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U.S. DISTRICT COURT
EASTERN DIST. TENN.

BY_____DEPT. CLERK

IN THE UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
AT CHATTANOOGA

UNITED STATES OF AMERICA, ex rel., LISA K. STRATIENKO, and THE STATE OF TENNESSEE,	)	CIVIL ACTION NO. 1:10-CV-322
Plaintiffs,	)	Collier/Carter
	)	FILED IN CAMERA AND UNDER SEAL
v.	)	
CHATTANOOGA-HAMILTON COUNTY HOSPITAL AUTHORITY d/b/a ERLANGER MEDICAL CENTER,	)	DO NOT PLACE IN PRESS BOX DO NOT ENTER ON PACER
Defendant.	)	JURY TRIAL DEMANDED

COMPLAINT

Plaintiff, Lisa K. Stratienko ("Stratienko" or "Relator"), on behalf of the United States of America (the "United States") and the State of Tennessee, for her Complaint against the defendant, Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Medical Center ("CHCHA"), alleges based upon personal knowledge, relevant documents and information and belief as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States and the State of Tennessee arising from false and/or fraudulent records, statements and claims made, used and caused to be made, used or presented by the Defendant and/or its agents, employees and co-conspirators in violation of the federal False Claims Act, 31 U.S.C. § 3729, et seq., as amended (the "FCA" or the "Act"). As

required by the FCA, Relator is providing to the Attorney General of the United States and to the United States Attorney for the Eastern District of Tennessee a statement of all material evidence and information related to the Complaint. This disclosure statement is supported by material evidence known to Relator establishing the existence of Defendant's false claims.

2. In addition to violating the FCA, Defendant's actions also violate the comparable provisions of the Tennessee Medicaid False Claims Act, Tenn. Code Ann. §§ 71-5-181 *et seq.* and the Tennessee False Claims Act, Tenn. Code Ann. §§ 4-18-101, *et seq.* (collectively referred to as the "TFCA").

3. Further, this action is to recover damages and other monetary and equitable relief for unjust enrichment, fraud, payment by mistake of fact and disgorgement of illegal profits.

II. JURISDICTION AND VENUE

4. This Court has jurisdiction over this action under 28 U.S.C. §§ 1331 and 1345 and supplemental jurisdiction to entertain the State of Tennessee's claims pursuant to 28 U.S.C. § 1367, as well as supplemental jurisdiction to entertain common law and equitable claims pursuant to 28 U.S.C. § 1367.

5. The Court has personal jurisdiction over the Defendant because, among other things, the Defendant has a place of business in this district and Defendant engaged in wrongdoing in this district.

6. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b) and 31 U.S.C. § 3732(a).

7. Under the FCA and the TFCA, this Complaint is to be filed *In Camera*, is to remain under seal for a period of at least sixty (60) days, and shall not be served on the Defendant until the Court so orders. The government may elect to intervene and proceed with the action within sixty (60) days after it receives both the Complaint and the material evidence and information.

8. As required under the FCA and TFCA, Relator has provided to the Attorney General of the United States, the United States Attorney for the Eastern District of Tennessee, and the Attorney General for the State of Tennessee a statement of all material evidence and information related to the Complaint. This disclosure statement supports the existence of false claims by the Defendant.

III. PARTIES

9. Relator is a citizen and resident of the state of Tennessee. She brings this action on behalf of the United States and residents of the State of Tennessee.

10. Defendant, CHCHA, is a public nonprofit corporation that owns and operates Erlanger Health Systems ("EHS"), including Erlanger Medical Center ("EMC"). (Throughout this complaint, the defendant CHCHA hospital system will be referred to as "Erlanger"). EMC operates as a tertiary care teaching hospital with its principal campus, a level one trauma center, located in downtown Chattanooga, Tennessee. EMS provides educational support, including teaching opportunities, to the University of Tennessee

College of Medicine ("UTCOM"). Erlanger also operates clinics and other health care providers through the Chattanooga metropolitan area in Hamilton County, Tennessee and in North Georgia. At all times relevant to this action, Erlanger was in the business of providing inpatient, outpatient and other medical services to thousands of patients. Erlanger may be served with process through its registered agent for service of process in the State of Tennessee, National Registered Agents, Inc., at 2300 Hillsboro Rd., Suite 305, Nashville, TN 37212.

IV. LEGAL FRAMEWORK

1. The Medicare and Medicaid Programs

11. In 1965, Congress enacted Title XVIII of the Social Security Act, known as the Medicare Program, to pay for the costs of certain healthcare services. Entitlement to Medicare is based on age, disability or affliction with end-stage renal disease. See 42 U.S.C. §§ 426, 426A. Part A of the Medicare Program authorizes payment for institutional care, including hospital, skilled nursing facility and home health care. See 42 U.S.C. §§ 1395c-1395i-4.

12. The United States Department of Health and Human Services ("HHS") is responsible for the administration and supervision of the Medicare Program. The Centers for Medicare and Medicaid Services ("CMS") is an agency of HHS and is directly responsible for the administration of the Medicare Program.

13. Under the Medicare program, CMS makes payments retrospectively (after the services are rendered) to hospitals for inpatient and outpatient services. Medicare

enters into provider agreements with hospitals in order to establish the hospitals' eligibility to participate in the Medicare Program. However, Medicare does not prospectively contract with hospitals to provide particular services for particular patients. Any benefits derived from those services are derived solely by the patients and not by Medicare or the United States.

14. As detailed below, Defendant submitted or caused to be submitted claims both for specific services provided to individual beneficiaries and claims for general administrative costs incurred in treating Medicare beneficiaries.

