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-TRM-SKL

AMENDED COMPLAINT

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

JURY TRIAL DEMANDED

PLAINTIFFS-RELATORS' SEALED AMENDED 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.

Case No. 1:21-cv-84-TRM-SKL

AMENDED COMPLAINT

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

JURY TRIAL DEMANDED

PLAINTIFFS-RELATORS' SEALED AMENDED QUI TAM COMPLAINT

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

TABLE OF CONTENTS

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"), one of the seven largest public hospitals in the nation,[2] 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. More specifically, to maximize Erlanger's recoupment of government monies for operating rooms and other ancillary services, Defendants knowingly allowed, facilitated, and/or promoted surgeons to double- and triple-book surgeries and recoup compensation for surgeries to which they were otherwise not entitled. Defendants, who previously violated the False Claims Act and were subject to a Corporate Integrity Agreement, fully understood what they were doing; they knowingly violated state and federal laws designed to protect patients and ensure the integrity of the bills Defendants sought 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. Engaging in proscribed overlapping[3] surgeries was only part of Defendants' wrongful schemes to cheat government healthcare systems while placing patients – many poor or

---

[1] Matthew 6:24.

[2] *See* https://www.local3news.com/erlanger-ranked-7th-largest-public-hospital-in-nation/article_cf12bd84-0e6e-5233-b46c-c3ea5598ab57.html.

[3] Overlapping surgeries are frequently referred to as "concurrent" surgeries. However, the term "concurrent" has murky and contradictory definitions in the medical community. To avoid confusion, we will generally use the term "overlapping," but the two terms are synonymous for purposes of this Amended Complaint.

a minority – at risk. Among other illegal conduct, Defendants induced physicians to refer patients to Erlanger by providing them with exorbitant compensation and permitting them to shirk legal and medical responsibilities or delegate those responsibilities to unqualified staff through shared credentials.

3. Plaintiffs-Relators in this case, Doctors Stephen Adams, Julie Adams, and Scott Steinmann, are all highly established physicians and medical school professionals who have authored more than 400 articles. When they 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 and academic positions because they were – in the view of Erlanger's leadership – a "threat to the enterprise." Defendants and their agents intentionally and unlawfully interfered with Plaintiffs-Relators' contractual relationship with the University of Tennessee. Moreover, following Plaintiffs-Relators' termination, the Defendants and their agents intentionally and unlawfully interfered with their ability to find work and academic appointments elsewhere. This conduct was retaliatory and intended to unlawfully interfere with Plaintiffs-Relators' prospective economic advantage.

4. The Plaintiffs-Relators are three highly respected senior physicians, including Erlanger's former 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. Plaintiffs-Relators witnessed that Erlanger effectively instituted a two-tiered health system in which the most vulnerable patient populations

– patients who had poor health literacy or communication challenges, were "poor," or had no or inadequate insurance – were often relegated to "service patient" category status and received inferior care. Service patients were generally managed by residents with little supervision from the teaching physician. This system has disparately impacted low-income and minority patients, particularly those that are elderly or disabled.

5. Though Defendants' derelictions involved countless patients, this Complaint, brought under the federal False Claims Act and the 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.

6. 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.

7. 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. Furthermore, billing requirements were ignored. For example, teaching surgeons regularly attested to the impossibility of being present for the entirety of two surgeries occurring simultaneously in order to bill for both procedures. Similarly, surgeons billed for services as the

teaching physician in instances where three surgeries occurred at the same time despite being specifically prohibited from doing so by the regulations.

8. 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 for medical claims arising under Medicare, Medicaid, and other government-supported programs.

9. In addition to violations relating to overlapping surgeries and in further pursuit of financial gain, Defendants also violated the False Claims Act by allowing unqualified and unsupervised staff members to impersonate physicians and then perform tasks like generating and signing prescriptions, including for controlled substances, and signing orders for imaging studies and surgeries – all of which must be performed by a physician under Medicare and Medicaid rules. False claims were then submitted for those services. Further, Erlanger providers falsely created documents, including fabricating preoperative history and physical exams (H&Ps) without the required pre-surgical patient evaluation or encounter having occurred. H&Ps are bundled into the global surgical payment and are required as a CMS condition of participation. https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/globallsurgery-icn907166.pdf; https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/scletter08-12.pdf. Erlanger not only falsified the medical record but generated false documents to bypass these requirements.

10. Defendants also violated federal law governing referrals and remuneration paid to physicians in the healthcare setting, targeting additional and unlawful remuneration – above fair-market-value and for work not personally performed – as an inducement to the physicians who generate crucial revenue for Defendants through their referrals. This conduct violates conditions

of payment imposed by Medicare, Medicaid, and other government payors, and resulted in the submission of additional false claims.

11. Seeking to redress the foregoing violations, Plaintiffs-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 and additional claims set forth above that violate 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").

12. 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 and continue to be punished, with their distinguished careers now diminished if not destroyed. The punishment meted out violated the FCA's anti-retaliation provisions. Additionally, the Defendants' misconduct gives rise to state law claims sounding in contract and tort.

I. INTRODUCTION

13. The Centers for Medicare & Medicaid Services ("CMS") provides that a teaching physician must be present for the critical or key elements of each surgery. 42 C.F.R. § 415.172(a)(1). 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."[4]

14. CMS will pay for surgeries involving residents "***only*** if a teaching physician is present during the key portion of [the] service or procedure." 42 C.F.R. § 415.172(a) (emphasis added). Under the applicable billing rules, a teaching physician may leave a surgery ***only*** after the key or critical elements have been completed (residents may finish the non-critical parts).[5]

15. 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***.[6]

16. 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.").

17. In the case of three overlapping surgical procedures, the teaching surgeon is considered to be acting in a supervisory role and CMS does not allow the surgeon to bill for professional fees at all.

18. When a claim is paid for a teaching physician under a physician fee schedule and

---

[4] 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)).

[5] Medicare Claims Processing Manual, Ch. 12, § 100.1.2.A (2022); *see also* 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)).

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

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.

19. CMS also requires that an attending surgeon be present for the entire viewing of an endoscopic procedure[7] and for the entirety of surgical cases lasting five minutes or less.[8]

20. For at least the last ten years, Defendants – in conspiracy with physicians and 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.[9] 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. 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;

---

[7] *See* Medicare Claims Processing Manual, Ch. 12, § 100.1.2.A.5 (2022).

[8] *See id.* at § 100.1.2.A.3.

[9] 31 U.S.C. § 3729 *et seq.*; Tenn. Code Ann. § 71-5-181, *et. seq.*.

- 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;

- the surgeon failed to document overlapping surgeries appropriately or recorded that he was present for one or both entire cases when this was false; and/or

- the surgeon was not present for the entire viewing of endoscopic procedures or for the entirety of surgical cases lasting fewer than five minutes.

21. To illustrate the extent of overlap of relevant surgeries, the following are graphical representations,[10] provided by Plaintiffs-Relators, of the timing and duration of some of the procedures carried out by surgeons at Erlanger:

22. 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, readily available when residents are performing the surgeries, or present for the entire procedure when required;

- 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;

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

- 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.

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

24. 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.

25. 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.

26. In addition to violations relating to overlapping surgeries, Defendants engaged in other categories of unlawful conduct that led to the submission of false and fraudulent claims for payment to the Government.

27. First, in order to provide an additional inducement to its high-producing

physicians, Erlanger embraced the practice of allowing non-physician staff members to log-in to its electronic medical record systems *using a physician's credentials* in order to perform physician work. Despite being warned by Plaintiffs-Relators repeatedly about this practice over the course of years, including that it violated the Health Insurance Portability and Accountability Act, PL 104–191, August 21, 1996, 110 Stat 1936 ("HIPAA"), and gravely endangered patients by subjecting them to errors by unqualified staff members, Erlanger and its leadership feigned ignorance and allowed it to continue. As Erlanger was well aware, individuals using a single physician's credentials were often logged in at two or more work stations in different locations at the same time and were performing tasks that were required under law to be performed by a physician. As a result, Erlanger submitted numerous false claims for work performed by staff members impersonating physicians including ordering imaging studies, ordering surgical procedures, and issuing prescriptions.

28. Second, and relatedly, because of its ongoing financial distress and because the ancillary revenue generated by surgeons and physicians employed by Erlanger provides the organization a desperately needed financial lifeline, Erlanger has been paying its surgeons and certain high-volume physicians unlawful remuneration for their referrals in violation of the Stark Law.[11] Erlanger's employed high-volume physicians and surgeons are plied with compensation above fair market value and/or for work not performed. They also receive special perquisites not provided to other employees in exchange for their referrals to Erlanger. This remuneration includes having unqualified staff members perform physician work, relieving surgeons of responsibilities and thus allowing them to perform more cases, earning more for both themselves

[11] This conduct may also constitute violations of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), which makes it unlawful to offer, pay, solicit or receive anything of value as an inducement to generate business payable by Medicare or Medicaid.

through additional wRVUs[12] and Erlanger through additional referrals for ancillary services. In addition, Erlanger generally requires its physicians and surgeons to direct their referrals to Erlanger, but fails to comply with rules regulating such directed referral arrangements under the Stark Law.

29. These corrupt practices have been embraced at the highest levels of the organization, leading to numerous false claims.

II. PARTIES

30. The Plaintiffs **United States of America** and **State of Tennessee** are the real parties in interest in this *qui tam* action.

31. Plaintiff-Relator **Stephen Adams, M.D.**, is a citizen of the State of Tennessee. He is licensed to practice medicine in Tennessee and Georgia. 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").[13] 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 has reviewed and edited manuscripts for multiple prestigious academic medical journals. In 1997, Dr. Adams became a Clinical Instructor at the Department of Family

[12] wRVU or RVU stands for "work relative value unit" and is the unit by which physician clinical productivity is typically measured, including by Medicare. Erlanger Surgeon employment contracts provide for additional per wRVU bonus compensation for surgeons who generate wRVUs above a certain threshold.

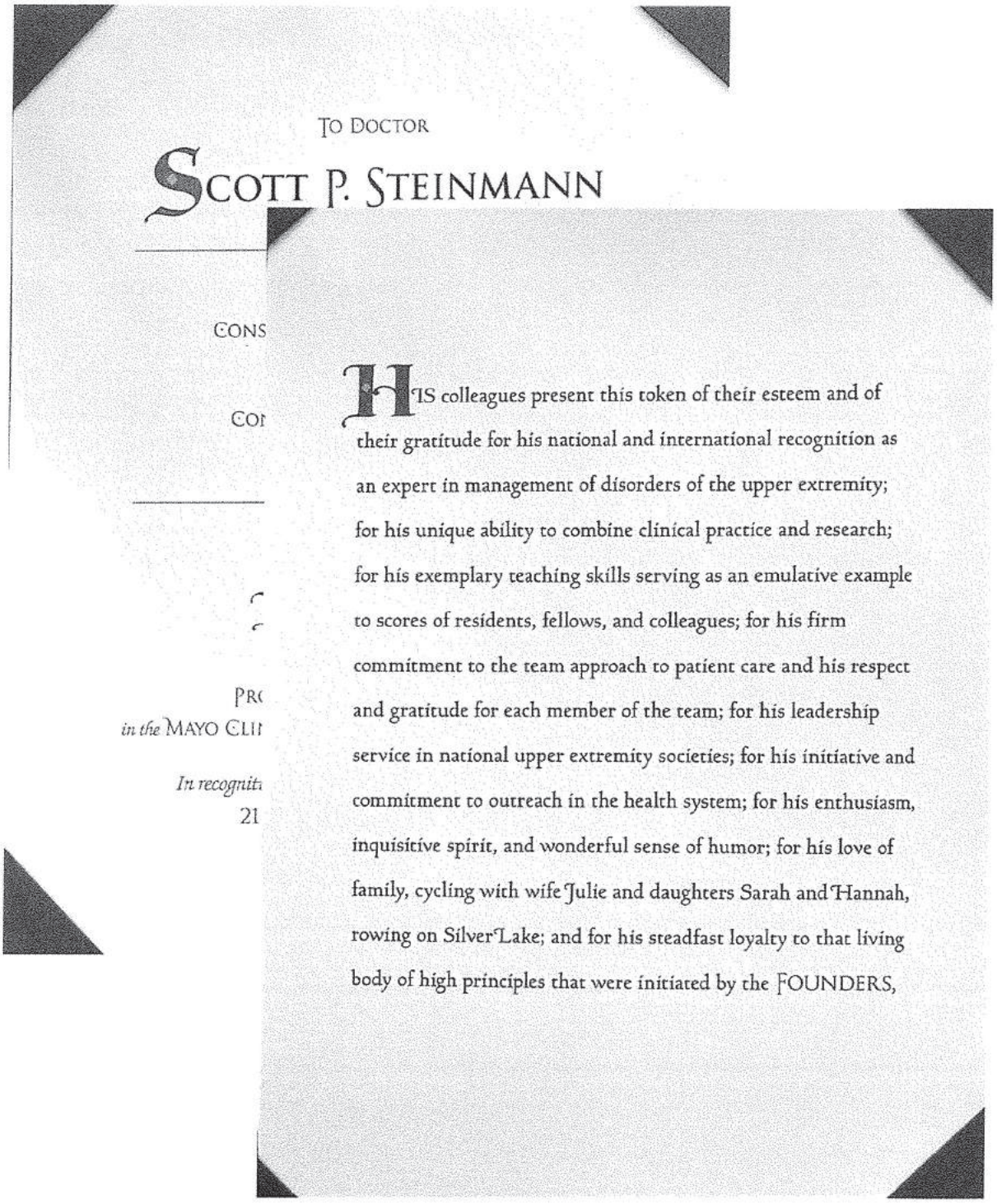
[13] There are several distinct UTCOM-related entities, including the UT Health Sciences Center, of which UTCOM is a division, as well as the Chattanooga unit of UTCOM, which has its main campus at Erlanger's Baroness Hospital. For purposes of this Complaint, all such entities are referred to collectively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

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 held the position of Chief Information Officer from December 2019 until June 2021. In the face of escalating retaliation, Dr. S. Adams resigned from his position at Erlanger and took a lower-ranking and lower-paying position outside of Erlanger.

32. Plaintiff-Relator **Julie Adams, M.D.**, is a citizen of the State of Tennessee and is licensed to practice medicine in Tennessee, Wisconsin, 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 orthopaedic surgery residency at the Mayo Clinic and, subsequently, a hand and upper-extremity fellowship in Philadelphia. She is a board-certified orthopaedic 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 orthopaedic 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 orthopaedic surgery conferences. Dr. Adams practiced at the University of Minnesota Department of Orthopaedics 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 Orthopaedic 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 orthopaedic surgeon and another with UTCOM to be a Professor of Orthopaedic Surgery. Dr. J. Adams was terminated by Erlanger on March 29, 2021.

33. Plaintiff-Relator **Scott Steinmann, M.D.**, is a citizen of the State of Tennessee and is licensed to practice medicine in Tennessee, Wisconsin, and Minnesota. He is a graduate of Columbia University and Cornell University Medical College. He completed an orthopaedic 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 orthopaedic 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 orthopaedic 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 Orthopaedic Surgery. He is now Emeritus Professor of Orthopaedics at the Mayo Clinic College of Medicine.



TO DOCTOR

SCOTT P. STEINMANN

CONS

COI

PRO

in the MAYO CLI

In recogniti

21

HIS colleagues present this token of their esteem and of their gratitude for his national and international recognition as an expert in management of disorders of the upper extremity; for his unique ability to combine clinical practice and research; for his exemplary teaching skills serving as an emulative example to scores of residents, fellows, and colleagues; for his firm commitment to the team approach to patient care and his respect and gratitude for each member of the team; for his leadership service in national upper extremity societies; for his initiative and commitment to outreach in the health system; for his enthusiasm, inquisitive spirit, and wonderful sense of humor; for his love of family, cycling with wife Julie and daughters Sarah and Hannah, rowing on Silver Lake; and for his steadfast loyalty to that living body of high principles that were initiated by the FOUNDERS,

34. Dr. Steinmann has served or presently serves as a member of numerous national orthopaedic 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 Orthopaedic 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. Dr. Steinmann was terminated by Erlanger on March 29, 2021.

