IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

[UNDER SEAL] Plaintiffs, v. [UNDER SEAL] Defendants.	CIVIL CASE NO.: 3:10CV472 HON. GRAHAM C. MULLEN FILED UNDER SEAL / QUI TAM COMPLAINT JURY TRIAL DEMANDED

SEVERED SECOND AMENDED QUI TAM COMPLAINT FOR VIOLATIONS OF FEDERAL AND STATE FALSE CLAIMS ACTS, THE ANTI-KICKBACK STATUTES, AND FOR UNLAWFUL RETALIATION AGAINST RELATORS

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UNITED STATES OF AMERICA, NORTH CAROLINA, FLORIDA GEORGIA, OKLAHOMA, TENNESSEE and TEXAS, ex rel. THOMAS L. MASON, M.D., STEVEN G. FOLSTAD, M.D., and MID-ATLANTIC EMERGENCY MEDICAL ASSOCIATES, PA Plaintiffs v. HEALTH MANAGEMENT ASSOCIATES, INC. and MOORESVILLE HOSPITAL MANAGEMENT ASSOCIATES, LLC, d/b/a LAKE NORMAN REGIONAL MEDICAL CENTER and STATESVILLE HMA, LLC, d/b/a DAVIS REGIONAL MEDICAL CENTER and EMERGENCY MEDICAL SERVICES CORPORATION and EMCARE, INC. and EMCARE HOLDINGS, INC. and EMERGENCY MEDICAL SERVICES, L.P. Defendants.	CIVIL ACTION NO.: 3:10CV472 HON. GRAHAM C. MULLEN **FILED UNDER SEAL** **DO NOT PLACE ON PACER** **DO NOT PLACE IN PRESS BOX** JURY TRIAL DEMANDED SEVERED SECOND AMENDED QUI TAM COMPLAINT

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I. INTRODUCTION

This qui tam action alleges violations of the federal False Claims Act, 31 U.S.C. § 3729, *et seq.*, and analogous state false claims acts related to emergency room ("ER") care provided in facilities owned, managed, or operated by Defendant Health Management Associates, Inc. ("HMA"). Qui Tam Relators Thomas L. Mason, M.D., Steven G. Folstad, M.D. and Mid-Atlantic Emergency Medical Associates, PA ("MEMA"), through their legal counsel Pietragallo Gordon Alfano Bosick & Raspanti, LLP and Wyatt & Blake, LLP bring this action on their own behalf, and on behalf of the United States of America and the States of North Carolina, Florida, Georgia, Oklahoma, Tennessee and Texas, against Defendants HMA, Lake Norman Regional Medical Center, Davis Regional Medical Center, Emergency Medical Services Corporation ("EMSC"), EmCare, Inc. ("EmCare"), EmCare Holdings, Inc. ("EmCare Holdings"), and Emergency Medical Services, LP. ("EMS LP"), collectively referred to hereafter as "the EmCare Defendants." Relators Folstad, Mason and MEMA also bring this action on their own behalf to recover damages for pendent state law claims.

II. JURISDICTION AND VENUE

1. This action arises under the laws of the United States of America to redress violations of the federal FCA, 31 U.S.C. § 3729 *et seq.*, and the federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b).

2. Subject-matter jurisdiction is conferred by 31 U.S.C. § 3732(a) and 28 U.S.C. §§ 1331, 1345.

3. The Court has jurisdiction over Defendants' violations of the false claims and Anti-Kickback Statutes of the States of North Carolina, Florida, Georgia, Oklahoma, Tennessee and Texas pursuant to 31 U.S.C. § 3732(b), because Defendants' violations of these state laws and their

violations of the federal FCA arise from the same transactions or occurrences. The Court has pendant jurisdiction over Defendants' state law violations and Relators' state law causes of action because these state law violations and claims and Defendants' violations of the federal FCA arise out of a common nucleus of operative facts.

4. The Court has personal jurisdiction over all of the Defendants because 31 U.S.C. § 3732(a) authorizes nationwide service of process, and because all of the defendants have at least minimum contacts with the United States, and can be found in, transact or have transacted, business in the Western District of North Carolina.

5. Defendants HMA and the EmCare Defendants regularly perform healthcare services and submit or cause the submission of thousands of claims for payment to federal and state health care programs, including, but not limited to, Medicare and Medicaid, and accordingly, are subject to the jurisdiction of this Court.

6. Venue lies under 28 U.S.C. § 1391(b),(c) and 31 U.S.C. § 3732(a) because the Western District of North Carolina is a district in which any one Defendant can be found or transacts business, and an act proscribed by 31 U.S.C. § 3729 occurred within this district. The Court also has jurisdiction over the causes of action brought under the laws of the various states for the recovery of funds paid by a State or local government because these arise from the same facts forming the basis of the action brought under 31 U.S.C. § 3730.

7. The specific facts, circumstances and allegations of the Defendants' violations of the federal and state False Claims Acts have not been publicly disclosed in a civil suit or administrative civil money penalty proceedings in which the government is already a party.

8. Relators Mason, Folstad and MEMA are the original source of all the information upon which this Complaint is based with regard to HMA, Lake Norman Regional Medical Center, Davis Regional Medical Center and the EmCare Defendants, as that phrase is used in the federal

and state FCAs, and they have provided information of the allegations of this Complaint to all the governments prior to filing their Complaints.

III. PROCEDURAL HISTORY

9. On September 23, 2010, *Qui Tam* Relators Thomas L. Mason, M.D., Steven G. Folstad, M.D. and Mid-Atlantic Emergency Medical Associates, PA ("MEMA"), filed their Original Complaint, under seal, alleging that Defendants Health Management Association, Inc. ("HMA"), Lake Norman Regional Medical Center, Davis Regional Medical Center, Emergency Medical Services Corporation ("EMSC"), EmCare Holdings, Inc. ("EmCare Holdings"), and EmCare, Inc. ("EmCare") submitted or caused the submission of false claims to federal and state health programs, in violation of the federal False Claims Act, 31 U.S.C. § 3729, *et seq.* and analogous state false claims acts. Defendants HMA, Lake Norman Regional Medical Center, and Davis Regional Medical Center are collectively referred to as the "HMA Defendants." Defendants Emergency Medical Services Corporation, EmCare Holdings, Inc., and EmCare, Inc. are referred to collectively as the "EmCare Defendants."

10. On April 18, 2011, Qui Tam Relators filed, under seal with this Court, their First Amended Complaint. Relators' First Amended Complaint, among other things; added factual allegations against the HMA and EmCare Defendants, and North Carolina state law causes of action (Count X – Tortious Interference with a Contractual Relationship, Count XI – Defamation and Slander Per Se, and Count XII – North Carolina Unfair and Deceptive Trade Practices Act) against the HMA Defendants.

11. On April 12, 2012, Qui Tam Relators filed, under seal with this Court, their Second Amended Complaint. Relators' Second Amended Complaint added factual allegations and North Carolina state law causes of action (Count X – Tortious Interference with a

Contractual Relationship, and Count XII – North Carolina Unfair and Deceptive Trade Practices Act) against the EmCare Defendants.

12. Pursuant to this Court's Order, and the federal False Claims Act, 31 U.S.C. § 3730(b), this case has remained under seal while the United States and the named states of North Carolina, California, Florida, Georgia, Illinois, Indiana, Louisiana, Nevada, New Jersey, New Mexico, Oklahoma, Tennessee, Texas, and Virginia, have investigated the allegations in Relators' Second Amended Complaint.

13. In the fall of 2012, in the midst of the various governments' investigations, the United States Department of Justice advised Relators' counsel that the United States intended, on or before January 31, 2013, to file a Motion with the Judicial Panel on Multidistrict Litigation ("MDL Panel") requesting a transfer of Relators' allegations in this case against the HMA and the EmCare Defendants. The United States also notified Relators' counsel that it intended to request that the MDL Panel transfer other cases against the HMA Defendants pending in other district courts.

14. Relators have been advised that the United States will be requesting that courts in which *qui tam* matters against HMA are currently pending, including this one, partially lift the seals in those cases to allow the Government to serve MDL pleadings and briefs on Defendant HMA and the other *qui tam* relators in other districts with cases against HMA.

15. Pursuant to the request by the United States, on December 10, 2012, Relators filed a severance motion to facilitate the Government's presentation of the transfer motion to the Judicial Panel for Multi-District Litigation in cases against HMA and the EmCare Defendants.

16. While Relators consented to the United States' impending motion to the Judicial Panel for Multi-District Litigation, they respectfully noted for the record their objection to the inclusion of their claims under North Carolina law against the HMA and EmCare Defendants

and that they intend, if necessary, and at the appropriate time, to request that those claims be transferred back to the Western District of North Carolina for resolution of substantive motions and trial.

17. This severed Second Amended Complaint is being filed pursuant to the Court's Order dated December 10, 2012.

IV. THE PARTIES

A. Plaintiffs/Relators

18. Plaintiffs/Relators Thomas L. Mason, MD and Steven G. Folstad, MD are residents of North Carolina and citizens of the United States. Plaintiff/Relator MEMA is a corporation existing under the laws of the state of North Carolina whose principal place of business is located in North Carolina.

1. Thomas L. Mason, MD, FACEP

19. Relator Thomas L. Mason, MD, FACEP, is board-certified in emergency medicine and licensed to practice medicine under the laws of North Carolina.

20. Since 1994, Dr. Mason has been in private practice. He is a principal shareholder in Relator MEMA, which provides emergency room coverage under professional services agreements with a number of hospitals in and around the Charlotte, North Carolina area.

21. Dr. Mason also served as the Medical Director, Emergency Department, Lake Norman Regional Medical Center, Mooresville, NC (1997 – November 2010). Until 2000, Dr. Mason also provided emergency room professional services at Presbyterian Hospital in Charlotte, NC, as well as Presbyterian Hospital - Matthews in Matthews, NC.

22. Thomas L. Mason, M.D earned a B.A. from the University of North Carolina, Chapel Hill, a B.A. from the University of North Carolina, at Greensboro, and his medical degree, with honors, from the University of North Carolina, Chapel Hill, North Carolina. Dr. Mason served

his internship and residency in Emergency Medicine at North Carolina Baptist Medical Center of Wake Forest University, where he was Chief Resident of Emergency Medicine.

23. Relator Mason also served until November 3, 2010, as Chairman, Emergeney Department Committee, Lake Norman Regional Medical Center, where he has served as the Chief of Staff and Vice Chief of Staff. In addition, he had also served as a member of the Medical Executive Committee ("MEC") at Lake Norman Regional Medical Center for 13 years. Dr. Mason has served as the Immediate Past President, President, and President–Elect of the Board of Directors, North Carolina College of Emergency Physicians ("NCCEP"). In 2006, Dr. Mason was named Emergency Physician of the year by the NCCEP.

24. Dr. Mason also serves as a Councilor, American College of Emergency Physicians, as an Oral Board Examiner, American Board of Emergency Medicine, and as Chairman, EMTALA Compliance Committee, Lake Norman Regional Medical Center. Relator Mason has served on the North Carolina Medicare Carrier Advisory Committee, the Audit and Review Committee, Iredell County Emergency Medical Services, Statesville, North Carolina, and as Chairman and Associate Chair of the Research Committee, North Carolina College of Emergency Physicians. Dr. Mason is a current and former member of many local and national prestigious professional scientific societies. He is a Fellow of the American College of Emergency Physicians ("ACEP").

25. Relator Mason began working in the Lake Norman ED in 1994. In 1996, MEMA was awarded the ED contract there. In approximately 1997, Dr. Mason became the Lake Norman ED Medical Director there, and he continued in that position until he was terminated on November 3, 2010. As Lake Norman ED Medical Director, Relator Mason served as a conduit between MEMA, HMA's hospital executives and administrators at Lake Norman, and HMA's corporate executives.

2. **Steven G. Folstad, MD, FACEP**

26. Relator Steven G. Folstad, MD, FACEP is board-certified in emergency medicine and licensed to practice medicine under the laws of North Carolina.

27. Steven G. Folstad, MD attended the University of Texas and the University of Houston prior to receiving his medical degree at Baylor College of Medicine in Houston, Texas. Dr. Folstad served his internship and his residency in Emergency Medicine at Wake Forest University Baptist Medical Center, Winston-Salem, North Carolina, where he served as Chief Resident. Relator Folstad currently serves as the Medical Director, Iredell County EMS.

28. Dr. Folstad is a current and former member of many local and national professional scientific societies. He is presently a Fellow of the American College of Emergency Physicians ("ACEP"), the North Carolina College of Emergency Physicians ("NCCEP") and the North Carolina Medical Society.

29. Dr. Folstad has served on the faculty of the Department of Emergency Medicine, Wake Forest University Bowman Gray School of Medicine, Winston-Salem, North Carolina as an instructor and an Assistant Professor, as well as the Assistant Residency Program Director and Resideney Program Director. Since 1997, Dr. Folstad has been in private medical practice. Currently, he is a principal shareholder, member of the Board of Direetors, and the President and Chief Executive Officer of Relator MEMA.

30. Dr. Folstad has provided emergency room coverage under professional services agreements between MEMA and a number of hospitals in the Charlotte, North Carolina area including, but not limited to, Defendant Davis Regional Medical Center located in Statesville. Dr. Folstad provided these services at Davis Regional until MEMA's contract was terminated on September 1, 2010. Relator Folstad began working at Davis Regional in 2000, when he took over as ED Medical Director there. Prior to his arrival at Davis Regional, he worked at Lake Norman,

Presbyterian-Matthews and Presbyterian-Charlotte. As Davis Regional ED Medical Director, Dr. Folstad served as a conduit between MEMA, HMA's hospital executives and administrators at Davis Regional, and HMA's corporate executives. Dr. Folstad also served as Chairman of the Department of Emergency Medicine at Davis Regional.

31. Dr. Folstad served as Medical Director of the ED at Davis Regional until January, 2008, when he became the President and Chief Executive Officer ("CEO") of MEMA. In that position, Relator Folstad is responsible for the internal operations of MEMA. He also served as MEMA's primary contact with HMA corporate executives regarding the professional services contracts to staff the Lake Norman and Davis Regional ERs.

3. **Mid-Atlantic Emergency Medical Associates, PA ("MEMA")**

32. Relator Mid-Atlantic Emergency Medical Associates, PA ("MEMA") is a professional medical corporation organized and existing under the laws of the State of North Carolina. MEMA's principal place of business is located at 1900 Randolph Road, Suite 900, Charlotte, North Carolina. Founded in 1976 as Mecklenberg Emergency Medical Associates, MEMA is a physician-owned practice providing high quality emergency and acute medical care throughout greater Charlotte and the Piedmont area of North Carolina. Prior to November 3, 2010. MEMA had 60 physician members. MEMA currently has 50 physician shareholders and may be losing others as a result of incidents alleged in the Complaint.

