the State of Tennessee, including Medicare and Medicaid.

8. Seeking to redress the foregoing violations, Plaintiff-Relators bring this *qui tam* action on behalf of the United States and the State of Tennessee, alleging federal and state FCA violations arising from surgical services and procedures provided to patients at Erlanger in violation of the rules and regulations of publicly funded insurance plans, including Medicare, Medicaid, TRICARE, and state employee health care plans (collectively "government payors" or "government health plans").

9. Doctors J. Adams, S. Adams, and Steinmann also bring this action as Plaintiffs seeking redress for the malicious and unlawful campaign of retaliation they have endured and for the consequent damages, under statute and at common law, they have suffered and continue to suffer. Their complaints relating to the Defendants' non-compliance certainly constitute protected conduct for which, as set forth below, they were punished. The punishment meted out stood in violation of the FCA's anti-retaliation provisions. Additionally, the Defendants' misconduct gives rise to state law claims sounding in contract and tort.

I. INTRODUCTION

10. The Centers for Medicare & Medicaid Services ("CMS") and Tennessee Medicaid, called TennCare, provide that a teaching physician must be present for the critical or key elements of each surgery. As the legislative history shows, CMS's predecessor, the Health Care Finance Administration ("HCFA"), expressly enacted the operative regulations after it "learned that some teaching physicians [were] billing Medicare and receiving Part B payment for services even when the service [wa]s performed by an intern or resident outside the presence of the teaching physician and the teaching physician ha[d] minimal involvement, or no

involvement, in the service."[2]

11. CMS will not pay for overlapping surgeries where the key or critical elements of each surgery take place at the same time. Under the regulations, a teaching physician may leave the first surgery ***only*** after the key or critical elements have been completed (residents may finish the non-critical parts).[3]

12. But if the teaching physician leaves the first surgery to begin a second, CMS requires him/her to have arranged for ***another qualified surgeon to be immediately available to assist the resident in the first case should the need arise***.[4]

13. Moreover, the services performed by interns and residents are already reimbursed under Medicare Part A. Because interns and residents are not fully accredited surgeons, CMS does not reimburse for surgical procedures performed by interns and residents without appropriate supervision. 42 C.F.R. § 415.170(b). Such supervision is a condition of payment. *See id.* ("Conditions for payment on a fee schedule basis for physician services in a teaching setting.").

14. In the case of three overlapping surgical procedures, CMS does not allow the surgeon to bill for professional fees at all. When a claim is paid for a teaching physician under a physician fee schedule and the teaching physician is not present or otherwise fails to comply with the billing requirements, CMS has paid for a service that was simply never provided.

15. For at least the last ten years, Defendants – in conspiracy with surgeons and

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[2] 60 F.R. 63124, at 63142 (HCFA Dec. 8, 1995) (available at https://www.govinfo.gov/content/pkg/FR-1995-12-08/html/X95-11208.htm (accessed Apr. 14, 2021)).

[3] CMS Manual System, Pub 100-04 Medicare Claims Processing (Transmittal 2303) (Sept. 14, 2011) (hereafter "2011 Manual") at 100.1.2.A (available at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2303CP.pdf, (accessed Apr. 2, 2021)).

[4] *Id.* (emphasis added).

others working in multiple departments at Erlanger – caused the submission of false claims for reimbursement to government payors in violation of the federal False Claims Act and the Tennessee Medicaid False Claims Act.[5] Specifically, Defendants billed or caused others to bill public payors for overlapping surgeries that did not conform in material respects to Medicare and Medicaid rules and regulations designed, *inter alia*, to protect patient safety and ensure that Medicare and Medicaid do not pay for services that are unapproved or not performed in compliance with applicable regulations. These violations caused improper billing of Medicaid and Medicare for surgeries in which:

- the patient's surgeon – the teaching physician – scheduled procedures for two other patients such that all three operations occurred, at least in part, at the same time;
- the teaching physician was not present during the "key and critical" portions of the surgery;
- the teaching physician was not present for ***any*** portion of the surgery, leaving the resident to complete the procedure without any attending present;
- the patient was left alone with the resident during surgery at times when his/her surgeon was involved in another surgery *and* no other qualified teaching physician was made immediately available to assist if needed or in time of emergency;
- the patient was administered anesthesia that was not medically reasonable or necessary while waiting – sometimes for an hour or more – for his/her surgeon – the teaching physician – to conclude work in another surgery and scrub in;
- the patient did not give valid informed consent to the overlapping surgery because Erlanger's written informed consent documents failed to mention that the surgeon would be involved in another surgery at the same time; and/or
- the surgeon failed to document overlapping surgeries appropriately or recorded that he was present for one or both entire cases when this was false.

16. To illustrate the extent of overlap of relevant surgeries, the following are

[5] 31 U.S.C. § 3729 *et seq.*; Tenn. Code Ann. § 71-5-181, *et. seq.*

graphical representations,[6] provided by Plaintiffs-Relators, of the timing and duration of some of the procedures carried out by surgeons at Erlanger:

17. Virtually every overlapping surgery Defendants have billed to Medicare and Medicaid is compromised by one or more of the violations detailed above. This is due in large part to Erlanger's profit-driven policies and practices, which effectively ensure that such derelictions occur, including, but not limited to:

- encouraging and/or failing to discipline teaching physicians who bill government payors when they engage in three overlapping surgeries;
- in cases of two overlapping surgeries, encouraging and/or failing to discipline teaching physicians who are not present during the key and critical parts of one or both surgeries or readily available when residents are performing the surgeries;
- failing to require that another teaching physician be designated to be available to assist when patients are left alone with a resident during overlapping surgeries;
- designing patient consent forms that conceal facts regarding the surgeon's decision to conduct two or more surgeries at the same time;
- encouraging, ignoring, and/or failing to audit patient charts for teaching physicians' false attestations used to support false billing statements;
- ignoring, marginalizing, retaliating against or attempting to force out physicians, including Plaintiffs-Relators, who complained about Erlanger's practice of double- or triple-booking, including patient harm caused by such practices; and
- suppressing an internal investigation conducted by Erlanger about the above unlawful practices.

18. These intentional and systemic acts and omissions continue to cause Defendants

[6] Section V.A.1, *infra*, contains a chart detailing these non-compliant cases and dozens of others.

to routinely submit false claims for payment for surgeries and unreasonable and unnecessary anesthesia services to government payors, which pay for a significant proportion of surgeries at Erlanger annually.

19. Further, Defendants know that they have been overpaid by Medicare and Medicaid in connection with these unlawful requests for payment but have not taken the appropriate steps to satisfy obligations owed to government payors.

20. Had federal, state, and other government-sponsored health care programs known that Erlanger's surgical procedures, as outlined above, were not eligible for reimbursement, they would not have reimbursed Defendants for such procedures. Governing regulations forbid such reimbursement, and the legislative history, past prosecutions, and guidance from the Office of the Inspector General ("OIG") underscore the significance of these regulations and the importance of compliance.

II. PARTIES

21. Plaintiff-Relator **Stephen Adams, M.D.**, is a citizen of the State of Tennessee, where he is licensed to practice medicine. He is a Cum Laude graduate of the University of Tennessee Chattanooga and a graduate of the University of Tennessee Health Sciences Center College of Medicine ("UTCOM").[7] He completed a Family Medicine residency at the University of Alabama. Dr. Adams is board-certified in both Family Medicine and Medical Informatics and is an appointed Professor in the Department of Family Medicine, UTCOM in Chattanooga. He has authored or co-authored numerous book chapters and academic peer reviewed articles and

[7] There are several distinct UTCOM-related entities, including the UT Health Sciences Center, of which UTCOM is a division, as well as the Chattanooga unit of UTCOM, which has its main campus at Erlanger's Baroness Hospital. For purposes of this Complaint, all such entities are referred to collectively as UTCOM.

has reviewed and edited manuscripts for multiple prestigious academic medical journals. In 1997, Dr. Adams became a Clinical Instructor at the Department of Family Medicine, UTCOM and has subsequently advanced to the rank of Professor of Family Medicine. He served as the Family Medicine Residency Program Director (2007- 2014). He has served on countless Erlanger and UTCOM committees. In 2014 he became the Chief Medical Informatics Officer at Erlanger, and since June 2020 he has held the position of Chief Information Officer at Erlanger.

22. Plaintiff-Relator **Julie Adams, M.D.**, is a citizen of the State of Tennessee and is licensed to practice medicine in Tennessee and Minnesota. She is a Summa Cum Laude graduate of Clemson University and a graduate of the University of Alabama School of Medicine. Between 2002 and 2008, Dr. Adams completed an orthopedic surgery residency at the Mayo Clinic and, subsequently, a hand and upper-extremity fellowship in Philadelphia. She is a board-certified orthopedic surgeon with a subspecialty certification in hand surgery. She currently serves on the Board of Directors for the American Association of Hand Surgeons, is the President of the Hand Surgery Endowment, and is an active member of multiple national orthopedic and hand surgery professional organizations. She serves as the Chair of the Ethics and Professionalism Committee for the American Society for Surgery of the Hand and has chaired multiple national hand or orthopedic surgery conferences. Dr. Adams practiced at the University of Minnesota Department of Orthopedics from 2008 to 2014, and served as that department's Compliance and Risk Management Officer; she subsequently practiced at the Mayo Clinic from 2014 to 2019 where she achieved the rank of Professor of Orthopedic Surgery. Dr. Adams is the author or co-author of more than 100 book chapters and peer-reviewed academic articles. In 2019, Dr. Adams and her husband, Dr. Steinmann, were recruited to join the faculty at UTCOM and to come to Erlanger. In July 2019, she entered a contract with Erlanger to become an

orthopedic surgeon and another with UTCOM to be a Professor of Orthopedic Surgery.

23. Relator **Scott Steinmann, M.D.**, is a citizen of the State of Tennessee and is licensed to practice medicine in Tennessee and Minnesota. He is a graduate of Columbia University and Cornell University Medical College. He completed an orthopedic surgery residency at Columbia University, a shoulder and elbow fellowship at Columbia University, and a hand surgery fellowship at Mayo Clinic. He is a board-certified orthopedic surgeon with a subspecialty certification in hand surgery. Dr. Steinmann served in the United States Navy as Chief Medical Officer on the U.S.S. Milwaukee and was attending orthopedic surgeon and director of upper extremity surgery at the United States National Naval Medical Center in Bethesda, Maryland, now known as Walter Reed National Military Medical Center. After serving in the U.S. Navy, Dr. Steinmann practiced at the Mayo Clinic from 1999 to 2019, where he achieved the position of Professor of Orthopedic Surgery. He is now Emeritus Professor of Orthopedics at the Mayo Clinic College of Medicine. Dr. Steinmann has served or presently serves as a member of numerous national orthopedic professional organizations and is the author or co-author of more than 300 published works, including books, book chapters, and peer-reviewed academic articles. In 2019, Dr. Steinmann and his wife, Dr. J. Adams, were recruited to join the faculty at UTCOM and he was also recruited to serve as the Chair of the UTCOM Department of Orthopedic Surgery. He entered into contracts with both Erlanger and UTCOM for these positions. The terms of the contract were – along with salary guarantees at both institutions – three years as to Erlanger and five years as to his position as Chair at UTCOM.

24. Defendant **Chattanooga-Hamilton County Hospital Authority (d/b/a Erlanger Medical Center and Erlanger Health System)** is a non-profit corporation affiliated with UTCOM. Its purported mission is "to compassionately care for people." Erlanger includes seven

hospitals and emergency rooms, eight Express Care locations, three community health centers, and numerous physician practices ranging from family medicine to specialty care in Tennessee, Georgia, and North Carolina. Erlanger touts itself as a "nationally-acclaimed, multi-hospital health system" that delivers "the highest quality, to diverse populations, at the lowest cost, through personalized patient experiences across all patient access points."[8] Erlanger Baroness Hospital, located at 975 East 3rd Street, Chattanooga, Tennessee, serves as Erlanger's headquarters and is the primary UTCOM campus in Chattanooga.[9] It is the region's only academic teaching hospital as well as the only "Level 1" trauma center for patients from 50 counties.[10] Annually, more than "600,000 people are treated by the team of [Erlanger] healthcare professionals" and about 150 residents and fellows participate in graduate-level medical training.[11] Erlanger is the nation's tenth largest public health system and is "increasingly recognized as one of the most influential."[12] For years, Erlanger has presented itself as an exceptional academic and healthcare institution, one that is trusted and relied upon by many hundreds of thousands of patients residing across a significant geographic region. Notwithstanding its noble marketing spin, however, Erlanger paid a $40 million settlement in 2005 to resolve allegations of government billing fraud leveled by DOJ and the State of Tennessee.[13]

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[8] *See* https://www.Erlanger.org/about-us/about-us (accessed March 29, 2021).

[9] *Id.*

[10] *Id.*

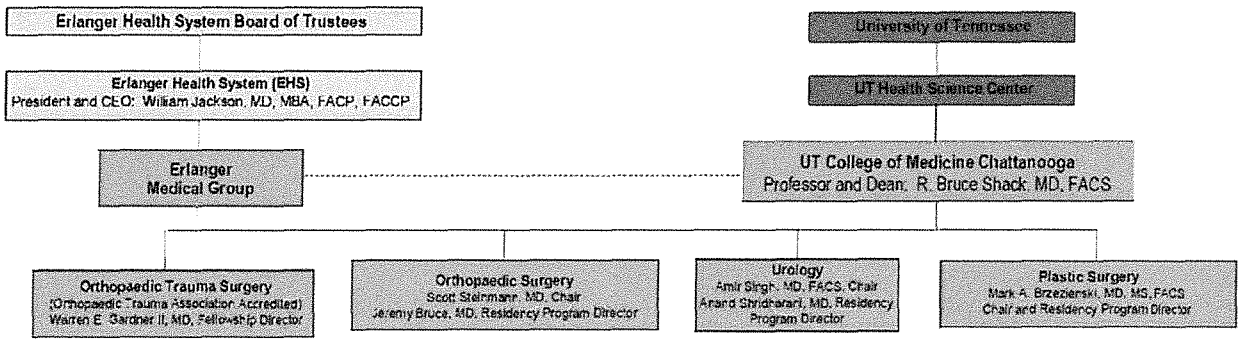
[11] *Id.*; *see also* https://www.Erlanger.org/about-us/a-teaching-hospital/residencies-and-fellowships (accessed Apr. 5, 2021).

[12] *See* http://landing.Erlanger.org/annual-report/ (accessed Apr. 5, 2021).

[13] *See* https://www.chattanoogan.com/2005/10/24/74681/Erlanger-Agrees-To-Pay-40-Million-On.aspx (accessed Apr. 6, 2021).

25. Defendant **UT-Erlanger Medical Group, Inc.** (a/k/a/ Erlanger Medical Group or "EMG") was a Tennessee nonprofit corporation with its principal address at 975 East 3rd Street, Chattanooga, Tennessee. It was a physician group and the professional home of many of the surgeons and medical leadership staff implicated in this complaint. Although it was officially dissolved and terminated on September 17, 2020, it remains active as a leadership and administrative entity at Erlanger to this day. On the Erlanger website, EMG is touted as "Tennessee's fastest growing physician practice" with a physician "who's right for you, near you."[14]

26. Below is a flow chart depicting the relationships among Erlanger leadership, Erlanger's surgical departments, and the University of Tennessee:



27. Defendant **The Plastic Surgery Group** ("PSG") is a Tennessee limited liability company with its principal address at 901 Riverfront Parkway, Suite 100, Chattanooga, Tennessee. Founded in 1958, PSG claims to be Chattanooga's largest plastic surgery practice and a nationally recognized innovator in cosmetic, plastic, and reconstructive surgery.[15] Relevant

[14] Because EMG's identity and staff are subsumed within Erlanger, it is generally referred to as Erlanger throughout this Complaint.

[15] *See* https://www.refinedlooks.com/our-practice (accessed Apr. 5, 2021).

here, physicians at PSG practice medicine at and are paid by Erlanger, but some of the bills for their professional services, including those submitted to Medicare, are administered by PSG.

28. Defendant **University Surgical Associates, P.C.** ("USA") is a Tennessee corporation located at 979 East 3rd Street, Suite C-300, Chattanooga, Tennessee. Its physicians have admitting and surgical privileges at Erlanger Health System, among other medical facilities.

29. Defendant **Anesthesiology Consultants Exchange, P.C.** ("ACE") is a Tennessee corporation with its principal address at 979 East 3rd Street, Suite C235, Chattanooga, Tennessee. ACE is the sole provider of anesthesia services at Erlanger in Chattanooga. On its website, ACE states "[e]xcellence in anesthesia is our goal" and that its team approach allows its anesthesia providers to "individualize your anesthesia management while maintaining a consistently high quality of care throughout your surgical experience."[16] At the Erlanger Baroness campus, ACE provides anesthesia services for "acute trauma, neurosurgery, cardiovascular, orthopedic, urologic and general surgery specialties in 21 operating suites."[17]

30. The names and titles of some individuals responsible for the conduct alleged herein are presented in the chart below.

Name	Title
Chandra Alston	Associate Vice Chancellor for Human Resources, UTCOM
Sheila Boyington	Erlanger Board of Trustees
Jeremy Bruce, M.D.	Orthopedic Surgeon and Orthopedic Residency Program Director, UTCOM Chattanooga
Mark Brzezienski, M.D.	Plastic Surgeon, PSG, Plastic Surgery Chair and Residency Program Director, UTCOM Chattanooga,
R. Phillip Burns, M.D.	Erlanger Board of Trustees; USA surgeon
Floyd Chasse	Sr. VP & Chief Human Resources Officer, Erlanger
Jim Coleman Jr.	Erlanger Board of Trustees
H. Kennedy Conner	Erlanger Board of Trustees

[16] *See* https://aceanesthesia.com/about/ (accessed Apr. 5, 2021).

[17] *Id.*

Bryce Cunningham, M.D.	Orthopedic Surgeon
Julie Dean	Former Erlanger Chief Compliance Officer
Mark Freeman, M.D.	Erlanger Orthopedic Medical Director; Head of "Ortho Board"
Warren Gardner, M.D.	Orthopedic Surgeon and Orthopedic Trauma Fellowship Director, UTCOM Chattanooga
John Germ	Erlanger Board of Trustees
Vicky Gregg	Erlanger Board of Trustees
Matthew Higgins, M.D.	Orthopedic Surgeon and Erlanger Chief of Orthopedics
Polly Hofmann	Senior Associate Dean, Faculty Affairs UTCOM
William Jackson, M.D.	Erlanger CEO and former Erlanger Chief Medical Officer
James Kennedy, M.D.	Plastic Surgeon
Dirk Kiner, M.D.	Orthopedic Surgeon
Meridith O'Keefe	Erlanger Senior VP of Physician Services
Linda Moss Mines	Erlanger Board of Trustees
Henry Okafor, M.D.	Urologic Surgeon
Karen Percent	Director Erlanger Audit Services
Olivia Ralph	UTCOM Senior Compliance Officer, Investigations/EEO/Title IX
Jason Rehm, M.D.	Plastic Surgeon, PSG
James Sattler	Erlanger Board of Trustees
Steve Schwab, M.D.	Chancellor, UTCOM
R. Bruce Shack, M.D.	Dean of UTCOM Chattanooga
Amar Singh, M.D.	Urologic Surgeon and Chair of Urology, UTCOM Chattanooga
Scott Strome, M.D.	Executive Dean, UTCOM
Alana Sullivan	Former Erlanger Chief Compliance Officer
J. Britton Tabor	Erlanger Executive Vice President and CFO/Treasurer
Benjamin Waldorf, M.D.	Urologic Surgeon
Gerald Webb II	Erlanger Board of Trustees
Jeffrey Woodard	Erlanger Chief Legal Officer
Christopher Young, M.D.	Anesthesiologist, Erlanger Chief of Staff, Erlanger Board of Trustees

31. On information and belief, other Erlanger surgeons and personnel have been involved in improper overlapping surgeries and other violations and will be identified through discovery.

III. JURISDICTION AND VENUE

32. Plaintiffs-Relators bring this action on behalf of themselves and the United States for violations of the False Claims Act, 31 U.S.C. §§ 3729-3733, and on behalf of the State of

Tennessee, pursuant to Tenn. Code Ann. § 71-5-181 *et seq*.

33. This Court has federal subject matter jurisdiction over this action pursuant to 28 U.S.C. § 1331 and 31 U.S.C. § 3732 and supplemental jurisdiction over the Tennessee state claims pursuant to 28 U.S.C. § 1367 and 31 U.S.C. § 3732.

34. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because Defendants can be found in and transact business in this District. In addition, the acts prohibited by 31 U.S.C. § 3729 and 31 U.S.C. § 3730(h) occurred in this District. 31 U.S.C. § 3732(a).

35. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) because Defendants transact business in this District and numerous acts proscribed by 31 U.S.C. § 3729 and 31 U.S.C. § 3730(h) occurred in this District.

36. Plaintiffs-Relators' claims and this Complaint are not based upon prior public disclosures of allegations or transactions in a federal criminal, civil, or administrative hearing in which the Government is already a party, or in a congressional, Government Accountability Office, or other federal report, hearing, audit, or investigation, or from the news media, as enumerated in 31 U.S.C. § 3730(c)(4)(A).