35. 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."[14] Erlanger Baroness Hospital, located at 975 East 3rd Street, Chattanooga, Tennessee, serves as Erlanger's headquarters and is the primary UTCOM campus in Chattanooga.[15] It is the region's only academic teaching hospital as well as the only "Level 1" trauma center for patients from 50 counties.[16] 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

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

[15] *Id.*

[16] *Id.*

training.[17] Erlanger is the nation's tenth largest public health system and is "increasingly recognized as one of the most influential."[18] 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.[19]

36. 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."[20]

37. Below is a flow chart depicting the relationships among Erlanger leadership, Erlanger's surgical departments, and the University of Tennessee at the time of Relators' employment:

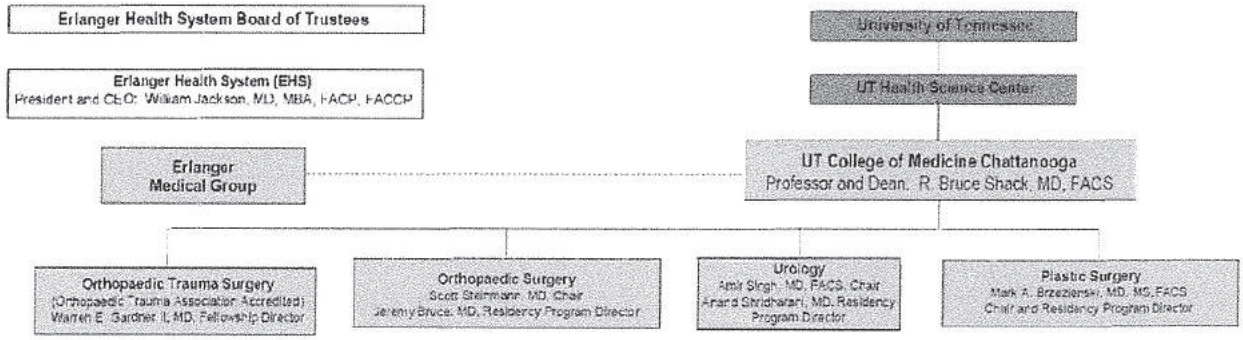
---

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

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

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

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



38. 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.[21] Relevant 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.

39. 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.

40. 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."[22] At the Erlanger

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

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

Baroness campus, ACE provides anesthesia services for "acute trauma, neurosurgery, cardiovascular, orthopaedic, urologic and general surgery specialties in 21 operating suites."[23]

41. 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, Chair as of July 2022
Jeremy Bruce, M.D.	Orthopaedic Surgeon and Orthopaedic 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.	New CEO of Erlanger, former Erlanger Board of Trustees
H. Kennedy Conner	Erlanger Board of Trustees
Bryce Cunningham, M.D.	Orthopaedic Surgeon
Julie Dean	Former Erlanger Chief Compliance Officer
Mark Freeman, M.D.	Erlanger Orthopaedic Medical Director; Head of "Ortho Board"
Warren Gardner, M.D.	Orthopaedic Surgeon and Orthopaedic Trauma Fellowship Director, UTCOM Chattanooga
John Germ	Erlanger Board of Trustees
Vicky Gregg	Erlanger Board of Trustees
Matthew Higgins, M.D.	Orthopaedic Surgeon and Erlanger Chief of Orthopaedics
Polly Hofmann	Former Senior Associate Dean, Faculty Affairs UTCOM, retired
William Jackson, M.D.	Former Erlanger CEO (terminated June 2022) and former Erlanger Chief Medical Officer
James Kennedy, M.D.	Plastic Surgeon, PSG (deceased)
Dirk Kiner, M.D.	Orthopaedic Surgeon
Meridith O'Keefe	Former Erlanger Senior VP of Physician Services
Linda Moss Mines	Erlanger Board of Trustees
Henry Okafor, M.D.	Urologic Surgeon
Karen Percent	Former Director Erlanger Audit Services
Olivia Ralph	UTCOM Senior Compliance Officer, Investigations/EEO/Title IX

[23] *Id.*

Jason Rehm, M.D.	Plastic Surgeon, PSG
James Sattler	Former Erlanger Board of Trustees
Steve Schwab, M.D.	Chancellor, UTCOM
R. Bruce Shack, M.D.	Former Dean of UTCOM Chattanooga (retired Nov. 2021)
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	Former Erlanger Executive Vice President and CFO/Treasurer (terminated 2021)
Benjamin Waldorf, M.D.	Urologic Surgeon
Gerald Webb II	Former Erlanger Board of Trustees
Jeffrey Woodard	Erlanger Chief Legal Officer
Christopher Young, M.D.	Anesthesiologist (ACE), former Erlanger Chief of Staff, former Erlanger Board of Trustees (removed Nov. 2021)

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

III. JURISDICTION AND VENUE

43. 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*.

44. 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 state claims pursuant to 28 U.S.C. § 1367 and 31 U.S.C. § 3732.

45. 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).

46. 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.

47. 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).

48. 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.* Plaintiffs-Relators have made additional disclosures of relevant information and analysis to the Government since the Complaint was filed on April 20, 2021.

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

A. GOVERNMENT HEALTH CARE PROGRAMS

49. 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").

50. 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.

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

52. 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.

53. 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.

54. 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.

55. 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."[24]

56. 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.

57. 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.

58. 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

59. 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

---

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

collected from the beneficiaries. *Id.*

60. 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.[25] 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.*

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

61. 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.

62. 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

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

presence of a teaching physician "except as provided in § 415.172").

63. 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).

64. 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." Medicare Claims Processing Manual, Ch. 12, at § 100.1.2.A.2 (emphasis added).

65. 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).[26]

66. 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.

67. In addition to the above, CMS also requires that a teaching physician be present for the entire viewing in an endoscopic procedure and for the entire procedure in surgical cases

[26] 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).

lasting five minutes or less. *Id.* at § 100.1.2.A.3. and § 100.1.2.A.5 (2022).

68. 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.[27] *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.[28]

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

70. 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.

71. In sum, the teaching physician must appropriately document his/her involvement

---

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

[28] *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).

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.

72. 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*

73. 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.*

74. 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).

75. 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*

76. 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).

77. 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).

78. 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:[29]

- 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, administering anesthesia, implanting devices, and placing invasive lines;

79. For surgeries in which residents will perform important parts of the surgery, the physician is encouraged to discuss the following with patients:

- 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

---

[29] 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).

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. *Laws Requiring That Physicians – not Their Staff – Order Services for Patients and Accompanying HIPAA Violations*

80. Applicable law is clear that there are certain tasks that must be performed by a physician, not delegated to staff impersonating a physician. For example, under 42 C.F.R. § 424.10(a), physicians are supposed to "decide[] upon admissions, order[] tests, drugs, and treatments, and determine[] the length of stay" in the hospital. Similarly, under 42 C.F.R. § 412.3(a) a patient must be formally admitted "pursuant to an order for inpatient admission [issued] by a physician or other qualified practitioner." *See also,* 42 C.F.R. § 412.3(b) ("The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. *The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients*, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff.") (emphasis added).

81. Moreover, physicians must certify the necessity of services provided as a condition for Medicare payment. 42 C.F.R. § 424.10(a) (citing sections 1814(a)(2) and 1835(a)(2) of the Social Security Act). To that end, as a general rule, "all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary. . . . *Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary*." 42 C.F.R. § 410.32(a) (emphasis added). Similarly,

"imaging, clinical laboratory services, and DMEPOS items . . . must have been ordered by a physician or, when permitted, an eligible professional (as defined in § 424.506(a) of this part)." 42 C.F.R. § 424.507(a)(1)(i). Although there are other eligible professionals, including some physician assistants and nurse practitioners, who can order these types of services, *id.*, "[t]he claim . . . must contain the legal name and the National Provider Identifier (NPI) of the physician or the eligible professional . . . who ordered the item or service."[30]

82. State law also required that physicians exercise oversight of physician's assistants and nurse practitioners working with them, which was not done.[31]

83. Erlanger's embrace of password sharing to allow staff to impersonate physicians violates HIPAA, PL 104–191, August 21, 1996, 110 Stat 1936, because it allows unauthorized access to protected health information ("PHI"). HIPAA is a material set of provisions safeguarding patient privacy and, as such, is material to government insurers' decisions to pay claims. As Section 261 of HIPAA explains, the purpose of the statute is "to improve the Medicare program …, the Medicaid program …, and the efficiency and effectiveness of the

---

[30] Under Tennessee law, "'Health care prescriber' means a: (A) Physician licensed under chapter 6 or 9 of this title; . . . (C) Nurse licensed under chapter 7 of this title; . . . (F) Physician assistant licensed under chapter 19 of this title." Tenn. Code Ann. § 63-1-102. Medical assistants are not included among the "Health care prescribers" who may issue prescriptions, including for opioids. See also, Tenn. Code Ann. §§ 63-6-201, 63-6-203; 63-1-402 (requiring all prescribers of controlled substances to be licensed and to complete related CME).

[31] *See* https://publications.tnsosfiles.com/rules/1000/1000-04.20190812.pdf. At § 1000.4.4.(4) c Tennessee law also requires that, "[w]ithin ten (10) business days after the physician assistant has examined a patient who falls in one of the following categories, the supervising physician shall make a personal review of the historical, physical, and therapeutic data gathered by the physician assistant on that patient and shall so certify in the patient's chart within thirty (30) days: (a) when medically indicated; (b) when requested by the patient; (c) when prescriptions written by the physician assistant fall outside the protocols; (d) when prescriptions are written by a physician assistant who possesses a temporary license; and (e) when a controlled drug has been prescribed." Tenn. Comp. R. & Regs. 0880-02-.18(7). In addition, "a supervising physician shall personally review at least twenty percent (20%) of charts monitored or written by the physician assistant every thirty (30) days."

health care system, … through the establishment of standards and requirements for the electronic transmission of certain health information."

84. Pursuant to HIPAA, Erlanger is required to "[i]mplement technical policies and procedures … to allow access [to PHI] only to those persons or software programs that have been granted access rights as specified in § 164.308(a)(4)." 45 CFR § 164.312(a)(1). It is also required to "[a]ssign a unique name and/or number for identifying and tracking user identity" as well as "[i]mplement policies and procedures to protect electronic [PHI] from improper alteration . . ." *Id.* at § 164.312(a)(2)(i) (emphasis added); *id.* at § 164.312(c)(1). Finally, Erlanger is required to "[i]mplement procedures to verify that a person or entity seeking access to electronic [PHI] is the one claimed." *Id.* at § 164.312(d).

85. Erlanger is required under HIPAA to train all "members of its workforce" on policies and procedures with respect to protected health information. *See* 45 C.F.R. § 164.530(b)(1)-(2). It is also required to implement a "security awareness and training program" for all members of its workforce. *See* 45 C.F.R. § 164.308(a)(5). As an Accountable Care Organization, Erlanger is also required under 42 C.F.R. § 425.300 to provide compliance training and to have mechanisms to address compliance problems.

86. While HIPAA violations on their own do not constitute false claims, the HIPAA violations here were carried out in pursuit of a fraudulent scheme, leading to the submission of false claims.

5. *Stark Law Rules*

87. The Stark Law, 42 U.S.C. § 1395nn *et seq.*, is a strict liability statute that prohibits physicians from referring Medicare and Medicaid patients for certain designated health services ("DHS") to any entity with which they have a financial relationship, including a "compensation arrangement," and prohibits that entity from submitting claims that result from

such referrals, unless certain safe harbors are satisfied. A "'referral' by a 'referring physician'" is any physician's request for DHS or establishment of a plan of care that provides for DHS, 42 U.S.C. § 1395nn(h)(5)(A), (B), & (C), other than DHS that are "personally performed or provided by the referring physician" 42 C.F.R. § 411.351. Significantly, "[DHS] is not personally performed or provided by the referring physician if it is performed or provided by any other person, including, but not limited to, the referring physician's employees, independent contractors, or group practice members." 42 C.F.R. § 411.351. Thus, all of the inpatient and outpatient hospital services associated with DHS personally performed by a surgeon (*i.e.*, the surgery itself) are considered DHS. 42 U.S.C. § 1395nn(h)(6)(K).

88. The statute defines compensation arrangement as "any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity other than" exceptions not relevant here. 42 U.S.C. § 1395nn(h)(1)(A); see also 42 C.F.R. §§ 411.354(c) & (d). "Remuneration," in turn, is broadly defined as "any remuneration, directly or indirectly, overtly or covertly, in cash or in kind." 42 U.S.C. § 1395nn(h)(1)(B)). Remuneration need not be in the form of a 'kickback'; instead, remuneration can include anything of value – and in any form. Moreover, unlike the AKS, the remuneration need not be given in return for, or to induce, a referral for federal healthcare services. The Stark Act is a strict liability statute; the purpose of the remuneration is irrelevant.

89. Violations of the Stark Law render claims submitted to the government false claims. Because compliance with the Stark Act (like the AKS) is a condition of payment for Medicare and Medicaid, claims submitted for services rendered in violation of these statutes can form the basis of liability under the FCA.

6. *TennCare's Reimbursement Policies*

90. 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

91. 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[32] 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, Tenn. Code Ann. §§ 71-5-182(a)(1)(A), (B), & (C), is substantially the same.

92. These statutes also 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).

93. In addition, the 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

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

---

[32] 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).

A. FALSE CLAIMS FOR THREE OVERLAPPING SURGERIES OR FOR TWO OVERLAPPING SURGERIES LACKING ADEQUATE RESIDENT SUPERVISION

95. Particularly troubling was Defendants' routine practice of allowing teaching surgeons and other high-volume physicians (collectively, the "Erlanger Surgeons") to book and conduct multiple surgeries or procedures at roughly the same time without adequate supervision over the participating residents. In addition to unnecessarily placing patients at greater risk of complications, these procedures violated Medicare and Medicaid rules on billing for the services of a teaching physician under Medicare Part B.

1. *Erlanger's Practices Concerning Overlapping Surgeries*

96. The practice of overlapping surgeries is a long entrenched "tradition" at Erlanger, as Dr. R. Bruce Shack, Dean of UTCOM Chattanooga, explained to Plaintiffs-Relators 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.

(Emphasis added).

97. In 1993 and 1994, during Dr. S. Adams' third and fourth years of medical school, he did clinical rotations at Erlanger. Surgery was one of the rotations. At that time, Erlanger residents routinely operated without direct supervision from attending surgeons. Surgeons dubbed the resident cases "service cases" because the patients generally were insured by government payors or lacked insurance accepted by PSG. Operations on "service" patients were typically supervised by a more senior resident. Dr. S. Adams personally participated in numerous surgeries where this was the case. It was the normal procedure and no one questioned it.

98. Dr. S. Adams returned to Erlanger in 1997 as a faculty member in the Department of Family Medicine. The FM faculty practice includes low risk obstetrics and, at the time, depended upon the OB/GYN residents and faculty to provide backup for patients who developed complications or needed a c-section. In the first few years it was not uncommon for those patients to receive care (including surgical intervention) from a resident without the presence of an attending OB/GYN. Most of those patients were insured through Medicaid. There was ongoing friction between the OB/GYN residency and certain private obstetricians because the obstetricians enrolled large numbers of Medicaid patients but then did not actually attend the delivery. The expectation was that the residents would perform the delivery and then the private obstetrician would submit the charges to Medicaid without actually being present.

99. Dr. Adams recalls that he was once walking down the hall in the labor and delivery area and a nurse started calling for help because a patient was giving birth unexpectedly; neither the attending obstetrician nor any resident was present on labor and delivery (the residents assigned to be there were performing emergency surgery). Dr. Adams stepped in and delivered the baby. He was asked to not document his presence at the delivery; he agreed to not submit a bill but insisted on putting a delivery note in the chart.

100. In another instance, a graduate of the OB/GYN residency related a story where a patient experienced a cord prolapse (where the umbilical cord passes out before the baby is delivered). This is a true emergency as the baby will die quickly without an immediate c-section. She was a first-year resident at the time and the more senior residents were all in clinic. The event was paged as an emergency, but no one came until after she performed the emergency c-section alone and ran into complications. She was told they were aware of an emergency, but were confident in her skills and assumed "she had it covered." At the time this was standard

practice and this near miss did not trigger any immediate changes in policy or procedure.

101. In a March 3, 2021, conversation between Dr. Steinmann and orthopaedic trauma surgeon Warren Gardner, M.D., an Erlanger Surgeon since 2010, Dr. Gardner explained:

> 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.

(Emphasis added).

102. On March 25, 2021, orthopaedic trauma surgeon Bryce Cunningham, M.D., who was a resident at Erlanger from 2011 to 2016, explained to Dr. Steinmann:

> When I was a resident it was three [orthopaedic 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.

(Emphasis added).

103. In 2014, Dr. S. Adams became Erlanger's Chief Medical Information Officer. Through that role and through personal communications with Alana Sullivan, former Chief Compliance Officer for Erlanger, Yvonne Mazarredo, Erlanger's Compliance Auditor, and others, he was made aware of ongoing issues with non-compliant coding as well as ongoing audits of overlapping surgeries.

104. Dr. S. Adams recalls that the 2015 report in the *Boston Globe* exposing problems with overlapping surgery at Massachusetts General Hospital sparked considerable concern and discussion at Erlanger. He frequently ate lunch at the same time as Orthopedic Chairman Richard Alvarez, M.D., and overlapping surgery was a frequent topic of conversation between him and others in the physician lounge. He repeatedly stated in Dr. S. Adams' presence that it

was occurring at Erlanger, and "someday they're going to get in trouble." Nevertheless, Dr. Alvarez did nothing to correct the situation and overlapping surgeries persisted at Erlanger.

105. Dr. S. Adams personally became involved in data extraction for the purpose of analyzing overlapping surgeries around the time that Erlanger implemented the Epic EHR system in early 2018.