33. All but one of MEMA's physicians are board-certified in emergency medicine. Until late summer of 2010, MEMA physicians provided Emergency Room ("ER") coverage under professional services agreements with five hospitals, three Presbyterian facilities in Mecklenberg County and two HMA hospitals in Iredell County, North Carolina. Since Defendant HMA summarily terminated MEMA's contracts, MEMA has been unable to replace these contracts.

34. MEMA physicians have staffed EDs in both for-profit hospitals and not-for-profit

facilities. MEMA physicians staff emergency rooms at two for-profit HMA facilities (HMA's Lake Norman and Davis Regional), and three non-profit hospitals in the Presbyterian/Novant network (Presbyterian Hospital - Charlotte, Presbyterian Hospital - Matthews, and Presbyterian Hospital - Huntersville). Accordingly, they are in a unique position to see the differences in approaches to care between profit and non-profit hospitals on a daily basis.

35. Defendant HMA acquired Defendant Lake Norman Regional Medical Center in January of 1986. From July 1, 1996 until November 3, 2010, MEMA was the exclusive provider of ER physician services at Lake Norman pursuant to a professional services agreement with Defendant HMA. From October 2000 until September 1, 2010, MEMA had been the exclusive provider of ER physician services at Defendant Davis Regional Medical Center pursuant to a professional services agreement with Defendant HMA.

36. Patients seen by MEMA physicians receive at least two bills for medical treatment, one from the hospital where they receive emergency and/or in-patient treatment (for facility charges), and one from MEMA (for charges related to the emergency physician's professional services). Patients may also receive charges from other physicians who render care to patients in the ED or during a hospital admission.

B. The Defendants

1. Health Management Associates ("HMA")

37. Defendant Health Management Associates, Inc. ("HMA") is a multi-billion dollar Delaware for-profit corporation whose principal place of business is located at 5811 Pelican Bay Boulevard, Naples, Florida 34108. HMA transacts business throughout the United States, including within the Western District of North Carolina. It is one of the largest for-profit hospital management companies in the United States.

38. HMA is a publicly traded company. HMA trades on the NYSE under the symbol

"HMA." HMA was incorporated in Delaware in 1979, but began operations through a subsidiary that was formed in 1977. HMA reported nearly $5.15 billion and $4.6 billion in net revenues in 2010 and 2009, respectively, which represents an increase of 12%. Defendant HMA operates acute care hospitals, clinics and other health care entities located in predominately non-urban areas in the Southeast and Southwest of the United States. As of December 2009, HMA had approximately 33,700 employees, including 7,200 part-time employees.

39. As of February 19, 2010, through its subsidiaries, HMA operated 55 hospitals in 15 states, totaling approximately 8,400 beds. HMA's current facilities include 18 hospitals in Florida, three medical centers in North Carolina, as well as hospitals in the following states: Alabama (2), Arkansas (2), Georgia (3), Kentucky (1), Mississippi (10), Missouri (2), Oklahoma (2), Pennsylvania (3), South Carolina (2), Tennessee (3), Texas (1), Washington (2), and West Virginia (1). HMA also operates physician clinics to support these facilities.

40. HMA reports that in 2009 and 2008, Medicare accounted for 32% of HMA's hospital net revenue. Medicaid accounted for 9% of HMA's hospital net revenue in 2009, up from 8% in 2008. HMA states in its financial reports the importance of physicians who can refer patients to or recommend that patients receive services at HMA facilities: "Physicians make admitting and other decisions regarding the appropriate course of patient treatment which, in turn, affect hospital revenue."

41. Most of the physicians who staff HMA hospitals are not HMA employees. They are independent contractors who are usually staff members of other hospitals. As of December 2009, HMA directly employed approximately 610 physicians, half of whom were primary care physicians working at out-patient practices owned and operated by HMA.

42. At the end of 2006, HMA reported that its business strategy to improve hospital operations included targeted marketing strategies, and "various clinical means to increase the

utilization of the services provided by our hospitals, particularly emergency and outpatient services." Of note, HMA reported to Wall Street that its growth during 2009 resulted from both increased emergency room visits and increased hospital admissions.

43. One significant clinical tool that HMA uses to increase utilization of services is Pro-MED, which HMA describes as "a computer-accessed diagnostic tool that helps doctors assess a patient's condition, formulate a diagnosis and suggest a course of treatment." HMA's reliance on Pro-MED systems to increase utilization of hospital services across the HMA network of hospitals is central to the maximization of revenue.

HMA'S IREDELL COUNTY, NORTH CAROLINA FACILITIES

2. Defendant Lake Norman Regional Medical Center

44. Defendant Mooresville Hospital Management Associates, LLC, d/b/a Lake Norman Regional Medical Center ("Lake Norman"), is a North Carolina limited liability corporation whose principal mailing address is 5811 Pelican Bay Boulevard, Suite 500, Naples, Florida 34108. Lake Norman Regional Medical Center is located at 171 Fairview Road, Mooresville, North Carolina 28117.

45. Defendant Lake Norman is a 105-bed for-profit acute care hospital with approximately 211 full time employees. It is a Medicare-Certified facility which provides ER services, maternity care, surgery, comprehensive outpatient services and other programs for the residents of its region. Defendant HMA acquired the former Lowrance Hospital in 1986 and changed the facility name to Lake Norman Regional Medical Center. Defendant HMA considers Lake Norman to be among its "flagship facilities." MEMA had been the exclusive provider of ED physician services at Lake Norman from 1996 until its discharge on November 3, 2010.

46. In 2000, HMA replaced the Lake Norman facility with a new $41 million hospital and medical campus on 30 acres. Considered one of HMA's highest performing, regional hospitals,

Lake Norman received Magnet designation in 2007, Elite Performer status for patient satisfaction, and top-tier performance in CMS's Core measures for hospitals in 2009. Core measures track evidence-based scientifically-researched standards of care which have been shown to result in improved clinical outcomes for patients.

47. Lake Norman's hospital CEOs have included: P. Paul Smith, FACHE (1996 - May 2008); J. Michael Cowling (May 2008 – February 11, 2009); Vickie Briggs, interim CEO (February 11, 2009 - June 2009); and Greg Lowe (June 2009 – present).

48. Defendant Lake Norman reported gross patient revenues of $364 million in 2009, according to the most recently filed Medicare Cost report. In the Lake Norman ER, Medicare billed visits accounted for 21.8% of all payer-billed patient visits in 2008 and for 2010. In 2009, Medicare visits accounted for 21.4% of all payer-billed visits to the Lake Norman ER. Medicaid-billed visits accounted for 15.1 % and 17.5%, respectively, of payer-billed visits to the Lake Norman ER in 2008 and 2009. In 2010, Medicaid-paid visits have accounted for 19.6% of ER visits to the Lake Norman ER.

3. Davis Regional Medical Center

49. Defendant Statesville HMA, LLC, d/b/a Davis Regional Medical Center ("Davis Regional"), is a North Carolina limited liability company whose principal mailing address is 5811 Pelican Bay Boulevard, Suite 500, Naples, Florida 34108, and whose principal place of business is located at 218 Old Mocksville Road, Statesville, North Carolina 28625.

50. Defendant Davis Regional is a 149-bed (as of 2009) for-profit hospital with approximately 393 employees. It is a Medicare-Certified Acute Care facility. Defendant HMA acquired Davis Regional in October of 2000. Defendant Davis Regional's gross patient revenues in 2009 were $214 million, according to the most-recently filed Medicare cost report. In the Davis Regional ER, Medicare-billed visits accounted for 19.2% of all payer-billed visits in 2008, 19.6% of

such visits in 2009, and 19.9% of payer-billed visits thus far in 2010. Medicaid-billed visits accounted for 31.6% of all payer-billed visits to the Davis Regional ER in 2008, 33.25% of such visits in 2009, and 35% of payer-billed visits in 2010.

4. EmCare Defendants

51. Defendant Emergency Medical Services Corporation ("EMSC") is a Delaware for-profit corporation whose principal place of business is located at 6200 S. Syracuse Way, Suite 200, Greenwood Village, Colorado. EMSC is one of the leading providers of emergency medical services and facility-based outsourced physician services in the United States. EMSC transacts business throughout the United States, including within the Western District of North Carolina. EMSC is a publicly traded company. It is listed on the NYSE as "EMSC." EMSC was founded and incorporated in Delaware in 2005, but its EmCare, Inc. subsidiary began operations in 1972.

52. EmCare, Inc. (a/k/a EmCare Inc.), is a corporation organized and existing under the laws of the state of Delaware. Its principal address is 6200 S. Syracuse Way, Suite 200, Greenwood Village, Colorado 80111. Upon information and belief, EmCare, Inc. was formerly known as EmCare Inc, a Texas corporation whose principal place of business was located at 1717 Main Street, Suite 5200 Dallas, Texas. EmCare transacts business throughout the United States, including within the Western District of North Carolina. Since its founding in 1972, EmCare has become the leading provider of outsourced emergency department staffing and hospital-based physician services to healthcare facilities in the United States.

53. EmCare Holdings, Inc. ("EmCare Holdings") is a corporation organized and existing under the laws of the State of Delaware. Its business address is 1717 Main Street, Suite 5200, Dallas, Texas 75201. EmCare Holdings transacts business throughout the United States, including within the Western District of North Carolina, and, according to documents filed with the Securities and Exchange Commission, is the primary operating subsidiary through which EMSC provides

outsourced emergency department staffing and hospital-based physician services to healthcare facilities in the United States.

54. Emergency Medical Services, L.P. ("EMS LP") is a limited partnership organized and existing under the laws of the State of Delaware. Its business address is 6200 S. Syracuse Way, Suite 200, Greenwood Village, Colorado. EMS LP is a subsidiary of EMSC, which controls 100% of the voting power in EMS LP. Upon information and belief, at certain times relevant hereto prior to December 21, 2005, the EmCare brand currently operated through EmCare Holdings was operated through EMS LP. Today, EMSC's sole source of revenue is from distributions from EMS LP, which, in turn, is funded from the operations of the EmCare brand nationwide.

55. Collectively, EMSC, EmCare, Inc., EmCare Holdings, and EMS LP are referred to as the "EmCare Defendants."

56. In 2005, a multi-billion dollar Canadian venture investor group led by Onex Partners LP, Onex Corporation, and members of EmCare's management team purchased American Medical Response ("AMR") and EmCare. Onex and affiliated entities formed EMSC to own and operate a number of subsidiaries, including EmCare. Upon information and belief, the Onex entities control EMSC, which operates its emergency services business under the EmCare® and AMR brands. In early 2011, Onex proposed a sale of EMSC for $3.2 billion.

57. During 2009, EMSC provided services in approximately 13 million patient encounters in more than 2,200 communities nationwide. EMSC reported nearly $2.6 billion in net revenues in 2009, of which 48% represented EmCare business.

58. EmCare executives include Terry R. Meadows, MD, Regional Chief Executive Officer ("CEO"), Southeast Region. Dr. Meadows also served as Regional Medical Director for EmCare from January 1998 until September 2001. In addition to serving as EmCare's CEO for the Southeast Region, Dr. Meadows also serves as Defendant HMA's account representative at

EmCare. EmCare has more than 500 exclusive contracts with hospitals and independent physician groups to provide emergency department, anesthesiology, hospitalist and radiology staffing, management and other administrative services. Defendant EmCare currently staffs at least 28 HMA facilities.

59. In early 2008, the EmCare Defendants announced a national agreement with Defendant HMA to provide outsourced emergency department management, hospitalist, radiology, ground ambulance, and air ambulance services on a preferred-provider basis. During 2009, EmCare provided services in approximately 9.8 million patient encounters in 39 states. As of December 31, 2009, EmCare had a 12% share of the outsourced emergency department services market.

60. EmCare reported net revenues for 2009 of $1.2 billion and $1.0 billion in 2008. EmCare reported identifiable assets of nearly $584 million as of December 2009. EmCare reports that its top ten hospital emergency department contracts represent $120.8 million, or 10%, of EmCare's net revenue for the year ended December 31, 2009. EmCare reports that it derives a significant portion of its revenue from services rendered to beneficiaries of Medicare, Medicaid and other government-sponsored healthcare programs. In 2009, EmCare received approximately 23% of its net revenue from Medicare and 5% from Medicaid.

61. EmCare enters into management services contracts with physicians or physician-owned professional corporations to deliver services to EmCare's hospital customers and their patients. As of December 31, 2009, EmCare contracted with approximately 3,330 physicians as independent contractors to fulfill its hospital contracts. EmCare provides its independent-contractor physicians with billing, scheduling, and other services. The physicians pay EmCare from the fees they collect from patients and third-party payors. EmCare codes and bills for its physicians through a wholly-owned subsidiary, Reimbursement Technologies, Inc. EmCare uses proprietary software to prepare and submit claims to Medicare, Medicaid and other third-party payors on behalf of its

independent contractor physicians.

EMCARE'S CONTRACTS WITH HMA TO PROVIDE ED PHYSICIANS

62. Defendant EmCare has provided ER physicians to staff HMA ERs since approximately 1996. In early 2008, HMA and EmCare announced a national agreement for EmCare to provide outsourced emergency department services on a preferred-provider basis. Upon information and belief, Defendant EmCare currently provides ED physicians and/or physician assistants in a majority of HMA's ERs.

63. EmCare emergency physicians currently staff the ED in the following six HMA facilities in Florida: Brooksville and Spring Hill Regional in Hernando County; Charlotte Regional in Punta Gorda; Lehigh Regional in Lehigh Acres; Pasco Regional in Dade City and Sebastian River Medical Center. EmCare also provides physicians to render in-patient care at Highlands Regional in Sebring.

64. EmCare emergency physicians currently staff the following eight HMA facilities in Mississippi: Natchez Community Hospital; Central Mississippi Medical Center in Jackson; Crossgates River Oaks Hospital in Brandon; River Oaks Hospital in Jackson; Biloxi Regional; Gilmore Memorial in Amory; Madison County Medical Center in Canton; and Riley Hospital in Meridian.

65. EmCare emergency physicians also staff ERs at HMA facilities in other states, including: two facilities in Alabama (Riverview Regional in Gadsden and Stringfellow Memorial in Anniston); one facility in Arkansas (Summit Medical Center in Van Buren); two facilities in North Carolina (Sandhills and Lake Norman – as of November 2010); three facilities in Pennsylvania (Carlisle, Heart of Lancaster, and Lancaster Regional); two facilities in South Carolina (Carolina Pines and Chester); one facility in Tennessee (University Medical Center in Lebanon); one facility in Texas (Dallas Regional in Mesquite), and two facilities in Washington state (Toppenish

Community Hospital and Yakima Regional Medical and Cardiac Center).

66. HMA hospitals with EmCare-staffed ERs are among the most compliant in meeting HMA's mandatory benchmark policies for ordering diagnostic tests (using Pro-MED's Complaint Test Mapping software) and for admissions.

