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

UNITED STATES OF AMERICA, THE STATE OF TENNESSEE AND THE STATE OF GEORGIA, ex rel. Thomas Bingham, Plaintiffs, vs. HCA, Inc., Defendant.	Case No: 1:08-cv-71 Collier/Lee **[FILED IN CAMERA AND UNDER SEAL PURSUANT TO 31 U.S.C. SEC. 3730(b)(2)]**

COMPLAINT

Qui tam Plaintiff Thomas Bingham ("Bingham"), by and through his attorneys, brings this complaint on behalf of the United States, the State of Tennessee and the State of Georgia and on his own behalf, pursuant to 31 U.S.C. §3730 of the Federal False Claims Act, § 71-5-183 of the Tennessee Medicaid False Claims Act and § 49-4-168.2 of the Georgia Medicaid False Claims Act, as follows:

I.

JURISDICTION AND VENUE

1. This is an action for civil damages and penalties under the False Claims Act, 31 U.S.C. § 3729 *et seq.*("FCA"), the Tennessee Medicaid False Claims Act, § 71-5-181 *et seq.* ("TMFCA") and the Georgia Medicaid False Claims Act, § 49-4-168 *et seq.* ("GMFCA"). This court has subject matter jurisdiction pursuant to 31 U.S.C. § 3730(a) and supplemental jurisdiction pursuant to 28 U.S.C. § 1359. The court has personal jurisdiction over the defendants

because at least one of the defendants resides, transacts business, or can be found in this district and the defendant committed acts within this district that violate 31 U.S.C. § 3729 as alleged herein.

2. Venue is proper in this district under 31 U.S.C. § 3732(a) because the defendant can be found, resides and transacts business in this district.

II.
PARTIES

3. *Qui Tam* Plaintiff Thomas Bingham is a Certified General Real Estate Appraiser in the State of Tennessee, Tennessee Certification No. 229. Bingham resides in Nashville, Tennessee. Bingham has been employed by Holladay Properties since September 2005. Through the end of 2007, most of Bingham's workload has consisted of conducting market rent/Fair Market Value ("FMV") studies.

4. Defendant HCA, Inc.("HCA"), is a Delaware Corporation with its principal executive offices located at One Park Plaza, Nashville, Tennessee 37203. Through its Tri Star Health System, HCA owns and operates Parkridge Medical Center ("PMC"), a 275 bed hospital located at 2333 McCallie Ave., Chattanooga, Tennessee 37404. PMC also operates two remote facilities, the Parkridge East Hospital and Parkridge Valley, a behavioral health facility. HCA Physician Services, Inc., ("HCAPS") and HCA Realty, Inc., ("HCAR") are separately incorporated, but wholly owned subsidiaries of HCA.

III.
THE LAW

The False Claims Act

5. The FCA prohibits the reckless, deliberately ignorant, or intentional submission of false or fraudulent claims and false statements in order to obtain or keep Federal money. It provides, in pertinent part:

pay for goods or services that are medically unnecessary, of poor quality, or even harmful to a vulnerable patient population. The AKS prohibits payment of kickbacks in order to protect the integrity of the Medicare program from these difficult to detect harms. First enacted in 1972, the AKS was strengthened in 1977 and 1987 to ensure that kickbacks masquerading as legitimate transactions do 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.

8. The AKS 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 items and services, including items and services provided under the Medicare program. In pertinent part, the statute states:

> (b) Illegal remuneration
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> * * *
>
> (2) whoever knowingly and willfully offers or pays any 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)(2). Violation of the statute can also subject the perpetrator to exclusion from participation in federal health care programs and civil monetary penalties of up to $50,000 per violation and up to three times the amount of remuneration paid. 42 U.S.C. § 1320a-7(b)(7); 42 U.S.C. § 1320a-7(a)(7).