15. To assist in the administration of Medicare Part A, CMS contracts with "fiscal intermediaries." 42 U.S.C. § 1395h. Fiscal intermediaries, typically insurance companies, are responsible for processing and paying claims and cost reports.

16. Upon discharge of Medicare beneficiaries from a hospital, the hospital submits claims for interim reimbursement for items and services delivered to those beneficiaries during their hospital stays. 42 C.F.R. §§ 413.1, 413.60, 413.64. Hospitals submit patient-specific claims for interim payments on a Form UB-92.

17. As a prerequisite to payment by Medicare, CMS required hospitals to submit annually a form CMS-2552 (formerly called a HCFA-2552), more commonly known as the hospital cost report. Cost reports are the final claim that a provider submits to the fiscal intermediary for items and services rendered to Medicare beneficiaries.

18. After the end of each hospital's fiscal year, the hospital files its hospital cost report with the fiscal intermediary, stating the amount of reimbursement the provider

believes it is due for the year. See 42 U.S.C. § 1395g(a); 42 C.F.R. § 413.20; 42 C.F.R. § 405.1801(b)(1). Hence, Medicare relies upon the hospital cost report to determine whether the provider is entitled to more reimbursement than already received through interim payments, or whether the provider has been overpaid and must reimburse Medicare. 42 C.F.R. §§ 405.1803, 413.60 and 413.64(f)(1).

19. Erlanger was, at all times relevant to this Complaint, required to submit annually a hospital cost report to the fiscal intermediary.

20. During the relevant time period, Medicare payments for hospital services were determined by the claims submitted by the provider for particular patient discharges during the course of the fiscal year. On the hospital cost report, this Medicare liability for services is then totaled with any other Medicare liabilities to the provider. This total determines Medicare's true liability for services rendered to Medicare beneficiaries during the course of a fiscal year. From this sum, the payments made to the provider during the year are subtracted to determine the amount due the Medicare program or the amount due the provider.

21. Under the rules applicable at all times relevant to this complaint, Medicare, through its fiscal intermediaries, had the right to audit the hospital cost report and financial representations made by Erlanger to ensure their accuracy and preserve the integrity of the Medicare Trust Funds. This right includes the right to make retroactive adjustments to hospital cost reports previously submitted by a provider if any overpayments have been made. 42 C.F.R. § 413.64(f).

22. Every hospital cost report contains a "Certification" that must be signed by the chief administrator of the provider or a responsible designee of the administrator. Under all relevant versions of the CMS Form-2552 certification, the provider certifies that the services provided in the cost report were not infected by a kickback and were billed in compliance with the Stark Law.

23. At all times relevant to this Complaint, the hospital cost report certification page included the following notice:

> Misrepresentation or falsification of any information contained in this cost report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under federal law. Furthermore, if services identified in this report were provided or procured through the payment directly or indirectly of a kickback or where otherwise illegal, criminal, civil and administrative action, fines and/or imprisonment may result.

24. At all times relevant to this Complaint, the responsible provider official was required to certify, in pertinent part:

> To the best of my knowledge and belief, it [the hospital cost report] is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instruction, except as noted.
>
> I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

25. Thus, the provider was required to certify that the filed hospital cost report is (1) truthful, i.e., that the cost information contained in the report is true and accurate; (2) correct, i.e., that the provider is entitled to reimbursement for the reported costs in accordance with applicable instructions; (3) complete, i.e., that the hospital cost report is based upon all information known to the provider; and (4) that the services provided in

the cost report were not infected by kickbacks and were billed in compliance with the Stark laws.

26. At all times relevant to this complaint, Erlanger submitted cost reports to CMS through its respective fiscal intermediaries which reports were signed by Erlanger employees who attested, among other things, to the certification quoted above.

27. Erlanger is, and was at all times relevant to this complaint, familiar with the laws and regulations governing the Medicare Program, including requirements relating to the completion of cost reports.

28. A hospital is required to disclose all known errors and omissions in its claims for Medicare reimbursement (including its cost reports) to its fiscal intermediary. 42 U.S.C. § 1320a-7b(a)(3) specifically creates a duty to disclose known errors in cost reports:

> Whoever … having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment … conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized … shall in the case of such a … concealment or failure … be guilty of a felony

29. The Social Security Act of 1964 authorizes the expenditure of federal funds to enable states to furnish medical assistance to indigent individuals who are aged, blind, disabled, or members of families with dependent children, under its Medicaid program. 42 U.S.C. § 1396. Medicaid is a joint state-federal funding program for medical assistance for the needy in which the federal government approves a state plan for the

funding of medical services and then subsidizes a significant portion of the financial obligations the state has agreed to assume.

30. The State of Tennessee participates in the Medicaid program pursuant to Tenn. Code Ann. § 71-5-101 *et seq*. The Department of Health and Human Services and the Centers for Medicare and Medicaid Services (CMMS) are agencies or instrumentalities of the United States, which provides a substantial portion of the funds used to administer the Medicaid Program in Tennessee.

31. In return for receipt of federal subsidies, the State of Tennessee is required to administer their Medicaid Programs in conformity with a state plan which satisfies the requirements of the Social Security Act and the accompanying regulations. The Tennessee Department of Health and Environment is responsible for administering Tennessee's Medicaid Program through its TennCare program.

32. During the years 2003 through present, Erlanger accepted and treated Medicaid patients, submitted claims for, and received federal funds in payment of, such services.