V. BACKGROUND ON FEDERAL & STATE-FUNDED HEALTH INSURANCE PROGRAMS

A. Medicare Program

1. Medicare Covers Only Medically Necessary Services

67. In 1965, Congress enacted Title XVIII of the Social Security Act, which established the Medicare Program to provide health insurance for the elderly and disabled. Medicare is a health insurance program for: people age 65 or older; people under age 65 with certain disabilities; and people of all ages with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). Medicare now has four parts: Part A; Part B, Part C (managed care plans), and the recently enacted Part D (prescription drug) Program.

68. Medicare Part A (Hospital Insurance) helps cover inpatient care in hospitals, including critical access hospitals, and skilled nursing facilities (not custodial or long-term care). Medicare Part A also helps cover hospice care and some home health care. Medicare Part B (Medical Insurance) helps cover doctors' services and outpatient care, including emergency care. Part B helps pay for covered health services and supplies when they are medically necessary. Over the last forty years, the Medicare Program has enabled the elderly and disabled to obtain necessary medical services from medical providers throughout the United States.

69. The Medicare Program is administered through the United States Department of Health and Human Services ("HHS") and, specifically, the Centers for Medicare and Medicaid Services ("CMS"), an agency of HHS. Much of the daily administration and operation of the

Medicare Program is managed through private insurers under contract with the federal government (particularly CMS).

70. To participate in Medicare, providers must assure that their services are provided economically and only when, and to the extent they are, medically necessary. Sections 1814(a)(2) and 1835(a)(2) of the Social Security Act, establish that, as a condition for Medicare payment, a physician must certify the necessity of the services and, in some instances, recertify the continued need for those services. 42 C.F.R. § 424.10. Regardless of the rules governing the particular type of care, in order for the federal government to cover Medicare Part A, Medicare Part B, or a Medicare Part C plan to provide coverage, all care must be "medically necessary."

71. Medical care is "medically necessary" when it is ordered or prescribed by a licensed physician or other authorized medical provider, and Medicare (or a Medicare Part C plan) agrees that the care is necessary and proper. Services or supplies that are needed for the diagnosis or treatment of a medical condition must meet the standards of good medical practice in the local area.

72. The severity of a patient's condition is directly related to Emergency Room charges submitted by hospitals to government-sponsored health care programs. Patient acuity impacts both outpatient Emergency Room care, as well as inpatient care for ER patients who are admitted to the hospital for in-patient care. There are various items that can increase the reimbursement sought by the hospital for the facility side of emergency care: the severity of the patient's illness or chief complaint; care rendered by the emergency room nurse, whether diagnostic tests or procedures are performed in the ER; the care documented by the emergency physician; and whether a consultant is called to examine the patient.

2. **Medicare Coverage for Hospital Emergency Room Services**

73. Emergency Room services are considered outpatient care. Charges for an ER visit usually have at least two separate components: facilities charges paid to the hospital and

professional charges paid to the physicians who treat the patients.

74. First, Medicare Part B covers the charge by the hospital for the emergency room itself. Medicare Part B pays the full Medicare-approved amount, except for a patient co-payment, which is the responsibility of the Medicare recipient.

75. The majority of hospital outpatient services (and certain Medicare Part B services that are furnished to hospital inpatients with no Part A coverage) are paid by Medicare on a Prospective Payment System ("PPS") basis.

76. ER charges are based on APCs or "Ambulatory Payment Classifications," the government's method of paying for facility outpatient services for the Medicare program. This is analogous to the Medicare Part A prospective payment system ("PPS") for hospital inpatient care ("Diagnosis Related Groups" or "DRGs"), discussed below. Ordering additional diagnostic studies can lead to a greater severity of care, which would impact the hospital's charge based on the APC.

77. Medicare considers patients kept in the hospital (usually for 23 hours or less) for observations as receiving "outpatient" services. Medicare Part B covers hospital care for observation patients based on lower outpatient APCs, rather than the higher rates paid for inpatient services under Part A.

78. Medicare may also pay the hospital a separate fee (in addition to the PPS payment based on the APC) for specific outpatient services, including clinical diagnostic laboratory services and medical services received in the ER (such as X-rays, or EKGs). For these services, Medicare Part B pays based on fee schedules, and hospitals are paid 80 percent of the Medicare-approved amount.

79. The emergency physician who cares for a patient in the ER usually bills the patient separately for his or her professional services. Medicare Part B pays 80 percent of the Medicare-approved amount for the doctor's services. The remaining portion is paid by the patient or by a

Medicare supplemental insurance policy.

3. Billing for Inpatient Care for Patients Admitted to the Hospital through the Emergency Room

80. The Medicare Part A program provides payment for inpatient hospital services under a prospective payment system (PPS). Under the inpatient PPS, hospitals are paid a prospectively-determined fixed amount for each hospital discharge. The fixed payment amount per inpatient discharge is based upon each patient's diagnosis related group, or DRG.

81. The DRG assigned to each admitted patient is based on his or her primary admitting diagnosis. The payment rate for each DRG is based on the estimated intensity of hospital resources necessary to treat the average patient with that particular diagnosis. CMS bases Medicare's DRG payment rates on national average costs, not the actual costs incurred by a hospital to provide care.

82. For patients admitted from a hospital clinic or ER, there is no APC payment to the hospital (no separate facility charge) for the outpatient services provided in the ER. The facility charge is limited to the Medicare reimbursement to the hospital under inpatient DRG methodology.

83. As with outpatient charges, inpatient care also involves both facilities charges by the hospital and professional fees by physicians. The hospital bills Medicare under Part A, based upon the DRG assigned to the patient's primary admitting diagnosis. The physician who treats the patient during the admission also bills Medicare Part B. The patients themselves may be responsible for payments not covered by other insurance.

B. The Medicaid Program

84. Medicaid was created in 1965, at the same time as Medicare, when Title XIX was added to the Social Security Act. The Medicaid program aids the states in furnishing medical assistance to eligible needy persons, including indigent and disabled people. Medicaid is the largest source of funding for medical and health-related services for America's poorest people. Medicaid is

a cooperative federal-state public assistance program which is administered by the states.

85. Funding for Medicaid is shared between the federal government and those state governments that choose to participate in the program. Federal support for Medicaid is significant. For example, the federal government provides approximately 50% of the funding for Medicaid programs in Florida, Georgia, Oklahoma, Tennessee, and Texas. The remaining funds are provided by the state. For example, for North Carolina, the federal government provided 55.2% of the funding for Medicaid in 2008. Title XIX of the Social Security Act allows considerable flexibility within the States' Medicaid plans and, therefore, specific Medicaid coverage and eligibility guidelines vary from state to state.

86. While Medicaid reimbursement for emergency room care varies by state, there is generally a reimbursement to the hospital for the outpatient services provided, and a separate reimbursement for laboratory services and radiology services performed in the ER.

87. Like the Medicare Program, Medicaid only covers services or supplies that are necessary for the diagnosis or treatment of a medical condition, in keeping with the standards of good medical practice in the local area.

C. **Other Federal Health Care Programs**

88. In addition to Medicaid and Medicare, the federal government reimburses a portion of the cost of emergency care and in-patient hospitalization under several other federal health care programs, including but not limited to CHAMPUS/TRICARE, CHAMPVA and the Federal Employees Health Benefit Program.

89. CHAMPUS/TRICARE, administered by the United States Department of Defense, is a health care program for individuals and dependents affiliated with the armed forces. CHAMPVA, administered by the United States Department of Veteran Affairs, is a health care program for the families of veterans with a 100 percent service-connected disability. The Federal

Employee Health Benefit Program, administered by the United States Office of Personnel Management, provides health insurance for hundreds of thousands of federal employees, retirees, and survivors.

VI. APPLICABLE LAW

A. The Federal False Claims Act

90. The federal False Claim Act (federal FCA) provides, in pertinent part:

(a) Any person who (1) knowingly presents, or causes to be presented, 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; (3) conspires to commit a violation of (1) or (2) is liable to the United States Government for a civil penalty of not less than $5,500 and not more than $11,000, plus three times the amount of damages which the Government sustains because of the act of that person. 31 U.S.C. § 3729(a)(1)(A), (B) and (C).

(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(b)(1).

B. The Federal Anti-Kickback Statute

91. Enacted in 1972, the main purpose of the federal Anti-Kickback Statute, 42 U.S.C. § 13207b(b), is to protect patients and federal health care programs from fraud and abuse by curtailing the corrupting influence of money on health care decisions.

92. When an entity pays kickbacks to a doctor in order to induce him/her to refer or recommend patients to the entity for goods and/or services, it fundamentally compromises the integrity of the doctor-patient relationship. Government-funded healthcare programs, such as

Medicare and Medicaid, rely upon physicians to decide what treatment is appropriate and medically necessary for patients, and, therefore, payable by that healthcare program. As a condition of its reimbursement, government healthcare programs require that the physicians must render their services without the conflict inherent in receipt of a kickback.

93. Many states, including those states identified as Plaintiffs herein, have enacted similar prohibitions against illegal inducements to health care decision-makers.

94. The federal Anti-Kickback Statute and analogous state laws make it a crime to knowingly and willfully offer, pay, solicit or receive any remuneration to induce a person:

(1) to refer an individual to a person for the furnishing of any item or service covered under a federal health care program; or

(2) to purchase, lease, order, arrange for or recommend any good, facility, service, or item covered under a federal health care program.

42 U.S.C. § 1320a-7b(b)(1) and (2).

95. The term "any remuneration" encompasses any kickback, bribe, or rebate, direct or indirect, overt or covert, in cash or in kind. 42 U.S.C. § 1320a-7b(b)(1).

96. Violations of the federal Anti-Kickback Statute must be knowing and willful. 42 U.S.C. § 1320a-7b(b)(1).

97. The federal Anti-Kickback Statute has been interpreted by the federal courts to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. Proof of an explicit *quid pro quo* is not required to show a violation of the Anti-Kickback Statute.

98. A violation of the federal Anti-Kickback Statute constitutes a felony punishable by a maximum fine of $25,000, imprisonment up to five years, or both. Any party convicted under the federal Anti-Kickback Statute *must* be excluded (i.e., not allowed to bill for any

services rendered) from Federal health care programs for a term of at least five years. 42 U.S.C. § 1320a-7(a)(1).

99. Even without a conviction, if the Secretary of HHS finds administratively that a provider has violated the federal Anti-Kickback Statute, the Secretary may exclude that provider from federal health care programs for a discretionary period, and may impose administrative sanctions of $50,000 per kickback violation. 42 U.S.C. § 1320a-7(b).

100. HHS has published safe harbor regulations that define practices that are not subject to prosecution or sanctions under the federal Anti-Kickback Statute because such practices would unlikely result in fraud or abuse. See, 42 C.F.R. § 1001.952. However, only those arrangements that precisely meet all of the conditions set forth in the safe harbor are afforded safe harbor protection. None of the practices at issue here meet these safe harbor regulations.

101. Compliance with the Anti-Kickback Statute is a condition of payment under the Medicare and Medicaid programs, and that condition applies regardless of which entity is submitting the claim to the government.

102. The Anti-Kickback Statute expressly provides that claims that arise from a kickback scheme are false and violate the False Claims Act. No further express or implied false statement is required to render such infected claims false, and none can wash the claim clean.

103. It is the very fact that the health care decision-maker has accepted a kickback that per se renders not payable the claims for goods or services as to which the kickback was given, not whether the decision-maker would have otherwise selected that good or service (here, ER, out-patient and in-patient services provided by HMA's facilities and/or physicians).

104. Moreover, as a prerequisite to participating in federally-funded health care programs, providers must certify (expressly or, through their participation in a federally-funded

health care program, impliedly) their compliance with the federal Anti-Kickback Statute.

105. As a prerequisite to participating in the various state Medicaid programs, providers must certify (expressly or, through their participation in the state-funded health care program, impliedly) their understanding of and compliance with both the federal Anti-Kickback Statute and applicable state anti-kickback laws.

106. Even in absence of an express certification of compliance, a party that submits a claim for payment impliedly certifies compliance with all conditions of payment, i.e., that it is properly payable. Consequently, if a hospital pays a kickback to induce the referral or recommendation of a patient for in-patient or out-patient services and related goods, it renders false the submitter's implied or express certification of compliance that the resulting claim meets the requirements of the Anti-Kickback Statute.

VII. FRAUD ALLEGATIONS BY RELATORS FOLSTAD, MASON AND MEMA AGAINST HMA, LAKE NORMAN REGIONAL MEDICAL CENTER, DAVIS REGIONAL MEDICAL CENTER AND THE EMCARE DEFENDANTS

A. HMA Masks Its Efforts to Bill Federal and State Healthcare Programs for Unnecessary Emergeney Room Services (Diagnostic Studies) and In-Patient Admissions of ER Patients under the Guise of "Quality Improvement"

107. HMA has adopted and proliferated illegal nationwide corporate practices and systemic ER schemes involving the use of Pro-MED ER products and systems, which are aimed at generating significant fraudulent revenues from charges for unnecessary diagnostic tests and hospital admissions. HMA imposed corporate benchmarks on the emergency physicians and staff in all 55 HMA hospital ERs in order to facilitate the fraud. The Relators resisted HMA's pressures and were terminated for engaging in protected conduct.

1. HMA's Corporate Leadership Structure

108. HMA is led by President and Chief Executive Officer, Gary Newsome. Immediately before he took over at HMA, Newsome was an executive at Defendant CHS from

1998 until 2008. Before he returned to HMA in 2008, Newsome had been employed by HMA as a senior executive from 1993 to 1998. During that time, Newsome held executive positions, including HMA Divisional Vice President of Group Operations, HMA Assistant Vice President of Group Operations, and Hospital CEO.

109. When Newsome arrived at HMA in September of 2008, he also joined HMA's Board of Directors. Newsome is based at HMA corporate headquarters in Naples, Florida. Before Newsome, HMA was led by President and Chief Executive Officer Burke Whitman.

110. In addition to CEO Newsome, HMA's corporate executives include Ronald Riner, MD, Chief Medical Officer ("CMO"), and Lynne West, RN, Corporate Director of Emergency Services. Dr. Riner performs his duties as CMO as a consultant through a contract between his consulting company, The Riner Group, and HMA.

111. When Newsome became HMA's CEO, he reorganized the corporate leadership so that all of HMA's hospital operations began to report directly to him. Reflecting that change, Kelly E. Curry, who had been HMA's Executive Vice President and Chief Operating Officer (previously directly responsible for hospital operations), became the company's Chief Administrative Officer, a new position. HMA leadership includes division-level executives for each of its five divisions. Before Newsome reorganized HMA in late 2008, there were eight divisions.

112. A Division President leads HMA's Divisions 1, 2, 4, and 5, which also have a Chief Financial Officer ("CFO"). The division CFO for Divisions 1, 2, 4, and 5 report directly to the division presidents, who, in turn, report directly to HMA's President and CEO, Newsome. Some of HMA's Florida hospitals are included in Divisions 3, which is led by a CFO only, who, upon information and belief, reports directly to Newsome.