106. Soon after Doctors Steinmann and J. Adams began their work as orthopaedic surgeons at Erlanger in October of 2019, they too saw that teaching physicians in orthopaedics and in other departments regularly booked two and sometimes three overlapping surgical cases (also "double booking" and "triple booking") with the same teaching physician listed on each surgery. The practice, as they witnessed it, 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."

107. In one instance, a young minority patient on government insurance was purportedly operated on by an Erlanger teaching surgeon and residents for a severe arm laceration that necessitated multiple nerve and tendon repairs. When Dr. J. Adams saw the patient a year or so later in her clinic, he still had no nerve function and had not recovered the full functioning of his tendons. In reviewing the operating record, Dr. Adams noted that the teaching surgeon not only left the surgery well before its completion, leaving unsupervised residents to complete a complex multi-step surgery, but never followed up with the patient during his recovery. The patient was attended to by residents in the "hand clinic" instead.[33]

[33] The hand clinic is an indigent-patient clinic in which the residents take primary responsibility for the patients: As one study of the clinic explained, "Virtually[] all aspects of patient care are

Apart from failing to provide adequate treatment to the patient, this conduct violated clear and long-standing government billing requirements and resulted in false claims.

108. Plaintiffs-Relators were further 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."

109. Plaintiffs-Relators identified approximately 8,497 overlapping surgical cases performed at Erlanger during just the Q4 2017 through Q1 2021 period that were submitted to government payors. Defendant PSG was involved in 660 of these cases while Defendant USA was involved in 391 of them. Given Dr. S. Adams' experiences, Plaintiffs-Relators believe there were tens of thousands of overlapping cases throughout the limitations period beginning in 2011 and continuing subsequent to the filing of the Complaint through the present.

110. All of these cases represent false claims because none complied with the backup

---

executed by residents including: obtaining history and physical examination information, interpretation of radiographic imaging, clinical care decision-making, patient consent, written and dictated clinical documentation, financial coding, scheduling, and associated administrative tasks." Day KM, M.D., et al., *Progressive Surgical Autonomy Observed in a Hand Surgery Resident Clinic Model*, J. Surg. Ed., Vol. 75 / Number 2, March/April 2018, at 451 (https://pubmed.ncbi.nlm.nih.gov/28967577/). In fact, "[t]he attending supervising [the hand clinic] does not typically engage in direct patient contact unless requested by the patient or resident personnel." *Id.*; *see also* Day KM, M.D., et al., Progressive Surgical Autonomy in a Plastic Surgery Resident Clinic, PRS Global Open 2017 (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5459631/) (describing similar autonomy for residents in the plastic surgery clinic).

surgeon requirement.[34] Relators believe that Erlanger has never complied with this requirement. As will be explained, a large percentage of them violated other aspects of the Teaching Physician Rule as well.

111. Relators attempted to address these issues by initiating dialogue within the Erlanger orthopaedics department, but they were rebuffed. In the Spring of 2020, they 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 non-compliant overlapping surgeries – including triple-booked ones – were a regular occurrence at Erlanger; 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.

112. 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 overlapping each other. For example, based on their analysis of Erlanger's surgical cases submitted to government payors during the period of Q4 2017 through Q1 2021, Plaintiffs-Relators have identified at least[35] 202 government-paid surgical cases that overlapped with two other cases simultaneously

[34] In addition, Erlanger's legacy surgical scheduling and recordkeeping systems covering the period from April 20, 2011, until Q4 2017 will contain thousands of additional false claims.

[35] These and the following figures do not include gastroenterology and cardiovascular procedures.

("triple overlap") that were performed at Erlanger.[36] Defendant PSG was involved in 47 of these triple overlaps.

113. Additionally, in the Q4 2017 to Q1 2021 period, Plaintiffs-Relators have identified 2,047 government-paid surgical cases that overlap by more than 50% and 1,455 that overlap by more than 75%. Additionally, Plaintiffs-Relators also identified 1,106 government-paid surgical cases that completely overlapped with another case, constituting a case within a case.

114. In addition to the above, Plaintiffs-Relators identified 1,897 government-paid endoscopic cases – which require the teaching physician's presence for the entire viewing – that overlapped with another case. At least 1,138 of these endoscopic procedures overlapped another endoscopic procedure. In addition, Plaintiffs-Relators identified 89 government-paid surgical cases lasting five minutes or less that overlapped with another surgical case, despite the requirement that the teaching physician be present for the entire duration.

115. Based on their collective knowledge about Erlanger, its practices, and records, Plaintiffs-Relators estimate that there have been at least three times this many cases since April 20, 2011, the relevant limitations period.

116. 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

---

[36] This analysis and the data underlying it have been shared with the Government. Plaintiffs-Relators have identified another 45 government-payor cases performed in cardiac procedure areas where OR logs indicate three simultaneous cases. Plaintiffs-Relators are aware that Defendant refunded payment to the government on a fraction of these triple-overlap cases, demonstrating Defendant's knowledge that none of them was billable. Nevertheless, Plaintiffs-Relators are also aware that those surgeons who performed these refunded cases were not reprimanded or otherwise impacted. Rather, they were credited with the RVUs, effectively incentivizing them to perform more overlapping cases.

both surgical procedures or the entire viewing where required. 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 for overlapping surgeries submitted by Erlanger to Medicare and TennCare was not payable and was a false claim because no qualified surgeon was immediately available to assist the resident for the entire procedure, as CMS requires.

117. 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.

118. Indeed, beginning in early 2020, Dr. J. Adams became aware that a number of her patients experienced post-surgical complications following non-emergent orthopaedic 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.

119. Her observations about patients under her care revealed problems that were in no

way unique to orthopaedic 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.

120. Most disturbing to Plaintiffs-Relators was that the teaching surgeons often booked these so-called "service cases" or "resident cases" to occur in one building, while they themselves performed surgery in a different building; for example, service cases might be scheduled in the "Main OR," while the attending surgeons themselves performed surgery in the "Plaza OR," which is in a separate building. Multiple other Erlanger Surgeons also booked overlapping procedures, relegating care of patients, often those on government-payor insurance, to unsupervised residents operating in a different location and different 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.

121. Illustrating this practice, during the Q4 2017 to Q1 2021 time period, Plaintiffs-Relators identified at least 693 government-paid cases overlapping one or more other cases billed under the same teaching surgeon's name occurring in another, geographically distant OR (e.g., Plaza OR and Main OR).

122. Although improper overlapping surgeries may have been diminishing in more recent years, this Complaint demonstrates that Erlanger continues to allow non-compliant overlapping surgery to be performed by Erlanger 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 conversation between Dr. Steinmann and orthopaedic 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 program 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: Hmm. 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!'

123. Despite this uncertainty about resident competence, Dr. Kiner highlights the residents' opportunities to operate early on in their residency and *on their own* in a December 9, 2021 video that Erlanger and UTCOM created to recruit potential orthopaedic residents:

> I'm the orthopaedic trauma residency director and orthopaedic trauma director for the hospital. I am in charge of [the orthopaedic residents'] trauma rotation, which is the busiest rotation, the most aggressive rotation, and trauma's cool 'cause it's where you learn to operate. . . . [W]e cover something like 12,000 square miles . . . which makes us obscenely busy. I think the operative experience early is fantastic. Um, you go to a lot of programs, especially these larger academic programs on the

various coasts and you'll see chief residents who can't nail a tibia on their own. *Our 2nd-year residents can nail a tibia on their own 'cause they get all that experience early on. Um, our chief residents can do darn near everything short of a both-column acetabulum on their own.*

124. The following is 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.

125. 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.*"[37]

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

---

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

payer.

2. *Examples of Defendants' False Claims*

127. 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.

128. 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.

129. 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 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.[38] 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.[39] 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 Medicare.

130. 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

---

[38] 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.

[39] One of the six overlapping 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.

of the abovementioned surgeries, including those pertaining to Patient 7.

131. 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.

132. Dr. S. Adams also observed that, on March 15, 2018, orthopaedic surgeon Dirk Kiner, M.D. performed fracture repair surgeries on two separate patients[40] 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.

133. The following table contains data from late 2017 to early 2020[41] that demonstrate

---

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

[41] Plaintiffs-Relators explain that there is also a legacy recordkeeping system, the Centricity Surgical Scheduling System, that almost certainly documents improper overlapping surgeries prior to October 2017. When the Epic electronic medical record software system was implemented by Erlanger in October 2017, the legacy hospital medical records were all ingested in a storage database called OnBase and linked with Epic so that they are available for clinical use and for medical records release. Additionally, Siemens DSS was a database that contained hospital admission and financial data dating back to approximately 1998, which is also stored on Erlanger's servers. The data collected by Plaintiffs-Relators on these cases from the time of Epic's implementation in Q4 2017 through Q1 2021 reflects less than 30% of the period covered by the statute of limitations in this case. The legacy systems contain records reflecting thousands of additional false claims.

numerous instances of surgeons covering two or more surgeries at once.

Date	Surgeon	Schedule
December 13, 2017 42 	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 3:53 p.m. – 5:22 p.m. (1:29), BEH Main OR, Medicare Part A/B, Open Radical Nephrectomy with Vena Caval Thrombectomy (**Patient 1**)[43] 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
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 12:54 p.m. – 3:57 p.m. (3:03), BEH Main OR, Medicaid GA, Open Reduction of Fracture of Shaft of Tibia, Without Fracture of Fibula, with Fixation Using Screws Without Cerclage
January 16, 2018	Dr. Singh	9:04 a.m. – 11:05 a.m. (2:01), BEH Main OR, BlueCare (Medicaid), Complete

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

[43] 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.

[redacted]		Laser Enucleation of Prostate with Morcellation and Control of Postoperative Bleeding 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 (**Patient 2**)[44]
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 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 [redacted]	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 (**Patient 3**)[45]

[44]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.

[45]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" 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.

		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	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 (**Patient 4**)[46] 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 11:14 a.m. – 11:40 a.m. (0:26), BEH Main OR, Amerigroup TN (Medicaid), Percutaneous Pyelostolithotomy with Stenting 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 12:56 p.m. – 1:13 p.m. (0:17), BEH Main OR, Blue Advantage (Medicare), 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

[46]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.

[redacted]		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 [redacted]	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 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 (**Patient 5**)[47] 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
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

[47]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.

[redacted]		with Fixation Using Intramedullary Implant and Interlocking Screws 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
April 15, 2018 [redacted]	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 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 [redacted]	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 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
June 29, 2018	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 (**Patient 6**)[48] 8:29 a.m. – 9:03 a.m. (0:34), Plaza OR, Medicare Part A/B, Lithotripsy Using Extracorporeal Shock Wave 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
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) 8:58 a.m. – 9:32 a.m. (0:34), Plaza OR, Amerigroup TN (Medicaid), Lithotripsy Using Extracorporeal Shock Wave 9:00 a.m. – 12:37 a.m. (3:37), BEH Main OR, Medicare Part A/B, Partial Cystectomy (**Patient 7**)[49] 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

[48]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.

[49]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.

		10:30 a.m. – 11:51 a.m. (1:21), Plaza OR, Medicare Part A/B, Lithotripsy Using Extracorporeal Shock Wave 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 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 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
October 24, 2018 	James Kennedy, M.D.	1:37 p.m. – 2:54 p.m. (1:17), Plaza OR, Medicare Part A/B, Interposition Arthroplasty of Intercarpal Joints 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 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 1:38 p.m. – 2:24 p.m. (0:46), Plaza OR, Alliant PPO, Interposition Arthroplasty of Intercarpal Joints

[redacted]		2:46 p.m. – 3:16 p.m. (0:30), Plaza OR, Humana Gold Plus (Medicare), Transposition of Median Nerve at Carpal Tunnel 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 [redacted]	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 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 [redacted]	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 (**Patient 8**)[50] 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

[50]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.

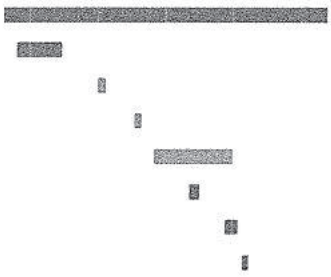
[redacted]		12:23 p.m. – 2:23 p.m. (2:00), BEH Main OR, Amerigroup TN (Medicaid), Open Reduction of Fracture of Shaft of Femur with Fixation Using Screws Without Cerclage 12:35 p.m. – 1:36 p.m. (1:01), BEH Main OR, Amerigroup TN Medicare, Percutaneous Skeletal Fixation of Fracture of Calcaneus with Manipulation
January 18, 2019 [redacted]	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 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
February 16, 2019 [redacted]	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 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 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
March 28, 2019 [redacted]	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 (**Patient 9**)[51] 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 [redacted]	Dr. Brzezienski	1:40 p.m. – 4:51 p.m. (3:11), Plaza OR, UHC Medicare Advantage, Arthrodesis of Metacarpophalangeal Joint Without Internal Fixation 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 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 8:41 a.m. – 11:49 a.m. (3:08), BEH Main OR, UHC Dual Complete (Medicare and Medicaid), Application of Unilateral

[51]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.

		Uniplane External Bone Fixation (**Patient 10**)[52]
June 27, 2019	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 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 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 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
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

[52]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.

		End, Neck, Internal Fixation or Prosthetic Replacement 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 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 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
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 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 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 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 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
July 11, 2019 [redacted]	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 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 [redacted]	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 Implant with Interlocking Screws and Cerclage 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

[redacted]		Without Intercondylar Extension, with Internal Fixation 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
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 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
March 3, 2020 [redacted]	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, Open Reduction of Fracture of Shafts of Radius and Ulna With Internal Fixation of Ulna
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

[redacted]		Depressed Fracture of Zygomatic Arch by Gillies Approach 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 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
November 16, 2020 [redacted]	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 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 [redacted]	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 12:50 p.m. – 1:20 p.m. (0:30), EEH OR, Medicare Part A/B, Revision of Peripheral Neurostimulator Electrode Array

134. 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

135. 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,[53] needlessly risking their health and increasing costs to government payors, which reimburse anesthesiologists and other anesthesia-care providers by the amount of time spent with patients under anesthesia.

136. 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.

C. FAILURE TO OBTAIN VALID INFORMED CONSENT

137. 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.

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

---

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

> 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.

139. 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 had they known the facts. 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.

140. 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.

141. 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.

142. 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.

143. 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.

144. 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

145. 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.

146. 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 a policy in place for the formal designation or documentation of a back-up attending surgeon that complies with the teaching physician rule criteria. Where residents are left alone, the records are silent.

147. In Q3 and Q4 of 2020, Dr. Steinmann worked with Erlanger Compliance Auditor Karen Percent, including communication through a series of emails. Dr. Steinmann discussed the back-up surgeon system at his previous institution and expressed concerns about Erlanger's lack of a system and about a non-compliant system that had been proposed.

148. In Q2 of 2021, a proposed back-up system was discussed by Erlanger whereby the on-call general surgery trauma surgeon would be the backup surgeon for all of Erlanger's downtown "Erlanger Baroness" location. To the Relators' knowledge, this was not implemented by Q3 of 2021. Nor is it adequate: the Baroness hospital location contains multiple procedural and operating room areas in geographically distinct locations and buildings, some more than 0.25 miles apart. The on-call general surgeon is frequently seeing critically ill or injured patients in

the emergency department or is engaged in operating on his or her own patients and, thus, is *not* immediately available to serve as a back-up surgeon.

149. Dr. S. Adams also had ongoing discussions with Percent on this subject. The two of them met with the Erlanger Medical Staff Officer's Council in Q2 2021 to discuss the proposal. Dr. Adams informed the Officer's Council that review of operative schedules revealed that the on-call trauma surgeons were indeed frequently involved in surgical procedures during their on-call days and, therefore, could not be deemed "immediately available." His concerns were dismissed.

150. The proposal for Erlanger's "East" location, which to the Relators' knowledge was never implemented, was even more problematic. In this location, Erlanger proposed that a urology surgeon in clinic serve as the back-up surgeon, although not always on campus and not necessarily "qualified."

151. 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.

152. 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.