33. Compliance with the Anti-Kickback Statute is a condition of payment under Medicaid.

2. The False Claims Act

34. The False Claims Act ("FCA"), 31 U.S.C. §§ 3729-3733, enacted to protect the federal treasury, establishes a number of specific acts related to the submission of false claims or false information in support of claims for payment by, or obligations to,

the United States, each of which constitutes a basis for liability. The FCA provides, in pertinent part that:

> (a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States 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 to get a false or fraudulent claim paid or approved by the Government; (3) conspires to defraud the Government by getting a false or fraudulent claim paid or approved by the Government; ... or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,
>
> * * *
>
> is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains because of the act of that person ....
>
> (b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

31 U.S.C. § 3729.

3. The "Stark Law"

35. Enacted as amendments to the Social Security Act, as codified at 42 U.S.C. § 1395nn, the statute commonly known as the "Stark law," prohibits a hospital (or other entity providing healthcare items or services) from submitting Medicare claims for payment based on patient referrals from physicians having a "financial relationship" (as defined by the statute) with the hospital. The regulations implementing 42 U.S.C. § 1395nn expressly require that any entity collecting payments for a healthcare service

"performed under a prohibited referral must refund all collected amounts on a timely basis." 42 C.F.R. § 411.353.

36. The Stark law establishes the clear rule that the United States will not pay for items or services prescribed by physicians who have improper financial relationships with the providers who benefit from their referrals. The statute was designed specifically to reduce the loss Congress determined the Medicare program suffered from increased questionable utilization of services that can and does result from a financial stake in referrals.

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

38. In 1993, Congress extended the Stark law (Stark II) to referrals for ten additional designated health services. See Omnibus Reconciliation Act of 1993, P.L. 103-66, § 152.

39. As of January 1, 1995, Stark II applied to patient referrals by physicians with a prohibited financial relationship for the "designated health services" which included inpatient and outpatient hospital services. See 42 U.S.C. § 1395nn(h)(6).

40. In pertinent part, the Stark law provides:

(a) Prohibition of certain referrals

(1) In general

Except as provided in subsection (b) of this section, if a physician (or an immediate family member of such physician) has a financial relationship with an entity specified in paragraph (2), then –

(A) the physician may not make a referral to the entity for the furnishing of designated health services for which payment otherwise may be made under this subchapter, and

(B) the entity may not present or cause to be presented a claim under this subchapter of bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

42 U.S.C. § 1395nn.

41. The Stark law broadly defines prohibited financial relationships to include any "compensation" paid directly or indirectly to a referring physician. The statute's exceptions then identify specific transactions that will not trigger its referral and billing prohibitions.

42. For example, compensation paid to a referring physician serving as a consultant to a hospital will fall within an exception to the statute if the contract (1) is in writing and signed by the parties; (2) is for a term of at least a year; (3) specifies the services covered, covers all the services to be provided by the physician, and the aggregate of such services is reasonable and necessary for the legitimate business purposes of the hospital; and (4) sets the payment for contract services in advance, consistent with fair market value for services actually rendered, not taking into account the volume or value of the referrals or other business generated between the parties. 42 U.S.C. § 1395nn(e)(3). Thus, compensation paid to a physician (directly or indirectly)

under a medical directorship in the absence of a written and signed agreement, that exceeds fair market value, for which no actual services are required, or which takes into account the volume or value of the referrals or other business generated between the parties, triggers the referral and payment prohibitions of Stark II with respect to designated health services referred by that physician.

43. Violation of the statute may subject the physician and the billing entity to exclusion from participation in federal health care programs and various financial penalties, including (a) civil money penalty of $15,000 for each service included in a claim for which the entity knew or should have known that payment should not be made under Section 1395nn(g)(1); and (b) and assessment of three times the amount claimed for a service rendered pursuant to a referral the entity knew or should have known was prohibited. See 42 U.S.C. §§ 1395nn(g)(3), 1320a-7a(a).

44. Compliance with the Stark Statute is and has been, since 2003, a condition of payment under the Medicare program.

4. The Anti-Kickback Statute

45. The Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b), arose out of congressional concern that payoffs to those who can influence healthcare decisions would result in goods and services being provided that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. To protect the integrity of the program from these difficult-to-detect harms, Congress enacted a per se prohibition against the payment of kickbacks in any form, regardless of whether the particular

kickback gave rise to overutilization or poor quality of care. First enacted in 1972, Congress strengthened the statute in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions did not evade its reach. See Social Security Amendments of 1972, Pub. L. No. 92-603, §§ 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare-Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

46. The Anti-Kickback Statute prohibits any person or entity from making or accepting payment to induce or reward any person for referring, recommending or arranging for federally-funded medical services, including services provided under the Medicare and Medicaid programs.

(b) Illegal remuneration

* * *

> (2) whoever knowingly and willfully offers or pays an remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person –
>
> > (A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program, or
> >
> > (B) to purchase, lease, order or arrange for or recommend purchasing, leasing or ordering any good, facility, service, or item for which payment may be made in whole or in part under a Federal health care program,
>
> shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

42 U.S.C. § 1320a-7b(b). Violation of the statute can also subject the perpetrator to exclusion from participation in federal health care programs and, effective August 6 1997, civil monetary penalties of $50,000 per violation and three times the amount of remuneration paid. 42 U.S.C. § 1320a-7(b)(7) and 42 U.S.C. § 1320a-7a(a)(7).

47. Compliance with the Anti-Kickback Statute is and was at all relevant times a prerequisite to payment under the Medicare and Medicaid programs.