The Stark Statute

9. 42 U.S.C. § 1395nn (commonly known as the "Stark Statute" or "Stark II) prohibits hospitals and certain other entities providing healthcare items and services from submitting Medicare claims for payment for items and services that are the product of patient referrals from physicians having an impermissible "financial arrangement" (as defined in the statute) with the hospital. The Stark Statute requires that the Medicare program deny payment for claims for any service billed in violation of its provisions. 42 U.S.C. § 1395nn(g). In addition, it requires that providers who have collected Medicare 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. The Stark Statute establishes the presumptive rule that providers may not bill and the Medicare program will not pay for designated health services (as defined in the statute) generated by a referral from a physician with whom the provider has a financial relationship. 42 U.S.C. §§ 1395nn(a)(1),(g)(1). The Statute was designed to protect the federal healthcare programs from paying for the costs of questionable utilization of services by removing monetary influences on referral decisions.

10. At all times relevant to this Complaint, the Stark Statute has applied to payments to referring physicians by hospitals and the resulting claims to the Medicare program. *See* 42 U.S.C. §§ 1395nn(h)(6)(K). In pertinent part, the Stark Statute 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 or bill to any individual, third party payor, or other entity for designated health services furnished pursuant to a referral prohibited under subparagraph (A).

42 U.S.C. §§ 1395nn.

11. The Stark Statute broadly defines prohibited financial relationships to include any "compensation" paid directly or indirectly to a referring physician. 42 U.S.C. § 1395nn(a)(2). The statute's exceptions then identify specific transactions that will not trigger its referral, billing, and payment prohibitions. 42 U.S.C. § 1395nn(b). It prohibits hospitals from billing the Medicare program for home health services referred by a physician with whom the hospital has a financial relationship, unless an express statutory or regulatory exception for the financial relationship applies. *See* 42 U.S.C. §§ 1395nn(a),(b). Most of the exceptions under the Stark Statute parallel the regulatory and statutory exceptions to the AKS. *See* 42 C.F.R. § 1001.952.

12. For example, compensation paid to a referring physician for the rental of office space will fall within an exception to the statute if, among other things: (1) the lease is set out in

writing, signed by the parties, and specifies the premises covered by the lease; (2) the space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee; (3) the rental charges over the term of the lease are set in advance, are consistent with fair market value("FMV"), and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties; and (4) the lease would be commercially reasonable even if no referrals were made between the parties. Additionally, compensation paid to a referring physician who has a bona fide employment relationship with the employer for the provision of services will fall within an exception to the statute if, among other things: (1) the amount of the remuneration under the employment is consistent with fair market value of the services, and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician; and (2) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer.

IV.
THE SCHEME

13. In January 2001, HCA entered into a Corporate Integrity Agreement with the Office of Inspector General of the Department of Health and Human Services as part of a settlement of certain proceedings against HCA which alleged that HCA had provided compensation to referring physicians in violation of the Anti-Kickback Statute and the Stark Statute. The agreement provided that further violations of these laws applicable to space lease transactions between HCA hospitals and healthcare providers could result in civil monetary penalties and criminal liability, including substantial fines and penalties.

14. Parkridge Medical Center, an HCA hospital, treats a large number of patients covered by Medicaid, Medicare and other federally sponsored health care programs. By virtue of the terms of HCA's Corporate Integrity Agreement and federal law, at all times herein

alleged, PMC knew that it was not permitted to submit claims for payment to Medicare, Medicaid or other federally sponsored health care program for services provided to any patient that had been ordered by a physician with whom HCA had a financial relationship which did not fall under an exception under the Stark Statute and AKS. Yet, beginning in approximately July 2007, HCA provided, and caused others to provide, unlawful remuneration to several physicians who were members of a multi-specialty partnership in order to obtain patient referrals; disguised this illegal remuneration as legitimate payments under real estate leasing arrangements and as an assignment of an existing real estate lease; knowingly solicited and relied on an erroneous real estate market rent / FMV appraisal; and submitted, and caused others to submit, to the federally sponsored health care programs, including Medicare and Medicaid, false or fraudulent claims for reimbursement and records in support of such claims for the services PMC rendered to the beneficiaries of such federally sponsored health care programs who were referred to PMC by members of the physician partnership who were receiving compensation from HCA and its subsidiaries in violation of the Stark Statute and the AKS.