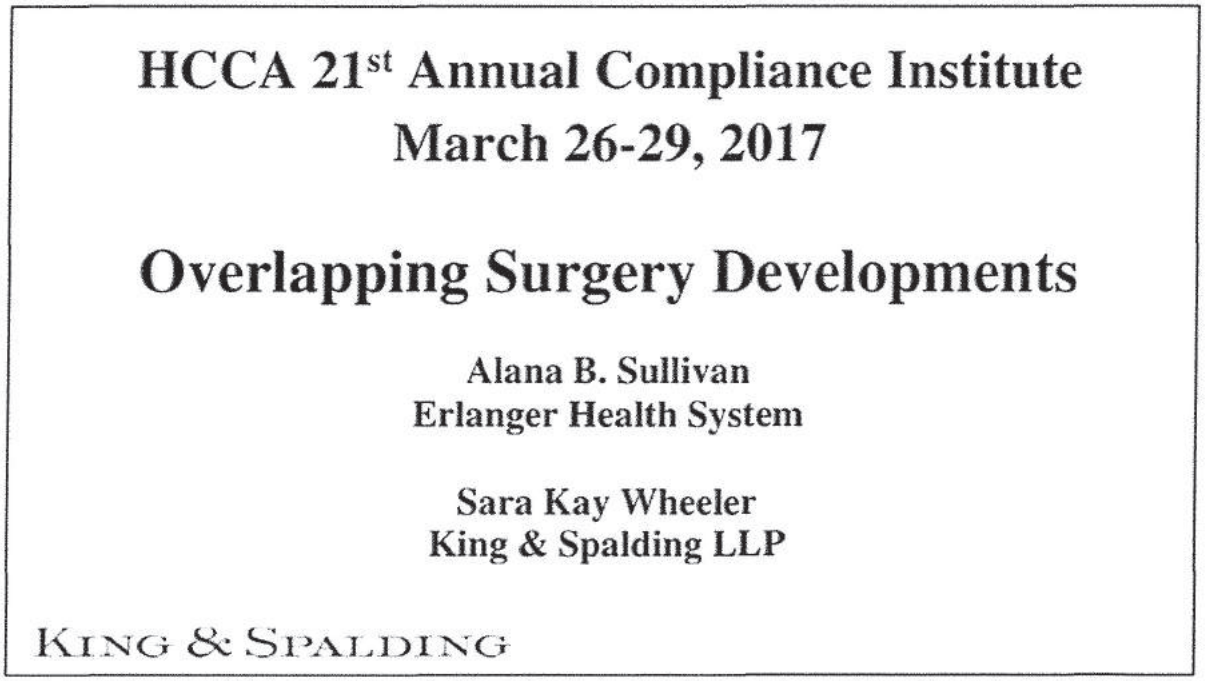
E. DEFENDANTS WERE WELL AWARE OF MEDICARE AND MEDICAID VIOLATIONS AND RESULTING FALSE CLAIMS LIABILITY

153. 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.

154. 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 wake of an explosive exposé on overlapping surgery published 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[54] 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." However, nothing was done in the wake of that report and problems persisted.

155. In March of 2017, Alana Sullivan, then-Chief Compliance Officer for Erlanger, gave a presentation on overlapping surgery issues at a healthcare compliance conference with a



HCCA 21st Annual Compliance Institute
March 26-29, 2017

Overlapping Surgery Developments

Alana B. Sullivan
Erlanger Health System

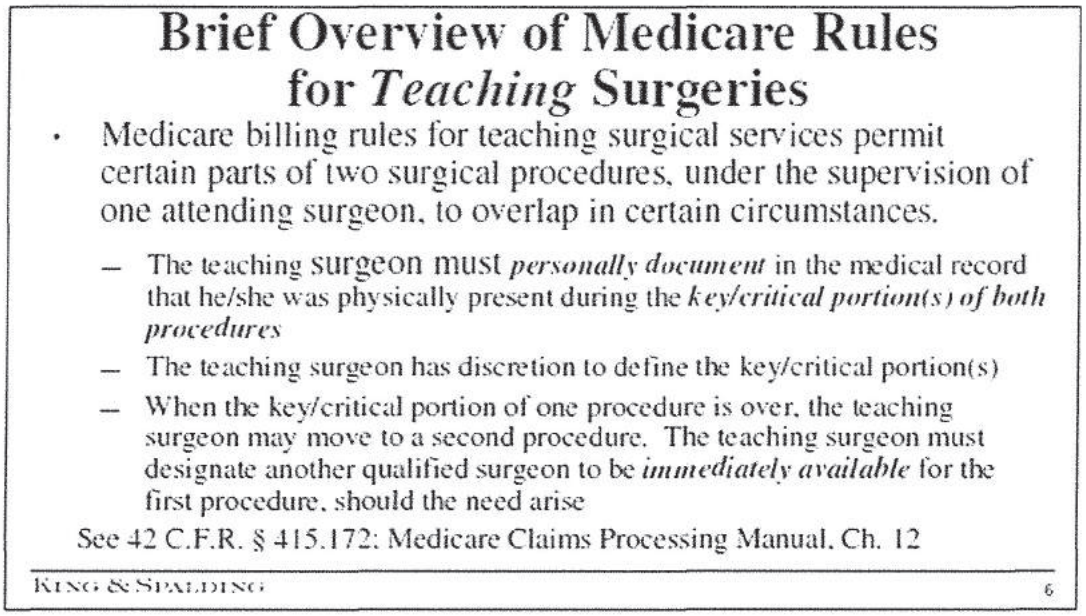
Sara Kay Wheeler
King & Spalding LLP

KING & SPALDING

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

partner from King and Spalding LLP. King & Spalding has previously served as false claims counsel for Defendants. Available at https://assets.hcca-info.org/Portals/0/PDFs/Resources/Conference_Handouts/Compliance_Institute/2017/311print2.pdf.

156. The presentation specifically noted that a teaching surgeon must ***personally*** document his presence for the key and critical potions of ***both*** procedures and may not move on to a second case until after completing the key and critical portions of the first case and ***only*** if he designates an immediately available back-up surgeon:



Brief Overview of Medicare Rules for *Teaching* Surgeries

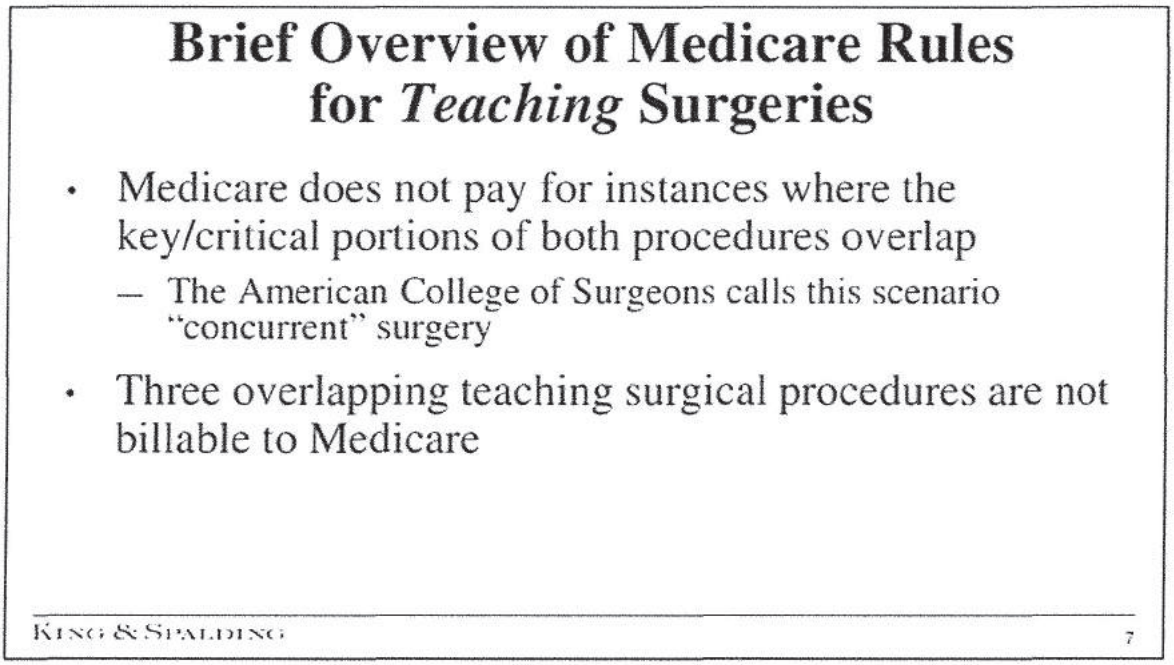
- Medicare billing rules for teaching surgical services permit certain parts of two surgical procedures, under the supervision of one attending surgeon, to overlap in certain circumstances.
  - The teaching surgeon must *personally document* in the medical record that he/she was physically present during the *key/critical portion(s) of both procedures*
  - The teaching surgeon has discretion to define the key/critical portion(s)
  - When the key/critical portion of one procedure is over, the teaching surgeon may move to a second procedure. The teaching surgeon must designate another qualified surgeon to be *immediately available* for the first procedure, should the need arise

See 42 C.F.R. § 415.172; Medicare Claims Processing Manual, Ch. 12

KING & SPALDING 6

Id. at p. 6.

157. The presentation also acknowledged that these requirements were conditions of payment by Medicare:



Id. at p. 7.

158. At the time of this presentation, Erlanger routinely ignored both of these mandatory conditions, as Sullivan was well aware. Notwithstanding, Sullivan did not do anything to ensure that Erlanger presented only valid bills for payment.

159. In April of 2018, Dr. S. Adams offered to develop an auditing program that would permit the effective tracking and monitoring of overlapping 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."

160. 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.

161. 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.

162. 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.

163. 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.

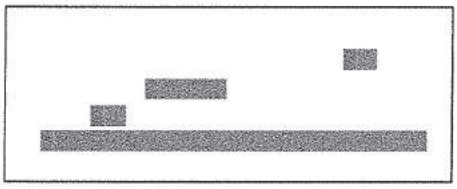
164. In a June 2020 meeting between Doctors Steinmann and Jackson, Dr. Steinmann raised his own worries about Erlanger's non-compliant practices with respect to overlapping surgeries and the continued absence of any policy to ensure eligible back-up surgeons are designated, stating "this has to stop yesterday." To this day, no adequate policy for the designation of a back-up surgeon is in place at Erlanger.

165. 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. As Dr. Chris Young, Anesthesiologist, Erlanger Chief of Staff, and member of the Board of Trustees explained to Plaintiffs-Relators 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, 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 orthopaedics 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.

166. 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:



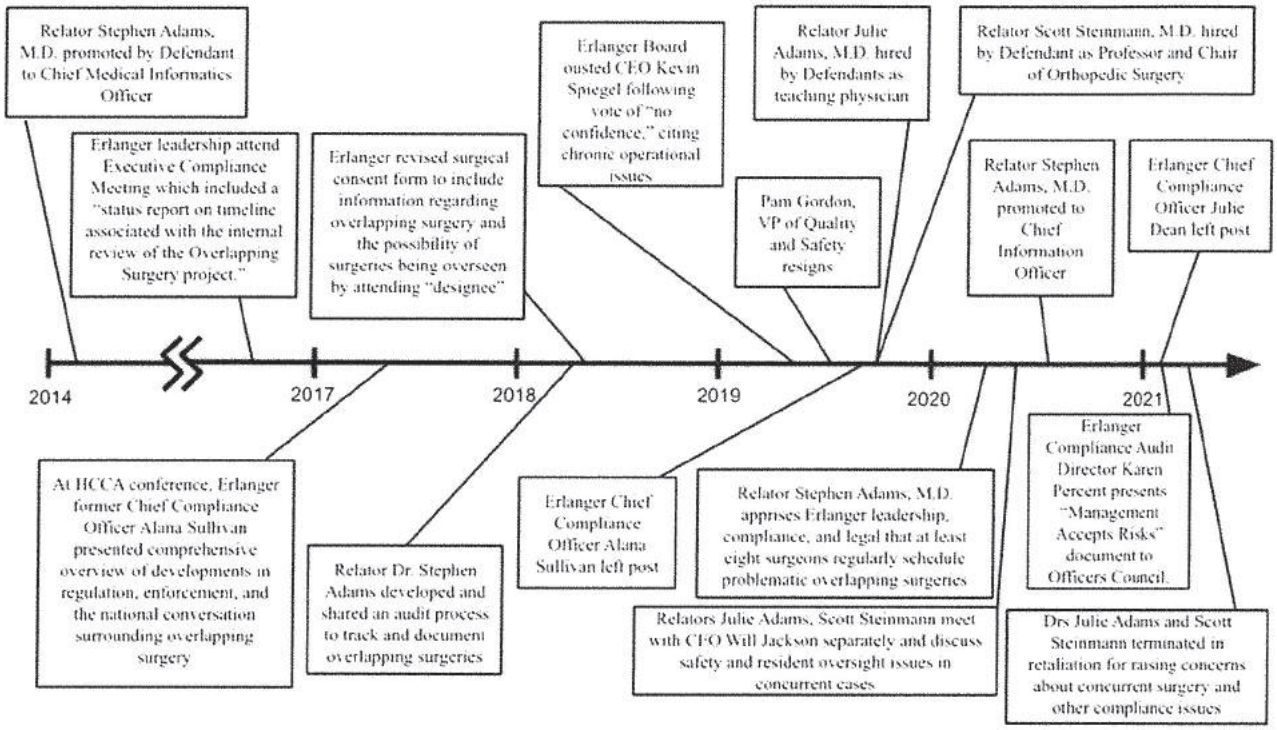
167. This schematic reflects multiple procedures "performed" by one teaching surgeon. The red denotes anesthesia start time, while the blue denotes surgical time. Here, three cases are sequentially performed, but a longer fourth procedure is ongoing at the same time.

168. 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.

169. 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.

170. 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

171. 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.

172. 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 overlapping 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).

173. 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.

174. In a case against the Pittsburgh Medical Center, a *qui tam* Plaintiff-Relator alleged the Center violated 42 C.F.R. § 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. The Government intervened and settled these allegations.

175. 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.

176. In 2021, settlement was reached with Massachusetts General Hospital on issues of overlapping surgery and informed consent after the district court denied a motion to dismiss.[55]

177. Another settlement with Northwell Health, Inc. and Lenox Hill Hospital of New York involved the overlapping scheduling of urologic procedures.[56] 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).

---

[55] *U.S. ex rel. Wollman v. Gen. Hosp. Corp.*, 394 F. Supp. 3d 174 (D. Mass. 2019).

[56] *See U.S. ex rel. Markelson v. Samadi*, 17 Civ. 7986, Dkt. 16 (S.D.N.Y. Nov. 8, 2019) (complaint in intervention).

178. 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.[57] 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."

179. 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).

180. 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 responsibilities of teaching physicians, explaining what surgical practices are and are not

[57] 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.

permissible for overlapping surgeries. *See supra* ¶¶ 13-18, 52-70. Defendants failed to adhere to this guidance.

181. 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.

182. 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, WHICH HAS LED TO ADDITIONAL FALSE CLAIMS

183. 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.

184. 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."[58]

185. 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."[59]

186. 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 hold still. The child died while in the scanner. A nursing leader relayed speculation that the underlying cause was a flaw in the Epic EHR system. Dr. S. Adams was asked to review the event through Erlanger's electronic health record audit system. Audit logs revealed evidence

---

[58] *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).

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

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, and the records indicate an error was made in medication dosage. Dr. Adams relayed this information to Erlanger leadership and heard nothing more about the case until he was contacted by an Erlanger attorney defending the hospital in the subsequent malpractice case who was unaware of any of the information Dr. S. Adams had relayed.

187. 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 is from a 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. 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. 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. . . .*

188. Relators learned that the former CEO, Dr. Jackson, who assumed his role in the fall of 2019, had little interest in the work required to change the culture of an institution rife with malfeasance.

189. Upon information and belief, each the following types of misconduct also resulted in false claims billed to government payors. More than half of Erlanger patients are covered by some type of government insurance. The rate for orthopaedic patients is even higher because they tend to be elderly.

1. *Sharing of Log-In Credentials Leading to Additional False Claims For Work Not Performed by a Physician*

190. Notwithstanding years of advocacy by Plaintiffs-Relators, Erlanger leadership has long permitted Erlanger Surgeons to provide their passwords and login information to support staff in order to have them perform the physician's tasks, including ordering lab tests and imaging studies, issuing surgery orders and confirming the surgical procedure and site, ordering medication for inpatient and outpatient care, including opioids, and reading and interpreting imaging studies. Despite the clear threat to patient safety such conduct presents as well as the illegality of practicing medicine without a license, Erlanger has permitted the practice as an

added benefit to Erlanger Surgeons. These practices have continued and led to the submission of numerous false claims, despite Plaintiffs-Relators years-long effort to stop the practice.

191. 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.[60] At Erlanger, however, Plaintiffs-Relators found that these standards have been shirked and ignored since as early as 1997.

192. On numerous occasions up through his departure, Dr. S. Adams provided to Defendants' leadership examples of simultaneous log-ins from the same physician'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.

193. The following are just a few examples of Dr. S. Adams' fruitless efforts to correct the password-sharing practice, reflecting Erlanger's knowing embrace of the practice that led to numerous false claims. Dr. S. Adams became aware of the full extent of password sharing during a meeting of the Physicians Advisory Group, a committee tasked with overseeing the implementation of the Epic EHR system in early 2018. Dr. Mark Freeman, Erlanger orthopaedic medical director and then Chief of Orthopaedics, expressed his dislike for the new system and

---

[60] 2013 HITECH Law; 45 C.F.R. § 164.312(a)(2)(i).

stated – in the presence of Erlanger administrators and compliance staff – that he was the only member of his group that hadn't shared his passwords with their staff and allowed them to document, order, and sign documents and orders for them. Similarly, James "Jay" Sizemore MD (Infectious Disease Specialist in private practice but contracted with Erlanger to provide antibiotic stewardship services), then-Chief of Staff at Erlanger, was caught sharing his passwords with his office staff rather than encouraging them to use the HIPAA compliant portal provided by the Epic EHR system.