FACTUAL ALLEGATIONS

1. The Corporate Integrity Agreement

48. In 2003, the Office of the Inspector General (OIG) of the United States Department of Health and Human Services (HHS) began an investigation of Erlanger and others which resulted in a settlement agreement whereby Erlanger paid $40 million.

49. On October 24, 2005, Erlanger entered into a corporate integrity agreement (the "CIA") with the OIG.

50. The CIA contains the following provision:

> *New or Renewed Arrangements.* Prior to entering into new Arrangements or renewing existing Arrangements, in addition to complying with the Arrangements Procedures set forth above, Erlanger shall comply with the following requirements (Arrangement Requirements):
>
> a. Ensure that each Arrangement is set forth in writing and signed by Erlanger and the other parties to the Arrangement.

51. The term "Arrangements" is defined in the CIA as follows:

> …every arrangement or transaction that:
>
> a. involves, directly or indirectly, the offer, payment solicitation, or receipt of anything of value; and is between Erlanger and any actual or potential source of

health care business or referrals to Erlanger or any actual or potential recipient of health care business or referrals from Erlanger. The term "source" shall mean any physician, contractor, vendor, or agent and the term "health care business or referrals" shall be read to include referring, recommending, arranging for, ordering, leasing, or purchasing of any good, facility, item, or service for which payment may be made in whole or in part by a Federal health care program; or

b. is between Erlanger and a physician (or a physician's immediate family member (as defined at 42 C.F.R. § 411.351)) who makes a referral (as defined at 42 U.S.C. § 1395nn(h)(5)) to Erlanger for designated health services (as defined at 42 U.S.C. § 1395nn(h)(6)).

52. Under the terms of the CIA, a Compliance Officer, acting on behalf of Erlanger, is required to execute and submit a certification to the OIG stating that "to the best of his or her knowledge, except as otherwise described in the applicable report, Erlanger is in compliance with all of the requirements of this CIA."

53. The CIA contains certain provisions setting forth stipulated penalties for violations of the Agreement by Erlanger. Those provisions include the following:

a. A Stipulated Penalty of $5,000 for each false certification submitted by or on behalf of Erlanger as part of its Implementation Report, Annual Report, additional documentation to a report (as requested by the OIG), or otherwise required by this CIA.

b. A Stipulated Penalty of $1,000 for each day Erlanger fails to comply fully and adequately with any obligation of this CIA....

54. The CIA contemplates that Erlanger may be excluded from participation in the federal healthcare programs if it materially breaches the terms of the CIA.

55. The CIA defines a "material breach" as follows:

a. a failure by Erlanger to report a Reportable Event, take corrective action , and make the appropriate refunds, as required in Section III.I;

b. a repeated or flagrant violation of the obligations under this CIA, including, but not limited to, the obligations addressed in Section X.A...

56. Accordingly, Erlanger's fulfillment of its obligations the CIA, which include the submission of certifications of compliance by Erlanger's Compliance Officer, is necessary for Erlanger's continued participation in the Medicare and Medicaid programs.

2. Erlanger's Post-Corporate Integrity Agreement Conduct

57. Since the execution of the CIA, Erlanger has participated in and/or facilitated various improper remuneration schemes/agreements with certain third parties in an effort to retain certain physicians' loyalty and greatly increase referrals to its facility.

A. The Erlanger/UTCOM/IMEF remuneration scheme.

58. Erlanger engaged in an improper financial arrangement with The University of Tennessee Health Science Center d/b/a The University of Tennessee College of Medicine Chattanooga ("UTCOM") and the Internal Medicine Education Foundation, Inc. ("IMEF") in an effort to increase referrals from local physicians.

59. UTCOM is a public entity which sponsors nine residency programs as part of the University of Tennessee Statewide Network of Graduate Medical Education.

60. IMEF is a not-for-profit Tennessee corporation.

61. Sometime in 2007, IMEF restated its charter to create a purported "faculty practice plan" retroactively. Erlanger funded UTCOM to pay IMEF for physicians services. UTCOM utilized IMEF as a conduit to funnel payments received from Erlanger to physicians who were serving as UTCOM faculty for its residency program at

Erlanger. Pursuant to this arrangement, IMEF not only received indirect payments from Erlanger through UTCOM, but also billed various governmental entities and other payors for medical services rendered by the physicians contracting with IMEF and the residents being supervised by those physicians.

62. Upon information and belief, the faculty physicians who received payments for teaching services also referred patients to Erlanger.

63. Upon information and belief, a substantial portion of the billings collected by IMEF for services rendered by the faculty physicians were distributed by IMEF to physicians who made referrals to Erlanger.

64. The board of directors of IMEF is and at all times has consisted exclusively of faculty members of UTCOM. These board members have control over the funds received by IMEF for the provision of health care services by both the faculty members who contract with IMEF and residents under their supervision.

65. In an attempt to disguise and/or conceal the source, recipient and purpose of the payments, contracts were entered into between UTCOM and IMEF for "teaching services". These contracts were submitted for approval by UTCOM without competitive bidding because of the statements contained in the University of Tennessee Justification for Non-Competitive Purchase and Contracts (the "Justification Documents"). The Justification Documents state that physicians were being retained by IMEF on behalf of UTCOM to offer specialized services for which there were no other available physicians.

In actuality, there were other physicians available to offer such specialized services. Accordingly, the Justification Documents contain false statements.

66. Contemporaneous written contracts were not executed between UTCOM and IMEF pertaining to the funds IMEF received from UTCOM, which were distributed by IMEF to its affiliated physicians.