15. HCA partially owns Diagnostic Plaza IV ("Plaza IV), a medical office building which makes up one of four on-campus, medical office buildings at the Parkridge Medical Center in Chattanooga. The remaining portion of Plaza IV is owned by Diagnostics Associates of Chattanooga ("DAC"), a Tennessee general partnership of physicians who practice in various specialties. According to the Office of the Assessor for Hamilton County, Tennessee, Plaza IV is a medical office condominium comprised of 12 condominium units totaling 86,810 usable square feet ("usf"), of which PMC (HCA) owns 45,252 usf and DAC owns 41,558 usf.

16. In addition to partial ownership of the Plaza IV medical office building, DAC's partners have also operated a multi-specialty group practice. In February 1998, DAC's partners moved the group practice to the Plaza IV building, adjacent to Parkridge Hospital. At the beginning of 2007, DAC's multi-specialty group practice consisted of at least 20 physicians. In approximately July, 2007, DAC's group practice was acquired by HCA Physician Services (HCAPS) as part of a broader compensation arrangement between DAC and HCA. HCAPS named the new group practice, Chattanooga Diagnostic Associates, LLC ("CDA"). CDA is now comprised of 13 physicians. Several DAC partners, including Thomas Mullady, Eugene Ryan

and Daniel Harnsberger, are now CDA employees and refer patients to PMC. All of DAC's physician partners, however, are believed to refer patients to PMC.

17. Concurrent with HCAPS acquisition of DAC's group practice, HCA/PMC, agreed to lease Plaza IV office space from DAC. The leasing arrangement, which was entered into on July 31, 2007, provided that DAC would lease 29,204 usf to HCA/PMC at a rental rate of $12.59 per usf, absolute net, for five years. From the 29,204 usf it had leased from DAC, on or about the same date HCA/PMC subleased 22,175 usf to its wholly owned entity, CDA, at the same terms.

18. The lease rate of $12.59 per usf net agreed to between DAC and HCA/PMC was excessive and inconsistent with fair market value as defined by the Stark and AKS Statutes and regulations. HCA knew that the rental rate was excessive. In early 2007, Bingham, who was employed by an outside property management service company then on contract with HCA, had prepared a comprehensive market rent study which included standard business lease terms for Plaza IV. Bingham's market rent study, which was approved and signed in March 2007 by Darrel Moore, PMC's CEO, and Jared Webb, the Assistant Asset Manager for HCA Corporate Real Estate, determined that an equivalent net rental rate of approximately $8.10 to $10.10 per usf represented fair market value.

19. HCA agreed to pay DAC the excessive rental rate because DAC's physician partners needed the extra money to satisfy several bank loans that had gone into default. In order to falsely justify the reasonableness of the higher lease rate, in May 2007, HCA obtained an erroneous fair market value study for Plaza IV from an unlicensed and uncertified appraiser and "split (some of) the difference" with Bingham's fair market value study arriving at a high enough rental rate for DAC's partners to meet their loan payment obligations.