194. After implementing Epic EHR, Erlanger's compliance department purchased sophisticated software designed to detect situations where Erlanger employees and medical staff were inappropriately viewing the medical records of people who were not their own patients. Erlanger's Privacy Officer quickly discovered that the software identified many more incidents of potentially wrongful chart access than her meager staff could possibly review. Rather than devote additional resources to investigate, Erlanger chose to place strict limits on the number of events that would be reported and reviewed. Dr. S Adams challenged this policy, and was told that identifying potential violations but not investigating them would generate excessive risk to the organization, and it would be better to not know about them.

195. On January 25, 2017, Dr. S. Adams alerted Alana Sullivan, Erlanger's then-Chief Compliance Officer, that many physicians were "giving their username/password to their staff."

196. On April 11, 2018, Dr. S. Adams wrote to Dr. Jackson that "[t]here are anecdotal reports from members of the medical staff that there is widespread sharing of passwords with nursing and other staff . . . Compliance now is reviewing evidence that strongly indicates that some physician accounts are being used by people other than that physician."

197. On October 11, 2018, Dr. S. Adams wrote to the members of the Information

Security Committee that "[t]here is a longstanding practice across the organization of sharing passwords among the staff, and prominent physicians openly give their credentials to staff in order to do 'mundane' tasks like validate orders and sign documents."

198. On November 8, 2018, Chief Compliance Officer Alana Sullivan wrote to Dr. Jackson, then Chief Medical Officer, regarding password sharing, stating, "we will work with Dr. S. Adams and any other appropriate people to get the issues well documented and begin to put together a plan." Dr. Jackson responded that "I would like us to ensure we have communication and remediation plan NLT Thanksgiving." Despite this purported commitment from Dr. Jackson and Compliance, the practice was not corrected.

199. On November 9, 2018, Dr. S. Adams wrote to James Ballou, Erlanger's Chief Information Security Officer, with a report containing a list of 1,052 medical records that were accessed by someone in an office at the same time that the surgeon user was concurrently logged in from another location during an operative case lasting more than an hour. This reflected only instances of password sharing meeting these parameters during the month of October 2018.

200. On December 6, 2018, Dr. S. Adams wrote to several individuals including Dr. Jackson, Karen Percent, Meridith O'Keefe, and Sullivan with a proposal to resolve some of the password-sharing violations by employing a new scribe function in Erlanger's EMR. He wrote, "In some cases our clinicians have made staff into de facto 'scribes' by sharing login credentials, and it is reported that some non-clinician staff are entering and authenticating both clinical notes and orders using credentials that aren't their own."

201. On July 26, 2019, Dr. S. Adams emailed Ballou to raise the alarm about the additional potential for harm staff impersonating physicians in the Epic EMR could cause: "It was an open 'secret' that physicians shared their remote access credentials with their staff prior

to changing to Epic." "Now in Epic the physician role offers tremendous power (and therefore danger) – prescribing medication, ordering tests, removing or adding to problem lists, history, allergies … And prescribing controlled substances." Still, the practice was allowed to continue.

202. 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."

203. 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 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.

204. On August 13, 2020, Dr. S. Adams emailed Julie Dean, Chief Legal Officer Jeffrey Woodard, and Dr. Jackson regarding a report of HIPAA violations in the Orthopaedics Department that he received from Dr. J. Adams as well as seeking relief from the retaliation she was facing for having approached Compliance with these issues. He also wrote, "And by the way, the staff still keep a log book of all the physicians usernames and passwords."

205. And in fact, the practice and the reasons for it were openly acknowledged by Erlanger's surgeons. Dr. J. Adams was told in a conversation with Dr. Jeremy Bruce, UTCOM

Orthopaedic 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."

206. Dr. Bruce also explained to Relator J. Adams that, unlike his colleagues, he only shared his password with his assistant when they were both in the office. "They only log into mine when I'm there, in the office with them . . . Unlike other physicians that have their staff doing all these . . . signing things and sign-outs." In fact, access logs reviewed by Plaintiffs-Relators showed him simultaneously logged in to different stations blocks apart while he was purportedly doing surgery.

207. Likewise, Dirk Kiner, M.D. told Dr. Steinmann he was upset about concerns being raised about "things like giving Epic passwords, getting things signed and approved and that sort of stuff that doesn't hurt anybody, doesn't change anybody's patient care or anything else, but rather just is a mode of convenience to get things done."

208. Illustrating the ongoing practice, in November 2020, Dr. S. Adams received an email regarding concerns about workflow from an orthopaedic surgeon, Brandon Cincere, M.D., whose current workflow involved having his nurse perform many of the tasks that he was required to do personally. Dr. Cincere was looking for options that would allow his nurse to continue to perform his work, including with regard to controlled substance prescriptions, order signing, and logging in as the surgeon. Dr. S. Adams responded by forbidding the proposed "ghost prescribing" of opioids and having nurses log-in as the surgeon.

209. Dr. S. Adams then forwarded the email to Dr. Jackson, Julie Dean, Jeffrey Woodard, and Dr. Donald Barker, the Chief Medical Officer. He asked them to read the email thread and then wrote, "I have ranted for almost 5 years about the dangers of staff authenticating

orders while signed in using the physician's credentials. This has given them the ability to authenticate opioid prescriptions and print them and this is part of the standard workflow." He concluded, "YOU NEED TO STOP THIS NOW."

210. In response to this message, Dr. Adams was admonished by Woodard, who told him to stop allowing his staff to put issues like this in writing because it created "excess liability for the institution." No steps were taken to correct the underlying misconduct.

211. When Dr. J. Adams brought the password sharing issue up again on February 10, 2021, in the presence of Floyd Chasse, head of Erlanger's human resources department, Jeff Woodard, 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.

212. Illustrating the value provided by having staff impersonate a surgeon, Plaintiffs-Relators Steinmann and J. Adams faced swift retaliation for having raised concerns about the practice. Dr. Jeremy Bruce told Dr. Steinmann that Dirk Kiner, M.D., was mad at them because "[i]t was the rumor mill of Julie going to Compliance, about the MAs having passwords, and… that they're concerned that you guys are going to Compliance about everything …are they going to legal about us?" "Are they going behind our group's backs?"

213. 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 Orthopaedics 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.*

214. Password sharing and allowing staff members to impersonate physicians has led to the criminal prosecution of physicians and staff for health care fraud as well as civil False Claims Act settlements.

215. While Erlanger's surgeons may face liability in their own right, Erlanger is equally culpable because, as Dean Bruce Shack admitted, Erlanger knew about the fraud and did nothing: "Your and Julie's report of being retaliated against based on your concerns about them sharing passwords and is really inappropriate obviously … but apparently that's been going on for years and they just kind of let it… ignored it." He also offered that "the people that are sharing their passwords and doing all of this kind of crap; clearly against the rules but they were doing it anyway, but apparently that's the way it had been done." 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.[61] 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. When Dr. Steinmann raised the importance of completing EOLs with Dr. Kiner, he responded, "[O]h yeah, I pay lots of attention to those, all sixteen of them a month . . . I just pay the closest of attention to those . . ."

216. 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

[61] Erlanger is required under HIPAA to train all "members of its workforce" on policies and procedures with respect to protected health information. *See* 45 C.F.R. § 164.530(b)(1)-(2). *See also* 45 C.F.R. § 164.308(a)(5) (security awareness and training program required); 42 C.F.R. § 425.300 (compliance program required).

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.

217. 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.

218. Erlanger's failure to implement and ensure federally mandated patient privacy training for its staff has resulted in the inappropriate and illegal release of protected health information. For example, Erlanger's Orthopaedic department uploaded a 411-page program information packet showcasing its orthopaedic trauma fellowship to a public website. The packet included a lot of patient-identifying information in its discussions of patient injuries and surgical care, including in some cases patient names, dates of treatment, and medical record numbers. Two of these patients were local law enforcement officers injured in the line of duty.

219. In a 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.

220. As a result of Erlanger's studied ignorance and refusal to end the practice of password sharing and staff impersonating physicians, numerous false claims for work not properly performed or performed by an unqualified staff member impersonating an Erlanger Surgeon were submitted to government payors. While the tasks completed by unauthorized medical staff using the Erlanger physicians' passwords and credentials are varied, all resulted in false medical records and subsequent false claims.

a) False Claims Resulting from Completing Patient Medical Records, Surgical Orders, Imaging and Laboratory Orders, and Prescriptions

221. After logging in using physician credentials, staff members including medical assistants and nurses and not physicians completed patient medical records, surgical, imaging and laboratory orders, and wrote prescriptions, including for opioids. These practices led to the submission of numerous false claims for work performed by a medical assistant or nurse and not the physician whose credentials were used.

222. Under 42 C.F.R. § 424.10(a), physicians are supposed to "decide[] upon admissions, order[] tests, drugs, and treatments, and determine[] the length of stay" in the hospital. Physicians must also certify the necessity of services provided as a condition for Medicare payment. 42 C.F.R. § 424.10(a) (citing sections 1814(a)(2) and 1835(a)(2) of the Social Security Act). As a general rule, "all diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary. . . . Tests not ordered by the physician who is treating the beneficiary are not reasonable and

necessary." 42 C.F.R. § 410.32(a). Similarly, "imaging, clinical laboratory services, and DMEPOS items . . . must have been ordered by a physician or, when permitted, an eligible professional (as defined in § 424.506(a) of this part)." 42 C.F.R. § 424.507(a)(1)(i).

223. In addition to constituting false claims, unqualified staff members impersonating physicians endangered patients. Among other hazards, this practice led to near miss wrong-site surgeries involving Dr. Bruce, who told Plaintiffs-Relators that he saved an "hour or more per day" by allowing his nurse or assistant 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 operating room nurse who stopped the case at the last minute.

224. 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. Dr. S. Adams was asked to assist with an analysis to determine why two Erlanger neurosurgeons working together performed surgery on the wrong side of a patient's head. Dr. Adams discovered that at Erlanger, the rate of wrong site surgery over the past five years was nearly *six times*[62] the national average. He wrote about his concerns to CEO Jackson and others in leadership but received no reply.

---

[62] "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.

225. 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." Another "never event" is inadvertently leaving an instrument, sponge, or other object in a patient during surgery. Operating room staff are required at the end of a surgical procedure to count all instruments and sponges and certify that none were left within the patient. Dr. Ben Dart, Erlanger Chief of Surgery had an experience where a sponge was left in one of his patients and he asked Dr. S. Adams to use EHR data to review Erlanger's compliance with the counting process. Dr. Adams found hundreds of examples where Erlanger OR staff marked final instrument and sponge counts as completed and correct prior to the actual completion of the surgery. Dr. Adams is unaware if Erlanger took any action to stop this dangerous behavior. Erlanger has permitted negligent pre-operative and operative practices to run rampant at the expense of patient safety and surgical outcomes.

226. More worrisome is the lack of actual reporting of complications at Erlanger. When Dr. J Adams identified a patient who had suffered a complication from a previous Erlanger surgery, she was told by administration personnel that no report needed to be documented; further, over the course of a calendar year, no complications were reported by the orthopaedic surgery department at Erlanger, despite Plaintiffs-Relators' knowledge of multiple complications having occurred in orthopaedics. Thus, the true rate of complications and near-

misses at Erlanger is unknown.

227. Even without full reporting on complications, Erlanger ranks among the worst hospitals with respect to many patient safety indicators, as found in the Fall 2022 Leapfrog group ratings. *See* https://www.hospitalsafetygrade.org/h/erlanger-baroness-hospital. In fact, it appears to be the worst of all hospitals with respect to "death from serious treatable complications." *Id.*

228. Erlanger's surgeons have repeatedly admitted to allowing their staff to impersonate them and perform their work, which has resulted in the submission of numerous false and fraudulent claims that government payors would have rejected had they been aware of the fraud.

b) Signing Admission Orders for Hospitalized Patients

229. In order for Medicare Part A to pay for an individual's inpatient stay at a hospital, including a critical access hospital, the patient must be formally admitted "pursuant to an order for inpatient admission [issued] by a physician or other qualified practitioner." 42 C.F.R. § 412.3(a). Part (b) of the regulation provides: "The order must be furnished by a qualified and licensed practitioner who has admitting privileges at the hospital as permitted by State law, and who is knowledgeable about the patient's hospital course, medical plan of care, and current condition. The practitioner may not delegate the decision (order) to another individual who is not authorized by the State to admit patients, or has not been granted admitting privileges applicable to that patient by the hospital's medical staff." *Id.* at 412.3(b) (emphasis added).

230. As one court recently explained, "Admitting a patient to the hospital for inpatient – as opposed to outpatient – treatment requires a formal admission order from a doctor 'who is knowledgeable about the patient's hospital course, medical plan of care, and current

condition.'"[63]

231. Despite these requirements, Erlanger Surgeons wrongfully delegated this task to their unqualified staff members, who would log in under their credentials and authenticate admission orders.

232. On November 22, 2018, Dr. S. Adams emailed Dr. Jackson and Erlanger's compliance department after he learned that admissions orders for orthopaedic surgery patients were being signed by unlicensed staff as yet another shortcut that was allowed for Erlanger Surgeons. Dr. Adams warned that Erlanger may have a potential billing problem without a valid physician order. His concerns were not addressed and government payors were nevertheless billed.

c) Test and Imaging Results Were Falsely Billed as Read by a Physician

233. 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

---

[63] *Winter ex rel. United States v. Gardens Reg'l Hosp. & Med. Ctr., Inc.*, 953 F.3d 1108, 1113–14 (9th Cir. 2020), *cert. denied sub nom. RollinsNelson LTC Corp. v. United States ex rel. Winter*, 141 S. Ct. 1380, 209 L. Ed. 2d 124 (2021). In 2018, 42 C.F.R. § 412.3 was modified, removing a sentence following 42 C.F.R. § 412.3(a) stating that "This physician order must be present in the medical record and be supported by the physician admission and progress notes, in order for the hospital to be paid for hospital inpatient services under Medicare Part A." However, despite this change, Section 412.3(a) still ties the presence of an admission order to eligibility for payment from Medicare. In *Winter*, the Ninth Circuit in March 2020 reversed the district court's dismissal of relator's complaint based on alleged false certifications of medical necessity by physician admission orders under 42 C.F.R. § 412.3, indicating that a legitimate admission order remains a material condition of payment.

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.

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

235. 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 orthopaedic 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.

236. 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.

237. The Plaintiffs-Relators allege that the supervising physicians do not actually look at the films in order to verify the interpretation, rather they – or their assistants – sign off on the results using the physician's credentials. In some instances, imaging and test results are never examined by any provider but are nevertheless billed to government payers.

238. For example, Josh Porter, an Orthopaedic Physician's Assistant, sees approximately 30 patients per day in his clinic three days a week, most of whom receive x-rays. Erlanger Surgeon Jesse Doty, M.D., his supervising physician, is supposed to review these x-ray images and Porter's report, and then edit or sign off. On information and belief, Dr. Doty does not review the imaging, nor do many other Erlanger attending surgeons.

239. 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. Instead, he was reinstated as Interim Chair following Dr. Steinmann's termination.

240. 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.

d) Falsifying the Performance of History & Physical Examinations

241. 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 C.F.R. § 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*."[64]

242. 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.

243. Rather than actually examining the patients prior to surgery, however, physician assistants or other staff would fake the documentation to make it appear compliant. Dr. S. Adams reported this problem multiple times, including to Dr. Jackson, but no action was taken to stop it.

244. In February of 2021, Dr. Adams presented to Erlanger's Officer Council evidence demonstrating that at least six physicians, including Dr. Manyam, chief of cardiology, Dr.

---

[64] *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). *See also*, 42 C.F.R. §§ 482.51(b)(1)(i)-(iii) (H&P examination required no more than 30 days or24 hours after admission and registration and prior to surgery); 482.22(c)(5)(i) (H&P requirement must be included in medical staff bylaws); 482.24(c)(4)(i)(A)(H&P examination must be documented in patient medical records).

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 (or those logged in using physician credentials) 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.

245. This record falsification allowed physicians like Dr. Manyam to generate a great deal of additional compensation.

246. Relator S. Adams also learned while assisting for an accreditation visit that Dr. DePasquale, the Chair of OB/Gyn, as well as one of his partners, Todd Boren, M.D., also engage in copying records from prior visits into patient H&P records without actually conducting the required appointment.

247. 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 compliance with even the most basic of CMS's regulations. Further, the preoperative H&P is

bundled into the global surgical package; failure to provide the H&P renders the surgical package billed by the hospital false. Rather than address these issues, Erlanger has turned a blind eye and has even maintained the very physicians who engage in these practices in leadership roles or promoted them to new ones, such as Freeman as Medical Director of Orthopedic Surgery and Manyam as Chief of Cardiology. Dr. S. Adams repeatedly warned Erlanger leadership over a several month-period, notifying leadership that Dr. Manyam and other physicians and their staff were falsifying H&Ps. Instead of correcting the practice, Erlanger put Dr. Manyam in charge of the Medical Quality Improvement Committee, the very system that should have investigated and corrected this behavior.