67. Upon information and belief, contemporaneous written contracts were not executed between IMEF and the physicians who received payments from IMEF for teaching services from funds received by IMEF from Erlanger (through UTCOM).

68. UTCOM entered into a series of contracts with IMEF, which had the effective dates of July 1, 2004, July 1, 2005, and July 1, 2006. However each of these contracts was not executed contemporaneously as of the effective date. Each was signed retroactively after the effective date.

69. Upon information and belief written contracts were not contemporaneously executed between IMEF and physicians who received payments from IMEF from funds received from billings for medical services.

70. Upon information and belief, contemporaneous written contracts were not entered into between UTCOM and Erlanger concerning the funds provided by Erlanger to UTCOM to pay IMEF.

71. Erlanger, UTCOM and IMEF have made payments directly or indirectly to physicians who provide referrals to Erlanger in the absence of contemporaneously executed written contracts which satisfy the requirements of Stark II or the Anti-

Kickback Statute. These payments to physicians working with IMEF without sufficient contemporaneously executed written contracts were in violation of Stark II and the Anti-Kickback Statute.

72. Erlanger and/or IMEF submitted bills to and received payments from CMS and TennCare for Medicare and Medicaid patients, respectively, referred by physician members of IMEF and/or physicians receiving funds from IMEF, to whom prohibited remuneration was paid.

73. Erlanger's failure to execute contemporaneous written agreements with UTCOM, IMEF and/or the individual physicians receiving funds funneled through IMEF constituted material violations of the CIA.

B. Erlanger/UTCOM/Physician Groups/Mutter remuneration schemes.

74. In an effort to retain physician "loyalty" and increase referrals, Erlanger, either directly or indirectly, entered into certain financial arrangements with physician groups, including but not limited to, Cardiovascular Group, P.C. d/b/a Chattanooga Heart Institute ("CHI"), University Surgical Associates, L.L.C. ("USALLC"), and The Plastic Surgery Group, P.C. (the "PSG") (CHI, USALLC, PSG and other physician groups are hereinafter collectively referred to as the "Groups"), and Mitchell L. Mutter, M.D. ("Mutter"). Many of these financial arrangements failed to meet any of the exceptions by which a hospital can comply with the Stark law, including, for example, agreements that provided for compensation substantially in excess of fair market value and payments made without any contemporaneously executed written agreements.

75. In the absence of contemporaneously executed written contracts, Erlanger made payments to one or more entities included in the Groups (the "Entities"). Despite this improper arrangement, both Erlanger and the Entities billed federal and State healthcare intermediaries and/or carriers for health care services rendered by physicians affiliated with the Entities.

76. In certain instances, Erlanger, UTCOM and the Groups signed and dated certain contracts retrospectively and/or non-contemporaneously after the effective dates of the contracts. Examples of such back-dating of contracts are as follows:

a. Erlanger contracted to obtain certain medical services pursuant to a contract which was effective December 1, 2004 but not executed until March 21, 2005.

b. UTCOM contracted to obtain certain teaching services pursuant to a contact which was for residents at Erlanger/UTCOM effective July 1, 2004 but not executed until July 20, 2004.

c. UTCOM contracted for a plastic surgery coordinator to be funded by Erlanger pursuant to a contact which was effective July 1, 2003 but not executed until approximately three years later.

d. UTCOM contracted to obtain medical services pursuant to a contract which was effective July 1, 2007 which was not authorized by UTCOM until March 15, 2008 and purportedly signed on June 17, 2007.

e. Erlanger entered into a financial arrangement and paid for the provision of certain medical services beginning December 1, 2004. However, the written contract relating to this financial arrangement was not executed until April 21, 2005. This arrangement was renewed on December 1, 2006; however, no written agreement was executed until December 28, 2006.

77. To retain certain physicians' loyalty and increase referrals, from 2005 until the present, Erlanger has made at least one physician from one or more of the Groups an officer of Erlanger's Medical Staff. Erlanger has exerted influence over the Medical

Staff leadership through the assistance of the Groups' physician(s) who was/were the officers. Notably, Erlanger's counsel also represented the Medical Staff, Medical Staff Leadership, CHI and IMEF. Erlanger unduly affected the election process of officers, governance procedures, the peer review process and the credentialing of physicians.

78. In an effort to retain certain physicians' loyalty and increase referrals, Erlanger contracted with CHI to provide cardiac services pursuant to a contract executed on April 21, 2005. Erlanger executed an amendment to its contract with CHI on December 28, 2006. Erlanger permitted CHI to deviate from or modify its obligations under such agreement in a commercially unreasonable manner. For example, on February 1, 2008, Erlanger amended its agreement with CHI to increase the compensation to be paid by Erlanger to CHI pursuant to the existing contract between the parties without a commensurate increase of work or responsibility. In addition, Erlanger contracted with CHI on March 30, 2009 for the provision of "cardiology call coverage." The justification for the execution of the contract for "cardiology call coverage", which was previously provided by the cardiologists on the medical staff, was inaccurate. This was to provide CHI with additional monies in an apparent attempt to increase patient referrals.

79. On January 25, 2010, Erlanger entered into an agreement with Mutter. Under the terms of the agreement, Erlanger agreed to pay Mutter in excess of market value for his services. Erlanger has billed federal and State healthcare intermediaries and/or carriers for health care services rendered by Mutter at Erlanger since January 25,

2010. Upon information and belief, Erlanger executed the agreement with Mutter for the purpose of increasing referrals to its facility from Mutter.