37. To the extent that there has been a public disclosure unknown to the Plaintiffs-Relators, the Plaintiffs-Relators are the "original source" under 31 U.S.C. § 3730(e)(4)(B). The Plaintiffs-Relators have material independent knowledge of the information on which the allegations are based and voluntarily provided that information to the Government before filing this *qui tam* action. *Id.*

IV. STATUTORY AND REGULATORY PROVISIONS APPLICABLE TO DEFENDANTS' FALSE CLAIMS

A. GOVERNMENT HEALTH CARE PROGRAMS

38. The federal and state governments, through Medicare and Medicaid, including TennCare, are among the principal payors responsible for reimbursing Defendants for surgical services. Medicare is a federal government health program that primarily benefits the elderly and the disabled. It was created by Congress in 1965 when it adopted Title XVIII of the Social Security Act. Medicare is administered by CMS, which is an agency of the U.S. Department of Health and Human Services ("HHS").

39. Medicare Part A covers the cost of inpatient hospital services, post-hospital skilled nursing facility care, and medical insurance. Medicare Part B covers the cost of the physician's services such as services to patients who are hospitalized, if the services are medically necessary and personally provided by the physician or, in the case of teaching hospitals, supervised by a teaching physician where strict requirements are satisfied.

40. CMS establishes rules for the day-to-day administration of Medicare. CMS contracts with private companies to handle day-to-day administration of Medicare.

41. CMS, through contractors, maintains and distributes fee schedules for the payment of physician services. These schedules specify the amounts payable for defined types of medical services and procedures.

42. Hospitals generally are reimbursed under Medicare Part A on a reasonable cost basis for services provided to Medicare beneficiaries. Resident salaries are included among the costs for which hospitals are reimbursed under Part A; thus, services provided by residents typically cannot be billed under Medicare Part B.

43. As a UTCOM-affiliated teaching hospital engaged in the training of residents,

Erlanger is eligible to be reimbursed for the teaching activities of clinical faculty physicians (also referred to herein as "teaching physicians"). Under specified circumstances, teaching hospitals may also properly bill under Medicare Part B for any medical services provided by teaching physicians when a resident is involved in those medical services.

44. Congress created Medicaid at the same time it created Medicare in 1965 by adding Title XIX to the Social Security Act. Medicaid is a public assistance program that provides payment of medical expenses primarily for low-income patients. Funding for Medicaid is shared between the federal and state governments. The federal government also separately matches certain state expenses incurred in administering the Medicaid program. While specific Medicaid coverage guidelines vary from state to state, Medicaid's coverage is generally modeled after Medicare's coverage. According to CMS, "[w]hen services are furnished through institutions that must be certified for Medicare, the institutional standards must be met for Medicaid as well."[18]

45. The Federal Employees Health Benefits Program ("FEHBP") provides health insurance coverage for more than 8 million federal employees and retirees and their dependents. FEHBP is a collection of individual health care plans, including Blue Cross and Blue Shield plans, Government Employees Hospital Association, and Rural Carrier Benefit Plan. FEHBP plans are managed by the U.S. Office of Personnel Management.

46. TRICARE is a federal program that provides civilian health benefits for military personnel, certain military retirees, and their families. TRICARE is administered by the Department of Defense and funded by the federal government.

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[18] *See* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/index.html?redirect=/certificationandcomplianc/02_ascs.asp (accessed Apr. 2, 2021).

47. At all relevant times to the Complaint, applicable Medicaid and TRICARE regulations relating to coverage of claims by providers and physicians have been substantially similar in all material respects to the applicable Medicare provisions described above. Medicare, Medicaid, TRICARE, FEHBP and other similar federal and state medical insurance programs are referred to collectively herein as "government payors."

B. MEDICARE AND MEDICAID REIMBURSEMENT RULES AND CERTIFICATIONS

48. To participate in the Medicare Program, hospitals enter "provider agreements" with the Secretary of Health and Human Services ("HHS"). *See* 42 U.S.C. § 1395cc. The Medicare Program pays the hospital directly for covered inpatient and outpatient services provided to Medicare beneficiaries except for any deductibles or coinsurance, which are collected from the beneficiaries. *Id.*

49. When submitting claims for reimbursement to Medicare, the provider is required to certify on CMS Form 1500, *inter alia*, that: 1) the information on the form is true, accurate and complete; 2) sufficient information is provided to allow the government to make an informed eligibility and payment decision; 3) the claim complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment; and 4) the services on this form were medically necessary.[19] The form further requires the provider to certify that the services on the form were "personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE." *Id.*

[19] CMS Form 1500 (available at: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/Downloads/CMS1500.pdf (accessed Apr. 2, 2021)).

1. *Medicare's Payment for Services of Attending Physician Surgeons in a Teaching Setting*

50. As explained above, in a teaching setting like that at Erlanger, in order to receive payment under Medicare Part B for services performed by a physician, the service must meet one of the following criteria: (a) the services are personally furnished by a physician who is not a resident or (b) the services are furnished by a resident in the presence of a fully licensed teaching physician. 42 C.F.R. § 415.170.

51. If a resident participates in a service furnished in a teaching setting, the service is eligible for a physician fee schedule payment "*only* if a teaching physician is present during the key portion of any service or procedure for which payment is sought." 42 C.F.R. § 415.172(a) (emphasis added). This provision is a specific application of § 415.170. *See* 42 C.F.R. §§ 415.170(b) (services by a resident are not billable under Medicare Part B unless furnished in the presence of a teaching physician "except as provided in § 415.172").

52. In the case of surgical, high-risk, or other complex procedures – such as all the procedures at issue in this Complaint – the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. 42 C.F.R. § 415.172(a)(1).

53. If a teaching physician engages in two surgeries that overlap, the CMS Medicare Claims Processing Manual states, ***"[t]he critical or key portions may not take place at the same time***. When ***all*** of the key portions of the initial procedure have been completed, the teaching surgeon may begin to become involved in a second procedure." 2011 Manual, at 100.1.2.A.2 (emphasis added).

54. Significantly, when a teaching physician "is not present during non-critical or non-key portions of the procedure and is participating in another surgical procedure, he/she ***must***

arrange for another qualified surgeon to immediately assist the resident in the other case should the need arise." *Id.* (emphasis added).[20]

55. Finally, "[i]n the case of ***three concurrent surgical procedures***, the role of the teaching surgeon . . . in each of the cases is classified as a supervisory service to the hospital rather than a physician service to an individual patient and ***is not payable under the physician fee schedule***." *Id.* (emphasis added). The teaching physician may not submit a claim for reimbursement under his/her name in such circumstances.

56. As the Senate Finance Committee Report, *Concurrent and Overlapping Surgeries: Additional Measures Warranted* (Dec. 6, 2016), notes, the American College of Surgeons ("ACS") confirmed and clarified CMS's guidelines in its own clinical guidelines in April 2016.[21] *Id.* at 4-5. As the Report notes, the ACS guidelines reflect what is necessary for patient safety. *Id.* Other surgical societies and organizations have also made public statements concerning overlapping surgeries and condemning the type of conduct alleged in this Complaint.[22]

57. Moreover, CMS policy expressly limits payment to services for which there is documentation demonstrating the appropriate level of services required by the patient. *See* Medicare Carriers Manual, Part 3 CMS Pub. 14-3 (Rev. 1780); 42 C.F.R. § 415.172 *et seq.*; *see*

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[20] CMS regulations require participating hospitals to "assure that personnel are licensed or meet other applicable standards that are required by State or local laws." 42 C.F.R. § 482.11(c) (Condition of participation; Compliance with Federal, state, and local laws).

[21] *See* https://www.facs.org/about-acs/statements/stonprin (accessed Apr. 1, 2021).

[22] *See, e.g.*, https://www.plasticsurgery.org/Documents/Health-Policy/Positions/ASPS-Statement_Concurrent-Surgery.pdf (accessed Apr. 8, 2021); https://www.healio.com/news/orthopedics/20160607/concurrent-surgery-defining-and-implementing-a-safe-practice (accessed Apr. 8, 2021); https://www.aans.org/pdf/Legislative/Neurosurgery%20Position%20Statement%20on%20Overlapping%20Surgery%20FINAL.pdf (accessed Apr. 8, 2021).

also 60 Fed. Reg. 63124-01, 1995 WL 723389 (HHS Dec. 8, 1995).

58. When a teaching physician seeks reimbursement for a service involving a resident in the care of his/her patients "it must be identified as such on the claim" and is not payable unless it complies with the Claims Processing Manual. 2011 Manual, at 100.1.8.B. In addition, "the teaching surgeon must personally document in the medical record that he/she was physically present during the critical or key portion(s) of both procedures." 42 C.F.R. § 415.172; *see also* 2011 Manual, at 100.1.2.A.2.

59. In sum, the teaching physician must appropriately document his/her involvement in the surgery when the resident performs elements of the surgery in the presence of, or jointly with, the teaching physician. The documentation must include sufficient information about the work performed during key portions of both procedures in the notes.

60. Medicare and Medicaid also require providers to make restitution when overpayments are identified unless the provider is without fault. *See* 42 U.S.C. § 1320a-7b(a)(3); *see also* 42 C.F.R. 405.350 *et seq.*; 42 C.F.R. § 489.20(b); OIG Compliance Guidance for Hospitals, 63 Fed. Reg. 8987, 8998 (HHS Feb. 23, 1998).

2. *Medicare Reimbursement Rules Pertaining to Reimbursement for Anesthesia*

61. Medicare reimburses anesthesia practitioners for the period of time during which they are "present with the patient." Medicare Claims Processing Manual, at 50 (Rev. 3583, 08-12-16). Specifically, the billing period or "anesthesia time" begins "when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the anesthesia practitioner is no longer furnishing anesthesia to the patient, that is, when the patient may be placed safely under postoperative care." *Id.* Furthermore, anesthesia time is a "continuous" time block; the actual amount of time spent with

the patient must be "reported on the claim" for payment. *Id.* For computing payment, anesthesia time is divided into 15-minute increments and rounded up to one decimal place. *Id.*

62. Administering anesthesia to patients while they wait for extended periods for their surgeon to scrub in from another surgery that was intentionally scheduled and conducted at the same time is not reimbursable. This is because "no payment may be made [under the Medicare statute] for any expenses incurred for items or services which … are not *reasonable and necessary* for the diagnosis or treatment of illness or injury to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A) (emphasis added).

63. It is not reasonable or necessary – indeed, it is dangerous – to place patients under anesthesia without medical justification.

3. *Medicare and Medicaid Reimbursement Rules Pertaining to Informed Consent*

64. Ensuring that Medicare and Medicaid patients have given adequate informed consent prior to medical procedures is a condition of participation in the Medicare program. *See generally* 42 C.F.R. § 482.13 (Condition of participation: Patient's rights). Obtaining proper informed consent is *also* a condition of payment. Specifically, the CMS State Operations Manual states that "[h]ospitals are required to be in compliance with the federal requirements set forth in the Medicare Conditions of Participation (COP) *in order to receive Medicare/Medicaid payment*." CMS – State Operations Manual – Regulations and Interpretive Guidelines for Hospitals (Rev. 151; 11-20-15) (emphasis added).

65. Among other requirements, CMS's COPs include numerous informed consent rules designed to protect Medicare and Medicaid patients. For example, patients must be involved, *inter alia*, in their own plan of care and be offered the ability to refuse treatment. 42 C.F.R. § 482.13(b)(1) & (2). Medicare and Medicaid patients also have the "right to receive care

in a safe setting." 42 C.F.R. § 482.13(c)(2). A "properly executed" informed consent form must be included in each patient's chart prior to surgery. 42 C.F.R. § 482.51(b)(2) (Condition of participation: Surgical services); *see also* 42 C.F.R. § 482.24(c)(2)(B)(v) (Condition of participation: Medical record services).

66. CMS's adoption of interpretive guidelines for informed consent highlights the importance of compliance and the centrality of appropriate informed consent to payment under Medicare. CMS's *Hospital Interpretive Guidelines for Informed Consent*, extensively revised in 2007, state that a "well designed consent process" would, among other things, include:[23]

- A description of the proposed surgery, including the anesthesia to be used;
- The indications for the proposed surgery;
- Material risks and benefits for the patient related to the surgery and anesthesia, including the likelihood of each, based on the available clinical evidence, as informed by the responsible practitioner's clinical judgment. Material risks could include risks with a high degree of likelihood but a low degree of severity, as well as those with a very low degree of likelihood but high degree of severity;
- Treatment alternatives, including the attendant material risks and benefits;
- The probable consequences of declining recommended or alternative therapies;
- Who will conduct the surgical intervention and administer the anesthesia;
- Whether physicians other than the operating practitioner, including but not limited to residents, will be performing important tasks related to the surgery, in accordance with the hospital's policies. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue,

[23] CMS "Revisions to the Hospital Interpretive Guidelines for Informed Consent" (Apr. 13, 2007) (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-17.pdf (accessed Apr. 2, 2021).

administering anesthesia, implanting devices, and placing invasive lines;

67. For surgeries in which residents will perform important parts of the surgery, discussion is encouraged to include the following:

- That it is anticipated that physicians who are in approved post-graduate residency training programs will perform portions of the surgery, based on their availability and level of competence;
- That it will be decided at the time of the surgery which residents will participate and their manner of participation, and that this will depend on the availability of residents with the necessary competence; the knowledge the operating practitioner/teaching surgeon has of the resident's skill set; and the patient's condition; and
- ***Whether, based on the resident's level of competence, the teaching physician will not be physically present in the same operating room for some or all of the surgical tasks performed by residents***.

Id. (emphasis added).

4. *TennCare's Reimbursement Policies*

68. At all relevant times to the Complaint, applicable TennCare regulations relating to coverage of claims by providers and physicians have been substantially similar in all material respects to the applicable Medicare provisions described above.

C. THE FALSE CLAIMS ACT AND THE TENNESSEE MEDICAID FALSE CLAIMS ACT

69. The federal False Claims Act provides, *inter alia*, that any person who (1) knowingly presents or causes another to present a false or fraudulent claim for payment or approval; (2) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; or (3) conspires to violate the False Claims Act is liable

for a civil penalty of not less than $11,803 and not more than $23,607[24] for each such claim, plus three times the amount of damages sustained by the government. 31 U.S.C. §§ 3729(a)(1)(A), (B), & (C). The Tennessee Medicaid False Claims Act is substantially the same. Tenn. Code Ann. §§ 71-5-182(a)(1)(A), (B), & (C).

70. These statutes also both contain a "reverse false claims" provision, which holds liable persons or entities for knowingly retaining overpayments from the government. 31 U.S.C. § 3729(a)(1)(G); Tenn. Code Ann. § 71-5-182(a)(1)(D).

71. In addition, both statutes prohibit employers from discriminating against an employee's terms and conditions of employment because of lawful acts done by the employee in furtherance of an *qui tam* action. 31 U.S.C. § 3730(h); Tenn. Code Ann. § 71-5-183(g).

V. SPECIFIC ALLEGATIONS OF DEFENDANTS' FALSE CLAIMS

72. Plaintiffs-Relators were dismayed to discover during their employment at Erlanger that Defendants flouted many established professional standards for patient safety and privacy.

A. FALSE CLAIMS FOR THREE CONCURRENT SURGERIES OR FOR TWO SURGERIES CONDUCTED WITHOUT ADEQUATE RESIDENT SUPERVISION

73. Particularly troubling was Defendants' routine practice of allowing teaching surgeons to book and conduct multiple surgeries at roughly the same time without adequate supervision over the participating residents. In addition to unnecessarily placing patients at greater risk of complications, these surgeries violated Medicare and Medicaid rules on billing for the services of a teaching physician under Medicare Part B.

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[24] As adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. § 2461; *see also* 86 F.R. 6, at 1725 (DOJ January 11, 2021) (setting forth 2021 adjustments). https://www.govinfo.gov/content/pkg/FR-2021-01-11/pdf/2020-29024.pdf (accessed Apr. 2, 2021).

1. *Erlanger's Practices Concerning Overlapping Surgeries*

74. Soon after Doctors Steinmann and J. Adams began their work as orthopedic surgeons at Erlanger in October of 2019, they saw that teaching surgeons there and in other departments regularly booked two and sometimes three overlapping surgical cases (also "double booking" and "triple booking") with the same surgeon listed as the lead on each surgery. The practice, as they witnessed it from the start and it largely remains today despite the Plaintiffs-Relators' advocacy, leaves residents in training at Erlanger alone to conduct some or all of a patient's surgery without the guidance of a teaching surgeon, who was often not present at all and, if he appeared, did so not to scrub in and supervise the procedure but just, as one surgeon explained, as a "check in."

75. Further, Plaintiffs-Relators were shocked to find that Erlanger did not require that qualified back-up surgeons be designated to be immediately available to assist residents when their teaching physicians were participating in another surgery. Such designations were rarely, if ever, done. When Plaintiffs-Relators raised a concern about this woeful deficiency, Dr. Christopher Young, Erlanger Chief of Staff and a member of its Board, acknowledged bluntly, "[Erlanger] do[es]n't even comply [with] this back-up thing."

76. Plaintiffs-Relators attempted to address these issues by initiating dialogue within the Erlanger orthopedics department, but they were rebuffed. They then spoke with Dr. William Jackson, Erlanger's CEO, who directed them to talk to Erlanger's compliance department ("Compliance"). It was through these conversations and others that Plaintiffs-Relators learned that the practice of non-compliant overlapping surgeries – including triple-booked ones – is widely accepted at Erlanger, and that the hospital was well aware that residents were left to perform operations unsupervised and without the assurance of a qualified backup attending surgeon who was immediately available to assist if needed.

77. To be clear: there is nothing minor or technical about the violations here. The procedures did not merely overlap at their margins; they were instead scheduled at or about the same time so that the teaching physician could maximize the number of cases performed by him and his residents. In many cases, two or more procedures were scheduled and carried out entirely within the duration of a third case, often resulting in three surgical procedures occurring concurrently.

78. Such scheduling made it not only logistically unlikely but physically unfeasible for the teaching physician to be present for and ready to participate in the key or critical parts for both surgical procedures. The federal regulations, however, specify that a teaching physician will not be paid unless he or she has completed all key or critical components ***and*** has designated another qualified surgeon to be immediately available to assist the unsupervised resident should the need arise. 42 C.F.R. § 415.172(a)(1). Because no qualified back-up surgeons were ever designated, virtually every claim submitted by Erlanger for overlapping surgeries to Medicare and TennCare was not payable and was a false claim.

79. Of great concern to Plaintiffs-Relators was the increased risk of adverse outcomes associated with insufficient or nonexistent resident oversight during overlapping surgeries, particularly Medicare patients, *i.e.,* those 65 and older, for whom the risks of surgery are most substantial. These risks were only compounded by the hospital's failure to follow Medicare and Medicaid rules, including those requiring back-up coverage of overlapping surgeries by another qualified teaching physician.

80. Indeed, beginning in early 2020, Dr. J. Adams became aware that a number of her patients experienced post-surgical complications following non-emergent orthopedic trauma surgery "performed" by her colleagues at Erlanger. Reviewing these patients' operative notes in

the ordinary course of treating them, Dr. J. Adams noted that the surgical times were excessively long, sometimes two-to-three times what she expected, and that the procedures were performed and dictated by residents, listing one or two residents without any apparent digital "fingerprint" from the attending teaching physicians, even though the surgeries were listed under their names and were presumably billed as their own.

81. Her observations about patients under her care revealed problems that were in no way unique to orthopedic trauma. Plaintiffs-Relators observed that the plastic surgery department at Erlanger, which operates in part and bills surgeries through Defendant PSG, often determined which patient of their overlapping cases would be operated on by unsupervised residents based on their insurance status. Surgeons dubbed the resident cases "service cases" because the patients generally were insured by government payors or lacked insurance accepted by PSG.

82. Most disturbing to Plaintiffs-Relators was that the teaching surgeons often booked so-called "service cases" or "resident cases" to occur in the "Plaza OR," while they themselves performed surgery in the "Main OR," which is effectively a separate building. That is, Erlanger often specifically and in flagrant violation of the law relegated its poorer patients, those whose care was underwritten by the government, to trainees who were not in fact qualified or credentialed generally to operate independently.

83. Incredibly, through conversation with surgeons and Erlanger leadership, Plaintiffs-Relators learned that these practices were commonplace for some departments at Erlanger. The following is a transcription of a conversation between Dr. Steinmann and orthopedic trauma surgeon Warren Gardner, M.D., on March 3, 2021 (emphasis added):

> Dr. Gardner: We used to have more opportunity for autonomy for residents. Tuesday, Wednesday, Thursday, *we always had a second room so a resident could run the room*. We don't anymore, the only day we potentially have that now is Thursday and then on weekends, sometimes, occasionally.

84. The following is a transcription of a conversation between Dr. Steinmann and orthopedic trauma surgeon Bryce Cunningham, M.D., on March 25, 2021. Dr. Cunningham completed his residency at Erlanger in 2016 (emphasis added):

> Dr. Cunningham: When I was a resident it was three [orthopedic trauma surgeons], and the guy on call had two rooms every day, the next day, and *generally simultaneous rooms.* So the chief [resident] would be sort of doing fractures in one room, one of the three attendings in the other room, and they would be simultaneous. Well, things have changed in the last ten years, in terms of, I don't think the hospital wants – certainly doesn't want concurrent surgery going on, so you'd be talking about a flip room then.

85. In spite of the surgeons' statements, this Complaint demonstrates that Erlanger continues to allow non-compliant overlapping surgery to be performed by these same surgeons to this day. Plaintiffs-Relators found it especially problematic that some teaching surgeons consider the skills of their residents, whom they allow to operate on their patients unsupervised, to be lacking or wholly inadequate. The following is a transcription of a conversation between Dr. Steinmann and orthopedic surgeon Dr. Kiner on March 18, 2021 (emphasis added):

> Dr. Kiner: Something happened a few years ago, and I don't know what it was, but we no longer are getting guys with what I would call "good hands." We're getting some that are fine, we're getting some that are okay.
>
> Dr. Steinmann: Smart, but not good hands?
>
> Dr. Kiner: I mean, they all seem smart, I mean, they know the answer when you ask them a question, sure, but just… Yeah. Starting with [Resident 1]. And since then, there's just been an increasing number per year. I'm moderately scared of the 4th years. [Resident 2] is good, [Resident 2] is fine to good. The other two are terrifying.
>
> . . .
>
> Dr. Steinmann: The reports [are] back from the interview trail from [Resident 3] and it's good. I've spoken with the [inaudible] who he's interviewed with and they've actually called me, texted me, saying 'this guy is the real deal.' . . .
>
> Dr. Kiner: He's well spoken, his hands, scary.
>
> . . .