113. Lake Norman Regional Medical Center, Davis Regional Medical Center, and a third North Carolina facility are included in HMA's Division 1. Britt T. Reynolds, HMA's current

Division 1 President, joined the company in December of 2008. Reynolds is based in HMA's corporate headquarters in Naples, Florida, and he reports directly to CEO Newsome. Reynolds replaced Page Vaughn as HMA's Division 1 President. HMA's Division 1 also has a Chief Financial Officer ("CFO"), who, like the Division CEO, works out of HMA's Naples, Florida headquarters.

114. Since 2003, R. Chris Hilton has been HMA's Division 1 CFO, where he is responsible for the financial operations at 12 hospitals, including Lake Norman and Davis Regional. Hilton reports directly to Division 1 President, Britt Reynolds.

115. In addition to divisional executives, such as the CEO and CFO, each HMA facility is led by a local hospital executive team, which generally includes a Chief Executive Officer, Chief Financial Officer, Chief Operating Officer, Chief Medical Officer, and Chief Nursing Officer. Each HMA hospital ED includes an ED Medical Director, who is provided by the physician group that renders emergency care under contract with HMA.

MEMA'S LONGSTANDING CONTRACT WITH HMA TO STAFF THE LAKE NORMAN EMERGENCY DEPARTMENT

116. Pursuant to the original contract between Relator MEMA's predecessor and Defendant HMA's Lake Norman, MEMA had the exclusive right to provide emergency physicians to the Lake Norman ED 24/7 and to provide medical services required of the ER. ER services include providing both emergency room care to ED patients as well as a record of that care.

117. MEMA also agreed to provide an ED Medical Director (a/k/a "Chief of Services") for the Lake Norman emergency room who was board certified in emergency medicine, internal medicine or family practice. The ED Medical Director is supposed to serve as the official link between the MEMA emergency physicians and the hospital. From 1997 until November 1, 2010, Relator Mason fulfilled MEMA's ED Director obligations at Lake Norman.

118. The MEMA ED physicians bill patients and third-party payors for their professional fees, while HMA's hospital, Lake Norman, bills for the ER facilities, equipment, supplies, and support services provided by the hospital. In addition, for patients admitted to the hospital, HMA and/or its subsidiaries bill for both professional fees and facilities' fees. The original three-year contract between MEMA and Lake Norman contained an automatic renewal provision, with either party having the right to terminate the agreement upon six (6) months prior written notice.

MEMA'S CONTRACT WITH HMA TO STAFF THE DAVIS REGIONAL ED

119. When HMA acquired Davis Regional in 2000, MEMA executed a professional services agreement with Defendant HMA's Davis Regional. This MEMA/HMA agreement became effective on November 1, 2000. The original three-year term automatically renewed, with either party having the right to terminate the agreement upon 120 days prior written notice.

120. Like the MEMA agreement at Lake Norman, MEMA had the exclusive right to staff physicians in the Davis Regional ER 24/7 and to provide medical services required of the ER. As with the contract at Lake Norman, MEMA services at Davis Regional included providing both care to ER patients and a record of that care.

121. MEMA agreed to provide a Medical Director for the Davis Regional ER who was board certified in emergency medicine, internal medicine or family practice. As with the Lake Norman contract, the Medical Director for the Davis ED served as the official link between the ER physicians and the HMA hospital.

122. Relator Folstad served as the ED Medical Director at Davis from 2000 until January of 2008, when he became President of MEMA. At that time, another MEMA physician, Steve Greer, MD, FACEP, became the Davis Regional ED Medical Director, and he continued in that position until MEMA was discharged on September 1, 2010.

123. The Davis Regional ER contract specified that MEMA emergency physicians would

bill patients and third parties for professional fees, while HMA's hospital, Davis Regional, would submit bills for use of its ER "facilities, equipment, supplies, and support services provided by the Hospital" (the facility charges).

124. In keeping with recommendations by the American College of Emergency Physicians ("ACEP"), MEMA physicians do not have privileges to admit patients to either Lake Norman or to Davis Regional. Instead, the MEMA physician, as the ED patient's treating physician, contacts an attending physician to discuss a patient for whom the MEMA physician recommends admission. The ED patients are primarily admitted to the HMA facilities by physicians with admitting privileges, including private physicians and physicians employed by, or under contract with, HMA to render in-patient care.

2. Emergency Department Staffing and ER Patient Flow at HMA's Hospitals

125. HMA's Division I, led by HMA Division CEO Reynolds since December of 2008, includes both North Carolina facilities staffed by MEMA physicians: Lake Norman Regional Medical Center (where Relator Mason served as ED Medical Director) and Davis Regional Medical Center. This Division encompasses a total of 12 hospitals, including facilities in Alabama, Pennsylvania, North Carolina, and South Carolina.

126. HMA staffs its ED through both independent-contractor emergency physicians and HMA employees. HMA retains independent contractor emergency physicians and physician assistants through professional services agreements. The remaining ED staff, including nurses, administrative support staff, and ministerial support, are HMA employees.

127. For more than a decade, MEMA physicians had the exclusive right to provide ED physician services for both HMA hospitals in Iredell County, North Carolina: Lake Norman (since 1996); and Davis Regional (since 2000).

3. Relators' Knowledge of ER Programs developed by Pro-MED Clinical Systems, LLC

a. Pro-MED Clinical Systems, LLC

128. Pro-MED Clinical Systems, LLC ("Pro-MED") is a privately-held Florida for-profit limited liability corporation whose principal place of business is located at 8641 N.W. 51 Place, Coral Springs, Florida 33075. Pro-MED transacts business throughout the United States, including within the Western District of North Carolina. Founded in 1991, Pro-MED reports that it is the largest provider of comprehensive Emergency Department systems in the United States, currently serving over 170 hospitals nationwide.

129. The vast majority of the 170 hospitals nationwide that use Pro-MED Emergency Department systems are owned, operated, managed or leased by Defendant HMA (55 hospitals) and by Community Health Systems ("CHS") (129 hospitals). Upon information and belief, Pro-MED is used extensively, and nearly exclusively, at HMA and CHS facilities.

b. HMA's Implements Pro-MED Systems: Patient Manager, Complaint Test Mapping (Practice Guidelines), and Case Management Software

130. When Dr. Mason took over the role of ED Medical Director at HMA's Lake Norman (in 1996), he understood that HMA was using a billing program called "Pro-MED." At that time, MEMA physicians at Lake Norman and Davis Regional used simple dictation to complete the physician record. Later, they used a paper physician record called T-System to document their care in patients' charts. MEMA used this T-system until 2009, when HMA mandated that all emergency physicians use the Pro-MED physician EMR.

131. Over the course of their tenure at HMA facilities, Relators became familiar with Pro-MED's products (ER software) and related consulting services, which Pro-MED provided to HMA and its more than 50 facilities throughout the country.

c. Pro-MED's ER Software Used at HMA's Hospitals

132. Pro-MED provides both products (ER software) and related consulting services to Defendant HMA and its facilities throughout the country. Defendant HMA employs Pro-MED "emergency room clinical pathway support service" in all HMA hospitals to increase the utilization of hospital emergency, out-patient and in-patient services. Pro-MED provides the ER clinical pathway support service to Defendant HMA facilities through the following software and/or applications: Patient Manager; Complaint Test Mapping (practice guidelines); and Case Management software.

133. Pro-MED's Patient Manager program provides ER staff with automated status boards to monitor the patients' activities from presentation to the ER through disposition. During this process, Pro-MED's Patient Manager uses color-coded alerts to highlight "high risk" patients who should be considered for admission. The Pro-MED Patient Manager includes an automated triage process.

134. Pro-MED touts its Patient Manager program as a means to "maximize the hospital's revenue potential." The Pro-MED Patient Manager includes applications to capture both the ED nurse's record and the ED physician record, both of which are included in the Pro-MED electronic medical record ("EMR").

135. Defendant HMA and Pro-MED have collaborated to implement the Pro-MED Patient Manager software, including the Pro-MED nurse EMR, in HMA EDs throughout the country since at least 2004. By October of 2006, approximately half of the HMA ER facilities also utilized the Pro-MED physician EMR.

PRO-MED COMPLAINT TEST MAPPING (PRACTICE GUIDELINES) SOFTWARE

136. Pro-MED's Complaint Test Mapping practice guidelines, ("CTM guidelines") are test sets which are automatically ordered by nurses in the ER based on the ER patient's chief

presenting complaint. Pro-MED CTM, as implemented at HMA, are discussed at length below.

137. Upon information and belief, the CTM guidelines are part of the Pro-MED Patient Manager application. Pro-MED claims that it developed CTM guidelines "in consonance with criteria formulated by the American College of Emergency Physicians, and other recognized professional sources that can be customized to each hospital's individual needs and resources."

138. Pro-MED developed the CTM guidelines used in EDs throughout the HMA network specifically for Defendant HMA. Defendant EmCare participated in the development of the HMA CTM (practice) guidelines. Pro-MED CTM guidelines have been in place at EDs throughout the HMA network since at least October 2003.

PRO-MED CASE MANAGEMENT SOFTWARE USED AT HMA TO INCREASE ADMISSIONS: QUALITY REVIEW AND QUALCHECK

139. Pro-MED reports that its Case Management software "[a]lerts clinicians when a patient meets criteria for case management consultation – before they are discharged" by providing "prompts for required documentation to support deserving admissions." Pro-MED's Quality Review and QualCheck programs recommend that patients be admitted when they do not actually qualify for an acute care admission through the ER.

140. Since 2003, HMA has employed a Pro-MED program called "Quality Review" by which ED patients were selected, based on very low threshold for admission, to receive closer scrutiny by ED physicians and/or ER management. Upon information and belief, "Quality Review" standards were selected by HMA and incorporated in the Pro-MED software.

141. Quality Review selection is triggered by information in the chart, including the nurse's EMR, which could include, a vital sign, a complaint, a test value, etc. For example, where the nurse EMR includes a notation that a patient has "the worst headache of their life," shortness of breath, or blood in the urine (a common symptom of a bladder infection) this would result in a

Quality Review indicator for admission. Quality Review patients are selected in real time, before the patient is discharged from the ER. When a Quality Review patient is not admitted, the emergency physician and/or ER management would have to justify the discharge. The purpose of the Quality Review is to increase admissions. The HMA "Quality Review" practice could be employed at any HMA facility, regardless of the software used by the physician to document the patient's chart.

142. In addition, Pro-MED's Case Management software prompts ER physicians at HMA hospitals to both consult an attending physician and to consider admission for every patient 65 and over.

QUALCHECK

143. In October 2006, Pro-MED presented Defendant HMA with Pro-MED QualCheck, a software enhancement to the Pro-MED Case Management program. Pro-MED represented to HMA that QualCheck could assist the ED physician and the hospital by using Medicare or another index as a quality and treatment check to identify patients, prior to discharge, who meet criteria for admission or further treatment. Pro-MED representatives told HMA that, to use Pro-MED QualCheck, the ED must first employ Pro-MED's physician EMR.

144. The Pro-MED QualCheck application scours the patient's electronic medical record, including the emergency physician's EMR, for indications that the patient met pre-set admission criteria selected by HMA. QualCheck then identifies patients "in real time" (while they are still in the ER) who meet selected admission criteria and alerts the emergency physician with an electronic prompt. When the emergency physician concludes that admission is not medically necessary, the emergency physician must override the QualCheck prompt to complete the patient record. The physician is expected to document the reason for the override. A second prompt also appears to document for critical care for those patients meeting HMA's corporate criteria.

145. Upon information and belief, Pro-MED's QualCheck admission parameters for HMA facilities are not based on medical necessity. QualCheck's admission parameters are based on the minimum standards that could justify admission and coverage under federal and state healthcare programs.

146. The parameters set by HMA and Pro-MED for the QualCheck software to prompt the ED physician to consider admission are quite broad, and QualCheck prompts the physician to admit patients for whom in-patient care is not necessary. For example, QualCheck flags patients for admission whose diagnostic studies are negative. QualCheck even flags patients who cannot be admitted (transfer patients and those who have passed away).

147. By October 2006, approximately half of HMA hospital EDs used the physician EMR function of the Pro-MED Patient Manager program. Around this same time, on Pro-MED's recommendation, HMA employed the QualCheck program in many of the HMA hospitals where the Pro-MED physician EMR was already in place.

148. In late 2008, after Newsome arrived at HMA, all of HMA hospital EDs were required to use the Pro-MED physician EMR component, in great part, to facilitate the use of QualCheck software to cause emergency physicians to recommend admission for more patients.

4. Patient Flow through HMA Emergency Rooms Using Pro-Med Systems

149. The processes employed at HMA facilities for moving patients through the ER are automated and designed to proactively facilitate Pro-MED software programs employed system-wide by HMA to track both patient progress and full utilization of hospital services.

150. The process for moving a patient through the ER, sometimes referred to as the "throughput," involves moving the patient from presentation at the ER to disposition from the ER.

151. A patient arriving at an ER using Pro-MED Systems, including at Defendant HMA's facilities, is first assessed by a hospital-employed triage nurse and not a physician. At HMA's Lake

Norman and Davis Regional ERs, the triage nurses are often the least experienced RNs in the department. HMA's triage nurses are neither physician's assistants ("PAs") nor nurse practitioners ("NPs").

152. Under the Pro-MED System implemented at HMA, the triage nurse uses information hastily gathered from the patient to determine the patient's so-called "chief presenting complaint." The ER triage nurse, without physician assistance, selects the patient's chief presenting complaint from a computerized drop-down menu in the Pro-MED Patient Manager program.

153. Selection of the chief presenting complaint, by a non-physician nurse, immediately triggers the Pro-MED CTM guidelines program. This protocol electronically orders a battery of diagnostic studies which correspond to the nurse (not physician) selected putative chief complaint.

154. Most patients present at emergency rooms with multiple symptoms or complaints. Determining which is the patient's primary or "chief complaint" upon which to base the diagnostic studies imposes an unreasonable burden on a time-challenged triage nurse.

155. HMA's procedures, which require triage nurses to determine the chief complaint and to order diagnostic testing without physician input, violates the North Carolina Nurse Practices Act, which prohibits a nurse, other than a Nurse Practitioner or Physician's Assistant, from ordering tests.

156. Similar statutes, in virtually every state, reserve for advanced nurses (nurse practitioners and physicians assistants) acts of diagnosis, including ordering diagnostic studies. HMA's procedures requiring triage nurses to order tests violate these statutes.

157. HMA's practices of using triage nurses to initiate diagnostic testing is also medically inappropriate based on the nurse's level of training and experience.