C. Erlanger/Monroe/CHI improper credentialing

80. Erlanger willfully allowed a physician practicing with CHI, V. Stephen Monroe, Jr., M.D. ("Monroe"), to perform medical procedures that he was not properly credentialed, qualified or trained to perform.

81. In 2003, Monroe joined CHI.

82. Monroe sought privileges to perform interventional peripheral vascular procedures at Erlanger.

83. At the time that Monroe applied for privileges at Erlanger, he did not have the requisite training, skill, experience, or education to perform interventional peripheral vascular procedures.

84. Despite Monroe's lack of qualifications, Erlanger nevertheless granted privileges to Monroe to perform interventional peripheral vascular procedures.

85. Erlanger either failed to investigate the adequacy of Monroe's credentials for interventional peripheral vascular work, or intentionally granted interventional peripheral vascular privileges to Monroe despite having knowledge of the deficiencies in his qualifications. An investigation into Monroe's education, training and experience would have revealed that he lacked the training, skill, experience and competency to safely and effectively perform such procedures.

86. Shortly after being granted privileges at Erlanger, Monroe began doing interventional peripheral vascular procedures at Erlanger.

87. In order to maintain interventional peripheral vascular privileges at Erlanger, a physician is required to perform a minimum of twenty-five (25) interventional peripheral vascular procedures on an annual basis. However, Monroe failed to perform the requisite number of interventional peripheral vascular.

88. In 2005, Erlanger was notified that Monroe did not have the requisite training, credentials, and/or qualifications to have interventional peripheral vascular privileges. Despite receiving this notification, Erlanger allowed Monroe to maintain his interventional peripheral vascular privileges, to renew such privileges, and to continue to perform interventional peripheral vascular procedures at Erlanger.

89. Erlanger, Monroe and CHI were all aware that Monroe lacked the sufficient qualifications to perform interventional peripheral vascular procedures. Nevertheless, the parties conspired together to defraud the United States Government and the State of Tennessee by causing false claims to be presented for Monroe's professional services in the form of claims for Medicare and/or Medicaid reimbursements for services and procedures performed by Monroe at Erlanger for which he was not qualified.

90. CHI, Erlanger and Monroe received funds to which they were not entitled, through Monroe's performance of procedures at Erlanger for which he was not qualified.

91. The claims for reimbursement for Monroe's interventional peripheral vascular procedures constitute false claims because Monroe's services were not

medically necessary or indicated for the well-being of the patients, and, in-fact, the procedures were performed solely for the purpose of generating profits for Erlanger, CHI and Monroe.

D. False Claims

92. As set forth in the foregoing allegations, Erlanger conspired with UTCOM, IMEF, and the Groups to provide and/or receive illegal remuneration and inducements to numerous physicians, directly and through physician groups, participated in prohibited relationships with individual physicians and physician groups, submitted false and fraudulent claims, and fraudulently obtained payments from the United States and the State of Tennessee on referrals by the numerous physicians described above in violation of the Stark law, the Anti-Kickback Statute, the False Claims Act, the Tennessee Medicaid False Claims Act and the Tennessee False Claims Act.

93. As set forth in the foregoing allegations, Erlanger, UTCOM, IMEF and the Groups established a corporate climate at Erlanger that tolerated and encouraged illegal remuneration as one way to ensure the success of the various parties' enterprises. Based on the pattern and practice of such illegal remuneration and prohibited relationships between Erlanger, UTCOM, IMEF and the Groups specifically indicated herein, combined with the participation of Erlanger management in this conduct, upon information and belief, additional violations of the Anti-Kickback Statute, the Stark law, the False Claims Act, the Tennessee Medicaid False Claims Act and the Tennessee False Claims Act likely have occurred at Erlanger's facilities.

94. Erlanger has, directly or indirectly, received substantial reimbursements from the State Medicaid/TennCare program and the State TRICARE/CHAMPUS, as well as from the federal Medicaid program and the federal Medicare program for claims submitted by Erlanger for inpatient and outpatient hospital services provided to patients referred by the physicians associated with IMEF, the Groups, UTCOM and Erlanger.

95. Relator did not become aware of the basis for the causes of action asserted herein until sometime on or after December 1, 2004.

III. DAMAGES

96. Relator avers that the United States and the State of Tennessee was damaged because of the acts of Erlanger in submitting or causing to be submitted false claims, statements and records in that the United States and the State of Tennessee has paid Erlanger, directly or indirectly, for items and services for which Erlanger was not entitled to reimbursement.

97. Erlanger profited unlawfully from the payment of illegal remuneration and prohibited relationships between Erlanger, UTCOM, IMEF, the Groups, and physicians associated with these parties, as set forth herein.

IV. CAUSES OF ACTION

Count I
(Violations of the Corporate Integrity Agreement)

98. Relator realleges and incorporates by reference in this count paragraphs 1 through 97 above.

99. Erlanger executed the CIA to promote compliance with the statutory regulations, written directives of Medicare, Medicaid, and all other federal health care programs (as defined in 42 U.S.C. § 1320a-7b(f) (Federal Health Care Program Requirements)).

100. Erlanger's failure to report the fact that it entered into financial arrangements in the absence of contemporaneously executed written contracts constitute a material breach of the CIA.

101. The numerous certifications made by Erlanger's Compliance Officer that Erlanger was in compliance with the terms of the CIA were false, and constituted a material breach of the CIA.

102. Erlanger's conduct should result in the imposition of stipulated penalties under the terms of the CIA.

103. Erlanger's failure to report and issuance of false certifications to the OIG, was designed to conceal, cover up, and disguise its unlawful activities. Upon information and belief, had the OIG been aware of such activities, it would have engaged in efforts to exclude Erlanger from participate in federal healthcare programs.