Dr. Steinmann: Well, [Resident 4] is a little bit scary.

Dr. Kiner: [Resident 3] is scarier. [Resident 3] has *the hands of a pediatric rapist.*

Dr. Steinmann: [Inaudible] Wow.

Dr. Kiner: He's got this spasmodic index finger. You know, he makes an incision and it's just 'OH MY GOD! STOP!' I mean sometimes it's okay, sometimes it's okay, but it's just, just, this uproarious finger [****]ing – 'just STOP! Slow down!'

86. The following is a transcription of a conversation between Dr. Steinmann and Dr. Gardner on March 3, 2021:

> Dr. Gardner: …We've gotten to the point where I feel like the residents, there aren't very many coming through now that I'd feel super comfortable letting [run their own room]. It used to be, you know, out of three, there was certainly two thirds every year that I'd felt very comfortable that, you know, 'you guys, I want you to work on this, I'm going to come in and get started with you, going to leave and go do this and come back – check on you.' I had no qualms doing that, now it's, you know, I'm just trying to scratch my head thinking, you know, who would I do that with anymore. And now I can probably think of four or five residents out of the fifteen whereas it used to be probably most of the residents. So, uh, it's a little discouraging.

87. In addition to lacking any official policy or process for ensuring residents are backed up by an "immediately available" qualified teaching physician during overlapping surgery, Erlanger's policies covering resident operating privileges fall short of CMS's requirements as well. UTCOM/Erlanger GME Policy #405 sets forth the required level of supervision of residents while they are in the operating room. It provides that "Operating / Delivery Room Direct Supervision by Attending Physician Departmental attending must be physically present within the building where the procedure occurs and *immediately available to the resident and patient, for the major components of the procedure*."[25]

88. This policy plainly violates CMS's requirements. Any procedures conducted

[25] *See* https://www.uthsc.edu/comc/gme/documents/chatt-gme-institutional-policies.pdf (accessed 4/1/2021) (emphasis added).

pursuant to this policy for which the teaching physician was not actually present for the key and critical portions (*i.e.*, "the major components") could not lawfully be billed to a government payer.

2. *Examples of Defendants' False Claims*

89. While Doctors J. Adams and Steinmann witnessed – from the time of their arrival forward – the routine practice of allowing surgeons to book and conduct multiple overlapping procedures, Dr. S. Adams, as Erlanger's Chief Information Officer, had already become concerned about Erlanger's persistent non-compliance across several areas. With respect to overlapping surgeries, Erlanger's surgical record data and schedules, accessed by Dr. S. Adams during the ordinary course of his employment, confirmed that numerous surgeons routinely "performed" overlapping or triple-booked surgeries in a manner that all but guaranteed unsupervised residents were left alone with patients in the operating room without any "immediately available" backup. Dr. S. Adams observed that in just four years, from 2017 to the present Defendants allowed 2,239 surgical procedures to start and end entirely within the duration of a second case "performed" by the same teaching physician. An additional 2,064 procedures started prior to the midpoint of a second ongoing case. Approximately half of these cases were falsely billed to Medicare or Medicaid.

90. For example, on December 13, 2017, Patient 1, a Medicare patient, underwent the surgical procedure "open radical nephrectomy with vena caval thrombectomy," which began at 3:53 P.M. and ran for one hour and twenty-nine minutes. Unknown to Patient 1 was that his or her attending surgeon, Amar Singh M.D. of the Urology Department, had scheduled two additional surgeries that afternoon: one beginning around 2:58 P.M, the other beginning at 4:36 P.M. At no point during Patient 1's one-and-a-half-hour procedure was Dr. Singh *not* engaged in another surgery. Further, for fourteen minutes, Patient 1's surgery overlapped with two other

procedures, making *all three cases* not billable to government payors. According to billing records, however, Erlanger did in fact bill and receive payment from government payors for all three cases.

91. Dr. S. Adams reviewed records demonstrating that on the morning of July 27, 2018, Dr. Singh scheduled a total of six procedures, each of which was billed to Medicare or a Medicare/Medicaid contracted insurance provider. These procedures include, beginning at 9:00 a.m., a three-and-a-half-hour partial removal of cystectomy or tumor removal for which Erlanger billed Medicare for both Part A and Part B services (Patient 7). Of the five other procedures, three occurred entirely or almost entirely within the duration of Patient 7's procedure while more than half of each of the other two procedures overlapped with one or more procedures.[26] Only about twenty-five percent of Patient 7's three-and-a-half-hour surgery was carried out *without* the simultaneous occurrence of at least one other procedure. In each instance where Dr. Singh performed key or critical surgical components or supervised a resident who did so, he was not "immediately available" to return to the one or more other patients who were simultaneously undergoing operations in other rooms.[27] Moreover, from 9:00 a.m. to 9:15 a.m., 10:30 a.m. to 11:05 a.m., and 11:49 a.m. to 11:51 a.m., Dr. Singh was the teaching surgeon for three simultaneously occurring operations. In other words, each of the six cases occurred at least in part simultaneously with two other procedures, such that *none* of the surgeries was billable to

[26] In fact, several of Dr. Singh's cases that morning were endoscopic procedures, which require the teaching physician's presence for the "entire viewing" in order to be billed to government payors. *See* 2011 Manual, at 100.1.2.A.5.

[27] One of the six concurrent cases Dr. Singh scheduled on the morning of July 27, 2018 was booked to take place in the Plaza OR while the other five were booked in the Main OR. Even if CMS regulations permitted Dr. Singh to be "readily available" during the critical components of cases, the physical distance between the Plaza and Main OR locations prohibits, in practice, a surgeon from returning from one to the other quickly if the need arises.

Medicare.

92. Despite Dr. Singh's failure to comply with Medicare and Medicaid regulations – including those pertaining to overlapping and triple-booked surgeries, informed consent, and medical necessity – Erlanger submitted claims for Patient 7 and the five other overlapping surgeries to government or government-contracted payors, which ultimately paid the claims. Billing data from Erlanger's data storage systems confirm the submission and payment of all six of the abovementioned surgeries, including those pertaining to Patient 7.

93. Erlanger submitted Part A and Part B claims to Medicare for Patient 7's surgery and related inpatient services. Specifically, Erlanger submitted claims for the primary surgical procedure "partial cystectomy" provided by Dr. Singh occurring on July 27, 2018 in the amounts of $62,491.55 and $4,934.00 for Medicare Part A and Part B, respectively. Claims were sent beginning August 7, 2018 and final payments were received by Erlanger on August 29, 2018 and September 10, 2018 for Medicare Part A and Part B, respectively. Medicare paid $1,373.47 for Part B and $12,376.88 for Part A coverage of the surgery.

94. Dr. S. Adams also observed that, on March 15, 2018, orthopedic surgeon Dirk Kiner, M.D. performed fracture repair surgeries on two separate patients[28] that both began around 10:30 a.m. and lasted for approximately three and four hours. Erlanger billed Medicare for both Part A and Part B services for both procedures, meaning both patients were at least 65 years of age. In short, it was impossible for Dr. Kiner to be immediately available for both surgeries, and without properly supervising the resident or designating a qualified back-up, the likelihood of complications for these elderly patients increased.

[28] One of which is Patient 5 as shown on the chart, *infra*.

95. The following table contains data 2017 to 2020[29] that demonstrate numerous instances of surgeons covering two or more surgeries at once.

Date	Surgeon	Schedule
December 13, 2017 30 	Amar Singh, M.D.	2:58 p.m. – 4:50 p.m. (1:52), BEH Main OR, Veterans Admin, Da Vinci Laparoscopy, Surgical Prostatectomy, Retropubic Radical, w/ Nerve Sparing (10762) 3:53 p.m. – 5:22 p.m. (1:29), BEH Main OR, Medicare Part A/B, Open Radical Nephrectomy with Vena Caval Thrombectomy (7624) (**Patient 1**)[31] 4:36 p.m. – 5:59 p.m. (1:23), BEH Main OR, Medicare Part A/B, Complete Laser Enucleation of Prostate with Morcellation and Control of Postoperative Bleeding (10106)
January 12, 2018 	Bryce Cunningham, M.D.	12:15 p.m. – 2:54 p.m. (2:39), BEH Main OR, Humana Gold Plus (Medicare), Open Treatment of Femoral Fracture, Proximal End, Neck, Internal Fixation or Prosthetic Replacement (27677) 12:54 p.m. – 3:57 p.m. (3:03), BEH Main OR, Medicaid GA, Open Reduction of

[29] Plaintiffs-Relators explain that there is also a legacy recordkeeping system that likely reflects improper overlapping surgeries in previous years as well.

[30] Red and blue bars represent the duration and timing of government-paid surgeries and commercially paid surgeries, respectively.

[31] Patient 1: Erlanger submitted Part A and Part B claims to Medicare for Patient 1's surgery and related inpatient services. Specifically, Erlanger submitted claims for the primary surgical procedure "open radical nephrectomy with vena caval thrombectomy" provided by Dr. Singh occurring on December 13, 2017 in the amounts of $33,543.72 and $4,251.00 for Medicare Part A and Part B, respectively. Claims were sent beginning December 18, 2017 and final payments were received February 5, 2018 and January 16, 2018 for Medicare Part A and Part B, respectively. Medicare paid $1,566.72 for Part B and $21,297.28 for Part A coverage of the surgery.

		Fracture of Shaft of Tibia, Without Fracture of Fibula, with Fixation Using Screws Without Cerclage (27682)
January 16, 2018 [redacted]	Dr. Singh	9:04 a.m. – 11:05 a.m. (2:01), BEH Main OR, BlueCare (Medicaid), Complete Laser Enucleation of Prostate with Morcellation and Control of Postoperative Bleeding (17896) 9:27a.m. – 12:35 p.m. (2:08), BEH Main OR, Medicare Part A/B, Da Vinci Laparoscopy, Surgical Prostatectomy, Retropubic Radical, w/Nerve Sparing (24434) (**Patient 2**)[32]
January 25, 2018 [redacted]	Warren Gardner, M.D.	9:01 a.m. – 1:04 p.m. (4:03), BEH Main OR, UHC Community (Medicaid), Application of Unilateral Uniplane External Bone Fixation (33419) 9:04 a.m. – 12:35 p.m. (3:31), BEH Main OR, Cigna Open Access/Broad Network, Debridement of Skin, Subcutaneous Tissue, Muscle Fascia, Bone and Muscle at Site of Open Fracture, with Removal of Foreign Material
February 5, 2018	Dr. Kiner	8:27 a.m. – 12:55 p.m. (4:28), BEH Main OR, Medicare Part A/B, Open Reduction of Transverse Fracture and Fracture of Wall of Acetabulum with Internal Fixation (37663) (**Patient 3**)[33]

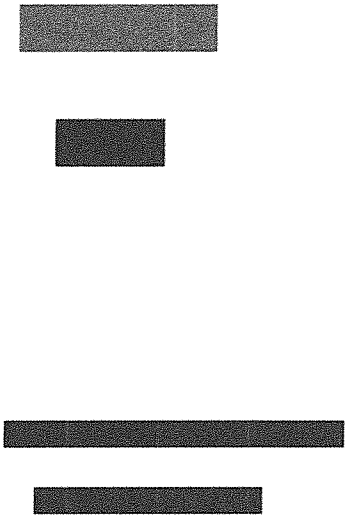
[32]Patient 2: Erlanger submitted Part A and Part B claims to Medicare for Patient 2's surgery and related inpatient services. Specifically, Erlanger submitted claims for the surgical procedures "Da Vinci laparoscopy, surgical prostatectomy, retropubic radical, w/nerve sparing" provided by Dr. Singh occurring on January 16, 2018 in the amounts of $33,761.06 and $5,233.00 for Medicare Part A and Part B, respectively. Claims were sent beginning January 29, 2018 and final payments were received Erlanger on May 4, 2018 and November 19, 2018 for Medicare Part A and Part B, respectively. Medicare paid $1,362.37 for Part B and $5,526.49 for Part A coverage of the surgery.

[33](Patient 3:): Erlanger submitted Part A and Part B claims to Medicare for Patient 3's surgery and related inpatient services. Specifically, Erlanger submitted claims for the surgical procedure "open reduction of transverse fracture and fracture of wall of acetabulum with internal fixation"

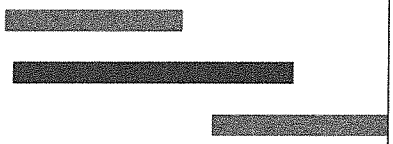
[redacted]		8:59 a.m. – 11:40 a.m. (1:41), BEH Main OR, N/A, Open Reduction of Fracture of Shaft of Humerus with Fixation Using Screws Without Cerclage
March 6, 2018 [redacted]	Dr. Singh	9:37 a.m. – 11:51 a.m. (2:14), BEH Main OR, Medicare Part A/B, Da Vinci Laparoscopy, Surgical; Partial Nephrectomy (49763) (**Patient 4**)[34] 10:31 a.m. – 11:16 a.m. (0:45), BEH Main OR, UHC Dual Complete (Medicare and Medicaid), Complete Laser Enucleation of Prostate with Morcellation and Control of Postoperative Bleeding (46375) 11:14 a.m. – 11:40 a.m. (0:26), BEH Main OR, Amerigroup TN (Medicaid), Percutaneous Pyelostolithotomy with Stenting (28785) 12:27 p.m. – 1:21 p.m. (0:54), BEH Main OR, Medicare Part A/B, Complete Laser Enucleation of Prostate with Morcellation and Control of Postoperative Bleeding (48794) 12:56 p.m. – 1:13 p.m. (0:17), BEH Main OR, Blue Advantage (Medicare),

provided by Dr. Kiner occurring on February 5, 2018 in the amounts of $100,647.20 and $4,602.00 for Medicare Part A and Part B, respectively. Claims were sent beginning February 16, 2018 and final payments were received by Erlanger on March 3, 2018 and October 24, 2019 for Medicare Part A and Part B, respectively. Medicare paid $1,541.81 for Part B and $20,335.06 for Part A coverage of the surgery.

[34]Patient 4: Erlanger submitted Part A and Part B claims to Medicare for Patient 4's surgery and related inpatient services. Specifically, Erlanger submitted claims for the surgical procedures "Da Vinci laparoscopy, surgical; partial nephrectomy" provided by Dr. Singh occurring on March 6, 2018 in the amounts of $33,889.25 and $3,356.00 for Medicare Part A and Part B, respectively. Claims were sent beginning March 8, 2018 and final payments were received by Erlanger on June 7, 2018 and September 16, 2018 for Medicare Part A and Part B, respectively. Medicare paid $1,241.87 for Part B and $5,919.55 for Part A coverage of the surgery.

		Cystourethroscopy with Resection of Bladder Tumor
March 7, 2018 	Mark Brzezienski, M.D.	3:16 p.m. – 5:51 p.m. (2:35), BEH Main OR, BlueCare (Medicaid), Application of Skin Substitute Graft, Each Additional 100 Sq. Cm or Greater Total Wound Surface Area (51854) 3:23 p.m. – 4:38 p.m. (1:15), Plaza OR, BCBS Network S, Revision of Reconstructed Breast 4:39 p.m. – 5:13 p.m. (0:34), Plaza OR, UMR, Reconstruction of Nipple and Areola
March 15, 2018 	Dr. Kiner	8:00 a.m. – 9:16 a.m. (1:16), BEH Main OR, Commercial Generic, Open Reduction of Subtrochanteric Fracture of Femur with Fixation Using Intramedullary Implant and Interlocking Screws 8:15 a.m. – 8:56 p.m. (0:41), BEH Main OR, Medicare Part A/B, Open Reduction of Subtrochanteric Fracture of Femur with Fixation Using Intramedullary Implant and Interlocking Screws (55957) 10:18 a.m. – 2:03 p.m. (3:45), BEH Main OR, Medicare Part A/B, Open Reduction of Transcondylar Fracture of Humerus with Intercondylar Extension, with Internal Fixation (56078) (**Patient 5**)[35]

[35]Patient 5: Erlanger submitted Part A and Part B claims to Medicare for Patient 5's surgery and related inpatient services. Specifically, Erlanger submitted claims for the surgical procedure "open reduction of transcondylar fracture of humerus with intercondylar extension, with internal fixation" provided by Dr. Kiner occurring on March 15, 2018 in the amounts of $304,082.35 and $14,237.00 for Medicare Part A and Part B, respectively. Claims were sent beginning April 11, 2018 and final payments were received by Erlanger on April 27, 2018 and October 4, 2018 for Medicare Part A and Part B, respectively. Medicare paid $3,622.25 for Part B and $76,790.59 for Part A coverage of the surgery.

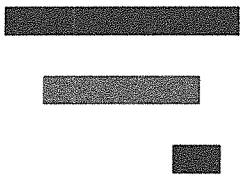
		10:38 a.m. – 1:09 p.m. (2:31), BEH Main OR, Medicare Part A/B, Open Treatment of Femoral Fracture, Proximal End, Neck, Internal Fixation or Prosthetic Replacement (55886)
April 14, 2018 	Dr. Kiner	12:59 p.m. – 3:24 p.m. (2:25), BEH Main OR, Medicare Part A/B, Open Reduction of Subtrochanteric Fracture of Femur with Fixation Using Intramedullary Implant and Interlocking Screws (70303) 1:19 p.m. – 3:04 p.m. (1:45), BEH Main OR, UHC Community (Medicaid), Open Reduction of Fracture of Olecranon with Internal Fixation (70323)
April 15, 2018 	Dr. Kiner	9:10 a.m. – 11:11 a.m. (2:01), BEH Main OR, Cigna Open Access/Broad Network, Percutaneous Skeletal Fixation of Fracture of Unilateral Posterior Pelvic Bone and Dislocation of Unilateral Sacroiliac Joint 9:16 a.m. – 12:27 p.m. (3:11), BEH Main OR, Tricare Standard, Debridement of Skin, Subcutaneous Tissue, Muscle Fascia, Bone and Muscle at Site of Open Fracture, with Removal of Foreign Material (70553) 11:32 a.m. – 1:42 p.m. (2:10), BEH Main OR, BC/BS Out of State Network P, Open Reduction of Trimalleolar Fracture of Ankle with Internal Fixation of Medial Malleolus Without Fixation of Posterior Lip
April 16, 2018 	Dr. Brzezienski	2:54 p.m. – 3:09 p.m. (0:15), Plaza OR, Humana Gold Plus (Medicare), Excision of Mucous Cyst of Tendon Sheath of Finger 2:55 p.m. – 3:45 p.m. (0:50), Plaza OR, Medicare Part A, Incision and Drainage

		of Abscess of Subfascial Soft Tissue (70728) 3:04 p.m. – 3:09 p.m. (0:05), Plaza OR, Medicare Part A/B, Excision of Mucous Cyst of Tendon Sheath of Finger (60013)
June 29, 2018 [redacted]	Dr. Singh	8:05 a.m. – 10:28 a.m. (2:23), BEH Main OR, Amerigroup TN (Medicaid), Complete Laser Enucleation of Prostate with Morcellation and Control of Postoperative Bleeding (69517) (**Patient 6**)[36] 8:29 a.m. – 9:03 a.m. (0:34), Plaza OR, Medicare Part A/B, Lithotripsy Using Extracorporeal Shock Wave (121868) 8:51 a.m. – 11:27 a.m. (2:36), BEH Main OR, Medicare Part A/B, Da Vinci Laparoscopy, Surgical Prostatectomy, Retropubic Radical, w/Nerve Sparing (100190)
July 27, 2018	Dr. Singh	8:49 a.m. - 9:15 a.m. (0:26), BEH Main OR, Medicare A, Cystourethroscopy with Ureteroscopy and Removal of Calculus (note only Medicare A billed) (158847) 8:58 a.m. – 9:32 a.m. (0:34), Plaza OR, Amerigroup TN (Medicaid), Lithotripsy Using Extracorporeal Shock Wave (154884)

[36]Patient 6: Erlanger submitted claims to Amerigroup Tennessee, a TennCare State Medicaid program, for Patient 6's surgery and related inpatient services. Specifically, Erlanger submitted claims for the surgical procedure "complete laser enucleation of prostate with morcellation and control of postoperative bleeding" provided by Dr. Singh occurring on June 29, 2018 in the amounts of $27,125.19 for hospital charges and $1,423.00 for professional charges. Claims were sent beginning July 3, 2018 and final payments were received by Erlanger on December 6, 2018. TennCare paid $606.83 for professional charges and nothing for hospital charges.