158. Therefore, the patient's diagnostic studies are ordered and initiated in HMA hospital EDs by the ER triage nurse based on his/her determination of the patient's chief complaint. HMA's

ER process requires that triage nurses order CTM tests before the ED physician has seen the patient. After triage, the patient either returns to the waiting room, or is taken to an available ED exam room, but has not yet been examined by the ED physician.

159. Once a test is ordered at triage using the Pro-MED CTM, it is confirmed in the Pro-MED system with a host time. Once the Pro-MED CTM program sets the ER testing process in motion, the HMA staff immediately initiates diagnostic studies wherever the patient is located (i.e., the patient may be taken from the waiting room to x-ray, or to a chair in the treatment area to have blood drawn). At times, when the emergency physician enters the exam room, the patient is not there because they have already been taken for diagnostic studies which have previously been ordered by nurses.

160. Once the ER patient is in the exam room, the emergency physician conduets a comprehensive patient assessment and uses his or her own medical judgment to determinc the patient's chief complaint. The emergency physician's determination often does not correspond to the chief complaint selected by an HMA triage nurse.

161. The emergency physician will then review the diagnostic studies that have been ordered through the Pro-MED CTM guidelines. If the chief complaint entered by the nurse at triage does not accurately represent the patient's medical condition, additional relevant tests will need to be ordered by the physician. Where unnecessary lab tests have been initiated, the emergency physician must wait for these results. Often the CTM guidelines tests are not appropriate, and Pro-MED does not improve the efficiency or efficacy of the patient care.

162. The Pro-MED CTM and Patient Management programs do not take into consideration that some patients will quickly be seen by the emergency physician, who can then determine from the outset which diagnostic studies are appropriate.

163. Once the diagnostic studies are complete, the ED physician makes a diagnosis,

provides treatment, and arrives at a disposition for the ER patient. At times, the ED physician will consult with the patient's private physician, another attending physician, or a specialist to discuss follow-up out-patient treatment or possible admission.

164. While the ED physicians at HMA facilities can write orders to discharge patients or to transfer them to another facility, emergency physicians at HMA hospitals typically do not have admitting privileges. Thus, when the emergency physician, considered the ED patient's treating physician, contacts a hospitalist or other attending physician with admitting privileges, it is to recommend retaining the patient at the hospital for in-patient treatment.

165. Therefore, the ED physician can arrive at one of three possible dispositions for the ED patient: discharge to home; transfer to another facility; or a call to an attending physician to discuss admission to the hospital or other out-patient follow-up care.

166. A patient can be kept at the hospital for either observation (technically considered out-patient treatment) or admission for in-patient treatment. The orders for these last two dispositions (observation or admission) are written by a physician with admitting privileges (HMA hospitalists, an attending member of the medical staff, or a patient's private attending physician).

167. Following the patient's disposition, the HMA hospital compiles the billing record for its own charges and for the professional component. The hospital provides the emergency physician group with a copy of the ED chart in order to facilitate billing for the professional side of the ER charges.

5. HMA's Billing Process, Including Providing a Billing Record to MEMA

168. Mechanically, Lake Norman and Davis Regional processed the patient records slightly differently. At Lake Norman, Relator Mason observed that a clerk in the ER would make four copies of the physician record (the paper T-sheet): one was kept in the ER, one went to medical records, one was provided to MEMA for billing, one was used by the Lake Norman billing

department for coding and submission. Someone at Lake Norman then printed the other components of the billing record and scanned the package to MEMA's billing company with a face sheet that listed the documents attached. At Davis Regional, the clerk who did the coding for the hospital's ER charges also made copies of the physician record (the paper T-sheet) for MEMA. This was not done in the hospital billing department.

169. Pursuant to the contracts between MEMA and Lake Norman and Davis, approximately five days after discharge, HMA provided MEMA with documentation of the patient's demographic, insurance, and clinical information (the chart) which was scanned and electronically transferred by HMA to MEMA's billing company.

170. The clinical information (chart) which HMA provided to MEMA for billing purposes would include the following components:

- Face sheet (identifies the patient name, number, date of service, and practice ("MAD" for Davis Regional and "MAN" for Lake Norman patients);
- Demographics page from the Admission Record;
- Consent to Conditions of Treatment and Admission;
- Discharge Instructions;
- Initial Assessment Form, which provides triage information, including triage time and chief complaint ascribed at triage;
- Order Procedure Form to be completed by the physician, typically tailored to the type of emergency;
- Emergency Physician record (prior to the EMR being installed in June of 2009, a T-System paper record);
- (Sometimes) Nurse Documentation generated by Pro-MED Clinical Systems, LLC;

- (Sometimes) Order Summary generated by Pro-MED Clinical Systems, LLC, which lists the diagnostic tests (those recommended by HMA's CTM guidelines, the tests ordered in the ER by the triage nurse, as well as those ordered by the physician after he saw the patient), the procedures performed, and the level of care ascribed to the patient visit by Pro-MED;
- (Sometimes) EKG printouts, lab results, etc.;
- (Sometimes) Admission records for patients admitted to the hospital.

171. Both HMA hospitals provided MEMA with a face sheet, admission record, consent to treatment, discharge instructions, initial assessment form (triage record), and the emergency physician's portion of the chart (the T-sheet physician record and Order Procedure Form). However, MEMA received slightly different Pro-MED records from Lake Norman and Davis Regional. From Lake Norman, MEMA typically received the Pro-MED Nurse Documentation report, including a table showing acuity "points" ascribed by Pro-MED to various nursing tasks. The Pro-MED Nurse Documentation report MEMA received from Davis Regional did not include the table of nursing acuity points. However, MEMA did typically receive from Davis Regional a report not provided by Lake Norman: the Pro-MED Orders Summary, which listed the Pro-MED CTM tests, both the true and false tests, noting with a host time which were ordered, as well as any procedures or treatments ordered by the emergency physician. The Pro-MED Orders Summary typically also included an ED Level of Care ascribed by Pro-MED.

172. Upon information and belief, the component records included in the clinical information (chart) which HMA provided to MEMA for billing the professional component of the ER charges was also utilized by HMA to bill the facilities charges associated with the patients' care. The following components of the chart which HMA provided to MEMA are directly relevant to the HMA hospital facilities charges: Initial Assessment Form, (triage information); Nurse Documentation generated by Pro-MED Clinical Systems, LLC (including points table); Order

Summary generated by Pro-MED Clinical Systems, LLC; any EKG printouts, lab results, etc.; any appropriate admission records; and/or, Discharge Instructions. At times, HMA supplied MEMA with the same facility patient billing chart and the copy of the chart intended for MEMA's billing company.

173. After the HMA facility codes the patient's chart, it submits a claim to Medicare, Medicaid, or other third-party payors for any facility charges associated with emergency care, in-patient care, or observation. In this claim, HMA certifies to the accuracy and medical necessity of the emergency services rendered, including the tests ordered.

174. Relators understand that the coding of the patient chart and billing were conducted slightly differently at Lake Norman and Davis, but that both facilities relied on the same component records.

175. In addition to HMA's facility charges and the emergency physician's charges, there may be professional charges related to other physicians (including HMA physicians) who render medical care during the patient's hospital stay.

6. HMA's "Quality" Improvements Using Pro-MED Software and Services – Creating Revenue through Unnecessary Tests and Admissions

176. Some time before October of 2003, HMA embarked on a campaign to increase admission to its facilities. Upon information and belief, HMA's campaign focused on selecting patient charts based on very low admission thresholds, flagging them for elose scrutiny by the ED physician, and requiring that emergency physicians admit a minimum number of ER patients.

177. Since at least 2003, with active participation by Pro-MED, HMA has directed the treatment of ER patients through executive fiat (corporate selection of diagnostic tests and minimum admissions levels), and insidiously interfered with the emergency physicians' independent judgment of the appropriate and medically necessary care for the ED patient.

178. Defendant HMA and Pro-MED have dedicated considerable time, effort and resources to implement Pro-MED ED software in HMA facilities nation-wide. These efforts to automate the delivery of service in HMA EDs and to direct patient care from HMA's corporate headquarters reveals a scheme to illegally increase and maximize hospital revenue.

179. HMA touts its efforts to drive ER volumes through executive mandates on the number of diagnostic tests ordered and minimum ER patients' admission rates, as promoting the delivery of "consistent and high-quality care." The true purpose of HMA's corporate testing and admissions benchmarks is to illegally pressure emergency physicians and nursing staff at HMA's facilities to generate greater revenues for HMA through hundreds of millions of dollars in unnecessary hospital services.

7. HMA Implements Pro-MED CTM Guidelines to Generate Illegal Charges from Unnecessary ER Tests – Not to Improve Patient Satisfaction - and Interfering with the Physician's Delivery of Appropriate Care

180. As originally formulated for HMA, the Pro-MED CTM guidelines program included 700 tests which correspond to 515 chief (presenting) complaints. These tests guidelines are not evidence-based standing orders developed to enhance patient care. The CTM guidelines were developed to drive revenues for HMA.

181. In addition to the increased revenues from the tests themselves, upon information and belief, HMA derives additional facilities' revenues based on inflated severity of care justified by the unnecessary tests as well as from charges for the tests themselves.

182. Sometime before October of 2003, HMA installed the Pro-MED Complaint Test Mapping software in all of its hospitals and established a corporate benchmark requiring that ER triage nurses order, and emergency physicians not cancel, a minimum number of the tests included in the CTM guidelines.

183. Dr. Riner stated in a November 4, 2009 email that, as he understood it, Terry R.

Meadows, MD (EmCare Regional CEO, Southeast Region, and EmCare Senior Vice President of Systems Relations), and Michael Wheelis, MD, an EmCare physician from Natchez Community Hospital, developed the CTM guidelines used by HMA.

184. The CTM guidelines, as developed by HMA and Pro-MED, divide the diagnostic studies into two groups. HMA claims that the first group, those tests marked "Y" or "true" are basic tests "intended to ensure a consistent high quality work up for all patients…and to decrease the "door to workup time and decrease the length of stay…thereby decreasing the number of LWOT's (patients who left without treatment) and increasing patient and family satisfaction." The "true" tests are the ones that the nurses are expected to order. They are automatically ordered by the triage nurse who selects the chief complaint. The ordering of tests by the triage nurse, prior to the emergency physician's authorization, violates myriad state nursing licensure laws.

185. HMA uses Pro-MED software to track each "Y" test (those ordered by triage nurses before the ED physician speaks with the patient). The percentage of guidelines tests is calculated by dividing the number of Y tests not cancelled by the ED physician by the number of tests initially ordered by the triage nurse using Pro-MED's CTM program. Interestingly, HMA has never criticized any ED for ordering too many tests. This is due, perhaps, to the fact that HMA's Pro-MED system does not even track the "extra" tests ordered by the ED physician after he examines the patient (these are the tests marked "N" or "false" on the CTM guidelines).

186. Amazingly, from at least 2003, the HMA national corporate benchmark for ordering CTM guidelines tests was set at 80% or greater. In 2010, HMA raised this corporate benchmark to 85% with no change in the patient population it was serving. No evidence-based medical reason exists for either the initial or the increased testing benchmark.

187. HMA, through this explicit corporate benchmark for guidelines tests ordered, pressures the ED physician not to cancel CTM guidelines tests, even if the physician concludes that

they are not medically necessary.

188. HMA and Pro-MED designate other tests as "N" or "false" tests, those which "should be considered once the physician examines the patient." These are not automatically ordered by the triage nurse using CTM guidelines program. Although HMA has a record of the tests ordered by the physician after he/she actually assesses the patient and determines the chief complaint, there is no ED performance metric associated with these tests. In addition, the tests ordered by the emergency physician do not count toward meeting HMA's CTM guidelines. HMA's implementation of Pro-MED CTM guidelines interferes with the emergency physician's medical necessity determination because the tests are ordered by the triage nurse before the physician has seen the patient.

189. When the triage nurse automatically orders diagnostic tests for ER patients, they cannot accurately reflect the emergency physician's determination of medical necessity. When unnecessary, irrelevant, or excessive tests are ordered, the ED physician must manually override the Pro-MED software in an attempt to cancel CTM guidelines tests which, based on the physician's assessment of the patient, are not medically necessary.

190. As the Pro-MED program is designed, once the diagnostic test has been ordered by the triage nurse using Pro-MED CTM, it cannot be cancelled or deleted within the Pro-MED program. The test order must be deleted from the hospital's own computer system. At HMA's Lake Norman and Davis Regional, deleting or canceling a test ordered through Pro-MED CTM required that the physician create a paper record canceling the test and then physically deliver that record to the appropriate department (the lab or radiology). Thus, trying to manually cancel tests initiated by the triage nurses using Pro-MED CTM program was time consuming -- and often futile.

a. Limited Flexibility – before October 2008, some EDs Edit HMA Corporate Test Guidelines

191. Before 2008, a few HMA hospital EDs were accorded some flexibility in employing the CTM guidelines. In these limited situations, the local hospital CEO permitted the emergency physicians to edit the Pro-MED CTM guidelines to remove the excessive test sets. In other words, the ED Director could locally edit the "Y" tests to eliminate unnecessary tests which otherwise would have been ordered for a patient using HMA's standard CTM guidelines. However, the ED was not permitted to stop the practice of triage nurses ordering tests.

192. For example, Paul Smith, the CEO at Lake Norman until May of 2008, permitted Relator Mason, the ED Director, to employ "local edits" to HMA's standard Pro-MED CTM guidelines used in Lake Norman's ED. Dr. Mason reduced, as best he could, the CTM diagnostic studies to the bare minimum that might be triggered by the triage nurse's selection of the chief complaint. Before October of 2008, MEMA physicians also edited HMA's standard CTM guidelines used at Davis Regional to leave only what was most likely medically appropriate for the chief complaint listed. Thus, until October of 2008, the MEMA emergeney physicians at Lake Norman and Davis Regional avoided ordering many unnecessary tests included in HMA's standard Pro-MED CTM guidelines program.

193. While Lake Norman and Davis Regional emergency physicians used local edits and other means to reduce the incidents of unnecessary tests, at the other 53 (or more) HMA hospitals, HMA executives exerted control over the CTM guidelines employed in the ED.

194. HMA, since 1979, through its subsidiary Paintsville Hospital Company, has done business as Paul B. Hall Regional Medical Center. At this 72-bed Medicare and Medicaid approved facility, the ER physicians see 500 patients each week. (The same number of patients visit the Lake

Norman and Davis Regional ERs).

195. When Pro-MED alerted HMA that edits to the CTM guidelines by emergency physicians at HMA's Paintsville hospital caused ED revenues to fall by $300,000 each month, HMA reasserted corporate control over the CTM guidelines tests. HMA instructed Pro-MED to reset the CTM guidelines at Paintsville to HMA's standard CTM guidelines tests. ER revenues at Paintsville immediately returned to their previous levels.

b. HMA's Complaint Test Mapping Guidelines Generate Many Medically Unnecessary Tests

196. While the emergency physician can typically determine the appropriate and necessary work-up quickly when assessing the patient, with mandatory CTM guidelines, unnecessary tests often have been completed by the time the physician first sees the patient.