2. *Stark Law Violations*

248. The Stark Law, 42 U.S.C. § 1395nn et. seq., is a strict liability law that prohibits physicians from referring Medicare and Medicaid patients for certain designated health services ("DHS") to any entity with which they have a financial relationship, including a "compensation arrangement," and prohibits that entity from submitting claims that result from such referrals, unless an exception applies. The Stark Law is intended to prevent physicians' financial interests from affecting whether they refer patients for procedures and where the patient is referred.

249. Under the Stark Law, a referral by a referring physician is a physician's request for DHS or establishment of a plan of care that provides for DHS, 42 U.S.C. § 1395nn(h)(5)(A), (B), & (C), other than DHS that are "personally performed or provided by the referring physician," 42 C.F.R. § 411.351. DHS is not personally performed or provided by the referring physician if it is performed or provided by any other person, including, but not limited to, the referring physician's employees, independent contractors, or group practice members. *Id.* Thus, all of the inpatient and outpatient hospital services associated with DHS personally performed by a surgeon (i.e., the surgery itself) are considered DHS. 42 U.S.C. § 1395nn(h)(6)(K).

250. The Stark Law defines a compensation arrangement as "any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity . . ." 42 U.S.C. § 1395nn(h)(1)(A); *see also* 42 C.F.R. §§ 411.354(c) & (d). "Remuneration," in turn, is broadly defined as "any remuneration, directly or indirectly, overtly or covertly, in cash or in kind." 42 U.S.C. § 1395nn(h)(1)(B)). Remuneration need not be in the form of money; instead, remuneration can include anything of value and in any form. *See also* 42 U.S.C. § 1396b(s) (extending the Stark law prohibition on referrals to Medicaid reimbursements).

251. Violations of the Stark Law render claims submitted to the government false because compliance with the Stark Act (and the AKS) is a condition of payment for Medicare and Medicaid.

252. The exceptions to the Stark Law that allow compensation arrangements generally require that the physician's compensation not take into account the volume or value of the physician's referrals and that the compensation must not exceed fair market value. Erlanger fails to satisfy either of these conditions.

253. Based on their first-hand experiences, including numerous conversations, Plaintiffs-Relators believe that Erlanger has hired the Erlanger Surgeons at excessive salaries and benefits in order to secure their referrals. Notably, there is precedent for Erlanger's scheme. In 2005, Erlanger paid $40 million to resolve the government's allegations of Stark Law and AKS violations premised on the hospital's payments to surgeons and surgical groups for their referrals.[65] Defendant University Surgical Associates was also fined $1 million. The settlement

[65] *See* https://www.chattanoogan.com/2005/10/24/74681/Erlanger-Agrees-To-Pay-40-Million-On.aspx.

agreement describes the scheme as follows:

> Beginning in 1995, Erlanger entered into a series of transactions through which it paid remuneration intended to induce physicians to refer patients to its facilities. To facilitate the payment of such remuneration, Erlanger funded the formation of a "faculty practice plan" known as University of Tennessee Physicians, Inc. ("UTP"), and, thereafter, entered into a number of purported professional service agreements, including medical director contracts, recruiting agreements, joint venture agreements and leases with several large physician groups practicing in the area including Galen Medical Group, P.C. ("Galen"), Orthopaedic Associates, P.C. ("OA"), and University Surgical Associates, P.C. ("Surgical"). Through these various financial arrangements, Erlanger paid remuneration, directly or indirectly, to certain physicians who were at any time affiliated with UTP during the time period between January 1, 1995, and August 31, 2003 ("Covered Time Frame") (the "UTP Physicians") as well as to certain physicians who were, at any time during the Covered Time Frame, owners, members and/or employees of Galen, OA and Surgical (collectively with the UTP Physicians, the "Covered Physicians"). These financial arrangements failed to meet the requirements of Section 1877 of the SSA, 42 U.S.C. § 1395nn (also known as the Stark law), and violated the Anti-Kickback Statute, Section 1128b of the SSA, 42 U.S.C. § 1320a-7b(b).

254. As part of the settlement, Erlanger entered into a Corporate Integrity Agreement and hired a compliance officer, but its underlying financial problems persisted. The Corporate Integrity Agreement had a five-year term and expired in 2010.

255. Some individuals who were involved in this prior scheme remain involved at senior levels at Erlanger. For example, Phil Burns, M.D., now a member of the Erlanger Board of Trustees, was involved in the misconduct resolved in 2005.

256. After the CIA from the 2005 settlement expired, and as a means to address its continuing financial difficulties, Erlanger again engaged in this prohibited conduct, but under a new guise by employing surgeons with compensation above fair market value in order to secure their referrals.

257. In 2013, Kevin Spiegel became Erlanger's CEO and set out to stanch the organization's hemorrhaging finances by expanding aggressively and hiring surgeons as

employed physicians in order to secure their referrals.[66] In order to convince surgeons to become Erlanger employees, Spiegel promised them "the world," as former Erlanger Chief of Staff Chris Young, M.D., put it to Plaintiffs-Relators when he discussed the dynamic that developed between Erlanger and the employed surgeons. Dr. Young also told Relator Dr. J. Adams that Spiegel told the surgeons he was recruiting to "come on in, paid them whatever he thought would get them in the door."

258. Spiegel, and later Will Jackson, M.D., induced surgeons to become, and remain, employees and provide their financially lucrative referrals to Erlanger by plying them with remuneration that exceeds FMV and otherwise fails to meet Stark Law requirements.[67]

259. This remuneration involves monetary compensation above FMV and for work not actually performed, incentive compensation that increases in connection with the volume of referrals, as well as special benefits not provided to others. Indeed, the password sharing, which allows surgeons to avoid spending time on non-compensable obligations, is an additional form of remuneration provided to employed Erlanger Surgeons.

260. Erlanger's surgeons are also allowed to shirk their academic duties despite receiving academic salaries that likely exceed FMV, meaning they are being compensated by Erlanger for work they are not actually performing.

261. In addition, Erlanger requires its employed physicians to direct their referrals to

---

[66] *See generally* https://www.chattanoogan.com/2015/11/5/311976/Erlanger-Adds-4-Orthopaedic-Specialists.aspx; https://www.chattanoogan.com/2014/2/4/268830/Erlanger-Welcomes-University.aspx; https://www.chattanoogan.com/2016/4/28/323109/Erlanger-Adds-Orthopaedic-Specialists.aspx; https://www.chattanoogan.com/2015/5/23/300984/Roy-Exum-A-Great-Orthopaedic-Success.aspx; https://www.chattanoogan.com/2015/1/23/292646/Erlanger-Leaders-And-Physicians-Tear.aspx.

[67] Although Plaintiffs-Relators focus on violations of the Stark Law in this disclosure, they are cognizant that much of the conduct here may also implicate the Medicare Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b).

Erlanger as a condition of employment, but fails to meet Stark Law safe harbors required for such an arrangement.

262. Erlanger's employed surgeons make numerous referrals to Erlanger in connection with ancillary services for every surgical procedure performed.[68] Those surgeons have a compensation agreement with Erlanger and claims are then submitted to government payors for the surgeon's fee and the various referred ancillary services.[69] Because Erlanger and its employed surgeons fail to qualify for a safe harbor, these referrals violate the Stark Law and are false claims.

a) Evidence Suggests that Erlanger Impermissibly Compensated Employed Surgeons Based on the Volume or Value of their Referrals

263. Information gathered by Plaintiffs-Relators suggests that Erlanger pays excessive compensation to its employed surgeons in order to secure their referrals.

264. For example, during his employment, Dr. S. Adams learned that Erlanger's employed physician practice runs a $20 million annual *deficit* due in part to the extravagant compensation provided to Erlanger Surgeons, but the hospital recovers the difference through the downstream revenue that results from their referrals. Pay exceeding collections can provide evidence of compensation above fair market value and that surgeons are being compensated based on their referrals.

---

[68] Erlanger provides information for patients and payers on the median cost of procedures performed at Erlanger at the following website: https://www.erlanger.org/patient-and-family-resources/billing-insurance-information/our-charges (accessed Dec. 27, 2021). Illustrating the magnitude of downstream revenue Erlanger realizes as a result of the surgical procedures performed by its employed surgeons, Erlanger states that the median physician fees for a hip replacement is only $2,886, while the hospital fees are $37,293.

[69] For example, the examples of non-compliant overlapping surgeries set forth above also resulted in numerous referrals to Erlanger for ancillary services, facilities and other costs that were billed to government payors associated with each surgical case.

265. Similarly, Dr. S. Adams was also told by the former CFO, Britt Tabor, that Erlanger was losing $1 million per year on the employed dermatology group. When Dr. S. Adams attempted to investigate these losses, he was told to stop by CEO Will Jackson's deputy, Meridith O'Keefe.

266. Dr. Jackson also admitted the financial importance of referrals from the surgical disciplines to Dr. J. Adams, stating that "I have to be concerned about the financials of this organization…your discipline, cardiothoracic, urology, GI, I didn't create the economics in this industry, but that's what drives it."

267. Dr. Jackson also acknowledged to Dr. J. Adams that special rules applied to high-producing employed surgeons: "it's not unique to Ortho…it's probably a little bit unique in terms of the magnitude of it, that uh, we're orthopaedists, we manage things a certain way, we've outlived every administration, this is how we are going to do things . . . that's how things work with certain surgical subspecialties." In effect, Dr. Jackson embraced the unlawful practices of employed surgeons.

268. In 2021, after Plaintiffs-Relators J. Adams and Steinmann were terminated, Relator S. Adams was approached by Erlanger's newly hired Chief Operating Officer Robert J. Maloney. Maloney expressed his discomfort with operational and ethical problems he was finding at Erlanger. Maloney also shared that he had stopped attending Compensation Committee meetings after his concerns about paying physicians more than FMV were dismissed. Specifically, Maloney shared that Erlanger was paying Harish Manyam, M.D., a cardiologist, more than a full-time salary (i.e., more than 1.0 FTEs). In addition to his compensation from Erlanger, Dr. Manyam also earned substantial money from sources outside of Erlanger, including in 2019 more than $50,000 from industry as well as more than $174,000 in "associated research

funding."[70]

269. Maloney also expressed concerns to Dr. S. Adams about the rent that Erlanger charged physicians for office space being below FMV.

270. In another example, Relator S. Adams spoke with Karen Percent, the former Director of Erlanger's Audit Services, who told him that she believed there was a lot of "residual risk" in the way that FMV was calculated for physicians.

271. Although Erlanger has sometimes cut salaries and laid off staff in the face of financial hardship,[71] Erlanger Surgeons and other high-revenue-producing physicians are treated differently; they are paid excessively and exempted from several applicable laws and rules – with Erlanger's blessing – to maximize both their compensation and their convenience in exchange for their referrals to Erlanger.

b) Faculty Salaries Above Fair Market Value Used as Improper Inducement, including for Work Not Actually Performed

272. Erlanger pays physicians inducements in the guise of academic salaries in addition to their regular salaries for clinical duties. 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.

273. However, when Dr. Steinmann reviewed department financials in his role as the

---

[70] *See* https://openpaymentsdata.cms.gov/physician/307777 (accessed Feb. 1, 2022).

[71] *See, e.g.*, https://www.chattanoogan.com/2020/12/13/419893/Roy-Exum-Erlanger-s-Bogus-Bonus.aspx (accessed Jan. 8, 2022).

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.

274. When Dr. Steinmann attempted to create such a mechanism, he became the target of the orthopaedic 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.

275. 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 Orthopaedic Program Director. ACGME policy requires that an orthopaedic 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.[72] Thus, although he is paid a full salary for clinical activities and additional compensation for academic activities, he cannot possibly be performing both adequately. Additionally, the

[72] *See* further discussion *infra* at Section V.G.2(c).

academic compensation alone, without the addition of his UTCOM benefits, is roughly 4 times the national average compensation for an orthopaedic program director. Dr. Bruce has repeatedly demonstrated lack of awareness of ACGME requirements for an orthopaedic 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 orthopaedic program additionally fails to fulfill minimal requirements for clinic time and for resident oversight of patient care duties.[73] 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 Orthopaedic Surgery Medical Director.

276. By way of contrast and to establish actual FMV, Dr. J. Adams is aware that the

---

[73] As it stands, the Erlanger residency programs exist in substantial part as a vehicle to direct additional remuneration to Erlanger Surgeons through wRVUs generated by resident-performed surgery and without requiring them to actually perform the duties of teaching physicians. Erlanger Surgeons fail to dedicate time to academic activities instead using residents to fuel non-compliant overlapping or unsupervised surgeries. Indeed, numerous publications and websites provide surprising detail on the shocking level of autonomy Erlanger residents receive. *See* https://pubmed.ncbi.nlm.nih.gov/28967577/; https://uthsc.edu/comc/orthopaedic-surgery/fellowship-alumni.php; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5459631/.

Because wRVU production is prioritized while teaching and compliance with program requirements are not, the Erlanger orthopaedic residency fails to fulfill its requirements in a number of ways. UTCOM's failure to provide adequate oversight of resident trainees has not gone unnoticed. In October 2021, it was announced that UTCOM Memphis's plastic surgery residency was closed by the ACGME (the governing body for post graduate medical education) and another residency was placed on probation. Also at the same time, the UTCOM College of Medicine in Memphis as an institution and its residency and fellowship programs in Memphis, Jackson and Nashville were placed on probationary status, an extremely rare event. *See, e.g.*, https://news.uthsc.edu/announcements/college-of-medicine-residency-and-fellowship-accreditation/.

Orthopaedic Residency Program Director at a major university who supervised more than 40 residents was paid just $80,800. Separately, Dr. J. Adams was told that the prior University of Florida-Jacksonville Orthopaedic Residency Program Director was paid $50,000 for her position supervising 20 residents. Both of these programs have more residents, and thus more responsibility for a program director, than Erlanger's, which has 15 residents. Dr. Bruce's annual program director pay of $209,000 for fewer residents and work he was not required to perform is orders of magnitude higher than these comparable surgeons.

277. Drs. Nowotarski's compensation of $145,000 per year to supervise one new orthopaedic trauma fellow annually was also far beyond FMV.

278. Dr. Steinmann's predecessor as Chair, Dr. Richard Alvarez, was paid $484,555 annually for the academic portion of his salary, compared to $250,000 paid to Dr. Steinmann.

279. Dr. Channappa Chandra, M.D., the Orthopaedic Department's former Vice Chair, was paid $304,557 for the role. Plaintiffs-Relators understand that Dr. Chandra did not have substantial responsibilities in this position.

280. In other words, the allocation of academic salaries at Erlanger is untethered to actual work performed or effort involved. In another example, Dr. Robert Quigley, an Instructor, and Dr. Brandon Cincere, an assistant professor, are each paid more than $60,000 a year to take on a 5% teaching assignment. By contrast, Relator J. Adams, a full professor, was paid $72,000 a year for a 20% teaching effort; she devoted one day a week to academic pursuits and took a clinically reduced practice and salary for this. Yet she was deemed not eligible to receive health care benefits from UTCOM.

281. In another instance of compensation being paid above FMV in order to induce referrals, and as a potential AKS violation, Dr. S. Adams learned that Spiegel also "sweetened

the pot" with the position of Associate Dean, without any expectation of actual academic work, in order to hire Gastroenterologist Louis Lambiase, M.D.

282. Similarly, and like Dr. Bruce, Dr. S. Adams learned that Stephen DePasquale, M.D., the OB/Gyn Chairman, failed to devote any time to his academic duties instead working clinically 100% of the time.

283. 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.

284. Relators also raised concerns with Erlanger leadership about these practices, but nothing was done. For example, Dr. Steinmann reported his concerns about the excessive academic compensation for work that was not being performed to Erlanger CEO Will Jackson. Dr. Steinmann stated "Jeremy [Bruce] is not taking his 8 hours off to be program director [and] that's a minimum number by ACGME and he's being paid 209[,000] which is three to four times the going rate which is an inducement at one level." He also noted that Dr. Bruce was upset with him for raising the issue. Dr. Jackson responded simply, "I get it."

285. Dr. Steinmann also reported to Dr. Jackson that he spoke to Dr. Mark Freeman about being overcompensated for his lack of academic efforts, particularly in research: "We're paying almost 90 grand a year for the past ten years and he produced one paper. That's getting close to a million dollars."