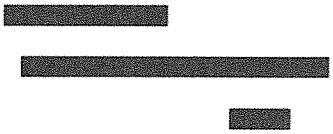
		9:00 a.m. – 12:37 a.m. (3:37), BEH Main OR, Medicare Part A/B, Partial Cystectomy (90977) (**Patient 7**)[37] 10:26 a.m. – 11:05 a.m. (1:39), BEH Main OR, UHC Community (Medicare/Medicaid), Cystourethroscopy with Ureteroscopy 16 and Pyeloscopy and Lithotripsy (145283) 10:30 a.m. – 11:51 a.m. (1:21), Plaza OR, Medicare Part A/B, Lithotripsy Using Extracorporeal Shock Wave (155046) 11:49 a.m. – 1:00 p.m. (1:11), BEH Main OR, Medicare Part A/B, Complete Laser Enucleation of Prostate with Morcellation and Control of Postoperative Bleeding (151465) 2:15 p.m. – 4:23 p.m. (2:08), BEH Main OR, Amerigroup TN (Medicaid), Diagnostic Laparoscopy of Abdomen, Peritoneum, and Omentum with Collection of Specimen by Washing (135774) 3:09 p.m. – 3:36 p.m. (0:27), BEH Main OR, no data, Cystourethroscopy with Ureteroscopy and Removal of Calculus 3:54 p.m. – 4:49 p.m. (0:55), Plaza OR, BlueCare (Medicaid), Lithotripsy Using Extracorporeal Shock Wave (158666)
October 24, 2018	James Kennedy, M.D.	1:37 p.m. – 2:54 p.m. (1:17), Plaza OR, Medicare Part A/B, Interposition

[37]Patient 7: Erlanger submitted Part A and Part B claims to Medicare for Patient 7's surgery and related inpatient services. Specifically, Erlanger submitted claims for the primary surgical procedure "partial cystectomy" provided by Dr. Singh occurring on July 27, 2018 in the amounts of $62,491.55 and $4,934.00 for Medicare Part A and Part B, respectively. Claims were sent beginning August 7, 2018 and final payments were received by Erlanger on August 29, 2018 and September 10, 2018 for Medicare Part A and Part B, respectively. Medicare paid $1,373.47 for Part B and $12,376.88 for Part A coverage of the surgery.

		Arthroplasty of Intercarpal Joints (235836) 2:18 p.m. – 3:01 p.m. (0:43), Plaza OR, Medicare Part A/B, Secondary Amputation of Joint of Single Thumb, with Neurectomies and Direct Closure (249228) 2:43 p.m. – 3:15 p.m. (0:32), Plaza OR, Cosmetic Pre-Pay, Removal of Intact Breast Implant
December 19, 2018 	Dr. Kennedy	1:21 p.m. – 3:20 p.m. (1:59), Plaza OR, BlueCare (Medicaid), Transfer of Adjacent Tissue for Repair of Defect of Neck, 10 Sq. cm or Less (277585) 1:38 p.m. – 2:24 p.m. (0:46), Plaza OR, Alliant PPO, Interposition Arthroplasty of Intercarpal Joints 2:46 p.m. – 3:16 p.m. (0:30), Plaza OR, Humana Gold Plus (Medicare), Transposition of Median Nerve at Carpal Tunnel (272250) 3:09 p.m. – 3:31 p.m. (0:22), Plaza OR, Aetna Erlanger, Partial Excision of Nail and Nail Matrix for Permanent Removal of Ingrown Nail
January 16, 2019 	Dr. Brzezienski	12:44 p.m. – 1:38 p.m. (0:54), Plaza OR, UHC Community (Medicare/Medicaid), Complex Repair of Lower Limb, 1.1 cm to 2.5 cm (327883) 12:53 p.m. – 1:29 p.m. (0:36), Plaza OR, Worker's Comp Generic, Neuroplasty of Single Digital Nerve of Digit of Hand 1:23 p.m. – 1:34 p.m. (0:11), Plaza OR, BC/BS HMO Georgia, Diaphysectomy of Proximal Phalanx for Osteomyelitis

January 17, 2019	Dr. Kiner	8:16 a.m. – 11:00 a.m. (2:44), BEH Main OR, Medicare Part A/B, Open Reduction of Transverse Fracture and Fracture of Wall of Acetabulum with Internal Fixation (333628) (**Patient 8**)[38] 8:53 a.m. – 11:18 a.m. (2:25), BEH Main OR, Cigna Open Access/Broad Network, Open Reduction of Fracture of Shafts of Radius and Ulna with Internal Fixation of Radius and Ulna 12:23 p.m. – 2:23 p.m. (2:00), BEH Main OR, Amerigroup TN (Medicaid), Open Reduction of Fracture of Shaft of Femur with Fixation Using Screws Without Cerclage (335743) 2:50 p.m. – 3:26 p.m. (0:36), BEH Main OR, Amerigroup TN Medicare, Percutaneous Skeletal Fixation of Fracture of Calcaneus with Manipulation (335919
January 18, 2019	Dr. Singh	7:43 a.m. – 10:37 a.m. (2:54), BEH Main OR, Medicare Part A/B, Complete Laser Enucleation of Prostate with Morcellation and Control of Postoperative Bleeding (333964) 8:07 a.m. – 10:48 a.m. (2:41), BEH Main OR, Blue Advantage (Medicare), Da Vinci Laparoscopy, Surgical Prostatectomy, Retropubic Radical, w/Nerve Sparing (266884)

[38]Patient 8: Erlanger submitted Part A and Part B claims to Medicare for Patient 8's surgery and related inpatient services. Specifically, Erlanger submitted claims for the primary surgical procedure "open reduction of transverse fracture and fracture of wall of acetabulum with internal fixation" provided by Dr. Kiner occurring on January 17, 2019 in the amounts of $161,689.57 and $8,469.00 for Medicare Part A and Part B, respectively. Claims were sent beginning January 17, 2019 and final payments were received by Erlanger on August 8, 2019 and February 20, 2019 for Medicare Part A and Part B, respectively. Medicare paid $2,334.50 for Part B and $49,292.88 for Part A coverage of the surgery.

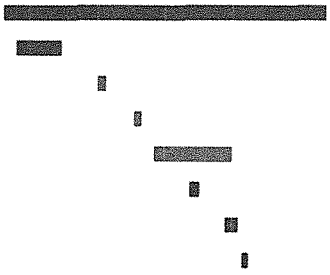
February 16, 2019 	Dr. Kiner	8:20 a.m. – 10:26 a.m. (2:06), BEH Main OR, Veterans Admin., Open Reduction of Fracture of Weight-Bearing Articular Portion of Distal Tibia with Internal Fixation of Tibia (367525) 8:34 a.m. – 12:30 p.m. (3:56), BEH Main OR, Amerigroup TN (Medicaid), Open Reduction of Fracture of Shaft of Humerus with Fixation Using Screws Without Cerclage (367400) 11:14 a.m. – 12:01 p.m. (0:47), BEH Main OR, Medicare Part A/B, Closed Reduction of Fracture of Proximal Tibial Plateau with Skeletal Traction (367512)
March 28, 2019 	Benjamin Waldorf, M.D.	9:19 a.m. – 10:40 a.m. (1:21), BEH Main OR, Medicare Part A/B, Cystourethroscopy with Resection of Bladder Tumor (393102) (**Patient 9**)[39] 9:37 a.m. – 10:32 a.m. (0:55), BEH Main OR, BC/BS Out of State Network P, Complete Electrosurgical Resection of Prostate by Transurethral Approach with Control of Postoperative Bleeding
April 1, 2019 	Dr. Brzezienski	1:40 p.m. – 4:51 p.m. (3:11), Plaza OR, UHC Medicare Advantage, Arthrodesis of Metacarpophalangeal Joint Without Internal Fixation (395350) 2:03 p.m. – 2:49 p.m. (0:46), Plaza OR, Cosmetic Pre-Pay, Laser Destruction of Cutaneous Vascular Proliferative Lesion, Over 50 Sq. Cm

[39]Patient 9: Erlanger submitted Part A and Part B claims to Medicare for Patient 9's surgery and related inpatient services. Specifically, Erlanger submitted claims for the primary surgical procedure "cystourethroscopy with resection of bladder tumor" provided by Dr. Waldorf occurring on March 28, 2019 in the amounts of $62,165.91 and $9,218.00 for Medicare Part A and Part B, respectively. Claims were sent beginning April 2, 2019 and final payments were received by Erlanger on July 10, 2019 and November 20, 2019 for Medicare Part A and Part B, respectively. Medicare paid $2,774.18 for Part B and $18,058.76 for Part A coverage of the surgery.

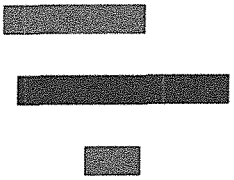
		3:35 p.m. – 4:53 p.m. (1:18), Plaza OR, UHC Commercial, Replacement of Tissue Expander with Permanent Prosthesis
April 25, 2019 [redacted]	Dr. Gardner	8:41 a.m. – 12:38 p.m. (3:57), BEH Main OR, Humana Gold Plus (Medicare), Open Reduction of Extra Articular Fracture of Distal Radius with Internal Fixation (440865) 8:41 a.m. – 11:49 a.m. (3:08), BEH Main OR, UHC Dual Complete (Medicare and Medicaid), Application of Unilateral Uniplane External Bone Fixation (440727) (**Patient 10**)[40]
June 27, 2019 [redacted]	Dr. Kiner	8:22 a.m. – 1:03 p.m. (4:41), BEH Main OR, CareSource (Medicaid), Open Reduction of Transverse Fracture and Fracture of Wall of Acetabulum with Internal Fixation (515333) 8:53 a.m. – 12:07 p.m. (3:14), BEH Main OR, BlueCare Plus (Medicare), Open Reduction of Fracture of Shaft of Humerus with Fixation Using Screws Without Cerclage (515253) 1:02 p.m. – 4:05 p.m. (3:03), BEH Main OR, Cigna – HealthSpring (Medicare), Open Reduction of Fracture of Shafts of Radius and Ulna with Internal Fixation of Radius and Ulna (515292)

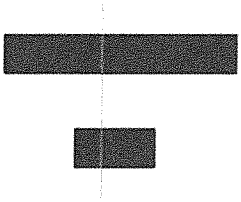
[40]Patient 10: Erlanger submitted claims for payment to United Healthcare Dual (UHC), a Medicare and Medicaid contracted provider, for Patient 10's surgery and related inpatient services. Specifically, Erlanger submitted claims for the primary surgical procedure "application of unilateral uniplane external bone fixation" provided by Dr. Gardner occurring on April 25, 2019 in the amounts of $208,557.65 for hospital and inpatient services and $8,696.00 for professional services. Claims were sent beginning May 10, 2019 and final payments were received by Erlanger on June 19, 2019 and January 6, 2020 for hospital service claims and professional service claims, respectively. UHC paid $3,308.08 for professional charges and $24,783.21 for hospital and inpatient services for the surgery.

		1:57 p.m. – 2:55 p.m. (0:58), BEH Main OR, Veterans Choice, Open Reduction of Fracture of Shaft of Femur with Insertion of Intramedullary Implant (515205)
June 28, 2019	Dr. Cunningham	8:37 a.m. – 10:24 a.m. (1:47), BEH Main OR, Humana Gold Plus (Medicare), Open Reduction of Subtrochanteric Fracture of Femur with Fixation Using Intramedullary Implant and Interlocking Screws (516489) 8:57 a.m. – 3:11 p.m. (6:14), BEH Main OR, Amerigroup TN (Medicaid), Open Treatment of Femoral Fracture, Proximal End, Neck, Internal Fixation or Prosthetic Replacement (516502) 11:43 a.m. – 2:01 p.m. (2:18), BEH Main OR, Blue Advantage (Medicare), Open Reduction of Trimalleolar Fracture of Ankle with Internal Fixation of Medial Malleolus Without Fixation of Posterior Lip (516179) 3:32 p.m. – 5:23 p.m. (1:51), BEH Main OR, Medicare Part A/B, Open Reduction of Transcondylar Fracture of Femur Without Intercondylar Extension, with Internal Fixation (516822) 4:28 p.m. – 5:34 p.m. (1:06), BEH Main OR, In-State SSI, Medicaid, Debridement of Bone, Including Epidermis, Dermis, Subcutaneous Tissue, Fascia, and Muscle, First 20 Square cms or Less (515513)
July 5, 2019	Jason Rehm, M.D.	11:37 a.m. – 4:22 p.m. (4:45), Plaza OR, BlueCare (Medicaid), Formation of Mycocutaneous Flap Graft of Upper Extremity (522233) 11:49 a.m. – 12:28 p.m. (0:39), Plaza OR, Blue Advantage (Medicare), Complex Repair of Lower Limb. 2.6 cm to 7.5 cm (522266)

		1:00 p.m. – 1:07 p.m. (0:07), Plaza OR, Aetna Erlanger, Incision of Tendon Sheath of Finger for Trigger Finger 1:33 p.m. – 1:39 p.m. (0:06), Plaza OR, BlueCard – Network S, Incision of Tendon Sheath of Finger for Trigger Finger 1:51 p.m. – 2:59 p.m. (1:09), BEH Main OR, Healthscope Benefits, Debridement of Bone, Including Epidermis, Dermis, Subcutaneous Tissue, Fascia, and Muscle, First 20 Square cm or Less 2:23 p.m. – 2:30 p.m. (0:07), Plaza OR, Medicare Part A/B, Transposition of Median Nerve at Carpal Tunnel (496214) 2:54 p.m. – 3:05 p.m. (0:11), Plaza OR, Medicare Part A/B, Excision of Mucous Cyst of Tendon Sheath of Finger (505751) 3:09 p.m. – 3:14 p.m. (0:05), Plaza OR, Medicare Part A/B, Incision of Tendon Sheath of Finger for Trigger Finger (512458)
July 11, 2019  	Dr. Kiner	8:18 a.m. – 10:57 a.m. (2:39), BEH Main OR, Blue Advantage (Medicare), Open Reduction of Intra Articular Fracture of Distal Radius with Internal Fixation of 2 Fragments (532310) 8:25 a.m. – 11:48 a.m. (3:23), BEH Main OR, N/A, Open Reduction of Fracture of Shaft of Tibia with Fixation Using Intramedullary Implant with Interlocking Screws and Cerclage
July 14, 2019	Dr. Cunningham	1:04 p.m. – 4:01 p.m. (2:57), BEH Main OR, BC/BS HMO Georgia, Open Reduction of Fracture of Shaft of Tibia with Fixation Using Intramedullary

[redacted]		Implant with Interlocking Screws and Cerclage (535626) 1:40 p.m. – 2:56 p.m. (1:16), BEH Main OR, MRA Generic Auto, Open Reduction of Fracture of Shaft of Radius with Internal Fixation and Closed Reduction of Dislocation of Distal Radioulnar Joint with Percutaneous Skeletal Fixation 4:48 p.m. – 6:45 p.m. (1:57), BEH Main OR, Medicare Part A/B, Open Reduction of Transcondylar Fracture of Femur Without Intercondylar Extension, with Internal Fixation (535906) 4:55 p.m. – 8:07 p.m. (3:12), BEH Main OR, Medicare B Only, Open Reduction of Trimalleolar Fracture of Ankle with Internal Fixation of Medial Malleolus Without Fixation of Posterior Lip (536251)
December 6, 2019 [redacted]	Matthew Higgins, M.D.	11:46 a.m. – 2:20 p.m. (2:34), COE OR, Medicare Part A/B, Arthroplasty of Medial and Lateral Femoral Condyle and Tibial Plateau with or Without Resurfacing of Patella (625435) 11:54 a.m. – 1:18 p.m. (1:24), COE OR, N/A, Open Reduction of Extra Articular Fracture of Distal Radius with Internal Fixation 2:33 p.m. – 4:41 p.m. (2:08), COE OR, UMR, Open Reduction of Fracture of Shaft of Humerus with Fixation Using Screws Without Cerclage 3:27 p.m. – 4:54 p.m. (1:27), COE OR, Humana Gold Plus (Medicare), Open Treatment of Femoral Fracture, Proximal End, Neck, Internal Fixation or Prosthetic Replacement (720208)

March 3, 2020 	Jeremy Bruce, M.D.	1:37 p.m. – 3:12 p.m. (1:35), EEH OR, AARP Medicare Complete, Arthroplasty of Medial and Lateral Femoral Condyle and Tibial Plateau with or Without Resurfacing of Patella 1:57 p.m. – 4:43 p.m. (2:46), EEH OR, Commercial Generic, Cystourethroscopy with Ureteroscopy and Pyeloscopy and Lithotripsy with Insertion of Double-J Stent
July 24, 2020 	Dr. Rehm	2:33 p.m. – 4:42 p.m. (2:09), BEH Main OR, UHC Community (Medicare/Medicaid), Open Reduction of Depressed Fracture of Zygomatic Arch by Gillies Approach (980493) 2:49 p.m. – 5:37 p.m. (2:48), Plaza OR, Cigna Local Plus, Primary Repair of Flexor Tendon of Hand in Zone 2 Digital Flexor Tendon Sheath, Without Free Graft 2:46 p.m. – 3:09 p.m. (0:23), Plaza OR, BC/BS Network P, Debridement of Subcutaneous Tissue, Including Epidermis and Dermis, First 20 Square cm or Less
November 16, 2020 	Dr. Brzezienski	2:51 p.m. – 3:52 p.m. (1:01), Plaza OR, Hamilton County Jail, Open Reduction of Dislocation of Single Metacarpophalangeal Joint with Internal Fixation 2:57 p.m. – 4:28 p.m. (1:31), Plaza OR, BC/BS Federal, Replacement of Tissue Expander with Permanent Prosthesis (1108376) 3:26 p.m. – 3:50 p.m. (0:24), BEH Main OR, BC/BS Network S, Closed Reduction of Fracture of Nasal Bone with Stabilization

November 18, 2020 	Henry Okafor, M.D.	12:23 p.m. – 1:51 p.m. (1:28), EEH OR, Medicare Part A/B, Cystourethroscopy with Ureteroscopy and Pyeloscopy and Lithotripsy with Insertion of Double-J Stent (1123467) 12:50 p.m. – 3:20 p.m. (0:30), EEH OR, Medicare Part A/B, Revision of Peripheral Neurostimulator Electrode Array (1127787)

96. These are only a few examples of Erlanger's non-compliant overlapping surgery practice that has continued through the present day. In each of the examples above, confirmed through the review of data, including claims information, at least one or more of the patients involved in overlapping surgeries was insured by a government payor or covered by a Medicare or Medicaid contracted provider.

B. UNREASONABLE AND UNNECESSARY ANESTHESIA CLAIMS

97. Even where there were no major complications, otherwise healthy patients were sedated or made unconscious, paralyzed, and/or intubated for an unnecessarily prolonged period of time awaiting surgery,[41] needlessly risking their health and increasing costs to government payors, which reimburse anesthesiologists by the amount of time spent with patients under anesthesia.

98. Although Erlanger's compliance department raised the question of the impact of unnecessarily prolonged anesthesia time on patients, it rejected Dr. S. Adams' repeated offers to provide comprehensive data that would have require less than a day of work to compile.

[41] *See* https://pubmed.ncbi.nlm.nih.gov/31490337/.

C. FAILURE TO OBTAIN VALID INFORMED CONSENT

99. Over the years, Defendants have utilized various informed consent forms – which are to be reviewed and signed by patients before surgery – but only in 2018 did the forms become modified to state that the patient's surgeon might not be present during the entire surgery because the surgeon might perform another surgery at the same time. For every overlapping surgery performed at Erlanger prior to this update, there was no documentation that patients were made aware that much or all of their operations were performed by residents so that their surgeons could engage in a second, and sometimes third, surgery.

100. The 2016 Senate Finance Committee Report sets out CMS's COPs and corresponding interpretive guidelines, which, among other things

> require hospitals to take certain steps to ensure that patients consent to planned surgeries. For example, this guidance states that a well-designed informed consent policy should include a discussion of a surgeon's possible absence during part of the patient's surgery, during which residents will perform surgical tasks, and that the informed consent policy should assure the patient's right to refuse treatment.

At 10.

101. Submitting claims for overlapping surgeries where valid informed consent has not been obtained, much less documented in the patient's file, is material. Defendants failed to provide full and proper disclosure with regard to the practices alleged herein because patients might not have consented to the surgery. Because a patient is the initial gatekeeper for the payment by any government payors, the matter of informed consent is material because, *inter alia*, it has a natural tendency to influence, or be capable of influencing, the payment or receipt of government money.

102. Along the same lines, failure to obtain informed consent violates longstanding rules of ethics. According to the American Medical Association, "[a] surgeon who allows a substitute to operate on his or her patient without the patient's knowledge or consent is deceitful.

The patient is entitled to choose his or her own doctor and should be permitted to acquiesce or refuse the substitution." AMA Council on Ethical and Judicial Affairs Opinion E-8.16, *Substitution of Surgeon without Patient's Knowledge or Consent*. The ethics opinion goes on to state:

> Under the normal and customary arrangement with patients . . . the operating surgeon is obligated to perform the operation but may be assisted by residents or other surgeons. With consent of the patient, it is not unethical for the operating surgeon to delegate the performance of certain aspects of the operation to the assistant provided this is done under the surgeon's participatory supervision, *i.e.*, the surgeon must scrub. If a resident or other physician is to perform the operation under non-participatory supervision, it is necessary to make a full disclosure of this fact to the patient, and this should be evidenced by an appropriate statement in the consent. Under these circumstances, it is the resident or other physician who becomes the operating surgeon.

103. Likewise, Dr. Mininder S. Kocher, in an article entitled *Ghost Surgery: The Ethical and Legal Implications of Who Does the Operation*, J. Bone Joint Surg. Am. 84: 148-150 (2002), concluded that

> [t]he substitution of an authorized surgeon by an unauthorized surgeon or the allowance of unauthorized surgical trainees to operate without adequate supervision constitutes 'ghost surgery.' These practices are legally and ethically iniquitous. Ghost surgery flies in the face of case law and violates an individual's right to control his or her own body and violates that person's right to information needed to make an informed decision."

At Erlanger, patients were never made aware that residents might be allowed to perform parts of their operations unsupervised.