Count II
(False Claims Act: Presentation of False Claims – 31 U.S.C. § 3729(a)(1); Tenn. Code Ann. § 71-5-182; Tenn. Code Ann. § 4-18-103)

104. Relator realleges and incorporates by reference in this count paragraphs 1 through 103 above.

105. Erlanger knowingly presented or caused to be presented false or fraudulent claims for payment or approval to the United States and the State of Tennessee, including claims for reimbursement for services rendered to patients unlawfully referred to Erlanger Facilities by physicians to whom Erlanger, UTCOM, IMEF and/or the Groups provided illegal remuneration and/or with whom Erlanger, UTCOM, IMEF and/or the Groups entered into prohibited financial relationships in violation of the Stark law and the Anti-Kickback Statute.

106. By virtue of the false or fraudulent claims made by Erlanger, the United States and the State of Tennessee suffered damages and therefore is entitled to multiple damages under the federal and State False Claims Acts, to be determined at trial, plus civil penalties for each violation of the respective Acts.

Count III
(False Claims Act: Making or Using False Record or Statement to Cause Claim to be Paid – 31 U.S.C. § 3729(a)(2) ; Tenn. Code Ann. § 71-5-182; Tenn. Code Ann. § 4-18-103)

107. Relator realleges and incorporates by reference in this count paragraphs 1 through 106 above.

108. Erlanger knowingly made, used, or caused to be made or used, false records or statements – i.e. false certifications made or caused to be made by Erlanger when initially submitting false claims for interim payments and false certifications made or caused to be made by Erlanger in submitting the cost reports – to get false or fraudulent claims paid or approved by the United States and the State of Tennessee.

109. By virtue of the false records or false statements made or caused to be made by Erlanger, the United States and the State of Tennessee suffered damages and therefore is entitled to treble damages under the federal and State False Claims Acts, to be determined at trial, plus civil penalties for each violation of the respective Acts.

Count IV
(Payment by Mistake of Fact)

110. Relator realleges and incorporates by reference in this count paragraphs 1 through 109 above.

111. This is a claim for the recovery of monies paid by the United States and the State of Tennessee to Erlanger, directly or indirectly, as a result of mistaken understandings of fact.

112. The false claims which Erlanger submitted or caused to be submitted to the United States' agents and/or the State of Tennessee's agents were paid by the United States and/or the State of Tennessee based upon erroneous understandings of material fact.

113. The United States and the State of Tennessee, acting in reasonable reliance on the truthfulness of the claims and the truthfulness of Erlanger's certifications and representations, paid, directly or indirectly, to Erlanger certain sums of money to which it was not entitled, and Erlanger is thus liable to account and pay such amounts, which are to be determined at trial, to the Unites States and the State of Tennessee.

Count V
(Unjust Enrichments)

114. Relator realleges and incorporates by reference in this count paragraphs 1 through 113 above.

115. This is a claim for the recovery of monies by which Erlanger has been unjustly enriched.

116. By directly or indirectly obtaining funds from the United States and the State of Tennessee to which it was not entitled, Erlanger has been unjustly enriched, and are liable to account and pay such amounts, or the proceeds therefrom, which are to be determined at trial, to the United States and the State of Tennessee.

Count VI
(Disgorgement of Illegal Profits, For Imposition of a Constructive Trust and an Accounting)

117. Relator realleges and incorporates by reference in this count paragraphs 1 through 116 above.

118. This is a claim for disgorgement of profits earned by Erlanger because of illegal remuneration and other compensation Erlanger paid or received as described herein.

119. Erlanger concealed its illegal activity through false statements, claims and records, and failed to abide by their duty to disclose such information to the United States and the State of Tennessee.

120. This Court has the equitable power to, among other things, order Erlanger to disgorge the entire profit it has earned from business generated as a result of its violations of the Stark law, the Anti-Kickback Statute, and the False Claims Act.

121. By this claim, Relator requests a full accounting of all revenues (and interest thereon) received by Erlanger arising out of referrals from physicians whom, directly or indirectly, received illegal remuneration from Erlanger or otherwise were involved in prohibited financial relationships with Erlanger. Relator further requests disgorgement of all such profits earned by Erlanger and/or the imposition of a constructive trust in favor of the United States and the State of Tennessee on those profits.

Count VII – Recoupment of Overpayments

122. Relator realleges and incorporates by reference in this count paragraphs 1 through 121 above.

123. This is a claim for recoupment, for recovery of monies unlawfully paid by the United States and the State of Tennessee to Erlanger contrary to statute or regulation.

124. The United States and the State of Tennessee paid to Erlanger, directly or indirectly, certain sums of money to which they were not entitled, and Erlanger is thus liable under the law of recoupment to account and return such amounts, which are to be determined at trial, to the United States and the State of Tennessee.

Count VIII
(Common Law Fraud)

125. Relator realleges and incorporates by reference in this count paragraphs 1 through 124 above.

126. Erlanger made or caused to be made material and false representations in requests for interim payments submitted by Erlanger in its cost reports with knowledge or reckless disregard for the truth of the falsity of the representations made, with the intention that the United States and the State of Tennessee would act upon the misrepresentations to their detriment. The United States and the State of Tennessee acted in justifiable reliance on Erlanger's misrepresentations by making interim payments on the false claims and then by settling the cost reports at inflated amounts.