286. Dr. Steinmann then stated that he told Dr. Freeman that he was planning to drop his academic compensation to bring it into compliance with FMV and into alignment with work

actually performed. Dr. Jackson seemed shocked that Dr. Steinmann would propose this and responded, "but again you need to understand…number 1, thank you for your courage, number 2, and I'm just keeping it real, I have no pathway to do this because I've told a lot of people in chair roles, including one last night, because I don't have an answer for it, the Dean is lovely, he's not looking for fights at this stage of his career, he's running out the clock."[74]

287. In fact, as Dr. Jackson knew, Erlanger controlled academic salaries and provided the funds to pay them to UTCOM.[75] UTCOM's financial security is closely tied to Erlanger's. Dr. Peter Buckley, Chancellor of the University of Tennessee Health Science Center, participated in a town hall at Erlanger on November 1, 2022 and stated (in relation to Erlanger's efforts to become a private entity), "[I]f the governance structure leads to a better performance and a better financial performance of Erlanger, it's likely that we would be – to some extent – the recipient of that. There's a phrase in academic medicine, 'no margin, no mission', and so the ability of Erlanger to do well financially is an opportunity for us."[76]

288. Former UTCOM Dean Bruce Shack, M.D., told Plaintiffs-Relators that with regard to Dr. Bruce, "there are rules you have to abide by if you are the program director, a

---

[74] Dr. Steinmann also suggested to Dr. Jackson that Erlanger hire an external consultant to help with cleaning up the residency. Dr. Jackson's response – declining to bring in the consultant – suggests he was already well aware of the deficiencies in Erlanger's program: "it adds additional vulnerability and risk to the program … you had a consultant who told you to do this two years ago … find yourself on probation."

[75] As Dr. Jackson knew, in its employed physician contracts, Erlanger also reserves the right to adjust physician compensation and suspend performance of a contract in the event that it determines that a provision fails to comply with the law, such as the Stark Law or AKS. Instead of using this provision to adjust the overpayments untethered to actual work flagged by Dr. Steinmann, Erlanger instead used this provision to reduce Dr. Steinmann's compensation, purportedly for failing to meet a FMV standard but in fact in retaliation for having raised concerns threatening these financially vital arrangements with Erlanger Surgeons.

[76] Chattanooga Times Free Press, 11/2/2022.

certain number of hours per week that you need to spend on the program, and those can't be hours on Sunday afternoon, during the forty hour work week you've got to put in X number of hours and it varies from one program to another but I know that there's pretty strict rules in orthopaedics about how much … And Jeremy, although he does a good job, and I think most people like him and I think he's a good surgeon, … he doesn't do it by the book. You know he does it the way he's always done it and functionally it's worked out okay but I think if we ever have a site visit …. They would say well, what are you doing and when are you doing it?"

289. No investigation or corrective action has been initiated in response to Plaintiffs-Relators various complaints.

c) Erlanger Uses Paid Academic Appointments with Few or No Requirements to Lower the Threshold at Which Surgeons are Eligible for per wRVU Incentive Compensation, Further Increasing Compensation above FMV

290. There is another important consequence of the percentage of academic effort assigned to Erlanger Surgeons – it lowers the threshold at which Erlanger Surgeons become eligible for productivity-based incentive compensation.

291. To illustrate, Dr. Steinmann's contract provides that his effort is 60% clinical and 40% academic. As a result, his wRVU target was reduced by 40% and set at 7,659 per year. Beyond that level, he was to be paid an additional $63.75 per wRVU per year. If Dr. Steinmann's effort was instead 100% clinical, his annual wRVU target would have been adjusted to 12,765, with incentive compensation only if he generated wRVUs above that level.

292. While Dr. Steinmann actually dedicated the time required by his contract to his academic efforts, many Erlanger Surgeons do not and, as a result, their designated percentage academic effort serves only to reduce the threshold at which they begin to earn per wRVU incentive compensation while they continue to work 100% clinically.

293. For example, in the case of Dr. Bruce, whose clinical effort is assigned at only 50% but who is in fact clinically active 100% of the time, his compensation is dramatically increased because he begins to earn incentive compensation at half the level of productivity that he should based on how he actually spends his time.[77]

294. The effect is the same for other Erlanger Surgeons whose expected level of productivity is reduced by their (purported) percentage of academic effort.

d) Erlanger's Surgeons Generate Extreme Levels of wRVUs, Securing Further Compensation above FMV and also Suggesting They Are Receiving Credit – and Compensation – for Work Not Personally Performed

295. At least some Erlanger Surgeons generate extreme wRVU levels above the 90th percentile, suggesting that their already above FMV compensation was further inflated in exchange for their referrals.

296. During one conversation, Dr. Kiner told Dr. Steinmann that he was currently generating 14,000 wRVUs annually but bragged that in prior years he had generated *24,000* wRVUs.

297. Dr. Kiner also told Dr. Steinmann that he and Dr. Nowotarski used to be the two "busiest" orthopaedic trauma surgeons in the country.

298. According to the 2016 MGMA report on orthopaedic surgeon productivity and compensation, the 90th percentile for Southern region orthopaedic surgeon wRVUs was 13,189, placing Dr. Kiner's current level of productivity above the 90th percentile and reflecting that 24,000 wRVUs per year is nearly double that level.

299. Dr. Kiner and Dr. Nowotarski's wRVU targets were also reduced from their

[77] In a conversation with Dr. Steinmann, Dr. Warren "Ren" Gardner explained that the reduction of his wRVUs target based on his percentage academic effort "was a super big deal."

normal levels by 15% and 23%, respectively, to account for the percentage of their effort that was designated as academic, even though they each worked clinically full time.

300. This extremely high level of productivity, further enhanced by their percentage academic effort, also suggests that Drs. Kiner and Nowotarski were receiving compensation well above the 90th percentile, which is a recognized red flag that compensation is above FMV.

301. As set forth above in the specific allegations of non-compliant overlapping surgeries, Dr. Kiner in particular was known to engage in non-compliant overlapping surgeries, which would have increased the wRVUs generated and credited to him.

302. According to Plaintiffs-Relators, the Erlanger recordkeeping system would have awarded wRVU credit to the attending surgeon engaging in non-compliant overlapping surgery even if the surgeon never participated in the case booked under his name, resulting in additional, unlawful compensation for work not personally performed by the surgeon.

e) Erlanger Provides Additional Remuneration to Erlanger Surgeons

303. As noted above, Plaintiffs-Relators believe permitting password sharing constitutes a form of remuneration to Erlanger Surgeons because it saves them considerable time and relieves them of tasks they are required by law to perform. There are several additional Erlanger practices that Plaintiffs-Relators believe constitute remuneration provided to the Erlanger Surgeons, including:

304. Exempting Erlanger Surgeons from hospital oversight of their relationships with industry, despite the potential for conflicts of interest;[78]

[78] For example, according to CMS, Dr. J. Doty received in excess of $786,000 between 2015 and 2020, including more than $577,000 from Arthrex, Inc., primarily as "[c]ompensation for services other than consulting, including serving as faculty or as a speaker at a venue other than a continuing education program." See https://openpaymentsdata.cms.gov/physician/84551. Of note, Arthrex recently paid $16 million to resolve claims it paid kickbacks to a single

305. Relatedly, allowing Erlanger Surgeons to dictate the medical equipment and devices they use, rather than setting up a cost-saving device formulary based on competitive bids;[79]

306. Allowing Erlanger Surgeons to run industry-sponsored clinical research studies outside of the supervision of Erlanger's research department, possibly to allow the Erlanger Surgeons to keep research funding.[80]

307. Allowing Erlanger Surgeons to spend time during business hours away from the Erlanger campus without recording it and then to cash in vacation time that was actually taken

---

orthopaedic surgeon. *See* https://www.justice.gov/opa/pr/medical-device-company-arthrex-pay-16-million-resolve-kickback-allegations.

[79] Dr. S. Adams personally brought up an opportunity to save millions of dollars each year with both the CEO and CFO but his approach was rejected. He also started to do a cost analysis of the orthopaedics service line to demonstrate what was already suspected by the supply chain team: surgeons' implant costs vary radically. In response, Erlanger's CFO, Britt Tabor, made it clear to Dr. S. Adams that this was not a topic that he was allowed to explore. Of note, in May of 2021, Drs. Steinmann and J. Adams spoke with Dr. Paul Apyan, a former Erlanger orthopaedic surgeon, who told them he was terminated shortly after he suggested curbing implant costs, which he said made the other orthopaedic surgeons furious.

Relators were told that Dr. Mark Freeman threatened to leave Erlanger if a device formulary was ever implemented. Notably, according to CMS, Smith & Nephew paid Dr. Mark Freeman more than $48,000 in 2019, a year in which he advocated in his role as medical director for Erlanger to purchase a new Smith & Nephew surgical robot. *See* https://openpaymentsdata.cms.gov/physician/1040701 (accessed Nov. 30, 2021). In 2020, Steris Corporation paid Dr. Freeman more than $6,000 for travel around the same time that Erlanger hired Steris as its vendor for instrument sterilization. *Id.*

[80] For example, Stephen DePasquale, M.D., a gynecological oncologist, received more than $412,000 in "associated research funding" in 2019. *See* https://openpaymentsdata.cms.gov/physician/217573. Dr. J. Doty also received associated research funding of more than $64,000 in 2020, including more than $55,000 from Arthrex, Inc. https://openpaymentsdata.cms.gov/physician/84551. Chief of Cardiology Harish Manyam, M.D., also received more than $174,000 in associated research funding in 2019 and $128,000 in associated research funding in 2020. https://openpaymentsdata.cms.gov/physician/307777.

but not recorded;[81]

308. Allowing – and paying for – Erlanger Surgeons to secure UTCOM's superior health insurance, from which other Erlanger physicians are excluded;

309. Allowing Erlanger Surgeons to falsify Erlanger's published call schedule in order to receive full pay for simultaneously covering the regular and pediatric call pools, contrary to Erlanger's own policy.[82]

310. These various perquisites were provided to Erlanger's surgeons in exchange for their referrals and served to further inflate the compensation received by Erlanger's surgeons above FMV.

f) Erlanger Surgeons Are Required to Refer to Erlanger, but Erlanger Fails to Comply With the Directed Referral Safe Harbor

311. While the ancillary services generated in connection with surgical procedures conducted by Erlanger Surgeons are likely to be the largest set of referrals from them, Erlanger Surgeons could also refer their patients for unrelated procedures and physician services.

312. Statements by Erlanger senior leadership indicate that Erlanger Surgeons were required by Erlanger to make their referrals within the organization. For example, in a conversation on November 13, 2020, Dr. Jackson explicitly instructed Dr. Steinmann to ask an Erlanger-employed physician working in the orthopaedic department, David Lowry, D.O., if he would send his referrals to Erlanger in connection with hiring a spine surgeon for the Erlanger

---

[81] For example, Dr. J. Doty, who earned more than $250,000 from industry in 2019, presumably for time spent away from Erlanger, reported to Dr. J. Adams that he was able to cash in his "unused" vacation days for additional compensation from Erlanger. By way of contrast, as a primary care physician Relator S. Adams' time away from work was actively tracked by Erlanger.

[82] Dr. J. Adams was told of this practice by David Bruce, M.D., shortly after she arrived in 2019. The specific example given was that Bryce Cunningham, M.D. took pediatric and orthopaedic call at the same time and was able to collect "full" funds.

Medical Group. Dr. Jackson made the following statements and requests:

313. "I've never touched referral patterns . . . On the other hand, to the degree that [inaudible] is providing a valuable service, and those patients are staying in our system, I like that."

314. "Don't mention my name . . . Ask Dave, where are you referring to, are you doing referrals to our neurosurgeons?"

315. "Dave, if I fill a void and we have an Erlanger employed EMG faculty member doing spine surgery, that you interview and vet, are you going to send 100% of your referrals here?"

316. "I have heard from reliable sources that Dave does not refer internally . . . I don't like that."

317. "The issue there Scott is, people don't see where their bread gets buttered. We do not have a mature medical group … If I'm part of a multispecialty group and I have viable options, I need to refer."

318. "But I'm not in the role to have that conversation with Dave and I'm not saying get into a pointed conversation with him, but I do think it is incumbent upon you to say, look Dave, if we bring in someone else here and you vet them, we'll make it easy for you, is this someone you would refer to…just to say, here's where we are at."

319. Similarly, Julie Dean, Erlanger's former Director of Compliance, stated that Erlanger-employed physicians "should be making their referrals to Erlanger." Ms. Dean told Relator J. Adams, "We've got a work group, that Meridith [O'Keefe] leads, that has been tasked by Britt Tabor to look at leakage, to look at any referrals that are being sent outside of the system by our employed doctors, which is completely legal for us to look at."

320. Steve Burkett told Dr. Steinmann that the reason why the prior Chair of the Erlanger Orthopaedics Department, Richard Alvarez, M.D., who was paid $484,555 for his academic position, had been removed by Spiegel was because of his unwillingness to fully relocate his practice – and concomitant referrals – to Erlanger from Parkridge Hospital, a competing local hospital. A similar issue arose with Mark Freeman, M.D., who eventually was convinced to move nearly all of his practice to Erlanger.[83]

321. While it is permissible under the Stark Law for an employer to impose a "directed referral requirement" on a physician, several requirements must be met:

> If a physician's compensation under a bona fide employment relationship, personal service arrangement, or managed care contract is conditioned on the physician's referrals to a particular provider, practitioner, or supplier, all of the following conditions must be met.
>
> (i) The compensation, or a formula for determining the compensation, is set in advance for the duration of the arrangement. Any changes to the compensation (or the formula for determining the compensation) must be made prospectively.
>
> (ii) The compensation is consistent with the fair market value of the physician's services.
>
> (iii) The compensation arrangement otherwise satisfies the requirements of an applicable exception at § 411.355 or § 411.357.
>
> (iv) The compensation arrangement complies with both of the following conditions:
>
> (A) The requirement to make referrals to a particular provider, practitioner, or supplier is set out in writing and signed by the parties.
>
> (B) The requirement to make referrals to a particular provider, practitioner, or supplier does not apply if the patient expresses a preference for a different provider, practitioner, or supplier; the patient's insurer determines the provider, practitioner, or supplier; or the referral is not in the patient's best medical interests in the physician's judgment.
>
> (v) The required referrals relate solely to the physician's services covered by the scope of the employment, personal service arrangement, or managed care contract, and the referral requirement is reasonably necessary to effectuate the legitimate business purposes of the compensation arrangement. In no event may the physician be required to make referrals

[83] Another sports medicine physician, Derek Worley, M.D., was reportedly terminated by Erlanger for directing too many of his referrals outside of Erlanger.

that relate to services that are not provided by the physician under the scope of his or her employment, personal service arrangement, or managed care contract.

(vi) Regardless of whether the physician's compensation takes into account the volume or value of referrals by the physician as set forth at paragraph (d)(5)(i) of this section, neither the existence of the compensation arrangement nor the amount of the compensation is contingent on the number or value of the physician's referrals to the particular provider, practitioner, or supplier. The requirement to make referrals to a particular provider, practitioner, or supplier may require that the physician refer an established percentage or ratio of the physician's referrals to a particular provider, practitioner, or supplier.

42 C.F.R. § 411.354(d)(4).

322. It does not appear that Erlanger meets those requirements. As an initial matter, Plaintiffs-Relators' own employment contracts do not contain a directed referral requirement, which suggests that the Erlanger Surgeons' employment contracts do not either. *Id.* at 411.354(d)(iv)(A). In addition, the academic and total compensation provided to Erlanger Surgeons appears violative of FMV, id. at § 411.354(d)(ii), and may also fail to satisfy any of the exceptions set forth in 42 C.F.R. § 411.354(d)(iii). Finally, Erlanger Surgeons' compensation arrangements may fail to satisfy 42 C.F.R. § 411.354(d)(vi) to the extent that their existence and amount of compensation may be contingent on the number or value of the physician's referral to Erlanger.

323. As a result of these practices in violation of the Stark Law, Erlanger has submitted numerous additional false claims to government payors for referrals from Erlanger's employed surgeons that were infected and unpayable due to the unlawful referral practices detailed above.

3. *Other Examples of Erlanger's Culture of Non-Compliance and Additional False Claims Submitted by Defendants*

a) Failing to Comply with Rules Governing Billing for Ultrasounds

324. Physicians at Erlanger frequently used ultrasound imaging to, *inter alia*, study a patient's body part or injured joint or extremity, to guide an injection, or to guide a biopsy or procedure and then billed government payers for these services without complying with

applicable rules, including that the imaging be saved permanently and a written report issued. In the Orthopaedics Department as well as in other Departments, rather than saving images permanently in the medical record and issuing the required report, the images were instead deleted from the ultrasound machine with no report ever drafted, even while bills were submitted to government payers.

325. To illustrate these requirements, according to Current Procedural Terminology ("CPT")[84] codes 76881 and 76882,[85] which cover extremity ultrasounds, a physician is required to have "permanently recorded images and a written report containing a description of each of the required elements . . ."[86]

326. According to the Radiology Guidelines for CPT codes, radiological procedures require image documentation and note that "A written report . . . signed by the interpreting individual should be considered an integral part of a radiology procedure or interpretation."[87] Likewise, in the section dealing with Diagnostic Ultrasounds, the Radiology Guidelines state that "All diagnostic ultrasound examinations requires permanently recorded images . . . . A final,

---

[84] CPT codes are also known as the Healthcare Common Procedure Coding System ("HCPCS") codes. CPT codes are the same as HCPCS Level I codes. *See* https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/HCPCS_Coding_Questions (accessed Sept. 5, 2022).