104. The Senate Report, at page 11, provides an example of language that adequately informs the patient about overlapping surgeries:

> My surgeon has informed me that my surgery is scheduled to overlap with another procedure she/he is scheduled to perform. I understand that this means my surgeon will be present in the operating room during the critical parts of my surgery but may not be present for my entire surgery. My surgeon has also informed me that she/he will supervise a surgical team which may include another attending surgeon, a surgery fellow and surgery residents and that some members of the surgical team will perform parts of my surgery. I understand that my surgeon or another qualified

> surgeon will be immediately available should the need arise during my surgery. My surgeon has answered all my questions about overlapping surgery and I give my consent.

105. The Report goes on to state that forms containing less explicit language are "too vague to truly inform patients about overlapping surgeries." Prior to 2018, *all* of the claims Defendants submitted to Medicare and Medicaid for overlapping surgeries were false because Erlanger did not obtain valid informed consent from any of these patients.

106. But even in 2018, the informed consent form Erlanger used falsely stated that, at the least, a "designee" would be present for the critical parts, when, in fact, Erlanger had no program for designating back-up teaching physicians. Thus, even after 2018, Defendants did not obtain true informed consent, rendering those claims false as well.

D. FALSE AND INADEQUATE RECORDKEEPING

107. In the course of Plaintiffs-Relators' duties, they were privy to some of the surgical records generated by physicians performing overlapping surgeries. These records routinely failed to provide an accurate accounting of the teaching surgeon's involvement in the case, including identifying the portion of the procedure deemed to be "key and critical," the time in which he entered and exited the surgery room, whether he was able to return to the surgery if necessary, and/or whether another surgery was conducted at the same time. Incredibly, in many cases, surgeons billing for two, three, or more overlapping operations attested to being present for the entirety of each case.

108. Nor do the records contain the name of a back-up teaching physician who was in fact immediately available and qualified to take over if necessary. To this day Erlanger does not have in place an official policy for the formal designation or documentation of a back-up attending surgeon. Where residents are left alone, the records are silent.

109. Appropriate documentation on overlapping surgeries is a condition of payment.

42 C.F.R. § 415.172(b). Erlanger submitted false claims to the government for all overlapping surgeries in which the surgeon's records did not comply with these regulations.

110. Indeed, Defendants took steps to conceal violations of CMS's overlapping surgery policies by, for example, deliberately setting up their new EPIC electronic medical record system so that it would fail to record in-room time for teaching physicians.

E. DEFENDANTS WERE WELL AWARE OF MEDICARE AND MEDICAID VIOLATIONS AND RESULTING FALSE CLAIMS LIABILITY

111. Defendants have long been aware that their surgeons' practices of allowing residents to operate unsupervised and without a designated back-up is both violative of CMS regulations and a risk to patient safety.

112. As an initial matter, Erlanger was well aware of the Medicare and Medicaid regulations concerning teaching physicians. For example, on January 20, 2016, Erlanger held an Executive Compliance Meeting. The meeting was held in the immediate wake of an explosive exposé on overlapping surgery in the *Boston Globe* related to practices at Massachusetts General Hospital. Present at the meeting were Erlanger's CFO, Chief of Staff, Compliance Officer, Compliance Auditor, the Senior Vice President of Human Resources, financial leaders from the physician practices, and the head attorney. The minutes[42] reference a report by the Compliance Auditor regarding overlapping surgery. They further state, "Yvonne Mazarredo and Alana Sullivan provided a status report on timeline associated with the internal review of the Overlapping Surgery project." Nothing apparently was done in the wake of that report, however, and problems persisted.

113. On March 19, 2017, Alana Sullivan, then-Chief Compliance Officer of Erlanger,

[42] Plaintiffs-Relators note that the minutes of this meeting were (accidently it seems) posted on the Hospital's intranet for all at Erlanger to read.

gave a presentation on overlapping surgery issues at a healthcare compliance conference. She noted that a teaching surgeon may move on to a second case ***only*** after completing the key and critical portions of the first case and ***only*** if he designates an immediately available back-up surgeon. At the time of her presentation, Erlanger itself had no such requirements and the hospital routinely ignored both of these mandatory conditions, as Sullivan was well aware at the time. She also noted that Medicare does not pay for overlapping procedures where the key and critical portions occur at the same time or for three overlapping procedures. Notwithstanding, Sullivan did not do anything to ensure that Erlanger presented only valid bills for payment.

114. In April of 2018, Dr. S. Adams offered to develop an auditing program that would permit the effective tracking and monitoring of concurrent procedures. When he presented the data, the Defendants took minimal action, issuing only a "handful" of refunds for ineligible overlapping surgeries and "talking to" one surgeon, Dr. Singh, about his practices. Erlanger leadership also became angry when Dr. S. Adams created a report of concurrency violations that spanned several months. He was instructed to not do so again, as this would "create too much liability for the organization."

115. When Dr. S. Adams agitated for change, Defendants made modest efforts to curtail some of the most egregious practices in the hopes of quelling dissent and largely maintaining the *status quo*. But Erlanger did nothing to stop the practice more generally. Policies were not developed and enforced. Employed surgeons continued to receive credit and accumulate RVUs for completion of noncompliant overlapping surgeries, even those identified by compliance; thus, Erlanger incentivized the practice. And Dr. S. Adams was told to slim down his data set and slow down his compliance efforts. Erlanger simply did not want to see just how non-compliant the hospital is, for fear that they would have to take real action.

116. In short, Defendants' efforts were perfunctory at best and had little effect on the frequency of overlapping surgeries at Erlanger. Indeed, they were willful in their insistence that their non-compliant behavior be allowed to continue without dissent or criticism.

117. Dr. S. Adams became frustrated with Erlanger's studied inaction and with the danger in which it placed patients as well as the fraud it was perpetrating upon the government. In March of 2020, almost two years later, although he certainly had not been invited to do so by leadership, Dr. S. Adams provided to the Erlanger CEO, CCO, CLO and others in leadership a list of at least eight surgeons who had regularly scheduled problematic overlapping surgeries. He did not receive a response and, to the best of his knowledge and as evidenced in this Complaint, Erlanger leadership made no efforts to cease surgeons' misconduct or enforce compliance. In fact, up to the filing of this Complaint, Plaintiffs-Relators have continued to observe serious issues of patient safety and compliance issues with overlapping surgeries.

118. In May of 2020, Dr. J. Adams met with Erlanger CEO Dr. Jackson and told him about those patients of hers that had developed complications following what she understood to be overlapping surgeries booked by her colleagues at Erlanger. She noted the excessive operating times and that the operative notes suggested that residents had performed the surgeries entirely and without the presence of the teaching physician *at any point*. To Plaintiffs-Relators' knowledge, Dr. Jackson made no efforts to investigate or designate responsibility to anyone else to investigate and address those issues. Instead, Plaintiffs-Relators later learned, Dr. J. Adams' concerns were relayed to the offending surgeons whose practices were in question, and those surgeons had then made efforts to pressure Erlanger and UTCOM leadership to fire Plaintiffs-Relators.

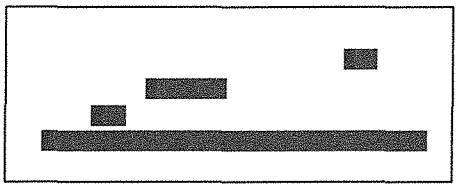
119. In a June 2020 meeting between Doctors Steinmann and Jackson, Dr. Steinmann

raised his own worries about Erlanger's non-compliant practices with respect to overlapping surgeries and the continued absence of any policy to ensure eligible back-up surgeons are designated, stating "this has to stop yesterday." To this day, no formal policy for the designation of a back-up surgeon is in place at Erlanger.

120. Through conversations with physicians as well as members of Erlanger leadership, Plaintiffs-Relators learned that inattention and negligence regarding overlapping surgery should have been expected; surgeons double- or triple-booking cases, then allowing residents to operate without a qualified back-up is understood by Defendant's leadership to be ingrained in the culture and an accepted practice at Erlanger. The following is a transcription of communications provided by Plaintiffs-Relators.

> Dean of UTCOM Chattanooga R. Bruce Shack, M.D. on February 22, 2021: The tradition here has been you run two rooms. You have your PAs or whoever it is, or your medical assistants, answering phone calls, taking care of business while you're in the operating room. And, you know, you have a, uh, a medical assistant or a senior resident in one room doing a case while you're in another room doing a case with a junior resident, but you know, you're available if you need to bounce back and forth.
>
> Dr. Young, Anesthesiologist, Erlanger Chief of Staff, and member of the Board of Trustees on February 17, 2021: We've talked about concurrent surgery for a couple years now, at least… and still, no, you can't jump in and out of cases, they [have to] be sequential, there's got to be some critical part where you actually did the critical part, okay, we're trying to be as open-minded about this as we possibly can. Yeah, [inaudible] and where we don't even comply is this back-up surgeon thing, which is another aspect of it. . . . Um. . . . We still have, not so much in orthopedics as much as it was, but in other services, people just totally ignore it, they'll jump in on a case then go and do something. . . .
>
> We will try, we'll bend over backwards, to be able just explain to somebody that there is a back-up surgeon and this is what their name is. Even if it might not meet the letter of the law, at least we can say we thought about it and there's something on a piece of paper that says there's a back-up surgeon. . . . Okay, again, some would say we're not really compliant with it. Okay, we watered it down to a place that is practical given the circumstances and patients are being taken care of. But it's - they just want to do it their own way. And I think that's the real danger with orthopedics right now, they think they can do whatever they want to do and get away with it.

121. Defendants' leadership was again made aware of the severity and chronic nature of non-compliant overlapping surgery at Erlanger during a February 2021 meeting between Karen Percent, Erlanger's Director of Audit Services, and the Officers' Council, made up of medical staff leadership. Percent presented a document entitled "Management Accepts Risks," which read, "Audit Services is requesting Officer Council /Leadership acknowledgement to the following: Although improvement has been made to the internal controls of overlapping surgery, certain risks will still exist and may be identified [by] outside auditors if reviewed." Specifically, Percent wanted leadership to acknowledge that the Main OR and Plaza OR can be accessible within five minutes or less, since many surgeons book two or more cases that overlap in those two locations. Leadership was also presented with the below surgery schedule schematic and asked to acknowledge that similarly booked cases are within compliance:



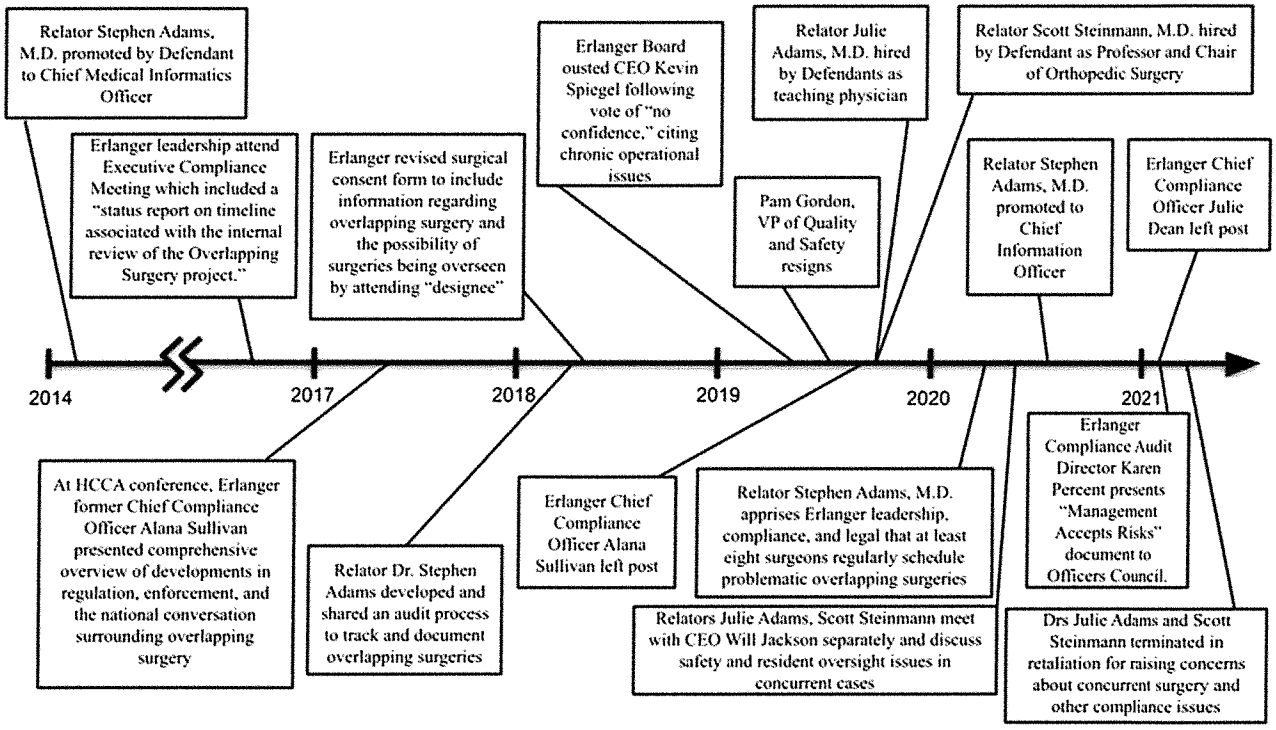
122. This schematic reflects multiple procedures "performed" by one teaching surgeon. The red denotes anesthesia start time, while the blue denotes surgical time. Here, three cases are sequentially performed, but a longer fourth procedure is ongoing at the same time.

123. The Officers' Council would not agree to Percent's requests, falsely claiming that she had provided "extreme examples," despite knowing since at least 2018 that similarly booked schedules and double-bookings with one case in the Plaza OR and the other in the Main OR, are commonplace at Erlanger.

124. Dr. S. Adams explained that in many of these cases surgeons often indicate on the operative record that they were "present for the entire procedure." To his credit, Dr. Young acknowledged, "[T]hat's just fraudulent," and that those surgeons "are going to be subject to

disciplinary action." To Plaintiffs-Relators' knowledge, however, virtually no efforts have been made to follow through on such discipline, nor have any efforts been made to repay the doubtless thousands of non-compliant surgeries that Erlanger fraudulently submitted to government payors.

125. Below is a timeline outlining the foregoing events relating to overlapping surgery and Plaintiffs-Relators' experiences at Erlanger.



F. DEFENDANTS' MEDICARE AND MEDICAID VIOLATIONS ARE MATERIAL

126. The expectation that critical procedures are safely performed and/or supervised by fully credentialed and qualified physicians and that patients are fully informed as to all material elements of their procedures is at the very core of the regulatory scheme. Violation of these requirements is material as that term is defined in the federal and state False Claims Acts and interpreted by the courts.

127. The centrality of 42 C.F.R. § 415.170 is underscored by its status as a condition of payment and by the legislative history. HCFA enacted the current regulations to limit reimbursement "under the physician fee schedule" to situations where a teaching physician is "present for a key portion of the time during the performance of the service for which payment is sought," and "[i]n the case of a surgery or a dangerous or complex procedure," where the teaching physician is "present during all critical portions of the procedure" and "immediately available to furnish services during the entire service or procedure." 60 F.R. 63124, at 63138. HCFA "specified that the teaching physician presence requirement is not met when the presence of a teaching physician is required in two places for concurrent major surgeries. The operative notes must indicate when the teaching physician presence in individual procedures began and ended." *Id.* Responding to various public comments on the enactment of 42 C.F.R. §§ 415.170, 415.172, HCFA explained the regulation clarified existing policy, particularly as to physical presence requirements. *Id.* at 63140; *see also id.* at 63142 (the "rule requiring physical presence clarifies current policy."). In HCFA's view, "a teaching physician should not receive a resource-based fee schedule amount when the physician has expended little or no resources with respect to the services." *Id.* at 63140. HCFA also stated:

> [W]e believe that, if we are to pay a fee to another physician who is medically responsible for the services the resident is furnishing to the beneficiary, it is entirely appropriate to ***require as a condition of payment that the supervising physician furnish a direct, personal physician service to the beneficiary***. This is the basis for the payment of physician services under Medicare. If the resident has personally furnished the service to the beneficiary and the intermediary is paying the teaching hospital for Medicare's share of the services performed by the resident, we believe it is appropriate ***not*** to pay a full fee to a supervising physician who was not present when the service was furnished. Furthermore, the Medicare beneficiary is responsible for a 20 percent coinsurance amount for that physician's services as well as any deductible liability. We believe it is fully consistent with a resource-based fee schedule that the physician in whose name the service is billed furnishes a service to the ***beneficiary***.

Id. at 63144 (emphasis added).

128. The Government has engaged in consistent action to punish and deter the conduct at issue here by intervening in and litigating cases of regulatory violations that are substantively similar or identical to those in this case.

129. In a case against the Pittsburgh Medical Center, a *qui tam* Plaintiff-Relator alleged the Center violated 42 CFR § 415.172 because teaching physicians billed and were paid for surgeries for which they were not physically present during the critical or key portions and they did not supervise. *See* Ex. B at ¶¶ 176-203. The Government intervened and settled these allegations. *See* Ex. C, Partial Intervention at p. 2 ("the neurosurgeon did not participate to the degree required by applicable regulations to support the procedure codes billed in a procedure performed by others, including residents, fellows, and physician assistants"); Ex. D, Stipulation of Dismissal (noting settlement).

130. The Government intervened in and settled a case against the Medical College of Wisconsin, alleging that billing surgeons were not present during "critical portions" of procedures or otherwise available to furnish services as required by regulation. There have been at least 9 settlements by teaching hospitals involving similar issues in recent years.

131. One such settlement with Northwell Health, Inc. and Lenox Hill Hospital of New York involved the overlapping scheduling of urologic procedures. Relevant to this Complaint, the Government's recovery in part hinged on the CMS billing rules for endoscopic procedures that require the teaching physician to be present for "the entire viewing" of the surgery, as defined below:

> To bill Medicare for endoscopic procedures (excluding endoscopic surgery that follows the surgery policy in subsection A, above), ***the teaching physician must be present during the entire viewing***. The entire viewing starts at the time of insertion of the endoscope and ends at the time of removal of the endoscope. Viewing of the entire procedure through a monitor in another room does not meet the teaching physician presence requirement.

2011 Manual, at 100.1.2.A.5 (emphasis added); *see also* 42 C.F.R. § 415.172(1)(ii) (same).

132. The Government also engaged in PATH audits, which resulted in 36 settlements with teaching hospitals, and many of these settlements involved overlapping surgeries and the regulatory violations at issue here.[43] In a 1998 report to the House of Representatives' Ways and Means Committee on its ongoing PATH audits, HHS's Office of the Inspector General expressly stated that it "does have a legal basis for applying the specific criteria used in the PATH initiative" and that the initiative "stem[med] from the continuing concern over Part B billings by physicians in a teaching setting."

133. In its 1998 report, OIG also explained that its "first concern is whether teaching physicians who billed part B for services furnished by residents provided sufficient 'personal direction' in the delivery of the service." *Id.* at 6. Moreover, "OIG considers that the requirement for sufficient personal direction is met if the physician was physically present while the service was delivered. If the medical records do not show evidence of the teaching physician's presence, the OIG considers the service to be part of the teaching physician's supervisory functions already paid under part A." *Id.* Finally, OIG explained that "[w]ith the increased attention to health care fraud and abuse in recent years, ***the government may now invoke the penalties and damages prescribed in the False Claims Act for practices that in the past might have been dealt with by seeking repayment***." *Id.* at 7 (emphasis added).

134. CMS, likewise, was not content to leave limitations on overlapping surgeries set forth in 42 C.F.R. § 415.170 and 42 C.F.R. § 415.172(a) open to interpretation by Defendants and other hospitals or providers. Rather, CMS provided extensive guidance on the

[43] HHS OIG reported that these 36 teaching hospitals settled False Claims Act or other similar cases related to these audits and investigations between 1995 and 2004, for amounts in excess of $225 million.

responsibilities of teaching physicians, explaining what surgical practices are and are not permissible for overlapping surgeries. *See supra* ¶¶ 32-54. Tennessee did the same. *See supra* ¶¶ 55-59. Defendants failed to adhere to this guidance.

135. CMS has emphasized the materiality of appropriate record-keeping by providing detailed guidance on documentation. Appropriate documentation is critical as it helps ensure substantive compliance and allow detection of non-compliance with the law when conducting overlapping surgeries. Similarly, CMS adopted interpretive guidelines setting forth the contours of informed consent, and codes of medical ethics have long warned that non-compliant overlapping surgeries, in the manner conducted by Defendants, are unethical. The legislative history also underscores the materiality of accurate and adequate documentation. In promulgating 42 C.F.R. § 415.172, CMS rejected comments arguing documentation requirements would be too onerous, explaining that "[t]he policy we are adopting cannot be enforced without some documentation of the presence of the teaching physician during procedures." Finally, the HHS Guidance Document entitled "Items Not Covered Under Medicare" underscores the materiality of Erlanger's violations.

136. No federal or state government payer has paid claims with actual knowledge that Defendants violated governing regulations and conditions of payment or participation. As the First Circuit has stated, "mere awareness of allegations concerning noncompliance with regulations is different from knowledge of actual noncompliance." *U.S. ex rel. Escobar v. Universal Health Servs.*, 842 F.3d 103 (1st Cir. 2016). As detailed herein, Defendants have acted to conceal the nature of their overlapping surgeries from regulators, patients, and the public at large.

G. DEFENDANTS' VIOLATIONS WITH RESPECT TO OVERLAPPING SURGERIES ARE JUST ONE PART OF ERLANGER'S GENERAL CULTURE OF NON-COMPLIANCE

137. For decades Defendants have enabled a culture of non-compliance and negligence. Beyond the practice of overlapping surgery, other problems affecting patient safety, privacy, and quality of care have gone unaddressed while members of Erlanger's leadership faltered, resigned, or were removed from office.