20. In addition to agreeing to pay DAC a commercially unreasonable and excessive rental rate for the DAC partners' Plaza IV property, on July 31, 2007, the same day that the HCA/DAC lease agreement was signed, HCA, through its wholly owned subsidiaries, HCAR and HCAPS, engineered an assignment of DAC's 15 year lease of 32,286 usf of HCA owned property in Plaza IV, which was set to expire in 2013, from DAC to CDA, an HCAPS entity, which completely and forever released DAC from its rental payment obligations under the lease. Ostensibly, the assignment of the lease was designed to provide office space in Plaza IV for the

new entity, CDA. In reality, however, the assignment of 32,286 usf from DAC to CDA constituted more disguised unlawful remuneration for DAC's partners. It did not constitute a *quid pro quo* that one would expect in an arm's length transaction between two entities bargaining for reasonable consideration. The assignment included far more usf than was reasonable and necessary for CDA's group practice. Approximately 22,380 usf of the assigned 32,286 usf remains vacant and unused. Moreover, instead of a termination of the DAC lease which would have resulted in a significant termination penalty and required the creation of a new lease between HCA and CDA/HCAPS, the assignment of the lease permitted CDA, a new referral source for HCA/PMC to assume the lease at a rental rate below FMV.

21. As a further part of its unlawful compensation scheme to induce a continuous stream of patient referrals to HCA/PMC from the DAC partners who became employees of CDA, HCA/PMC's lease of 29,204 usf from DAC contained a provision that permitted HCA/PMC to be released from the lease, in whole or in part, in the event that the number of physicians employed by CDA dropped to nine or less. Section 24.16 of the July 31, 2007, lease, stated the following: "[I]n the event that at any time during the Term the total number of physicians employed by Tenant or an affiliate of Tenant and practicing medicine in the Premises decreases to nine or fewer, the Tenant may elect to be released from the Lease with respect to a portion of the Premises, provided that the percentage of the premises released shall not exceed the percentage decrease in the number of physicians."

V.

FIRST CLAIM FOR VIOLATION OF THE FCA
(31 U.S.C. §§ 3729(a)(1) & (a)(2)) AGAINST HCA

22. Plaintiffs repeat and reallege paragraphs 1 through 21 as if fully set forth herein.

23. Since at least July 2007, the DAC physician partners to whom the defendant provided illegal remuneration and with whom the defendant entered into illegal financial relationships have referred large volumes of patients with health care coverage from Medicare and other federally sponsored health care programs to HCA/PMC. HCA/PMC, in turn, has

submitted and caused to be submitted claims for payment to the federal health care programs, including Medicare, in the hundreds of thousands, if not millions, of dollars, for services provided to these referred patients. These claims included HCFA Form - 1450s or their electronic equivalent. The defendant, HCA, through PMC, presented or caused to be presented these claims with actual knowledge of their falsity, or in deliberate ignorance or reckless disregard that such claims were false and fraudulent. Under the FCA, 31 U.S.C. § 3729(a)(1), such claims were false and/or fraudulent because defendant HCA was not entitled to be paid for them. The defendant was not entitled to be paid for these claims because (a) it was ineligible for reimbursement under the Stark Statute's express prohibition on Medicare billing and Medicare reimbursement for services that are the product of a referral from a physician with whom HCA has an illegal financial relationship and (b) HCA forfeited the right to bill the government healthcare programs for items and services by paying remuneration to physicians intending that remuneration to induce patient referrals in violation of the AKS.

24. In addition to the knowing submission of false claims in violation of the FCA, the defendant has also knowingly made, used, or caused to be made or used, false records or statements (i.e. the erroneous market value appraisal; and the false certifications and representations on the HCFA Form 1450s or their electronic equivalents) to get false or fraudulent claims paid or approved by the United States in violation of the FCA.

25. By virtue of the false or fraudulent claims knowingly made, used, or caused to be made or used by the defendant and the false records or false statements knowingly made or caused to be made by the defendant to get such false claims paid or approved, the United States has suffered damages and therefore is entitled to statutory damages under the False Claims Act, to be determined at trial, plus a civil penalty for each violation.

VI.

SECOND CLAIM FOR VIOLATION OF THE TENNESSEE MEDICAID FALSE CLAIMS ACT AGAINST HCA

26. Plaintiffs repeat and reallege paragraphs 1 through 25 as if fully set forth herein.

27. Since at least July 2007, the DAC physician partners to whom the defendant provided illegal remuneration and with whom the defendant entered into illegal financial relationships have referred large volumes of patients with health care coverage from Tennessee Medicaid to HCA/PMC. HCA/PMC, in turn, has submitted and caused to be submitted claims for payment to the Tennessee Medicaid program in the hundreds of thousands, if not millions, of dollars, for services provided to these referred patients.