197. Since at least 2003, HMA's systemic procedures and network-wide use of Pro-MED software has caused the ED triage nurses in its hospitals to illegally order tests, many of which were unnecessary, when applied indiscriminately to every patient with the same nurse-selected chief complaint.

198. Many of the test sets included in the HMA's original (prior to October 2008) Pro-MED CTM guidelines were abusive. From at least 2003 until 2008, HMA's implementation of the original Pro-MED CTM guidelines have caused triage nurses and/or emergency physicians in HMA hospitals to regularly order thousands of excessive and medically unnecessary diagnostic studies, which were billed to government and third party payors.

199. By way of example, for pregnant patients (less than 20 weeks gestation) who present with vaginal bleeding, what should be ordered routinely on each of these patients, all of whom are Medicaid eligible, is a urinalysis and either a Qualitative B-HCG or a Quantitative B-HCG. A urinalysis, if performed initially, would promptly differentiate vaginal bleeding from

blood in the urine due to a bladder infection. Pro-MED's original (pre-2008) CTM guidelines for HMA facilities does not include a urinalysis.

200. A Qualitative B-HCG is a quick, simple, and inexpensive urine test that tells if the patient is indeed pregnant. HMA's original CTM guidelines have, since at least 2006, called for a Quantitative B-HCG, complete blood count ("CBC"), and Type & Screen. Only the physician should determine whether the Qualitative or Quantitative B-HCG should be ordered based on his or her assessment of the patient. The CBC and Type & Screen are excessive for nearly all of the Medicaid patients whose chief complaint is described as "vaginal bleeding (pregnant less than 20 weeks)." These tests also subject the patients to unnecessary blood draws.

201. In another example, most patients over age 55 who present in the ER with a chief complaint for abdominal pain, would not need any tests if their history and examination, as reviewed by a physician, are benign. Medical studies show that 50% of all ED abdominal pain is completely benign. Those patients over 55 with abdominal pain who even need tests should receive a complete blood count ("CBC"), complete metabolic panel ("CMP") and urinalysis.

202. Under HMA's original Pro-MED CTM guidelines, patients over 55 with abdominal pain would have a complete work-up, ineluding the following tests: CBC (complete blood count), CMP (complete metabolic panel), urinalysis, EKG, and amylase. The EKG and amylase are unneeessary.

203. Another example of the excessive tests ordered by triage nurses using HMA's original CTM guidelines is the patient who presents in the ER with blood in their urine. The most common reason for blood in the urine is a bladder infection. The only medically necessary test for that is a urinalysis. However, people with kidney stones often have blood in their urine. If the triage nurse selects "kidney stone" as the chief complaint, the CTM guidelines orders all of the tests to work up a kidney stone diagnosis, including a basic metabolie panel ("BMP"), complete blood

count ("CBC") and a urinalysis ("UA").

204. HMA states that it uses CTM guidelines "to improve efficiency in the ED by allowing the nurse to order certain indicated tests from the point of triage based on the selected Chief Complaint."

205. The excessive tests ordered using HMA's original (pre-October 2008) CTM guidelines undermine the quality of patient care because the patient experiences unnecessary pain, discomfort, expense and inconvenience attendant to unneeded diagnostic studies. For example, every child less than 90 days old with a fever greater than 100.4 receives blood tests and x-rays. Every child between three and 24 months with a fever between 100.5 and 102.2 would receive blood tests. In addition, unnecessary tests undermine patient satisfaction because the ED staff and physicians are occupied with processing unnecessary tests.

8. HMA Imposes Benchmarks to Enforce Adherence to CTM Guidelines

206. Before October 2003, HMA established 13 corporate benchmarks for ED performance. Not surprisingly, five of the HMA's ED performance benchmarks focus on increasing admissions or the number of diagnostic tests ordered: % of Admissions; % of Total Patients with Quality Review Identified Who Were Discharged; % of Patients with Tests Ordered; % of Guidelines Tests Ordered; % of attendings called. As discussed below, in June of 2005, HMA added additional benchmarks aimed at illegally generating revenues through Medicare ER patients.

a. Patients with CTM Tests Ordered

207. HMA mandated that its ED triage nurses order Pro-MED Complaint Test Mapping (practice guidelines) tests immediately after triage. HMA employed corporate benchmarks to measure nurse performance for ordering tests, and chastised nurses who failed to meet these benchmarks. As explained above, Pro-MED's CTM guidelines are part of the Pro-MED Patient Manager application. HMA imposes two minimum standards for CTM tests ordered for ER

patients.

208. The first, "Patients With Tests Ordered" refers to patients who had at least one test ordered "using order entry in Pro-MED." This refers to the % of ER patients for whom the triage nurse orders tests using Pro-MED Complaint Test Mapping. At some point, HMA added the requirement that the triage nurse order CTM guidelines tests within 10 minutes of triage. This meant that CTM could more easily be initiated before the patient is seen by the ED physician.

209. On June 8, 2007, Pro-MED issued a Performance Review Letter for the ED at Davis Regional. In it, Pro-MED described the "Patients With Tests Ordered" benchmark as: "the total number of patients that had at least one diagnostic study ordered during the emergency visit." Pro-MED went on to claim that use of testing guidelines immediately following triage will "improve patient satisfaction, reduce risks, and reduce the length of stay."

210. In its report of July 2008, Pro-MED recommended that HMA hospitals: "incorporate the practice guidelines into a policy that clearly outlines the daily utilization, which includes having the nurse begin the workup (order CTM guidelines tests) immediately following triage at a rate of 70% or greater. (Emphasis added.)

211. HMA's benchmark from October 2003 until 2008 for % of Patients with Tests Ordered was 67%. In July of 2008, Pro-MED consultants suggested that this benchmark be increased to 70% in order to "improve the consistency of the workup."

212. HMA harassed its ER nurses to order CTM guidelines tests immediately and to advance HMA's other ED benchmarks. Nurses who did not support HMA's efforts, including Tonya Kirby, ER Nurse Manager at Lake Norman, were forced to resign. Joe Vice, RN, an ER nurse at HMA's Anniston, Alabama hospital, was an outspoken critic of HMA's implementation of Pro-MED programs, including CTM guidelines.

b. **CTM Guidelines Tests Ordered**

213. The second "tests" benchmark imposed by HMA, as described in Pro-MED's 2007 facility report for Davis Regional, measures the % of CTM guidelines tests "identified by complaint type and approved by the medical staff and initiated by the clinical staff." This benchmark actually measures the % of all CTM guidelines tests not cancelled by the ED physician. This benchmark tracks each test cancelled, not each patient for whom CTM guidelines were followed.

214. Although HMA and Pro-MED indicate that the CTM guidelines tests were "approved by the medical staff," Relators are not aware of any HMA policy or procedure before CMO Riner mentioned it in his November 2008 memo. Relators were not asked to present HMA's CTM guidelines to the MEC at Lake Norman or Davis Regional until January 2009, when HMA required the medical staff to approve CTM guidelines tests.

215. HMA's corporate benchmark from October 2003 until 2010 for % of guidelines tests was 80%. In April 2010, HMA increased the CTM "testing guidelines" benchmark to require that ED physicians not cancel a minimum of 85% of tests included in HMA's standard Pro-MED Complaint Test Mapping guidelines.

216. Physicians at many HMA facilities met and exceeded HMA's CTM guidelines benchmark of 80%. These include Dr. Wheelis' Natchez, MS Hospital, which has ordered CTM tests at least 93.5% of the time since March of 2008. Others include: Gafney, Williamson, Barton, Florida; Gasden and Anniston in Alabama; Van Buren, Arkansas; Sebastian, Barton, Haines City, Lehigh Acres, Punta Gorda, Naples, and Key West in Florida; Winder, Georgia; Paintsville, Kentucky; Jackson and Clarksdale in Mississippi; Carlisle, Pennsylvania; Hartsville and Chester, South Carolina; Lebanon, Tennessee; Toppenish and Yakima, Washington; and Williams, West Virginia.

217. Relying on their individual medical judgment as to each unique patient's medical needs, since October 2003, MEMA physicians at Defendant Davis Regional and Lake Norman often did not meet HMA's corporate benchmarks for % of guidelines tests.

9. HMA Implements Pro-MED Patient Manager Software, Including Quality Review, Physician EMR, and QualCheck, and Related ED Benchmarks to Generate Illegal Revenues from Unnecessary Admissions to HMA Hospitals

218. Since at least 2003, HMA has employed policies and procedures to illegally increase in-patient admissions and to avoid outpatient observations for patients entering the Emergency Room at HMA's hospitals nationwide.

219. HMA's policies to increase ER admissions and the corporate mandates HMA imposed on emergency physicians illegally interfere with the physicians' independent medical judgment of what is the most appropriate and medically necessary care for each ER patient.

220. HMA established a corporate benchmark for Quality Review patients of "discharge no more than 35%." This meant that HMA required emergeney physicians to recommend to admit at least 65% of patients selected for admission by the Quality Review program, without regard for the medical necessity of that admission. Upon information and belief, the HMA Quality Review benchmarks were in place and enforeed throughout the HMA system sinee 2003.

221. Pro-MED's QualCheck program increases admissions beeause it immediately alerts the ER physician that a patient meets HMA's very low admission criteria. The emergency physician who does not agree that admission is necessary, must then manually "override" the QualCheck program's recommendation for admission.

222. HMA established a corporate benchmark for QualCheck overrides (< 30%), meaning emergeney physicians must admit at least 70% of patients selected for admission by the low standards HMA selected for the QualCheck program. HMA's mandate was enforced without regard for the physicians' determination of medical necessity of that admission.

223. Many HMA facilities met or exceeded this QualCheck benchmark by admitting more than 70% of QualCheck patients. These include: Dade City; Amory, Mississippi; Jacksoncentral; Gasden, Alabama; Port Charlotte, Florida; Statesboro; Punta Gorda, Florida; Brandon; Hamlet; Anniston; Brooksville; Crystal River; and Sebastian, Florida.

a. Admissions Benchmarks: Emphasis on Revenues from Medicare Patients

224. Three of the HMA's ED performance benchmarks are aimed at increasing admissions: % of Admissions; % of Total Patients with Quality Review Identified Who Were Discharged; % of attendings called. As discussed below, in June of 2005, HMA added additional benchmarks aimed at illegally generating revenues through Medicare ER patients.

PERCENT OF ADMISSIONS

225. The % of admissions measure is calculated by dividing the number of ER patients admitted to the hospital for inpatient care by the total number of new ED patients. HMA's corporate benchmark since October 2003 for "% of admission" has been 16%. HMA's minimum overall admission rate for emergency patients shows a blatant disregard for the sanctity of the doctor-patient relationship. The medical necessity of even one admission must be determined by the emergency physician after an examination of the patient, not influenced by corporate benchmarks.

226. Federal and state laws and regulations require a determination of medical necessity for each patient – negating the validity of any "minimum" admission rate set by the hospital's corporate leaders.

227. Although HMA's official corporate benchmark for overall ER admissions was 16%, the actual goal HMA imposed on each hospital may be higher. For example, at Lake Norman, the admission goal was 25%. This was communicated to ED Nurse Manger Tonya Kirby by Jamie Stoner in approximately February 2010.

228. Many HMA facilities met or exceeded HMA's official minimum admissions benchmark. These included: Anniston, Gasden, and Hartsville.

229. Lake Norman admits currently approximately 15% of their daily volume of 70 patients. Amazingly, meeting HMA's goal of 25% would require Lake Norman emergency physicians to admit seven (7) additional patients per day. An average admission carries a minimum charge of $5,000. Seven (7) admissions would bring additional revenues to HMA's Lake Norman of $35,000 per day, or $12 million per year. HMA's enforcement of policies to illegally admit ED patients has caused unnecessary ER admissions at nearly all HMA's 55 facilities, generating at least $600 million in illegal in-patient charges per year.

CALLING ATTENDING PHYSICIANS TO INCREASE HOSPITAL ADMISSIONS

230. HMA executives knew that if an emergency physician calls the patient's private attending physician, there is a higher likelihood that the patient will be admitted to the hospital. Calling an attending also has the potential to increase the ER patient's level of care, which affects the reimbursement available under government healthcare programs, even for patients who are not admitted.

231. As stated above, on April 15, 2010, Robin Clark, Chief Nursing Officer (CNO) at Davis Regional, admitted to Relator Steve Folstad in the midst of a daily Flash Meeting that HMA's true purpose in requiring ED physicians to call the patient's attending physician was to increase admissions to the hospital.

232. Since October of 2003, HMA has mandated that emergency physicians call the attending physician for more than 30% of ER patients. In contrast, upon information and belief, nationally, ED physicians call the patients' attending physician in 15-20% of ER cases.

233. MEMA often makes calls to attending physicians to arrange follow-up for patients who should be rechecked in a day or two, or to consult with a specialist to discuss a particular case.

However, these calls aimed at providing quality medicine are not HMA's focus. In fact, HMA does not give the emergency physician credit for calls to physicians or other specialists without admitting privileges at the HMA hospital.

234. In April 2010, HMA increased the benchmark for attendings called to greater than 35% of all patients. As described below, HMA has effectively set a special benchmark for attendings called for patients over 65 at 100%.

235. Relying on their individual medical judgment as to each unique patient's medical needs, since October of 2003, MEMA physicians at Defendant Davis Regional and Lake Norman did not meet HMA's corporate benchmarks for "% of attendings called." For example, from October 2003 until June 2005, MEMA physicians at Defendant Davis Regional called the attending physician for 15.4% to 21.2% of all ER patients.

b. HMA's National Demands to Increase Medicare Admissions

236. Beginning in June of 2005, the administrator at Davis Regional began to provide Pro-MED Executive Summary Reports to MEMA's ED Director, Relator Folstad. He continued to receive these reports for the duration of his tenure as ED Director at Davis. These Executive Summary reports were issued for every hospital in HMA's system.

237. Beginning in June of 2005, from time to time Relator Mason would also receive monthly Executive Summary Reports. He continued to receive these reports until MEMA received its notice of termination on May 3, 2010. The Pro-MED Executive Summary Report for June 2005 included a separate report to track lucrative Medicare-eligible patients who entered its hospital ERs: the "Patients 65 and Older Report."

238. This "Patients 65 and Older Report" details the following data for patients 65 and older: patients total number, admissions total number, % admitted; attending called total number; % attending called.

239. HMA established ED performance benchmarks for each Medicare standard: % patients admitted (> 50%); % attending called (> 75%).

240. HMA employed these illegal ER admissions benchmarks and through corporate executives, division leaders, and hospital administrators brought considerable pressure upon emergency physicians to meet them.