138. In July 2019, Erlanger's Vice President of Patient Quality and Safety, Pam Gordon, left her post, stating, "I can no longer in good faith and good conscience remain in my role," and that "this has caused me health issues and many sleepless nights."[44]

139. Gordon's departure came just a month after the Erlanger Medical Executive Committee passed a unanimous vote of "no confidence" against three executives; CEO Kevin Spiegel, COO Robert Brooks, and Vice President of Operations Tanner Goodrich. The committee stated, "despite over 3 years of complaints and concerns from patients and physicians, hospital management has been ineffective in addressing these issues." Among the cited failures were "chronic operational issues, including inefficiency, poor morale and policies that cause overcrowding in the main campus emergency department and operating rooms."[45]

140. Indeed, overlapping surgeries is not the only area of practice where Defendants have failed to meet basic standards of trainee oversight. Sometimes these failures carry the risk of the gravest and most tragic outcomes. On September 5, 2019, anesthesia was administered to a child during an MRI scan; this is a standard procedure for young children, who often struggle to

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[44] *See* https://www.beckershospitalreview.com/quality/erlanger-vp-resigns-over-patient-safety-concerns-i-can-no-longer-in-good-conscience-remain-in-my-role.html (accessed Apr. 4, 2021).

[45] *See* https://www.timesfreepress.com/news/local/story/2019/jun/23/lost-confidence-erlanger-doctors-and-ceo-comes/497308/ (accessed Apr. 6, 2021).

hold still. The child died while in the scanner. A nursing leader relayed speculation that the underlying cause was a medication dosing error. Dr. S. Adams was asked to review the event through Erlanger's electronic health record audit system. Audit logs revealed evidence suggesting that the supervising Certified Registered Nurse Anesthetist (CRNA) left the child in the care of a CRNA student and was using a workstation outside of the MRI room to complete documentation of other patients' records instead of attending to the anesthetized child and trainee. Dr. Adams relayed this information to Erlanger leadership and heard nothing more about the case.

141. The extent of Erlanger's culture of non-compliance and willful blindness is perhaps best illustrated by the candid statements of Dr. Young, Erlanger's Chief of Staff and a member of the Board of Trustees. The following was transcribed from a recorded conversation between Dr. Young and Dr. S. Adams held on April 3, 2021, following the termination of Doctors J. Adams and Steinmann (emphasis added):

> Dr. Young: You and I have talked about this for a long time. *There are so many issues at the hospital, so many compliance issues at the hospital*, so many things, that I think, really, for . . . for . . . you know, Scott and Julie to come into this environment. . . . I think it's just a culture shock, to say, A: "okay this happens," and B: people, you know, *many people don't seem to care about it*. They just want to do it anyway. I mean I had a meltdown this morning because *even after all this s**t, after all this stuff talking about concurrent surgery, all this stuff that's happened this week, the, you know, the - what happened to Scott and Julie – I walked in this morning and into two cases posted, same surgeon, same time. [inaudible] But people just don't seem to mind that, you know, this is, you can't do this.* And I don't know what you have to do to shake them, to shock them, to do something to them to say there are things you simply cannot do. *And people are going to get in trouble for this. That is just... it's just a matter of time before something happens*. And I think, you know, whether it's sharing passwords or concurrent surgery, or, you know, all the things that have been raised, and I think raised really with the best intent to how do we make this better.
>
> . . . .
>
> This goes back to culture, which I think in some ways, medical staff has to be able to respond to this, or to say, "this is not what we want." Now, we would hope that

> would come - we would be working with - that the administrators would understand that that's a desirable thing too. But they do live in a - some state of denial about how bad things are. And maybe that's the only way they can live with themselves, to say that, you know, "it's not that bad," or you know, "it's the thing doctors wanted" or whatever they think. But… you know, it's bad. It's bad. *I feel worse about this hospital today than I've ever felt in my life*. And, you know, I think what we have today, I think there is a lot of desperation. That-that is apparent. And this is what I'm talking to the board about, about the desperate nature of, uh, you know, structurally we can't keep doing what we're doing. Part of it's money, part of it is control. With Kevin [Spiegel, former CEO of Erlanger] it was about control. But even with Kevin I think he was like "okay, well, this is not going to work. You know, we don't have what we need." *We started, you know, deciding that we're going to control physicians or guide patients or do things that are not legal. Okay [laughs]. Not staff, not do these things, or incentivize people in a way that would cause them to act outside of ethical bounds. Whether it's, you know, trying to do too many cases, or not coding right, or sharing your password, or concurrent surgery. All those things kind of flow from, you know, more RVUs, more money. . .*
> .

142. Plaintiffs-Relators have learned that the current CEO, Dr. Jackson, who assumed his role in the fall of 2019, has little interest in the work required to change the culture of an institution rife with malfeasance.

1. *Sharing of Log-In Credentials*

143. Among the problematic practices common at Erlanger is the sharing of physician login credentials among nurses, medical assistants, and other clinical staff so the doctor can minimize time spent reviewing records or documenting in the medical record at a computer. In some cases, this involves a nurse or medical assistant creating and authenticating orders for a patient's prescriptions, including for controlled substances, while the physician is not in the office. Prescribing a patient medication amounts to practicing medicine without a license since nurses or medical assistants are performing the doctor's duties without the physician's presence and without written protocols authorizing their activities.

144. Under normal circumstances, a medical assistant or nurse can function in a scribe capacity, using his or her login credentials, to electronically document the physician's exam

findings, diagnoses, prescriptions, and surgery orders for a patient. The physician is then required to use his or her own unique login to access the patient's chart and review and edit it as needed before authenticating and "signing off" on the patient's care orders. Among other things, this process, as is standard in medical centers across the country, serves to protect patient privacy and patient safety under the HIPAA requirements.[46] At Erlanger, however, Plaintiffs-Relators found that these standards have been shirked and ignored since as early as 1997.

145. Beginning June of 2018 and on numerous occasions up through the present, Dr. S. Adams provided to Defendants' leadership examples of simultaneous log-ins from the same surgeon's credentials at as many as three different workstations within the hospital. Although Dr. Adams has been able to work with members of Erlanger's compliance department and others to implement a scribe feature and educate physicians on proper documentation authentication, to this day the problem continues.

146. On August 7, 2020, Doctors J. Adams and Steinmann notified Julie Dean, Erlanger's Chief Compliance Officer, about the improper credential sharing; they were told it was a standard workflow. Dr. Adams followed up with an email dated August 24, 2020, stating,

> My husband, Scott Steinmann and I were told when we started, to give staff our log in credentials. We were told that its ok to log in and then let staff document for you and this was the standard work flow…. Scott has been working with staff who ask for his login and most recently he was working with a MA who said "hey, Dr Steinmann, your log in and password aren't in the binder." These were reported by him and me."

147. Dean's email response, dated September 3, 2020, stated,

> Compliance personnel interviewed several individuals in Suite C430 on 8/27/20. No one admitted to asking for physician usernames and passwords. None of them admitted to having a log book or any list of user names and passwords. I then requested Dr. Steinmann to give me the name of the MA and he provided the name [Medical Assistant A]. I met with [Medical Assistant A] on 9/2/20. [Medical

[46] 2013 HITECH Law; 45 C.F.R. § 164.312(a)(2)(i).

> Assistant A] confirmed that she did ask for Dr. Steinmann's username and password. She did not admit that there is a log book or other list of usernames and passwords. With regard to the "standard workflow" referenced above, this is an interim workflow that compliance agreed to prior to your arrival at Erlanger, while the MA Scribe template is being built in eChart/EPIC. While it is not a perfect interim workflow, it does not violate HIPAA and eliminates the need to share passwords.

148. Dr. J. Adams was told in a conversation with Dr. Jeremy Bruce, UTCOM Orthopedic Surgery Residency Program Director, on November 6, 2020 that the "group's major issue is that they don't like you going to compliance." "We all are busy and efficient and to be efficient we need to share our passwords and are worried [Dr. J. Adams] will turn us in." When Dr. J. Adams brought the credentials issue up again on February 10, 2021, in the presence of Floyd Chasse, head of Erlanger's human resources department, Jeff Woodard, Erlanger's Chief Legal Officer, and Dean, she was told by Woodard that there had been an "amendment" to the HITECH law that allows the sharing of credentials. Plaintiffs-Relators and their counsel have found no record of such an amendment.

149. In a March 10, 2021 email chain, Holly Neerman, a Privacy and Information Security Analyst in Erlanger's compliance department, informed Erlanger leadership as well as Dr. S. Adams that there had been several instances of "suspicious accesses" of the login credentials of Dr. Bruce, Erlanger's Orthopedics Program Residency Director, which were apparently used by nurses, physician's assistants, athletic trainers, and others. In a subsequent email in the chain, Neerman confided to Dr. S. Adams that she had "a feeling that there is still a log book somewhere with everyone's login." *Id.*

150. Indeed, Dr. Bruce had stated to Plaintiffs-Relators that he could "save an hour or more a day" by allowing his nurse to perform the bulk of his documentation and "sign off" on his charts. In March 2021, it was discovered that his nurse created a surgery order for the wrong shoulder of a patient, then verified and authenticated the order using Dr. Bruce's credentials.

This patient would likely have undergone an operation on the wrong side of his or her body had it not been for a vigilant nurse who stopped the case at the last minute.

151. Performing surgery on the wrong side of a patient's body, on the wrong part of the body, or on the wrong patient entirely is called "wrong site surgery." This is called a "never event" because it should never happen; safety protocols are specifically designed to prevent such events. At Erlanger, the rate of wrong site surgery over the past five years was nearly *six times*[47] the national average. Plaintiffs-Relators were disturbed to learn the frequency of such an easily avoidable but devastating surgical error at their place of employment; even more so after learning that the hospital had only recently begun to address the issue seriously. During March 2021 meetings with clinical staff, Defendants' surgical leadership concluded that the majority of the errors were "related to site marking," with specific instances including "wrong level of spine was marked," "site marking did not occur pre-op," and "incorrect site marked in the OR." Perhaps most telling: "timeout was performed, but team not paying attention." In short, Erlanger has permitted negligent pre-operative and operative practices to run rampant at the expense of patient safety and surgical outcomes.

152. Another standard of participation for Medicaid and Medicare is that institutions like Erlanger must provide and document physician training in certain areas, including training on HIPAA requirements. Erlanger does this via assigning "Erlanger online learning" or "EOLs." Dr. Bruce told Dr. J. Adams on November 6, 2020, that his nurse does his online training for him.

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[47] "Current estimates for wrong-site surgery and retained surgical items are one event per 100,000 procedures and one event per 10,000 procedures, respectively…" https://pubmed.ncbi.nlm.nih.gov/26061125/ (accessed Mar. 31, 2021). Out of 200,000 procedures Erlanger reported five wrong site surgeries, one near miss, and six wrong site ancillary procedures.

153. When Dr. S. Adams ran a program to audit logins, he discovered that several surgeons were logged in and doing EOL training at a site distant from where they were at the same time doing surgical cases. In other words, someone else was logged in under their credentials doing EOL training for them. Dr. Adams informed Dean and Percent in November 2020 and offered to do a fuller analysis, but they rejected the information. Dean said that additional information would likely bring additional trouble for Dr. J. Adams, and that the administration would be unlikely to take significant action against surgeons for not doing the training. Based on her directive, Dr. S. Adams did not do the full analysis to determine the full extent of the problem.

154. Significantly, in November and December of 2020, the compliance department was responding to an inquiry from the DOJ Office of Civil Rights regarding a HIPAA breach involving patient health information. The inquiry required Erlanger to provide documentation that its employees had completed required HIPAA training. Erlanger submitted a "Year-End Dashboard evidencing completion of training during fiscal year 2020," despite knowing that the report was inaccurate, and purposefully avoided taking any steps to determine how widespread the practice was.

155. In a recorded phone call between Dean and Dr. J. Adams on December 17, 2020, Dean said that she was aware that some of Dr. Adams' colleagues did not do their own trainings. However, in a subsequent meeting on February 10, 2021, with Dean, Woodard from Erlanger's legal department, and Floyd Chasse, Dean expressed surprise when Dr. Adams stated that some surgeons did not do their own EOLs. Dean responded that that had not been her experience and she was unaware of the problem.

2. *Unread Test Results*

156. In October 2019, Dr. S. Adams alerted Erlanger's CEO, CCO, COO, and others

of another significant patient safety issue: Erlanger was billing Medicare and Medicaid for patient tests and analyses that were never reviewed by the patient's physician. Specifically, Dr. Adams relayed that Erlanger's electronic patient health information portal showed nearly 400 clinician accounts with no sign of log-on activity for the prior 90 days, despite many of those accounts having received patient test results or other important patient information. This issue affects more than 5,000 unique patients and represents more than 17,000 test results that may not have been reviewed by any clinician. Dr. Adams provided examples of potentially dangerous test results that were among those never seen by the patient's doctor:

- Computed tomography (CT) scan from 2018 showing probable lung cancer;
- CT scan that was more than a year old and required a three-month follow-up CT scan to evaluate pulmonary nodules;
- Severe iron deficiency anemia in a 59-year-old; and
- At least two near-miss cancer diagnoses.

157. Despite repeatedly lobbying administrators and medical staff leaders, this issue remains unresolved as of April 2021.

158. Both Dr. S. Adams and Dr. J. Adams have repeatedly raised the problem of improper billing associated with imaging studies or imaging guided injections; as well as unresulted – *i.e.*, unread – imaging studies. Specifically, at the beginning of December 2019, Dr. J. Adams spoke to Chris Werner, an orthopedic administrator, regarding unresulted x-rays. Dr. Adams had not been given the correct credentials to "read" the x-rays and enter a result in the system. Recognizing this, she asked repeatedly to have the system fixed, and in the interim, have the unread x-rays sent to radiology in order to be read and resulted. These multiple requests were ignored for months, until she was finally given access to "read" and "result" the films herself in April 2020. At that time, Dr. Adams discovered that none of the films she had asked to be sent to

radiology had been read, resulting in delinquent films from October to December 2019. This is a patient safety concern, as no official interpretation of the films was entered into the system, as well as a billing and coding concern.

159. Dr. S. Adams had previously raised the issue of physician assistants and nurse practitioners independently reading and billing for interpretation of x-rays. The current system at Erlanger is problematic: PAs and NPs read the films and then the supervising physician co-signs the interpretation.

160. The Plaintiffs-Relators allege that the supervising physicians do not actually look at the films in order to verify the interpretation, rather they simply "sign off." Additionally, Plaintiff-Relator Dr. J. Adams is aware from discussions in the Spring of 2020, with Dr. Richard Alvarez, Former Chair of Orthopaedic Surgery and Erlanger physician, that he had "hundreds" of unresulted and unread x-rays in his queue, and when he was asked by leadership to result those, he responded, "Don't hold your breath." To Plaintiffs-Relators' knowledge, he has not been sanctioned or evaluated in any way.

161. Finally, Dr. J. Adams expressed concerns regarding the radiograph exams she had expressly asked, multiple times, to be sent to the radiologist to be reviewed. These were sitting in her queue, despite her requests. An email exchange between Dr. Adams, Samantha Reid, an office manager, and Werner on Friday, March 26, 2021, documents those concerns and that Dr. Adams noted unread radiographs dating back to December 2020. After being terminated on Monday, March 29, 2021, Dr. Adams repeatedly brought up the concern of the unread radiographs, including an email to Chasse and in discussions over the phone with Martha Burgett, Erlanger's Director of Risk Management, and has to date received no response or verification that those unread radiographs will be resulted.

162. Additionally, in around May of 2020, an office-based ultrasound machine became available for Dr. J. Adams' practice. Knowing the rules regarding appropriate documentation required for billing of diagnostic ultrasounds and ultrasound guided procedures, Dr. Adams was surprised to find that there existed no mechanism to appropriately save and interpret images and document same in the electronic medical and imaging system, a billing requirement. Yet, as both Dr. J. Adams and Dr. S. Adams were aware, ultrasound guided injections and diagnostic ultrasounds had been performed in the orthopedic surgery department for more than a decade. A discussion with Dr. W. Hunter Garrett and Dr. Brandon Cincere revealed that the standard workflow among orthopedic surgeons and others had simply been to save images on the machine, rather than upload them to the electronic medical system for permanent storage. This process fails to meet the documentation requirements for billing.

163. Prior to Dr. J. Adams' and Dr. S. Adams' inquiries and specific independent work with the Epic analyst, Melissa Kirkland to build a de novo system that was completed around December 2020, there was no appropriate system to meet the documentation requirements required for billing. Nevertheless, Erlanger billed Medicare and Medicaid and other government payors for these ultrasound guided procedures and diagnostic studies.

3. *Insisting on Falsification of Compliance Documents*

164. J. Britton Tabor, Erlanger's Executive Vice President and CFO/Treasurer is presently pressuring Dr. S. Adams to falsely attest compliance with the Payment Card Industry Data Security Standard. Erlanger has known since 2018 that it is not following the standard, and the subject is due to be reported to the Board's Audit and Compliance Committee. When Dr. Adams told Tabor that he wouldn't sign it, a meeting was held with Tabor and multiple other members of the Erlanger finance team. Tabor told Dr. Adams that executives aren't expected to read all the details of requirements – they should trust that their team has done the work. It turns

out that no one on the finance team has read the 139 pages in the standard.

4. *Unbundling of Surgical Billing Codes*

165. Dr. J. Adams and Dr. Steinmann have, in the normal course of caring for patients, reviewed operative notes. The practice seen of unbundling of codes, excessive application of surgical codes, and codes for procedures not done was observed.

166. Dr. Adams was told not to file an e-safe safety report regarding a patient who had sustained an intraoperative laceration to a nerve by one of the Erlanger physicians. The patient reported that "the resident did the whole case" and noted immediate numbness following the procedure. Despite multiple clinic visits, the laceration went undiagnosed. The patient subsequently presented to Dr. Adams, who performed an exploration and nerve repair in early 2020. When she asked Werner, the orthopedic administrator, how to ensure the patient was not charged for the complication and the subsequent surgery required to fix the problem, he told her that it was not necessary to file an e-safe. Notably, the Erlanger orthopedic department reported "no complications" for a year, except for two hand complications. In late 2020 or early 2021, Doctors Jackson and S. Adams had a conversation about this and acknowledged that it was problematic.

5. *Failure to Perform History & Physical Examinations*

167. Dr. S. Adams also found that, since at least 2017, surgeons at Erlanger regularly performed surgery without first conducting a history and physical examination ("H&P") of the patient. Per 42 CFR 482.24(2)(i)(A), CMS' "Condition of participation: Medical record services," medical records must document evidence of an H&P completed "no more than 30 days before or 24 hours after admission or registration, but *prior to surgery or a procedure*

requiring anesthesia services."[48] In other words, all patients scheduled for surgery must undergo an H&P examination within the allotted timeframe prior to surgery or the hospital does not meet CMS's conditions for participation or payment.

168. In February of 2021, Dr. Adams presented to Erlanger's Officer Council evidence demonstrating that at least six surgeons, including Dr. Manyam, chief of cardiology, Dr. Freeman, and two department chairs routinely fabricated documentation of an H&P prior to operating on patients. Specifically, Dr. Adams showed evidence of the following:

- Physicians and advance practice providers copied notes from previous H&P examinations (without a patient visit) then authenticated as if an up-to-date, in-person H&P had occurred;
- Surgeons copied notes from prior exams, changed 2-3 words, then saved and authenticated as a new H&P, again without any patient examination or encounter;
- H&Ps generated using a mix of copied text from templates and prior exams then authenticated late into the night prior to surgery (also without performing any history, or exam, or patient encounter); and
- Discussions of informed consent documented and filed by a clinician who never saw the patient.

169. Failure to perform an H&P examination prior to surgery is not just an issue of eligibility for Medicare payment; it is a matter of patient safety. Especially in the case of the elderly, for whom surgery can pose significant risks, the H&P is necessary to ensure that the patient is healthy enough to undergo anesthesia in addition to the operation; it is crucial to ensure no new conditions have developed since the patient was last seen that might change the surgical plan. Plaintiffs-Relators note that the Erlanger surgeons' practice of performing surgery without an up-to-date H&P should not come as a surprise; this is an institution that values the revenue from increased patient throughput and surgeon productivity more than patient safety and

[48] *See* https://www.govinfo.gov/content/pkg/CFR-2011-title42-vol5/pdf/CFR-2011-title42-vol5-sec482-24.pdf (emphasis added) (accessed Apr. 2, 2021).

compliance with even the most basic of CMS's regulations.

6. *Violations of Tennessee's Laws on Prescribing Opioids*

170. Dr. Steinmann and Dr. Adams routinely observed noncompliance with Tennessee laws regarding opioid prescribing practices. In the state of Tennessee, an initial prescription generally may not exceed a three-day prescription for 180 morphine milligrams equivalents ("MME").[49] In select cases, a doctor may prescribe more than that, but this requires checking the state Controlled Substance Medical Database and documentation in the chart that the dangers of opioids were disclosed and that alternative pain regimens were considered.[50] An opioid consent is also required.[51] Further, the prescription of benzodiazepines and opioids concomitantly is prohibited.[52]

171. In cases of acute trauma, an exemption may be considered, but the ICD 10 code and "trauma exempt" must be written on the prescription. As of January 1, 2021, all prescriptions for controlled substances prescribed in the Tennessee must be electronically relayed to the pharmacy with a two-factor authentication.[53] Doctors J. Adams, S. Adams and Steinmann have

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[49] *See* https://oig.hhs.gov/oas/reports/region4/41800124_Factsheet.pdf (the "OIG Factsheet") (accessed Apr. 12, 2021); *see also* https://www.tnmed.org/assets/files/TriMED/2018Presentations/UnderstandingOpioidLaw.pdf (accessed); https://www.tn.gov/content/dam/tn/opioids/documents/FAQ%20Implementation%20of%20TN%20Together.pdf (accessed).