[85] There are many other CPT codes that require the permanent storage of ultrasound imaging and a report, which Erlanger has likely violated. Other CPT codes that were likely violated by these practices include but are not limited to 76872, 76942, 76998, 76999, 20604, 20606, and 20611.

[86] CPT 2018 Professional at p. 471, American Medical Association. *See also*https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=55037 (accessed Sept. 5, 2022); *see also* https://searchltf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-Proposed-Rule-RUC-Comment-Letter.pdf at pp. 69-70 (accessed Sept. 5, 2022).

[8787] CPT 2018 Professional at p. 447, American Medical Association.

written report should be issued for inclusion in the patient's medical record."[88] It also states that "Use of ultrasound, without thorough evaluation of organ(s) or anatomic region, image documentation, and final, written report, is not separately reportable."[89]

327. The National Correct Coding Initiative Policy Manual for Medicare Services, Chapter IX, deals with Radiology Services and states that "A HCPCS/CPT code shall be reported only if all services described by the code are performed."[90]

328. The Medicare Claims Processing Manual also provides that "For services furnished to hospital patients, A/B MACs (B) pay only if the services meet the conditions for fee schedule payment and are identifiable, direct, and discrete diagnostic or therapeutic services to an individual patient, such as an interpretation of diagnostic procedures and the PC of therapeutic procedures. *The interpretation of a diagnostic procedure includes a written report.*"[91] (emphasis added). 42 C.F.R. § 410.32(d)(2) also requires that the provider who ordered a diagnostic service "must maintain documentation of medical necessity in the beneficiary's medical record." Many of Erlanger's physicians failed to follow these billing rules with regard to ultrasounds.[92]

329. By regulation, CPT codes have been adopted as the standard medical data codes sets applying to government run health care programs and providers are required to fully comply with the requirements of the applicable CPT codes. According to 45 C.F.R. § 162.1002, "The

---

[88] *Id.* at 468.

[89] Id.

[90] *See* https://www.cms.gov/files/document/chapter9cptcodes70000-79999final112021.pdf at IX-3. (accessed Sept. 5, 2022).

[91] *See* Medicare Claims Processing Manual, Ch. 13, § 20.1 (2022).

[92] Plaintiffs-Relators have first-hand information that Orthopaedics and Erlanger's Sports Medicine physicians deleted images and failed to issue reports. These deficiencies may also have occurred in Urology and OB/Gyn, which also used ultrasound heavily in their practices.

Secretary adopts the following maintaining organization's code sets as the standard medical data code sets: . . . (5) The combination of Health Care Financing Administration Common Procedure Coding System (HCPCS), as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT–4), as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following: . . . (iii) Radiologic procedures."

330. Relator Dr. S. Adams learned of these issues and raised concerns about them to Erlanger's leadership because of his information technology duties at Erlanger. Despite this, Erlanger leadership turned a blind eye.

331. Relators also learned more details of this behavior around May of 2020 when 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. J. 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 orthopaedic surgery department for more than a decade, as well as in other departments. A discussion with Dr. W. Hunter Garrett and Dr. Brandon Cincere revealed that the standard workflow among orthopaedic surgeons and others had simply been to save images on the machine, which ultimately would delete and overwrite when memory became full, rather than upload them to the electronic medical system for permanent storage. This process fails to meet the documentation requirements for billing. On information and belief, these practices were also engaged in by Derek Worley, M.D., Bill Moore Smith, M.D., W. Hunter Garrett, M.D., Matthew

Chatfield, M.D., Brandon Cincere, M.D., and others.

332. 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.

333. Relators also suspect violations of these rules in cases from the Urology and Gynecology Departments, both of which frequently use ultrasound to guide procedures.

334. Prior to Plaintiffs-Relators' efforts, when the storage capacity on the ultrasound machine was full, older images were simply deleted with no permanent record created. The required written reports were simply ignored. In one instance, Dr. S. Adams learned that when a physician's employment with Erlanger ended, more than 1,000 ultrasound studies performed and billed by that physician were deleted from the ultrasound machine and permanently lost. Additionally, according to Dr. S. Adams investigation of this issue, there were approximately 1,500 ultrasound guided procedures that failed to have an associated ultrasound report in the electronic medical record. Similarly, there were approximately 2,500 ultrasound guided injections that also failed to contain required documentation.

b) Insisting on Falsification of Compliance Documents

335. J. Britton Tabor, Erlanger's Executive Vice President and CFO/Treasurer pressured 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 was 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 turned out that no one on the finance team had read the 139 pages in the standard.

c) Unbundling of Surgical Billing Codes

336. 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.

337. 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 orthopaedic 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 orthopaedic 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.

d) Violations of Tennessee's Laws on Prescribing Opioids

338. 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 milligram equivalents

("MME").[93] 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.[94] An opioid consent is also required.[95] Further, the prescription of benzodiazepines and opioids concomitantly is prohibited.[96]

339. 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.[97] Doctors J. Adams, S. Adams and Steinmann have each noted, in the routine course of taking care of their patients and reviewing their charts, that orthopaedic 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.

---

[93] *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.

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

[95] *Id.*

[96] *Id.*

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

340. 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 orthopaedic surgeons at Erlanger demanded to have their medical assistants or nurses provided the credentials to prescribe and authenticate controlled-substance prescriptions.

341. 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 orthopaedic 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.

342. 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.

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

344. 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.

345. 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.

346. 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.

347. 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 ([i.e.], 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. It[']s not an exciting topic but I do think it[']s 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

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

e) Allowing the Performance of Unnecessary Procedures

349. 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."[98] 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."[99] "Surgical release is []

---

[98] *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)).

[99] *Id.*

not routinely recommended unless patients . . . fail appropriate nonsurgical treatment."[100]

350. 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. During just the Q4 2017 to Q1 2021 period, Dr. S. Adams identified approximately 144 surgeries for suprascapular neuropathy performed by Dr. Dorizas on government-insured patients.

351. But other Erlanger orthopaedic 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.

352. 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 regarded Duke-trained electrodiagnostician, did not know how to properly perform electrodiagnostic testing. Notably, Dr. Dorizas and other Erlanger orthopaedic 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

---

[100] *Id.*

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.

353. 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.

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

354. 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).

355. As detailed below and set forth supra, 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 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. Since their termination, Doctors Steinmann and J. Adams' difficulties in obtaining permanent positions indicates ongoing retaliation by Defendants. Dr. J. Adams and Steinmann are aware of certain Erlanger orthopaedic surgeons who have told other physicians that they are difficult to work with and "had to be gotten rid of."

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

356. 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 surgical 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."

357. In 2019, shortly after Doctors Steinmann and J. Adams became employed by Erlanger in orthopaedic 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.

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

359. 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.

360. 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*

361. The August 2020 investigation by Erlanger's compliance department angered some members of the orthopaedic 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.

362. As to Dr. S. Adams, Erlanger engaged in a campaign of retaliation, including threats of termination and a diminution of his compensation. Fearing he would be terminated, Dr. S. Adams resigned from his position as CIO at Erlanger. He took a lower-ranking and lower-

paying position at a different health system which specifically does not involve patient care. To ensure his clinical practice remains up-to-date and because he enjoys teaching, a written agreement was provided to Dr. S. Adams from Erlanger and UTCOM, allowing him to participate in clinical care and rounding with residents at UTCOM and Erlanger. However, in the Fall of 2021, Dr. S Adams, a member of the Erlanger medical staff in good standing, was locked out of the Epic EHR by order of then-CEO Jackson. Further, other physicians and Erlanger employees were told Dr. S. Adams represented a "danger" to Erlanger. After a certain amount of time without direct patient care, a physician could be deemed inactive and become ineligible to resume seeing and treating patients. As of December 22, 2022, Dr. S. Adams has been out of clinical practice for 18 months. As that time lengthens it becomes increasingly unlikely that he would be granted inpatient credentials at any facility.

363. 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 orthopaedic department to the compliance department. The message could not be clearer: If you want a future in this department, you will be quiet.

364. 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 orthopaedics 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.

365. 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 Orthopaedic 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 Orthopaedic 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."

366. 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, Chief Medical Officer of the Erlanger Medical Group, 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.

367. 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.

368. 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 orthopaedic surgeons in the orthopaedics 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.

369. 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.

370. With the evident support of Erlanger leadership, the retaliatory campaign against Plaintiffs-Relators continued unabated. For instance, on December 9, 2020, the Erlanger Orthopaedic 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 Doctors 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.

371. 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.

372. 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.

373. The contractual arrangements arose thus: Dr. Steinmann was recruited from his prior position as Professor of Orthopaedic 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. . . .

374. 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 Orthopaedics Medical Director, Dr. Freeman who chairs the self-styled "Ortho Board" to which the governance of the department has traditionally devolved.

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

376. 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.

377. 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.

378. 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.

379. 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.

380. 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.

381. 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 represented "a threat … to the enterprise."

382. Erlanger's retaliatory campaign against Doctors J. Adams and Steinmann continued 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.

383. 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.

384. 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:

> 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.

385. 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.

386. Notwithstanding, Doctors Steinmann and J. Adams face the possibility 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 derived 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. Because of Erlanger's purposeful retaliatory conduct, this compensation and other benefits, already greatly reduced, will disappear completely at the end of 2022.

387. 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.

388. Since their termination by Erlanger, Doctors Steinmann and J. Adams engaged in a nationwide search for new permanent positions at other academic centers and teaching hospitals, an identifiable class of third parties. Repeatedly, they pursued promising prospective opportunities, went through multiple rounds of interviews, and received signals that offers of permanent employment would be forthcoming, only to grow cold.

389. Drs. J. Adams and Steinmann expanded their search to nonacademic and non-teaching jobs, including private practice and hospital employment, with similar result. On information and belief, Erlanger and, specifically, its employed surgeons and administrators have purposefully continued their retaliation by spreading malicious falsehoods about Doctors Steinmann and J. Adams to prevent them from securing prospective employment after their

terminations. Plaintiffs-Relators have been greatly damaged by this improper conduct.

390. While Erlanger terminated its relationship with Doctors J. Adams and Steinmann, it chose 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 elected to continue its retaliation by threating his job security, letting him know that they were watching him, and cutting his compensation in terms of bonuses and additional increases in pay.

391. Because of this ongoing retaliation, and after observing the damage done to the professional lives of Drs. J. Adams and Steinmann, Dr. S. Adams determined that he had no choice but to leave Erlanger, accepting a lower ranking and lower paying position with another healthcare system in Chattanooga. During his 23 years with UTCOM/Erlanger, Dr. S. Adams received eight awards for excellence in teaching. The room where clinical supervision of Family Medicine residents occurs was named in his honor and there is an endowed annual Stephen M. Adams Annual Resident Teaching Award. Dr. S. Adams retained medical staff privileges at Erlanger after he was no longer Chief Information Officer. Despite written approval from both UTCOM and Erlanger leadership to continue teaching residents and providing clinical care on a part-time basis, Dr. S. Adams was subsequently personally banned by former CEO William Jackson from having any role in resident education, even as an unpaid volunteer, because he purportedly a "risk to the organization." Not only is this reputationally and professionally harmful, but also it means that Dr. S. Adams will no longer have an outlet to be involved in direct patient care, putting his ability to maintain clinical privileges at risk.

392. Each of the Relators has suffered severe and compounding damages as a result of Defendants' retaliatory conduct, including ongoing emotional distress, damage to their health and well-being, reputational harm, and damage to their future professional opportunities.

VI. COUNTS

COUNT I

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

393. All of the preceding allegations are incorporated herein.

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

395. 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, overlapping surgeries where valid informed consent was not obtained, and other violations as set forth above.

396. 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.

397. 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)

398. All of the preceding allegations are incorporated herein.

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

400. 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.

401. 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)

402. All of the preceding allegations are incorporated herein.

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

404. 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, overlapping surgeries where valid informed consent was not obtained, and other violations as set forth above.

405. 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.

406. 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)

407. All of the preceding allegations are incorporated herein.

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

409. 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.

410. 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)

411. All of the preceding allegations are incorporated herein.

412. 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).

413. 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.

414. 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)

415. All of the preceding allegations are incorporated herein.

416. 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).

417. 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, overlapping surgeries where valid informed consent was not obtained, and other violations as set forth above.

418. 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.

419. 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)

420. All of the preceding allegations are incorporated herein.

421. 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).

422. 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.

423. 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.

424. 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)

425. All of the preceding allegations are incorporated herein.

426. 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).

427. 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, overlapping surgeries where valid informed consent was not obtained, and other violations as set forth above.

428. 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.

429. 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)

430. All of the preceding allegations are incorporated herein.

431. 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).

432. 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.

433. 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)

434. All of the preceding allegations are incorporated herein.

435. 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).

436. 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*.

437. 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

438. All of the preceding allegations are incorporated herein.

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

440. 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.

441. 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.

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

COUNT XII

Tortious Interference with Business Relationships

443. All of the preceding allegations are incorporated herein.

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

445. 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 Plaintiffs-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.

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

COUNT XIII

Inducement to Breach of Contract

447. All of the preceding allegations are incorporated herein.

448. 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.

449. 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.

450. Plaintiffs-Relators are entitled to treble damages resulting from or incident to UTCOM's termination of Plaintiffs-Relators' contracts pursuant to Tenn. Code. Ann § 47-50-109 and all other legal and equitable relief necessary to make them whole.

COUNT XIV

Intentional Interference with Prospective Business Relationships

451. All of the preceding allegations are incorporated herein.

452. Plaintiffs-Relators J. Adams and Steinmann, as described above, have sought academic and surgical positions at other teaching hospitals and academic institutions, an identifiable class of third parties, as well as nonacademic and non-teaching jobs, including private practice and hospital employment, but have been unsuccessful in their endeavors to date.

453. By virtue of the conduct described above, Defendants have intentionally interfered with Plaintiffs-Relators' prospective business relationships with these other teaching hospitals and academic institutions and with employers offering nonacademic and non-teaching jobs.

454. Defendants knew and understood that Plaintiffs-Relators were seeking

prospective employment and that their wrongful actions might have an adverse impact on Plaintiffs-Relators' relationships with these prospective employers but acted in any event in a manner designed to lead to a disruption or termination of those relationships. Because Defendants acted with an improper motive towards Plaintiffs-Relators, they have committed tortious interference with their business relationships with other teaching hospitals and academic institutions.

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

VII. PRAYER FOR RELIEF

456. 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[101] 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 or be awarded front pay and awarded two times the amount of back pay, interest on the back pay, and/or compensation for any special damages, including emotional distress,

[101] 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).

reputational harm, and litigation costs and attorney's fees, under 31 U.S.C. § 3730(h) and Tenn. Code Ann. § 71-5-183(g);

E. The Plaintiffs-Relators be awarded three times the damages resulting from or incident to UTCOM's termination of Plaintiffs-Relators' academic contracts pursuant to Tenn. Code. Ann § 47-50-109;

F. The Plaintiffs-Relators be awarded damages arising from Defendants' intentional interference with prospective economic advantage;

G. 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;

H. 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);

I. Interest; and

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

VIII. JURY DEMAND

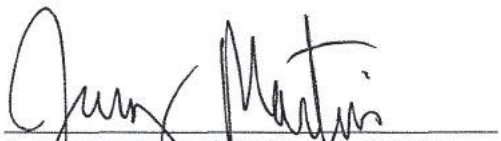
457. Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Plaintiffs-Relators hereby demand a trial by jury.

Dated: January 4, 2023

Respectfully submitted,

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

By their attorneys,



Jerry E. Martin (TBPR No. 20193)
Seth M. Hyatt (TPBR No. 31171)
BARRETT JOHNSTON
MARTIN & GARRISON LLC
414 Union Street, Suite 900
Nashville, TN 37219
Telephone: (615) 244-2202
Facsimile: (615) 252-3798
jmartin@barrettjohnston.com
shyatt@barrettjohnston.com

Reuben A. Guttman
rguttman@gbblegal.com
Traci L. Buschner
tbuschner@gbblegal.com
Justin S. Brooks
jbrooks@gbblegal.com
Elizabeth H. Shofner
lshofner@gbblegal.com
GUTTMAN, BUSCHNER
& BROOKS PLLC
1509 22nd Street, NW
Washington, D.C. 20037
Tel: (202) 800-3001

CERTIFICATE OF SEVICE

I hereby certify that on January 4, 2023 a true and correct copy of the foregoing *First Amended Complaint* was served via email and / or mailed first class, postage prepaid, to the following:

Joseph C. Rodriguez, Ohio Bar No. 0072958
Robert C. McConkey. III, BPR No. 018118
Assistant United States Attorney
Office of United States Attorney
800 Market St., Suite 211
Knoxville, 1N 37902
(865) 545-4167
joe.rodriguez@usdoj.gov
robert.mcconkey@usdoj.gov

Counsel for the United States

W. Anthony Hullender, BPR No. 19436
Deputy Attorney General
Medicaid Fraud & Integrity Division
Tennessee Attorney General's Office
P.O. Box 20207
Nashville, Tennessee 37202-0207
Telephone: (615) 532-2536
Tony.Hullender@ag.tn.gov

Counsel for the State of Tennessee

JERRY E. MARTIN