28. The defendant, HCA, through PMC, presented or caused to be presented these claims with actual knowledge of their falsity, or in deliberate ignorance or reckless disregard that such claims were false and fraudulent. Under the Tennessee Medicaid False Claims Act, § 71-5-182, such claims were false and/or fraudulent because defendant HCA was not entitled to be paid for them. The defendant was not entitled to be paid for these claims because HCA forfeited the right to bill any federally sponsored state Medicaid program for items and services by paying remuneration to physicians intending that remuneration to induce patient referrals in violation of the AKS.

29. In addition to the knowing submission of false claims in violation of the TMFCA, the defendant has also knowingly made, used, or caused to be made or used, false records or statements (i.e. the erroneous market value appraisal; and false certifications and representations on Medicaid claim forms or their electronic equivalents) to get false or fraudulent Medicaid claims paid or approved in violation of the TMFCA.

30. By virtue of the false or fraudulent claims knowingly made, used, or caused to be made or used by the defendant and the false records or false statements knowingly made or caused to be made by the defendant to get such false claims paid or approved, the State of Tennessee has suffered damages and therefore is entitled to statutory damages under the TMFCA, to be determined at trial, plus a civil penalty for each violation.

VII.

THIRD CLAIM FOR VIOLATION OF THE GEORGIA MEDICAID FALSE CLAIMS ACT AGAINST HCA

31. Plaintiffs repeat and reallege paragraphs 1 through 30 as if fully set forth herein.

32. Since at least July 2007, the DAC physician partners to whom the defendant provided illegal remuneration and with whom the defendant entered into illegal financial relationships have referred large volumes of patients with health care coverage from Georgia Medicaid to HCA/PMC. HCA/PMC, in turn, has submitted and caused to be submitted claims for payment to the Georgia Medicaid program in the hundreds of thousands, if not millions, of dollars, for services provided to these referred patients.

33. The defendant, HCA, through PMC, presented or caused to be presented these claims with actual knowledge of their falsity, or in deliberate ignorance or reckless disregard that such claims were false and fraudulent. Under the Georgia Medicaid False Claims Act, § 49-4-168.1, such claims were false and/or fraudulent because defendant HCA was not entitled to be paid for them. The defendant was not entitled to be paid for these claims because HCA forfeited the right to bill any federally sponsored state Medicaid program for items and services by paying remuneration to physicians intending that remuneration to induce patient referrals in violation of the AKS.

34. In addition to the knowing submission of false claims in violation of the GMFCA, the defendant has also knowingly made, used, or caused to be made or used, false records or statements (i.e. the erroneous market value appraisal; and false certifications and representations on Medicaid claim forms or their electronic equivalents) to get false or fraudulent Medicaid claims paid or approved in violation of the GMFCA.

35. By virtue of the false or fraudulent claims knowingly made, used, or caused to be made or used by the defendant and the false records or false statements knowingly made or caused to be made by the defendant to get such false claims paid or approved, the State of Georgia has suffered damages and therefore is entitled to statutory damages under the GMFCA, to be determined at trial, plus a civil penalty for each violation.

VIII.
PRAYER

WHEREFORE, *Qui Tam* Plaintiff Thomas Bingham prays as follows:

A. Against the defendant, treble damages and civil penalties up to the maximum permitted by law, for the maximum *qui tam* percentage share allowed by law and for attorney's fees, costs and reasonable expenses; and

B. For any and all other relief to which the plaintiffs may be entitled.

IX.

JURY DEMAND

Plaintiffs request trial by jury.

Dated: March 25, 2008

By: _____
Phillip E. Benson

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