Morphine milligram equivalents, or MME, is a measurement of pain management physicians use to determine how different opioids relate to each other.

[50] *See* OIG Factsheet, at 1.

[51] *Id.*

[52] *Id.*

[53] Tennessee HB1993 was passed in 2018 and required electronic prescribing for Schedule II controlled substances. SB0810 was passed in 2019 and amended the previous Act to include a mandate for all controlled substances to be electronically prescribed. The Act allows for

each noted, in the routine course of taking care of their patients and reviewing their charts, that orthopedic patients who undergo elective outpatient surgical procedures such as knee or shoulder arthroscopy are frequently prescribed excess opioids with "trauma exempt" written on the prescription, even though these are not trauma cases.

172. In the fall of 2020, Dr. S. Adams' team attempted to set up Erlanger physicians for the two-factor authentication process. The team rapidly ran into resistance when orthopedic surgeons at Erlanger demanded to have their medical assistants or nurses provided the credentials to prescribe.

173. In clinic one day, Dr. J. Adams prescribed opioids for one patient such that the patient needed to sign an opioid consent. Although most of the other orthopedic surgeons and advanced-practice providers in the department routinely wrote prescriptions that required an informed consent and opioid policy in order to be compliant with Tennessee law, none of the clinic staff knew how to create the consent.

174. In the normal course of caring for their patients and doing an appropriate chart review, Doctors Adams and Dr. Steinmann observed opioid prescribing practices that violate Tennessee law. For example, surgeons would prescribe 40 tablets of oxycodone to patients following procedures such as a shoulder arthroscopy or a knee arthroscopy without putting the required documentation in the medical chart or obtaining an opioid contract or consent. In many cases, patients were given prescriptions for benzodiazepine medications at the same time.

175. In February or March 2021, Dr. J. Adams was told by Erlanger orthopedic physician Dr. Dale Ingram that he had recently prescribed opioids following a shoulder

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exceptions and waivers, and has specific penalties for noncompliance with the law. *See* https://mdtoolbox.com/eprescribe-map.aspx (accessed Apr. 15, 2021).

arthroscopy for a female patient, who then overdosed and died. Dr. Ingram explained that although the family was angry with him for prescribing the opioids, he "didn't tell her to take them all at once."

176. During the normal process of reviewing a patient's chart in March 2021, Dr. J. Adams found that the patient had been prescribed a total of 2,475 MME over the course of a 49-day period after a surgery by the trauma service in January 2021.

177. Notably, Dr. S. Adams has been asked twice by Dr. Young, Erlanger's Chief of Staff, to review opioid prescribing for compliance issues. Ashley Fleishmann, an attorney in Erlanger's compliance department, also reached out to Dr. S. Adams on the same topic. He outlined likely violations of both Tennessee and federal prescribing laws that he and Dr. J. Adams had witnessed. Karen Voiles and Fleischman and discussed it with Woodard, Erlanger's chief legal officer. Dr. S. Adams offered to investigate the issues further, but the offer thus far has been declined.

178. Dr. Steinmann and Dr. J. Adams learned through discussions with residents that they had very little understanding of the state's opioid laws. The residents presented a proposed "opioid policy" as part of a required quality improvement project ("QIP") that did not comply with state law or Erlanger policies. Dr. Adams brought this deficit up to Dean, Donna Gibson, and Dr. Bruce, the program director beginning in September 2020, but no action was taken.

179. In an email sent to Dr. Bruce on March 19, 2021, Dr. Adams stated:

> Hi Jeremy,
>
> [Resident 5] did a nice conference on Monday about pain control after surgery, as you know. I was excited to see all the interest it provoked.
>
> In several informal conversations over the past couple of weeks, it has become clear to me that many of the residents are unaware of the Tennessee state laws about opioids and prescribing. Worrisome was the QUIPs [*sic*] project that came through

as "completed" for the faculty to "sign off on" which was not actually compliant with the Tennessee state laws about opioid prescribing.

Some of the things we have discussed that they were unaware about or confused about are

1- safety issues (ie, don't prescribe benzos plus opioids)

2-requirements to assess the CSMD (when you do or don't have to look into it)

3- requirements for e prescribing (in March, a PGY 5 told me he was unaware of the Jan 1, 2021 rule that pharmacies in TN cannot fill paper rx for opioids, and also unaware of the $1000 fine that can be levied per rx)

4- trauma exemption rules vis a vis how to do it and when to do it.

5- when you have to have an opioid consent and when you don't, and how to do that.

6-MME limitations

7- what you have to document in the chart.

and others.

Part of our mission is to prepare them for practice. I don't want our department to get nailed for being an outlier, and also want them prepared for the real world. I have offered to give them a conference on the basics, if you are agreeable. Its not an exciting topic but I do think its important to them and to keep them and our department out of the headlines and to keep our patients safe. Please let me know your thoughts. Let me know if you are agreeable and throw out some times for me to do it.

Julie

180. Dr. Bruce's email response stated, "I promise most of us docs don't truly know most [of] the rules (me includ[ed])."

7. *Allowing the Performance of Unnecessary Procedures*

181. Suprascapular neuropathy is an extremely rare condition believed to involve compression of a nerve at the shoulder, leading to pain. The incidence of this condition is extremely low, likely in the low single digits, and has been described as "relatively

uncommon."[54] Moreover, a recent review article in the Journal of the American Academy of Orthopaedic Surgeons concluded that "[p]atients without an identifiable lesion should first be prescribed a course of nonsurgical management for a prolonged period."[55] "Surgical release is [] not routinely recommended unless patients . . . fail appropriate nonsurgical treatment."[56]

182. Dr. Steinmann, an internationally renowned shoulder and elbow surgeon, was shocked to discover that a surgical procedure to release the nerve compression was performed at Erlanger many times above the national average, and on almost every patient presenting with shoulder discomfort. This was particularly true of one surgeon, Dr. John "Jad" Dorizas, who billed for hundreds of such procedures every year. But other Erlanger orthopedic physicians often performed the procedure as well. In the course of taking care of patients and performing an appropriate review of their charts, each of the Plaintiffs-Relators independently observed several cases of patients who had undergone the procedure without any clear indication of medical necessity.

183. Conversations with Dr. Joshua Alpers, an Erlanger neurologist, revealed that he also had profound concerns about this practice and questioned the veracity of electrodiagnostic testing that diagnosed the condition. He stated that Dr. Dorizas became very angry after Dr. Alpers performed electrodiagnostic testing that failed to diagnose this condition, and subsequently Dr. Dorizas told other physicians that Dr. Alpers, a U.S. Army veteran and highly

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[54] *See* Strauss, Eric J. MD; Kingery, Matthew T. MD; Klein, David DO; Manjunath, Amit K. MD, *The Evaluation and Management of Suprascapular Neuropathy*, Journal of the American Academy of Orthopaedic Surgeons: August 1, 2020 - Volume 28 - Issue 15 - p 617-627 doi: 10.5435/JAAOS-D-19-00526 (available at https://journals.lww.com/jaaos/Fulltext/2020/08010/The_Evaluation_and_Management_of_Suprascapular.3.aspx (last viewed Apr. 6, 2021)).

[55] *Id.*

[56] *Id.*

regarded Duke-trained electrodiagnostician, did not know how to properly perform electrodiagnostic testing. Notably, Dr. Dorizas and other Erlanger orthopedic surgeons sent their electrodiagnostic testing studies to one physician, Dr. Kadrie, who on almost every study diagnosed suprascapular neuropathy. Dr. Alpers related to Dr. Steinmann and Dr. Adams independently that he was concerned about the high rate of suprascapular neuropathy diagnoses in the Chattanooga community and of surgery for this condition. He was told by Erlanger legal to file an e safe, but disclosed to Dr. J. Adams on March 17, 2021, that he had not done so because he feared retaliation and reprisals.

184. In addition, Plaintiffs-Relators noted that Dr. Dorizas billed such procedures as a "brachial plexus neurolysis" (CPT 64713), which reimburses at 11.4 wRVUs, rather than "decompression of a major peripheral nerve" (CPT 64708), which reimburses at only 6.36 wRVUS. According to 2018 government payor data, Dr. Dorizas ranks sixth in the nation for this specific procedural code.

8. *Faculty Salaries Used as Improper Inducement*

185. Erlanger pays several physicians inducements in the guise of academic salaries. For example, Dr. Bruce, Dr. Kiner, and Dr. Mark Freeman have academic affiliation with UTCOM. They receive compensation from UTCOM for academic activities ranging from $84,019 to $209,957 per year. Additionally, some physicians are provided benefits also paid by Erlanger through UTCOM, including health insurance and retirement, while others are not. Salary ranges for academic work in the department range from $24,500 – 209,957.

186. However, when Dr. Steinmann reviewed department financials in his role as the Chair of Orthopaedic Surgery, he was surprised to find that there was no substantiation of or support for the payment of these academic salaries and benefits. Significantly, there was no mechanism to ensure physicians did the academic work they were paid to do.

187. When Dr. Steinmann attempted to create such a mechanism, he became the target of the orthopedic department's ire. He spoke with Dean Shack of UTCOM, Dr. Robert Fore, the Designated Institutional Official ("DIO"), and Dr. Polly Hofmann about these troublesome findings during 2020 and 2021, but found there was no institutional appetite to correct the situation.

188. Specific issues Dr. Steinmann identified include the following:

- Despite UTCOM policy in which faculty are required to meet with the Chair at least annually for purposes of an annual review, Dr. Steinmann discovered that at least one faculty member, Dr. Freeman, had failed to meet at least one of the prior two years with the prior Chair;

- There was no oversight or enforcement that faculty perform the services for which they were paid;

- Dr. Steinmann noted that Dr. Bruce failed to fulfill his duties and required hours per ACGME policy as the Orthopedic Program Director. ACGME policy requires that an orthopedic program director devote at least eight hours per week during normal business hours (Monday through Friday, 8-5 p.m.) to Program Director activities such as meeting with residents, performing paperwork, developing program activities, and meeting with institutional officials. Dr. Bruce admitted to "taking a few hours" on Wednesday evenings and "sometimes" Saturday mornings "before the kids wake up" to perform these functions. When Dr. Steinmann and Dean Shack met with Dr. Bruce regarding these issues in the fall of 2020, asking him to fulfill his contractual obligations, Dr. Bruce's response was that if it was desired for him to take a day off of work to do Program Activities, "you have to pay me for it." To date, despite Dr. Steinmann's and Dean Shack's requests and the involvement of Dr. Fore and Dr. Hofmann, Dr. Bruce still does not fulfill his ACGME-required and contractually obligated hours of academic work. Notably, Dr. Bruce received a total of $209,000 for academic salary in 2020 in addition to his clinical salary from Erlanger, which is listed as a 1.0 FTE. Thus, although he is paid for both clinical and academic activities, he cannot possibly be performing both. Additionally, the academic compensation alone, without the addition of his UTCOM benefits, is roughly 4 times the national average compensation for an orthopedic program director. Dr. Bruce has repeatedly demonstrated lack of awareness of ACGME requirements for an orthopedic program. In July 2020, when Dr. Steinmann suggested residents return some patient phone calls to fulfill the ACGME requirements of mentoring residents in professionalism, Dr. Bruce and the department immediately became hostile. The orthopedic program additionally fails to fulfill minimal requirements for clinic time and for resident oversight of patient care duties. Dr. Steinmann has brought up these concerns

repeatedly to the DIO, Dr. Bruce, and Dean Shack during 2020 and 2021, with no change in the program and no response from UTCOM; and

- Dr. Freeman receives, in addition to his clinical receipts, $88,546 annually and health benefits for the rank of Assistant Professor. He takes no dedicated time off to fulfill academic duties. He has an allocation of this salary to research, yet over the past decade has produced only one paper. Dr. Freeman's goals and expectations from the prior Chair, when he did complete his annual review, were to write a case report. He did not accomplish that goal for years for the endorsed reason that "there was no resident interested." He additionally receives funds from Erlanger for his clinical activity at a 1.0 FTE as well as further compensation from Erlanger to be Erlanger Medical Group Orthopedic Surgery Medical Director.

189. The allocation of academic salaries at Erlanger is unfair and without merit. By way of contrast, Doctors J. Adams was contractually obligated to spend 25% of her time on academic activities and received an academic salary in addition to her clinical salary. Her academic salary as a full Professor of Orthopedic Surgery with an active academic presence nationally was $70,000. Yet she was deemed not eligible to receive health care benefits from UTCOM.

190. Moreover, the funds that UTCOM uses to pay these academic salaries are derived from Erlanger. Erlanger makes a lump sum payment to UTCOM, then UTCOM writes checks for academic work to physicians. These compensation numbers, without regard to merit or performance of duties, represent an improper inducement. When Dr. Steinmann raised legitimate concerns about this distribution of funds, he was attacked.

191. No investigation or corrective action has been initiated to date.

H. DEFENDANTS RETALIATED AGAINST PLAINTIFFS-RELATORS AND TERMINATED DOCTORS J. ADAMS AND STEINMANN IN VIOLATION OF THE FALSE CLAIMS ACTS AND STATE LAW

192. Employers are prohibited from discriminating against an employee, contractor, or agent in the terms and conditions of employment, including by discharge, demotion, suspension, threats, harassment, or in any other manner (collectively, "retaliate" or "retaliation") because of

lawful acts done by the employee, contractor, agent, or associated others in furtherance of a *qui tam* action or other efforts to stop violations of the False Claims Act. 31 U.S.C. § 3730(h)(1); *see also* Tenn. Code Ann. § 71-5-183(g) (same).

193. As detailed below, Defendants retaliated against all three Plaintiffs-Relators for their efforts to bring ethical and regulatory violations to the attention of Erlanger leadership and to implement changes in Erlanger's surgery practices. This retaliation included verbal harassment and abusive language towards all three Plaintiffs-Relators, altered referral patterns to "punish" Doctors Steinmann and J. Adams for bringing forward compliance concerns, threats to all three Plaintiffs-Relators by leadership and other physicians to remain silent about compliance matters, refusing to provide or cutting the necessary support and resources for Dr. S. Adams to carry out his duties as CIO, including resources to produce audit reports requested by compliance, and attempts by leadership and surgeons to abrogate Doctors Steinmann and J. Adams' contractual agreements, culminating in their wrongful termination on March 29, 2021.

1. *Plaintiffs-Relators' Efforts to Stop Defendants' Continuing Violations*

194. In early 2018, Dr. S. Adams brought up to Erlanger leadership that when he performed audits as a part of his job, he noted a systematic pattern of problematic scheduling. He alerted leadership repeatedly about the systemic problems, but was ignored. Soon thereafter, he was told by Dr. Melanie Blake, then Erlanger's Associate CMO, to "watch your back because compliance has it in for you."

195. In 2019, shortly after Doctors Steinmann and J. Adams became employed by Erlanger in orthopedic surgery, they began to observe the violations and misconduct set forth above. Between November 2019 and May 2020, they repeatedly attempted to address and resolve the issues within the department administration but were rebuffed. On May 18, 2020, Dr. J. Adams sought the advice of Erlanger's CEO, Dr. Jackson. He introduced her to Percent,

Erlanger's compliance auditor. Plaintiffs-Relators subsequently presented information about billing and coding errors, professionalism issues, scope of practice, violations of Erlanger policy, and potential violations of federal statutes to Dean, Erlanger's Chief Compliance Officer, and Percent, who acknowledged each of the issues identified to be valid.

196. Reporting these issues to Erlanger compliance resulted in an investigation that began on or about August 7, 2020.

197. Additionally, on December 17, 2020, January 20, 2021, March 3, 3021, and April 5, 2021, Dr. Steinmann had a series of in-person discussions with R. Phillip Burns, M.D., a surgeon at Defendant USA as well as UTCOM Professor and Chair of General Surgery and member of Erlanger's Board of Trustees, regarding the retaliation and Plaintiffs-Relators' patient care concerns. To Plaintiffs-Relators' knowledge, Dr. Burns has taken no action.

198. Similarly, Doctors J. Adams and Steinmann brought up in multiple meetings with Dean Shack the fact that they have followed UTCOM and Erlanger policy yet have been retaliated against by UTCOM employees. Doctors Steinmann and Adams also met with Chandra Alston, UTCOM Associate Vice Chancellor of Human Resources, and Olivia Ralph, UTCOM Senior Compliance Officer, on January 6, 2021 and again January 13, 2021, to express their concerns. To date, no investigation or corrective action has been performed by UTCOM despite its own policies about retaliation, bullying, and harassment. Rather, the misconduct has been allowed to proceed.

2. *Defendants' Retaliatory Conduct Against Plaintiffs-Relators*

199. The August 2020 investigation by Erlanger's compliance department angered some members of the orthopedic department as well as certain Erlanger leadership, resulting in a campaign to marginalize and then punish the Plaintiffs-Relators for their having the temerity to persist in their efforts to shine a light on Erlanger's dangerous and stubborn non-compliance with

federal and state law. Ultimately, Erlanger's campaign has resulted in the termination of Dr. J. Adams' and S. Steinmann's Erlanger employment, despite their strong performance. The decision, they were told, was "administrative" in nature; it was plainly designed to get them out of Erlanger before they brought the Erlanger "enterprise" down. As to Dr. S. Adams, Erlanger's campaign of retaliation has resulted in threats of termination and a diminution of his compensation, with retaliatory conditions ongoing.

200. From the start of Dr. J. Adams' advocacy for compliance, the retaliation she has suffered has not been subtle. For instance, shortly after she had submitted a formal complaint, on or about August 24, 2020, Meridith O'Keefe, Erlanger Senior Vice President, Physician Services, told her that she could not participate in the call pool, thus marginalizing her and making it much more difficult for her, as a newcomer to the area, to develop her practice, which, in turn, made it harder for her to meet her productivity goals and cost her compensation. O'Keefe was blunt: "Your colleagues do not want you seeing patients/sharing office space/office staff/participating in the group," not because of quality issues, moral or ethical issues, or skill issues, but because "you have ruffled some feathers." In other words, this exclusion was essentially *because of her protected conduct*. In that same conversation, O'Keefe chastised her for taking the issues outside of the orthopedic department to the compliance department. The message could not be clearer: If you want a future in this department, you will be quiet.

201. As for Dr. Steinmann, although he was Chair, he too was denied access to patients through departmental referrals and the normal ways patients were assigned within the department. Members of the Erlanger orthopedics department sought to start damaging – and entirely false – rumors that Doctors J. Adams and Steinmann had engaged in inappropriate efforts to secure patients, rumors designed to breed distrust and prevent them from succeeding in

their practices at Erlanger.

202. On information and belief, a meeting of the "Ortho Board," an informal departmental governance body at Erlanger, was convened in August of 2020. The board had apparently recently voted to exclude the UTCOM Chair of Orthopedic Surgery, *i.e.*, Dr. Steinmann, from such meetings. Nor was Dr. J. Adams invited. It is Plaintiffs-Relators' understanding that at this meeting and subsequent gatherings of the board, the group advocated for the termination of Doctors J. Adams and Steinmann. The position had nothing to do with their work as surgeons, their clinical acumen, or their stature. Rather, as one participant told Plaintiffs-Relators, "the biggest concern [voiced at these meetings] was you went to compliance." The participant further stated that while "some of us thought this could be worked out," Dr. Freeman, Erlanger Orthopedic Medical Director and UTCOM Assistant Professor and Director of Reconstructive Surgery and Arthroplasty, "was adamant that because he had to talk to legal, [the Plaintiffs-Relators] ha[d] to be fired."

203. This view was not just privately held by Dr. Freeman. Instead, it was presented to – and clearly adopted by – the Defendants. On information and belief, Dr. Freeman went to Dr. Argil Wheelock, the Erlanger Chief Medical Officer, and demanded that Plaintiffs-Relators be fired. Dr. Wheelock referred him to Dean Shack. Subsequently, Doctors Freeman and Bruce met with Dean Shack. Dr. Freeman demanded in that meeting that Plaintiffs-Relators be removed.

204. Aware of ongoing retaliatory conduct within the department, on November 5, 2020, Dr. J. Adams met with Dr. Jackson, Erlanger's CEO, and O'Keefe, hoping for redress and an assurance that she would not suffer retaliation for having used the appropriate hospital mechanisms to address the disturbing non-compliance she witnessed.

205. Instead, the message from Erlanger leadership was clear: it was she who would

need to change, not Erlanger. O'Keefe told Dr. J. Adams that "we are at a crossroads" in terms of her continued employment. She was told to speak to a list of five or six listed orthopedic surgeons in the orthopedics department, with "hat in hand" and humility, to apologize to them and ask how she could do better. Notably, Dr. Freeman, the surgeon who had most loudly called for her termination for raising compliance concerns, was not on the list. She was told to report back to O'Keefe and Dr. Jackson, which she did on November 23, 2020.

206. When she reported back, she was chastised for not speaking to the surgeon who had most loudly called for her termination for raising compliance concerns, Dr. Freeman and for "not taking ownership" of the situation. There was not a word of support for her having raised compliance problems. As for her speaking to compliance, O'Keefe's comments were essentially this: you should not have done this as you did, despite the fact that the compliance department should be available to all under such circumstances.