241. In addition to pressure exerted on Relators, other emergency physicians and staff were pressured to meet HMA's minimum admission rate. For example, in a September 2009 discussion with Relator Mason, Salvador E. Arceo, MD, an EmCare physician at HMA's River Oaks Hospital in Jackson, Mississippi, admitted to Relator Mason that he is pressured by EmCare and HMA superiors to admit QualCheck patients. Dr. Arceo stated that he admits them because it is easier to admit them then justify why they were not admitted. In addition, during a cocktail party in Chicago in February 2010, Joey Vice, RN, the manager of the HMA ED in Anniston, Alabama told Relator Mason that hospital administrators bring great pressure on ED managers to ensure that doctors in the ED order tests and admit patients.

242. HMA's official corporate benchmarks include a minimum admission rate of 50% of Medicare patients (65 and older). This exceeds the national average Medicare admission rate of 45% for Medicare beneficiaries.

243. Since at least July 2005, HMA facilities have been meeting and exceeding the 50% admission rate for patients 65 and older. These include: Brandon, Clarksdale, Jackson, and Natchez, Mississippi; Dade City, Haines City, Punta Gorda, and Sebastian, Florida; Durant and Midwest City, Oklahoma; Mesquite, Texas; Tullahoma and Lebanon, Tennessee.

244. Although HMA's official benchmark for admitting patients 65 and older is 50%, HMA executives expected their ED doctors to admit a much higher percentage. For example, when Relators Folstad and Mason attended the August 12, 2009 HMA Division 1 Meeting in Charlotte,

North Carolina, Britt Reynolds, HMA's Division 1 President (who is not a physician and has no clinical training), incredulously proclaimed to the emergency physicians present: "If you are not admitting 75% of your Medicare patients, you are not practicing quality medicine." HMA's minimum admission rate of 75% of Medicare patients grossly exceeds the 45% national average.

245. HMA would challenge ED physicians during daily Flash Meetings to justify why they did not admit all patients age 65 and older. Thus, HMA created an effective admission benchmark for Medicare patients of 100%. HMA also mandated that ED physician call the patient's private attending physician for 75% of patients 65 and over.

246. HMA's benchmark of 75% far exceeds the typical 15%-20% of cases where the ED physician needs to consult with a private attending physician to arrange for follow-up care or to discuss the discharge, transfer, or possible admission decision for patients, including those over 65. HMA's benchmark for calling attendings for patients over 65 receives particular scrutiny from HMA executives on a daily basis.

247. For example, on April 18, 2010, MEMA physician Steve Greer was challenged for not calling the attending physician (to encourage admission) for an elderly woman who fell at a nursing home. Her most serious injury was an abrasion to her knee. HMA Division 1 CEO, Britt Reynolds, as well as Division 1 Vice President, Angela Marchi, challenged Dr. Greer's independent medical judgment.

248. Some HMA facilities surpassed HMA's official benchmark (75%) for calling attendings for patients over 65. For example, in June 2005, the ED physicians at HMA's hospital in Mesquite, Texas, turned in a stellar performance (98%) for calling attending physicians for Medicare-eligible patients. Presumably, the admissions of patients increased.

249. During Relators' tenure at HMA, HMA executives expected that ED physicians would call the attending for a much higher % of patients over 65 then the official benchmark of

75%. This expectation continues to the present, as recently as December 14, 2010, the current ED Director at Lake Norman communicated to the ED physicians that the goal for PCP/Specialist/Hospitalist consults for patients >65 was 100%.

250. Relying on their medical judgment as to each unique patient's medical needs, since October 2003, MEMA physicians at Defendant Davis Regional often did not meet HMA's corporate benchmarks for % of admissions.

251. For example, between October of 2003 and June of 2005, MEMA physicians at Davis recommended admission for 11% to 15% of all new patients visiting the ER. In addition, MEMA physicians have historically admitted 45% of their Medicare patients, in keeping with the national average admission rate. This was far below HMA's goal of 75%.

c. HMA Aggressively Avoids 23 Hour Observations which have Lower Reimbursements than In-Patient Admissions

252. Government regulations have specific guidelines for patients who are required to be kept for observation rather than admitted to the hospital to inpatient treatment. The Medicare reimbursement to a hospital for a patient kept for observation is thousands of dollars less than for an in-patient admission.

253. While MEMA physicians do not have admitting privileges and do not make the admission versus observation decision, upon information and belief, other emergency physicians at HMA facilities do admit patients. HMA pressured admitting physicians to admit ER patients rather than keep them at the HMA facility for observation.

254. In early 2010, an action plan was implemented at Davis Regional which required the Emergency Room charge nurse for the shift to contact the HMA hospital administrator on call whenever an admitting physician recommended that a patient was to be kept for observation, rather than admitted. This plan was put in place to attempt to convince the admitting physician to change

the orders to in-patient admission.

255. In February 2010, HMA's CNO at Davis Regional, Robin Clark, began to police the ED at Davis to look for patients kept on observation status. In order to avoid keeping patients at the hospital under observation status, Davis administrators pressured the hospital medical staff to keep all patients requiring treatment as regular admissions. Relator Folstad heard that CNO Clark had even changed recommendations that patients be kept for observation to a physician recommendation for in-patient admission.

256. HMA's efforts to pressure admitting physicians to reduce observations and have observation patients admitted instead at Davis Regional and at other HMA facilities have been quite successful. For example, according to HMA's Pro-MED Physician Activity Report, for the four months of February through May 2010, the number of patients kept at Davis Regional for observation has been reduced to 1 (in February 2010). This represents the elimination of 31 observations compared to the previous four-month period (10/01/2009 – 1/31/2010), when 32 patients were kept for observation. Since February 2010, no ER patient has been kept at Davis Regional merely for observation. Upon information and belief, rather than be kept for observation, these patients were admitted to the hospital.

d. Benchmarks for Quality Review and QualCheck of Discharged Patients

257. Since at least October 2003, HMA has employed a "Quality Review" program, part of the Pro-MED Patient Manager software which flags patient charts for admission based on data entered in the ED nurses' Pro-MED EMR. This occurs while the patient is still in the ER.

258. The "% of Total Patients with Quality Review Identified Who Were Discharged" measures the % of patients for whom the ED physician, arguably, did not follow HMA's "Quality Review" recommendation for admission. Since 2003, HMA's corporate benchmark for % Quality Review patients discharged has been < 35%.

259. Although the Quality Review reports were not discussed with MEMA physicians on a daily basis until some time in 2009, Relators understood that HMA has pressured emergency physicians in other HMA facilities since 2003 to meet this benchmark.

260. Relying on their individual medical judgment as to each unique patient's medical needs, since October 2003, MEMA physicians staffing Defendant Davis Regional's ED did not meet HMA's corporate benchmarks for "% of Total Patients with Quality Review Identified Who Were Discharged." From October 2003 until June 2005, MEMA physicians at Defendant Davis Regional discharged between 49.2% and 64.1% of all patients identified as meeting admission standards by the HMA/Pro-MED "Quality Review." Beginning in 2006, HMA's use of Pro-MED's QualCheck enabled HMA to flag patients for admission based on the physician's EMR.

261. Although Pro-MED claims that its Case Management software, including the QualCheck program, facilitates admission decisions and prompts involvement of case managers, like Quality Review, the real purpose of QualCheck was to increase admissions.

262. In fact, HMA did not even have case managers for all of their EDs. For example, there was no case manager in the ED at Lake Norman. Rather, the CFO at Lake Norman, Jamie Stoner, instructed the ED Nurse Manager, Tonya Kirby, that she (Tonya) or her assistant must stay in the evening "to make sure the ED doctors are admitting the patients they are supposed to."

263. After 2006, when HMA implemented the QualCheck enhancement to the Pro-MED software, HMA imposed a corporate benchmark which required that emergency physicians override fewer than 30% of patients selected by QualCheck for admission.

10. The Fall of 2008: HMA Increases Pressures on Hospital ED Physicians to Meet Corporate Benchmarks Aimed at Unnecessary Admissions and Tests

264. A Pro-MED report, the Time Study Patient Flow Evaluation of July 2008,

introduced the Pro-MED "Dashboard Report" to HMA's emergency physicians. HMA used these reports and related Flash Meetings to police and enforce corporate ED benchmarks aimed at driving up volumes for ER tests and in-patient admissions.

265. During the summer of 2008, HMA announced that CEO Burke Whitman would be replaced in September of 2008 by a new leader, Gary Newsome. Upon information and belief, the July 2008 Pro-MED HMA Time Study Patient Flow Evaluation report introduced HMA's new plan for greater corporate control of HMA's ERs.

266. Beginning in August 2008, HMA's divisional and corporate management reviewed the ED metrics for testing and admissions with greater frequency and intensity. HMA scrutinized ED physicians' testing and admission decisions through Pro-MED products, which allowed both real time and retrospective daily and weekly reviews of the previous day's ED data to pressure emergency physicians and ER staff to meet HMA benchmarks to optimize revenue.

a. HMA Uses Pro-MED's Daily, Weekly, and Monthly Reports to Implement Its Illegal Program to Generate Revenues through Excessive Tests and Unwarranted Admissions

267. Since August 2008, HMA has used daily Pro-MED Dashboard Reports to review the emergency physicians' prior day performances against HMA's corporate benchmarks, including CTM guidelines tests and minimum admission rates. Dashboard Reports have been reviewed with ED staff during daily Flash Meetings.

268. The daily Pro-MED Dashboard Report for each of the 55 HMA facilities tracks approximately 23 data items, which include: new patient visits (Admissions #; Admissions %); QR disch % (quality review discharged); qual check criteria met not admit %; testing guidelines %; attd call %; patients 65 and older visits #; patients 65 and older adm %; patients 65 and older trans %; patients 65 and older PCP consult %.

269. In August 2008, HMA executives increased their efforts to police corporate ED

benchmarks by instituting the Daily ED Flash Meeting. At this meeting, held in the ER each morning at the end of the night shift, HMA hospital executives reviewed the previous day's ER activity contained in the Pro-MED daily Dashboard Report. HMA required ED physicians to justify why corporate ED benchmarks were not met.

270. For example, each morning all patients over 65 (even those with minor trauma), all patients who meet Quality Review criteria, and all QualCheck patients who are not admitted are reviewed. The emergency physician in attendance must justify each patient not admitted. Thus, although the official HMA benchmarks for admitting patients 65 and older and for admitting Quality Review and QualCheck patients was less than 100%, HMA used the Pro-MED reports and ED Flash Meetings to impose an effective benchmark of 100% for admissions of patients over 65.

271. In fact, emergency physicians at other HMA facilities throughout the country admitted to Relator Mason that they simply admit the vast majority of QualCheck and Quality Review patients, rather than deal with HMA executives' scrutiny and harassment. These include Kevin Sells, MD from Stringfellow Memorial in Anniston, Alabama and Salvador E. Arceo, MD, from River Oaks Hospital in Jackson, Mississippi. Dr. Sells and Dr. Arceo both told Relator Mason that they just admit QualCheck patients when prompted by the Pro-MED system.

272. Although ED Flash Meetings are held by the HMA hospital administration and attended by the ED Nurse Manager and the emergency physician, a hospital executive (i.e., the CFO, Comptroller, or the Hospital CEO) also usually attended.

273. During the September 2009 ED Core meeting in Naples, Florida, CEO Newsome required that hospital CEOs attend the daily ED Flash Meeting. Newsome added that he would make unannounced appearances at hospitals to ensure that the hospital CEO attended. Newsome did attend numerous ED Flash meetings at HMA hospitals, including some of those held at Lake Norman.

274. At HMA hospitals, a hospital administrator creates an ER Round Report which includes the results of each ED Flash Meeting for several days or a week. The ER Round Report is then provided to HMA corporate executives, the local hospital administration, and the ED Directors.

275. The ER Round Reports contain "Pro-MED Indicator(s)," including: admit rate, attending called %, 65+ admit rate, 65+ attending called %, QualCheck met not admitted, testing guidelines." The ER Round Report provides the benchmark data from the previous day, highlights benchmarks not met, and includes notes on discussions from the ED Flash Meetings. The ER Round Report form bears the following bolded note: "If results less than benchmark, then action notation is needed."

b. Newsome Leaves CHS and Returns to Defendant HMA Bringing Intensified Support for Focus on ER Revenues

276. When Newsome returned to HMA in September of 2008 and took over as CEO, HMA restructured its executive management team so that all of HMA's hospital operations began to report directly to Newsome. Gary Newsome has ardently supported Pro-MED, as evidenced by policies he instituted at HMA hospitals and comments he made during Earnings Calls.

277. For example, on February 24, 2009, during an Earnings Call for HMA's Q4 2008 (Newsome's first quarter at HMA), CEO Newsome was asked about CHS's "ability to grow earnings a little bit better than most of their peers in the industry." Newsome responded that CHS had benefitted from having "been steeped in the Pro-MED ER process so they understand that process and continue to perform well." Newsome also stated that CHS benefitted from a "discipline[d] approach to the business." Newsome added that he was deploying these same measures at HMA.

278. Newsome demonstrated his support for Pro-MED software in the HMA "Earnings Call Transcript" from April 28, 2009. In discussing HMA earnings from the first quarter for 2009,

Newsome described the Pro-MED enhancements made since the Fourth Quarter in 2008 (Newsome's first three months on the job): "We have completed the hardware and software upgrades for our clinical guideline driven ER patient system called Pro-MED. As you know this tool is designed by ER professionals that we used to improve patient flow, quality and the delivery of care in the ER." In the same call, Newsome credited HMA's "focus on ER Operations" as a contributing factor to HMA "volume improvements" for the last quarter of 2008 and the first quarter of 2009.

11. Revised (2008) Complaint Test Mapping Guidelines: HMA's Blatant Fraud and Unnecessary ER Tests

279. On or about October 23, 2008, HMA released the revised Pro-MED CTM guidelines. The document bears the following notation: "HMA/EmCare Master Complaint Test Mapping," as well as the Pro-MED trademark. The 2008 CTM guidelines (pretest order sets) consisted of a table listing 516 chief complaints and the tests ordered when each was selected.

280. HMA's CMO, Ronald N. Riner, MD, refers to the 2008 revised CTM guidelines as "Pro-MED ED Complaint Test Mapping (Pretest Order Sets)." These tests, according to HMA's CMO, Ronald N. Riner, MD, were developed "in an attempt to shorten" long wait times for patients in the ER.

281. For each chief complaint, the HMA CTM guidelines table lists the tests triggered when the complaint is selected by the triage nurse, whether the guidelines test is mandatory ("true") or to be considered by the physician ("false"), the charge code, and the department to perform the test (lab or radiology). As was the case for the original CTM guidelines, the emergency physician could add to the 2008 CTM guidelines locally by changing a "false" test to a mandatory "true," but they could not delete any of the "true" tests or change a true (mandatory) test to false (discretionary).