127. Had the true facts been known to the United States and the State of Tennessee, Erlanger would not have received the interim payments or the inflated amounts on the cost reports.

128. By reason of these interim payments and the inflated cost reports, the United States and the State of Tennessee has been damaged in an amount to be determined at trial.

V. REQUEST FOR RELIEF

Relator demands and requests that a judgment be rendered in this matter against Erlanger as follows:

129. That a judgment be entered in Relator's favor against Erlanger in the amount of each and every false or fraudulent claim, trebled as required by law, as well as such civil penalties as are required by law, together with all such further relief as may be just and proper.

130. That Relator be awarded the maximum amount allowed pursuant to the Stark law, the Anti-Kickback Statute, the False Claims Act, the Tennessee Medicaid False Claims Act, and the Tennessee False Claims Act.

131. That a judgment be granted for Relator, the United States and the State of Tennessee against Erlanger for any costs, including, but not limited, to, court costs, expert fees and all attorneys' fees incurred by Relator in prosecution of this suit.

132. That the United States and Relator recover any and all damages available to them as a result of Erlanger's stated violations of the Stark law, the Anti-Kickback Statute and the False Claims Act.

133. That the State of Tennessee and Relator recover any and all damages available to them as a result of Erlanger's stated violations of the Tennessee Medicaid False Claims Act and the Tennessee False Claims Act.

134. That a judgment be entered in Relator's favor against Erlanger in an amount equivalent to the damages sustained by the United States and the State of Tennessee and/or amounts by which Erlanger was unjustly enriched and/or amounts which Erlanger retained illegally, plus interest, costs and expenses, and all such further relief as may be just and proper.

135. For claims for disgorgement or illegal profits, for an accounting of all revenues unlawfully obtained by Erlanger from the United States and the State of Tennessee, the imposition of a constructive trust upon such revenues, and the

disgorgement of all illegal profits obtained by Erlanger and such further equitable relief as may be just and proper.

136. For claims for common law fraud, for compensation and punitive damages in an amount to be determined at trial, together with costs and interest, and for all such further relief as may be just and proper.

137. That Relator, the United States and the State of Tennessee be entitled to any and all other relief that they are entitled to, whether by law or equity.

138. That Relator, the United States and the State of Tennessee be granted any other and future relief as the Court deems just and proper.

Respectfully submitted,

GRANT, KONVALINKA & HARRISON, P.C.

By: _____

John P. Konvalinka (BPR #001780)
633 Chestnut Street, Suite 900
Chattanooga, Tennessee 37450-0900
(423) 756-8400
Attorney for Relator

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1:10-CV-322
CLC/WBC

JS 44 (Rev. 12/07)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

FILED
2010 NOV 30 P 3:55
U.S. DISTRICT COURT
EASTERN DIST. TENN.
DEPT. CLERK

I. (a) PLAINTIFFS
United States of America, ex rel., Lisa K. Stratienko, and The State of Tennessee

(b) County of Residence of First Listed Plaintiff _____
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorney's (Firm Name, Address, and Telephone Number)
John P. Konvalinka, Esq., Grant, Konvalinka & Harrison, P.C.
633 Chestnut Street, Suite 900, Chattanooga, TN 37450
(423) 756-8400

DEFENDANTS
Chattanooga-Hamilton County Hospital Authority d/b/a Erlanger Medical Center

County of Residence of First Listed Defendant Hamilton
(IN U.S. PLAINTIFF CASES ONLY)
NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE LAND INVOLVED.

BY Attorneys (If Known)

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☒ 1 U.S. Government Plaintiff
- ☐ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant) (For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excl. Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury

PERSONAL INJURY
- ☐ 362 Personal Injury - Med. Malpractice
- ☐ 365 Personal Injury - Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 444 Welfare
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 440 Other Civil Rights

PRISONER PETITIONS
- ☐ 510 Motions to Vacate Sentence

Habeas Corpus:
- ☐ 530 General
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition

FORFEITURE/PENALTY
- ☐ 610 Agriculture
- ☐ 620 Other Food & Drug
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 630 Liquor Laws
- ☐ 640 R.R. & Truck
- ☐ 650 Airline Regs.
- ☐ 660 Occupational Safety/Health
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
- ☐ 730 Labor/Mgmt.Reporting & Disclosure Act
- ☐ 740 Railway Labor Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Empl. Ret. Inc. Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 463 Habeas Corpus - Alien Detainee
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 810 Selective Service
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 875 Customer Challenge 12 USC 3410
- ☒ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 892 Economic Stabilization Act
- ☐ 893 Environmental Matters
- ☐ 894 Energy Allocation Act
- ☐ 895 Freedom of Information Act
- ☐ 900 Appeal of Fee Determination Under Equal Access to Justice
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN (Place an "X" in One Box Only)
- ☒ 1 Original Proceeding
- ☐ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from another district (specify)
- ☐ 6 Multidistrict Litigation
- ☐ 7 Appeal to District Judge from Magistrate Judgment

VI. CAUSE OF ACTION
Cite the U.S. Civil Statute under which you are filing (**Do not cite jurisdictional statutes unless diversity**):
False Claims Act, 31 U.S.C. 3729
Brief description of cause:
Submission of false or fraudulent claims for reimbursement

VII. REQUESTED IN COMPLAINT: ☐ CHECK IF THIS IS A **CLASS ACTION** UNDER F.R.C.P. 23 **DEMAND $** CHECK YES only if demanded in complaint: **JURY DEMAND:** ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY (See instructions): JUDGE _____ DOCKET NUMBER _____

DATE 11/30/2010 SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____