207. With the evident support of Erlanger leadership, the retaliatory campaign against Plaintiffs-Relators continued unabated. For instance, on December 9, 2020, the Erlanger Orthopedic Group met. An agenda item during the "physician-only" portion at the end was to address "open discussion of physician colleague issues." The agenda item was focused on a discussion of Doctor. J. Adams and Steinmann. Dr. Freeman led off the discussion – which focused on Plaintiffs-Relators' having publicized the problematic practices outlined in this Complaint – with personal smears against Plaintiffs-Relators. The discussion revealed the deep animosity of some members of the group against Doctors Steinmann and J. Adams and devolved into a spate of false allegations against all Plaintiffs-Relators, calling into question their professional integrity and suggesting the depth of reputation harm the Erlanger's members intentionally and maliciously were inflicting upon Plaintiffs-Relators precisely because they

spoke out against practices that endanger patients and perpetrate a fraud on the government.

208. On information and belief, following that Zoom meeting in December of 2020, Doctors Freeman and Kiner met with UTCOM's Dean Shack and again requested that Plaintiffs-Relators be removed. On information and belief, the issue was further escalated to UTCOM's central administration in Memphis.

209. Erlanger's leadership was well aware of the genesis of the departmental campaign and its retaliatory nature. Erlanger was also well aware of its contractual obligations, particularly to Dr. Steinmann, whom the institution, in coordination with UTCOM had recruited to serve as Chair.

210. The contractual arrangements arose thus: Dr. Steinmann was recruited from his prior position as Professor of Orthopedic Surgery at the Mayo Clinic to be Chair of Orthopaedic Surgery at UTCOM Chattanooga. He has a national and international reputation as an excellent surgeon and clinician, an advocate for patient care, and a trusted colleague. The job description he was recruited under reads:

> The Chair of Orthopaedics is the Chief Executive and Academic Officer of the Department and is responsible for the entirety of the clinical, educational, research, and medical staff activities of the Department. The Chair will be responsible for interdepartmental collaborative efforts that drive performance towards the organizational goals and priorities. The Chair will be responsible for achieving institutional objectives related to staff development, financial performance, regulatory compliance, marketing, and public relations. . . .

211. Dr. Steinmann learned that despite his stated purview as Chair of UTCOM's Orthopaedics department, practical authority in the areas of resource allocation, finances, and compliance, resides with the Erlanger's Orthopedics Medical Director, Dr. Freeman who chairs the self-styled "Ortho Board" to which the governance of the department has traditionally devolved.

212. After Dr. Steinmann had raised patient safety and compliance matters within

orthopedics and came to understand the Ortho Board's role in ratifying non-compliant conduct and resisting change to improve the department's practices, Dr. Steinmann spoke with O'Keefe and Dr. Jackson regarding the limitations on his ability to create needed change within the department. Although he had previously alerted them to concerns about the Ortho Board structure and they had appeared supportive, when he did so again after going to compliance, their support evaporated. For instance, when Dr. Steinmann pressed the issue in November of 2020, reviewing the language in his contract with Erlanger's CEO as well as O'Keefe, Dr. Jackson brushed him aside, falsely asserting that the above description of his job meant nothing in practical terms, as UTCOM made them write the job description that way, an allegation that has been refuted by UTCOM and Dean Shack. The real reason for Dr. Steinmann's persistently diminished role was retaliation.

213. During a meeting with Dr. Jackson and O'Keefe entitled "followup," held January 14, 2021, Dr. Steinmann was informed that Erlanger was planning to abrogate his contractual salary guarantee, which specifically permits a time for Dr. Steinmann, who came in as Chair from the Mayo Clinic and did not have an established practice in the area, to establish himself and his practice prior to requiring that he meet productivity standards. The reasons for the reduction in salary, they said, had to do with his productivity, ignoring the plain language and obvious intent of the contract. When he pressed the point, after being informed that his salary would be substantially reduced as of May 1, 2021, O'Keefe asserted that the reduction was necessary to contend with the fact that compliance had flagged Dr. Steinmann's salary as potentially violative of the of the Physician Self-Referral Laws, or Stark.

214. Upon questioning Dean and Percent, Dr. Steinmann learned that no flag had been put on his contract. Polly Hofmann, UTCOM Senior Associate Dean, confirmed the same. This

makes sense, as Dr. Steinmann's compensation for his Chair position was not outside of industry standards at all. Relevant here, it is industry standard in the area of academic medicine to provide a three- to five-year guarantee to any established physician who is recruited to a new location to become an academic department chair. The reasons proffered for the reduction of Dr. Steinmann's compensation were, in short, bogus. They were merely a pretext for the punishment Erlanger sought to mete out based upon Dr. Steinmann's audacity in raising serious patient safety and compliance concerns.

215. Faced with the persistent marginalization within their department and plainly retaliatory threats to their security by Erlanger's leadership, on March 24, 2021, Doctors J. Adams and Steinmann submitted an internal complaint outlining the course of retaliation they had suffered. They also raised concerns about an environment in which it is unsafe to speak up on behalf of patient safety issues, as well as the professionalism concerns that accompany such a situation.

216. They submitted their complaint through Erlanger's Occurrence Reporting Mechanism, known as "e-safe," which is designed to be a confidential, peer-reviewed mechanism through which problems can be raised directly to Medical Staff leadership and the Medical Executive Committee in a confidential manner without fear of reprisal. According to policy and protocol, each e-safe is to be confidentially reviewed, evaluated, and investigated.

217. That did not occur here. The process instead was this: Dr. J. Adams e-mailed the e-safe complaint to Pat Eller, Manager of the Officers of the Medical Staff, on March 24, 2021 at 7:44 am, after which Ms. Eller confirmed receipt and that, on that very day, she, with the assistance of Jackie Bishop, from Erlanger's Quality Improvement Department, "locked" the e-safe, as per the usual protocol. On information and belief, however, when the e-safe is "locked,",

Woodard, as Erlanger's Chief Legal Officer, is alerted to the e-safe's existence and given immediate access to the document.

218. On information and belief, the very next evening, on Thursday, March 25, 2021, Erlanger's Board of Trustees met. During an Executive Committee session at the end of the meeting, the Board was informed that the CEO wanted to terminate the employment of both Dr. Steinmann and Dr. J. Adams. While he apparently did not mention the e-safe in this presentation, on information and belief, Erlanger's CEO convinced the Board that he needed to do this because Doctors J. Adams and Steinmann represent "a threat … to the enterprise."

219. Erlanger's retaliatory campaign against Doctors J. Adams and Steinmann culminated on March 29, 2021, when Erlanger's leadership notified them of the decision to terminate their employment with Erlanger. They were told that there had been an "administrative decision to terminate [their] contract[s]" not for cause and having nothing to do with their delivery of medical care. Their hospital privileges, in fact, remain intact at this time.

220. Notwithstanding the "administrative" nature of the decision, Doctors J. Adams and Steinmann were instructed that they were relieved of all clinical duties, effective *immediately*. When Plaintiffs-Relators raised questions about the continuing care for their patients, some of whom had just undergone surgery mere hours before, they were told this was no longer their responsibility and were denied the ability to provide care during the postoperative global period for these patients to fulfill their ethical and professional obligations. Their patients were thus put at risk as there was no clear plan to address pending matters and ongoing patient care. The rush to move Plaintiffs-Relators out was contrary to established industry standards and protocols; it revealed the intensity of Erlanger's retaliatory ire against Plaintiffs-Relators for declining to do what they had been told and just be quiet and accept a lesser punishment for their

patient safety and compliance advocacy in the past.

221. On March 30, 2021 Doctors Steinmann and J. Adams met with UTCOM's Dean Shack who admitted that he had been informed of the termination only after Erlanger's CEO had notified Plaintiffs-Relators. Dean Shack relayed his conversation with Dr. Jackson from the day prior. A transcription of the exchange includes the following

> Dean Shack: Apparently Will [Jackson, CEO] was able to convince the [Erlanger Board of Trustees], the members of the board – the nine people that are actually the board members – that **you all were a threat to the - what's he call it - organization, the institution, he calls it, oh, the "enterprise," he calls it. . . . "We have to protect the enterprise,"** and I said, "well, what's their threat to the enterprise? They're working, they're doing what they need to do." But the board made the final decision and instructed Will to do what he did yesterday.
>
> Dr. J. Adams: . . . So it's interesting because we turned in that e-safe on Wednesday and the decision was made to fire us on Thursday.
>
> Dean Shack: . . . [A]fter the [Board of Trustees] meeting, the public board meeting, ended [on March 25, 2021], there was this private meeting. And that's when Will brought this up, and I don't know what his pitch to the board was to make them come to this conclusion, but he told me on a telephone call yesterday afternoon just after you left his office that it was to "protect the enterprise." And I said "well, what's the threat from these to two people to the enterprise?" And he said "I'll tell you tomorrow."

222. On information and belief, in taking this action and terminating Plaintiffs-Relators' employment, Erlanger was well aware that it was wrongfully interfering with Doctors Steinmann and J. Adams' academic appointments and compensation from UTCOM. Erlanger was well aware that, on its own, UTCOM would not have taken any action against Doctors Steinmann and J. Adams, as the school had just recently reviewed the Plaintiffs-Relators and found them successful in their positions.

223. Notwithstanding, Doctors Steinmann and J. Adams face the possibility now of losing their academic positions, which require as a condition of their appointments their "maintaining membership" with Erlanger. Critically here, Doctors Steinmann and J. Adams

derive economic benefit and professional stature from their academic appointments and endeavors. For Dr. J. Adams, her employment itself included a pledge of 25% protected time for academic endeavors and an annual salary, supplemental to her Erlanger compensation, of $70,000. For Dr. Steinmann, his UTCOM appointment as Chair included a salary of $250,000 derived from a combination of state funds and his professorial work involved in graduate medical education. All of this stands currently – and purposefully, from Erlanger's perspective – at risk.

224. On information and belief, as part of their retaliatory plan, Erlanger has intentionally interfered with Plaintiffs' advantageous relationship with UTCOM, seeking – without consulting the Dean – to cause a breach in that contractual relationship as well.

225. While Erlanger has terminated its relationship with Doctors J. Adams and Steinmann, it has chosen to take a longer view of its retaliatory campaign against Dr. S. Adams. Instead of terminating this long time, effective senior member of its administration, Erlanger's leadership has elected to continue its retaliation by threating his job security, letting him know that they are watching him, and cutting his compensation in terms of bonuses and additional increases in pay.

VI. COUNTS

COUNT I

Federal False Claims Act, 31 U.S.C. § 3729(a)(1)

226. All of the preceding allegations are incorporated herein.

227. This is a claim for treble damages and civil penalties under the False Claims Act, 31 U.S.C. § 3729(a)(1)(A).

228. By virtue of the conduct described above, Defendants knowingly caused to be presented to Medicare, Medicaid, and other government-funded health insurance programs false

or fraudulent claims for the improper payment or approval of claims for overlapping surgeries that did not comply with Medicare and Medicaid rules, overlapping surgeries that were not properly documented, overlapping surgeries where unreasonable and unnecessary anesthesia was provided to patients, and overlapping surgeries where valid informed consent was not obtained.

229. The United States, unaware of the falsity or fraudulent nature of the claims that Defendants caused, paid for claims that otherwise would not have been allowed.

230. By reason of these payments, the United States has been damaged, and continues to be damaged, in a substantial amount.

COUNT II

Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(B)

231. All of the preceding allegations are incorporated herein.

232. This is a claim for treble damages and civil penalties under the False Claims Act, 31 U.S.C. § 3729(a)(1)(B).

233. By virtue of the conduct described above, Defendants knowingly caused to be made or used false records or statements that caused false claims to be paid or approved by the United States government.

234. The United States, unaware of the falsity or fraudulent nature of the claims that Defendants caused, paid for claims that otherwise would not have been allowed.

By reason of these payments, the United States has been damaged, and continues to be damaged, in a substantial amount.

COUNT III

Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(C)

235. All of the preceding allegations are incorporated herein.

236. This is a claim for treble damages and civil penalties under the False Claims Act, 31 U.S.C. § 3729(a)(1)(C).

237. Defendants entered into a conspiracy or conspiracies through their member physicians, officers, and employees to defraud the United States by submitting and obtaining approval and payment for false and fraudulent claims for health care services provided to beneficiaries of federal health insurance programs, for among other things, overlapping surgeries that did not comply with Medicare and Medicaid rules, overlapping surgeries that were not properly documented, overlapping surgeries where unreasonable and unnecessary anesthesia was provided to patients, and overlapping surgeries where valid informed consent was not obtained.

238. The United States, unaware of the falsity or fraudulent nature of the claims that Defendants caused, paid for claims that otherwise would not have been allowed.

239. By reason of these payments, the United States has been damaged, and continues to be damaged, in a substantial amount.

COUNT IV

Federal False Claims Act, 31 U.S.C. § 3729(a)(1)(G)

240. All of the preceding allegations are incorporated herein.

241. This is a claim for treble damages and civil penalties under the False Claims Act, 31 U.S.C. § 3729(a)(1)(G).

242. By virtue of the conduct described above, Defendants knowingly made, used, or caused to be made or used false records or false statements that are material to an obligation to pay or transmit money to the Government.

243. Because Defendants have failed to reimburse the federal government for sums it received unlawfully by virtue of the conduct described above, the United States has been damaged, and continues to be damaged, in a substantial amount.

COUNT V

Federal False Claims Act, 31 U.S.C. § 3730(h)

244. All of the preceding allegations are incorporated herein.

245. This is a claim for reinstatement, two times the amount of back pay, interest on back pay, and/or compensation for special damages, including litigation costs and attorney's fees, under the False Claims Act, 31 U.S.C. § 3730(h).

246. By virtue of the conduct described above, Defendants discriminated against Plaintiffs-Relators in the terms and conditions of their employment because of Plaintiffs-Relators' lawful efforts to stop one or more of the violations alleged herein.

247. Plaintiffs-Relators, who were wrongfully terminated and/or otherwise discriminated against by Defendants, were injured and continue to be injured in a substantial amount. They are entitled to all legal and equitable relief necessary to make them whole.

COUNT VI

Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(A)

248. All of the preceding allegations are incorporated herein.

249. This is a claim for treble damages, consequential damages, and civil penalties pursuant to the Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(A).

250. By virtue of the conduct described above, Defendants knowingly caused to be presented to government funded health insurance programs, including Medicaid, false or fraudulent claims for the improper payment or approval of claims for overlapping surgeries that did not comply with Medicare and Medicaid rules, overlapping surgeries that were not properly documented, overlapping surgeries where unreasonable and unnecessary anesthesia was provided to patients, and overlapping surgeries where valid informed consent was not obtained.

251. The State of Tennessee, unaware of the falsity or fraudulent nature of the claims that Defendants caused, paid for claims that otherwise would not have been allowed.

252. By reason of these payments, the State has been damaged, and continues to be damaged, in a substantial amount.

COUNT VII

Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(B)

253. All of the preceding allegations are incorporated herein.

254. This is a claim for treble damages, consequential damages, and civil penalties pursuant to the Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(B).

255. By virtue of the conduct described above, Defendants knowingly caused to be made or used false records or statements material to false or fraudulent claims under the Medicaid program.

256. The State of Tennessee, unaware of the falsity or fraudulent nature of the claims that Defendants caused, paid for claims that otherwise would not have been allowed.

257. By reason of these payments, the State has been damaged, and continues to be damaged, in a substantial amount.

COUNT VIII

Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(C)

258. All of the preceding allegations are incorporated herein.

259. This is a claim for treble damages, consequential damages, and civil penalties pursuant to the Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(C).

260. Defendants entered into a conspiracy or conspiracies through their member physicians, officers, and employees to defraud the State of Tennessee

by submitting and obtaining approval and payment for false and fraudulent claims for health care services provided to beneficiaries of state health insurance programs, for among other things, overlapping surgeries that did not comply with Medicare and Medicaid rules, overlapping surgeries that were not properly documented, overlapping surgeries where unreasonable and unnecessary anesthesia was provided to patients, and overlapping surgeries where valid informed consent was not obtained.

261. The State of Tennessee, unaware of the falsity or fraudulent nature of the claims that Defendants caused, paid for claims that otherwise would not have been allowed.

262. By reason of these payments, the State of Tennessee has been damaged, and continues to be damaged, in a substantial amount.

COUNT IX

Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182(a)(1)(D)

263. All of the preceding allegations are incorporated herein.

264. This is a claim for treble damages, consequential damages, and civil penalties under the pursuant to the Tennessee Medicaid False Claims, Tenn. Code Ann. § 71-5-182(a)(1)(D).

265. By virtue of the conduct described above, Defendants knowingly made, used, or caused to be made or used false records or false statements that are material to an obligation to pay or transmit money to the state, relative to the Medicaid program.

266. Because Defendants have failed to reimburse the State of Tennessee for sums it received unlawfully by virtue of the conduct described above, the State of Tennessee has been damaged, and continues to be damaged, in a substantial amount.

COUNT X

Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-183(g)

267. All of the preceding allegations are incorporated herein.

268. This is a claim for reinstatement, two times the amount of back pay, interest on back pay, and/or compensation for any special damages, including litigation costs and attorney's fees, under the Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-183(g).

269. By virtue of the conduct described above, Defendants discriminated against Plaintiffs-Relators in the terms and conditions of their employment because of Plaintiffs-Relators' lawful acts done in furtherance of an action under the Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-182 *et seq*.

270. Plaintiffs-Relators, who were wrongfully terminated or otherwise discriminated against by Defendants, were injured and continue to be injured in a substantial amount. They are entitled to all legal and equitable relief necessary to make them whole.

COUNT XI

Breach of Contract

271. All of the preceding allegations are incorporated herein.

272. By virtue of the conduct described above, Defendant Erlanger breached its contractual obligations to the Plaintiffs-Relators who were wrongfully terminated.

273. The employment contracts between Erlanger and Plaintiffs-Relators are valid and enforceable under Tennessee law. Their wrongful termination constitutes a breach of those contracts resulting in financial damages and other injuries.

274. Erlanger had an implicit duty of good faith that it violated by terminating Plaintiffs-Relators in breach of the terms and condition of the contracts between the parties.

275. Plaintiffs-Relators are each entitled to all legal and equitable relief necessary to make them whole.

COUNT XII

Tortious Interference with Business Relationships

276. All of the preceding allegations are incorporated herein.

277. Plaintiffs-Relators Adams and Steinmann, as described above, hold positions at UTCOM that may be contingent upon maintaining a contractual relationship with Erlanger.

278. By virtue of the conduct described above, Defendants have interfered with an existing business relationship with UTCOM. Defendants knew and understood that their wrongful actions might have an adverse impact on Plaintiff-Relators' relationship with UTCOM but acted in any event in a manner designed to lead to a disruption or termination of that relationship. Because Defendants acted with an improper motive towards Plaintiffs-Relators, they have committed tortious interference with their business relationships with UTCOM.

279. They are entitled to all legal and equitable relief necessary to make them whole.

COUNT XIII

Inducement to Breach of Contract

280. All of the preceding allegations are incorporated herein.

281. Erlanger was aware of the contractual relationships between UTCOM and Plaintiffs-Relators Adams and Steinmann. Moreover, Erlanger knew that its wrongful termination of its own contracts with Plaintiffs-Relators would induce UTCOM to terminate its contracts with Plaintiffs-Relators based upon the requirements contained in the UTCOM agreement that Plaintiffs-Relators maintain a contractual relationship with Erlanger.

282. Erlanger's wrongful termination of Plaintiffs-Relators' contract was a foreseeable

and proximate cause for the ultimate termination of UTCOM's contracts with Plaintiffs-Relators.

283. They are entitled to all legal and equitable relief necessary to make them whole.

VII. PRAYER FOR RELIEF

284. WHEREFORE, for each of these claims, the *qui tam* Plaintiffs-Relators request the following relief from each of the Defendants, jointly and severally, as to the federal and state claims:

A. Three times the amount of damages that the federal and state governments sustain because of the acts of Defendants;

B. A civil penalty of not less than $11,803 and not more than $23,607[57] for each violation of 31 U.S.C. § 3729;

C. A civil penalty of not less than $5,000 and not more than $25,000 per violation pursuant to Tenn. Code Ann. § 71-5-182(a)(2);

D. The Plaintiffs-Relators be reinstated to the same level of seniority and awarded two times the amount of back pay, interest on the back pay, and/or compensation for any special damages, including litigation costs and attorney's fees, under 31 U.S.C. § 3730(h) & Tenn. Code Ann. § 71-5-183(g);

E. The Plaintiffs-Relators be awarded the maximum "Relator's share" allowed pursuant to 31 U.S.C. § 3730(d) and Tenn. Code Ann. § 71-5-183(d)(1)(A) for collecting the civil penalties and damages;

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[57] As adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, 28 U.S.C. § 2461; *see also* 86 F.R. 6, at 1725 (DOJ January 11, 2021) (setting forth 2021 adjustments). https://www.govinfo.gov/content/pkg/FR-2021-01-11/pdf/2020-29024.pdf (accessed Apr. 2, 2021).

F. The Plaintiffs-Relators be awarded reasonable attorneys' fees and costs pursuant to 31 U.S.C. § 3730(d) and Tenn. Code Ann. § 71-5-182(a)(3);

G. Interest; and

H. Such further relief as the Court deems just and proper.

VIII. JURY DEMAND

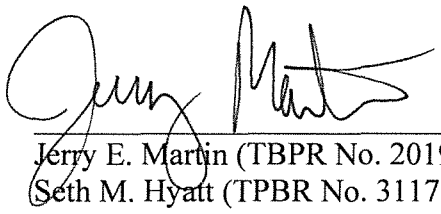
285. Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Plaintiffs-Relators hereby demand a trial by jury.

Dated: April 19, 2021

Respectfully submitted,

Plaintiffs-Relators
Stephen Adams, M.D.
Julie Adams, M.D.
Scott Steinmann, M.D.

By their attorneys,



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*Motions for Admission *pro hac vice* to be Filed