282. After HMA, EmCare, and Pro-MED created the 2008 Pro-MED CTM guidelines, HMA installed the program in each of its hospitals across the country. HMA maintained corporate benchmarks which required that emergency physicians order 80% of the 2008 Pro-MED CTM guidelines. Relators became immediately alarmed when they reviewed the 2008 Pro-MED CTM guidelines. They quickly concluded that HMA's new standard CTM guidelines would cause emergency physicians to order blatantly fraudulent and medically unnecessary ER tests.

283. For example, for the 75-year old patient who presented to HMA's ER after October 23, 2008 with a chief complaint of "confusion - new onset," the 2008 CTM guidelines would order: Bedside Glucose, CBC, CMP, CPK MB, Total CPK, Urine Drug Screen, ETOH, PT, PTT, Troponin I, Urinalysis, EKG, and Portable Chest x-ray. Of these, the following six tests would be unnecessary: CPK MB, Total CPK, PT, PTT, and Troponin I.

284. By way of further example, for the patient who presented to HMA's ER after October 23, 2008 with a chief complaint of "vaginal bleeding (pregnant less than 20 weeks)" HMA would immediately order the following tests: Quantitative B-HBG; CBC; Type and Screen; and a Complete OB Ultrasound. As discussed above, a urinalysis, should be performed initially to differentiate vaginal bleeding from blood in the urine. This is listed only as optional in the 2008 CTM guidelines. Medicaid patients seen in HMA's ERs would rarely need a Type and Screen. At best, only an Rh typing is needed. An OB Ultrasound costs hundreds of dollars, and, as with other tests, should never be ordered prior to the physician seeing the patient.

285. Thus, HMA's October 2008 CTM guidelines (imposed after Newsome arrived as CEO) caused excessive mandatory tests to be performed for thousands of patients who were treated in HMA's 55 ERs. The revised 2008 CTM guidelines were patently excessive from a fraud and abuse perspective.

286. The patient charts which MEMA received from HMA, when they included the Pro-

MED Orders Summary, illustrate the types and volume of excessive tests generated through HMA's October 2008 CTM Guidelines, which were issued in early November 2008.

287. Dr. Mason immediately raised his concerns about the 2008 CTM guidelines to HMA's CEO at Lake Norman, Michael Cowling. Mr. Cowling responded that emergency physicians at Lake Norman and Davis Regional were expected to meet HMA's corporate benchmark of 80% for the 2008 CTM guidelines.

288. Relators have observed first hand numerous cases where the Pro-MED CTM program automatically ordered tests that were medically unnecessary. A sampling of specific patients, listed anonymously, for whom HMA used Pro-MED systems to order tests before the physician assessed the patient and/or for whom unnecessary tests were ordered are provided in the table at Exhibit "A," which is incorporated by reference. These ER patients are examples of HMA's scheme to bill government payors for excessive and unnecessary ER tests.

12. HMA Executives Harass Emergency Room Physicians to Drive Tests and Admissions

289. As discussed above, shortly before Newsome's arrival in September 2008 at HMA, executives intensified efforts to pressure ED physicians to meet testing and admission benchmarks. For example, HMA Division executives harassed ED physicians through daily and weekly reports and meetings which highlighted physicians who did not admit patients.

290. As also discussed above, in late October of 2008, HMA issued and implemented new and more excessive CTM guidelines. At the same time, HMA denied the local ED Medical Directors the ability to edit the CTM guidelines and insisted that EDs implement HMA's standard 2008 CTM guidelines "as is."

291. Just days after HMA issued its 2008 CTM guidelines, on October 29, 2008, Relator Folstad (as the MEMA President) was called to a meeting with the Division 1 President, Vickie

Briggs, and Division 1 CFO, Chris Hilton. This was Relator Folstad's first meeting with Ms. Briggs. It occurred shortly after Newsome took over as CEO, and it was a direct result of Newsome's efforts to use corporate pressure to maximize ER charges and admissions.

292. During that meeting, Chris Hilton advised Dr. Folstad that MEMA was not taking good care of HMA's ER patients because its emergency physicians were not ordering enough tests, and not admitting enough patients. Vickie Briggs added that MEMA had a long reputation of being resistant to HMA's "patient initiatives." She asked Relator Folstad if MEMA was going to "get on board with HMA's new ER incentives." Briggs added that "if MEMA was not going to cooperate, HMA would be finding an ER group that would." Folstad asked for, but did not receive, any evidence which supported HMA's contentions that these tests actually helped patients.

293. On November 5, 2008, Relator Mason received a copy of a November 4, 2008 memo written by Ronald Riner, MD, HMA's contracted CMO, regarding the new (2008) Pro-MED CTM guidelines. Dr. Riner first acknowledged the "numerous questions and calls we [HMA] have received concerning the Complaint Test Mapping (Pretest Order Sets) that are being implemented in the Pro-MED software program."

294. Dr. Riner also acknowledged in his memo that "many" of the ED physicians and/or ED Directors throughout the HMA chain "have voiced concerns about the Pro-MED software program." HMA's CMO stated that HMA has "reviewed this and discussed this in great detail," but decided to remain with Pro-MED and focus on staff and ED physician training.

295. When Dr. Mason and other emergency physicians in the HMA system raised concerns with the revised 2008 CTM guidelines, HMA responded through its Chief Medical Officer, that ED physicians at HMA EDs nationwide were expected to use the CTM guidelines. HMA also demanded that EDs meet or exceed HMA's corporate benchmark of 80% for guidelines testing. Unfortunately, both the CTM guidelines and the benchmark bore no relationship to the

patients' true medical conditions or to evidence-based medicine.

296. From October 2008, when HMA prohibited ED Directors from editing the CTM guidelines, Relator Mason avoided unnecessary tests mandated by the Pro-MED CTM software by training ER triage nurses at Lake Norman to select benign chief complaints which would trigger minimal diagnostic tests in the Pro-MED program.

297. MEMA physicians at Davis Regional also attempted to circumvent HMA's fraudulent practices after October 2008 by compiling a list of chief complaints that initiated little or no testing and posting it at the triage desk for nurses to select from. However, once the Davis Regional hospital administration learned of the list, the ER nurses were prohibited from using it.

13. HMA Required ED Directors to Review and the Medical Executive Committees (MECs) to Approve the 2008 Pro-MED Complaint Test Mapping Guidelines in Attempt to Shift Responsibility for Fraudulent Tests to Emergency Patients

298. In the last paragraph of the November 2, 2008 memo, Riner, through HMA, attempted to cloak the CTM guidelines in legitimacy and shift the responsibility for ordering the outrageously unnecessary tests through CTM guidelines on to the ED Director and the emergency physicians: "**PLEASE NOTE** that the protocols being utilized will need to be vetted and approved by the appropriate medical staff organizational structure (either MEC or ED Department at each of your respective hospitals)."

299. Dr. Riner's memo reveals HMA's attempt, through the alleged MEC approval process, to attempt to create the illusion that the ED physicians were exercising their independent judgment to choose the appropriate and necessary diagnostic tests for their patients when they reviewed the 2008 CTM guidelines. In reality, HMA made clear that the standard 2008 CTM guidelines must be approved and that the ED directors could not deviate from them.

300. HMA pressured ED Directors to assist in having the hospital MEC approve the

2008 Pro-MED CTM guidelines. For example, HMA's CEO at Lake Norman made it clear to Relator Mason that the 2008 CTM guidelines must be used or MEMA would be terminated. Under extreme pressure from HMA, Relator Mason presented the 2008 CTM guidelines to the MEC at Lake Norman for approval. This was done with the understanding that HMA would continue to review them and Relators' complaints.

301. At Davis Regional, HMA also threatened the MEMA physicians with contract termination unless they presented the 2008 CTM guidelines to the MEC. Dr. Greer, the MEMA ED Director for Davis at the time, recommended the 2008 CTM guidelines to the Davis Regional MEC for approval only because it was made clear to him by HMA administration that recommending disapproval would cost MEMA the Davis Regional ED contract.

302. Through the memo by HMA's CMO (Dr. Riner), it is clear that HMA knows that the emergency physician alone is supposed to determine the medical necessity of diagnostic studies for ED patients: "Again, the physician bears the ultimate responsibility and accountability for the laboratory tests that are ordered on any patient. Cognizant of this fact we all need to work closely and expeditiously with our ED physicians to finalize protocols that will help manage patients efficiently and effectively." In stark reality, HMA pressured the ED physicians to rubber stamp the 2008 Pro-MED CTM guidelines.

303. Dr. Riner then stated that he "reminds" the ED Directors and physicians that the HMA 2008 Compliance Work Plan "requires that at least annually, we ensure that the Pro-MED Test Mapping protocols have been reviewed by the Emergency Department physicians and formally approved by the hospital's Medical Executive Committee. Copies of all changes to the test mapping protocols must be saved and available for audit." Riner said this when he knew full well that nurses had been ordering tests and that Medical Executive Committees had not been approving this. In fact, Relators first learned of this unknown HMA policy at the time of Dr. Riner's November 2008

memo.

304. In December 2008, MEMA's outside health care attorney, Alice G. Gosfield, Esquire, a nationally recognized health care attorney, in a non-privileged communication, wrote to HMA's Chief Medical officer and raised her clients' concerns about potential fraud and abuse related to HMA's CTM guidelines.

305. Relator Mason was first asked to review the 2008 CTM guidelines with the Lake Norman MEC in January 2009. Relator Folstad was never asked to review the CTM guidelines or to have it approved by the Medical Executive Committee ("MEC") while he was the Medical Director at Davis Regional (2000-2007).

14. Relators Attempt to Work with HMA to Reduce the Complaint Test Mapping Guidelines to More Acceptable Levels

306. Throughout the fall of 2008, and into 2009, Relator Mason repeatedly contacted Defendant HMA and offered his assistance in working with HMA and EmCare to reduce the 2008 CTM guidelines to acceptable medical levels. Relator Mason had conversations and/or communications with HMA executives, including, but not limited to, the hospital CEO at Lake Norman (Cowling), the CEO at Davis Regional (Metz), HMA's CMO, Dr. Riner and HMA's Corporate Director of Emergency Medicine, Lynne West.

307. In response to Relator Mason's criticism of the 2008 CTM guidelines, in the fall of 2008, Karen Metz, CEO of Davis Regional, contacted Relator Mason and invited him to participate in a meeting of other "concerned" emergency physicians to revise the 2008 CTM guidelines.

308. On January 8, 2009, HMA's contracted CMO, Dr. Riner, sent a memo to Relator Mason inviting him to the Naples meeting.

309. On January 23, 2009, Relator Mason discussed the revised CTM with HMA's quality review consultant, Lisa Nummi, RN/CNP (Certified Nurse Practitioner). After Dr. Mason

discussed MEMA's concerns with Pro-MED, Nummi agreed that the CTM generated fraudulent and unnecessary tests "for revenue generation."

310. Thereafter, on January 26, 2009, in a follow-up email to Relator Mason, Ms. Nummi stated that she was supposed to attend the February 3, 2009 CTM Task Force meeting, but was reassigned to another hospital and will be joining the meeting by conference call. Nummi assured Dr. Mason that she had relayed Dr. Mason's actual views to Dr. Riner. Ms. Nummi made it clear to Dr. Mason that she intended to be MEMA's ally at the "Quality meeting" in Naples on February 3, 2009.

a. HMA's National CTM Task Force Meets at Its Naples, Florida Headquarters

311. On February 3, 2009, the so-called CTM Task Force met at HMA's Naples, Florida corporate headquarters to review and "recommend revisions" to the fall 2008 version of the Pro-MED CTM guidelines. Under the direction of EmCare's Dr. Wheelis, the attendees discussed changes to the 2008 CTM guidelines intended to pare down the tests automatically ordered by HMA's triage nurses.

312. In addition to EmCare's Dr. Wheelis, the CTM national Task Force meeting attendees included HMA executives, HMA hospital emergency physicians and EmCare executives, including:

- Terry Meadows, MD, EmCare executive;
- George Loukatos, MD, EmCare physician at Central Mississippi Medical Center;
- Scot D. Fell, DO, an emergency medicine physician who practices at Venice Regional Medical Center, Venice, Florida (participated by conference call);
- Edwin D Moore, DO, a family practitioner who provides ER care through TeamHealth at HMA's Seven Rivers Regional Medical Center, Chrystal River, Florida;

- Relator Tommy Mason;
- Chris Pinderski, MD, an emergency physician at HMA's Poplar Bluff Regional Medical Center – North, and outspoken opponent of the 2008 CTM guidelines;
- Lisa Nummi (participated by conference call);
- Lynne West, HMA's Corporate Director of Emergency Medicine (participated by conference call).

313. When Relator Mason and the other attendees first sat down, they received a packet of documents. The packet of documents provided to Relator Mason included, but was not limited to: HMA's standard October 2008 Pro-MED CTM guidelines, as well as a copy of Pro-MED CTM guidelines that bore the name of a hospital in CHS's system.

314. The CTM guidelines report for the CHS facility was the same format as the Pro-MED CTM report that Relator Mason had received for HMA's CTM Guidelines. Relator Mason reealls that the CTM guidelines for the CHS facility were also substantively the same as HMA's excessive October 2008 CTM guidelines. The only difference was that, at the top of the page, in the place of HMA or a HMA facility, the CTM guidelines bore the name of a CHS hospital.

315. At the February 3, 2009 meeting, Relator Mason and the other attendees were told "this is the same CTM used by Mr. Newsome at CHS and the physicians there had no problems with it." Thus, Relator Mason understood that HMA's excessive October 2008 CTM guidelines were the same CTM Guidelines used system-wide at CHS hospital EDs. Relator Mason also understood that when Gary Newsome took over as HMA's CEO, he brought to HMA the Pro-MED CTM guidelines that he had used at CHS.

316. Although Relator Mason expected that the national Task Force would engage in a critical discussion of the revised CTM, he and Dr. Pinderski were the only outspoken critics of the 2008 CTM guidelines.

317. EmCare physicians who attended the Task Force meeting resisted removing tests from the revised CTM guideline. Instead, they preferred to create additional general chief complaints that would generate few or no tests. For example, the Task Force added a complaint called "abdominal pain, general" that would not have guidelines tests associated with it.

318. Upon information and belief, the reason to add benign complaints, rather than reduce the tests ordered for existing chief complaints, was to leave intact the excessive 2008 CTM guidelines so that HMA could still force the triage nurses at the majority of HMA facilities to use them.

319. EmCare physicians, including Drs. Wheelis and Meadows, did not advocate reducing the CTM guidelines, but were passive participants during the discussions.

320. Ultimately, the national Task Force issued "recommendations" that HMA revise the 2008 Pro-MED CTM guidelines. While the CTM Task Force both reduced the number of tests for the chief complaints listed and added chief complaints for conditions that would order only a few tests, the recommended revisions fell short of the changes requested by Drs. Mason and Pinderski.

321. For example, the Task Force removed the most egregious outrageous test sets (i.e., complete blood count for all children with a fever), but added a complaint for "abdominal pain-benign."

322. After the Task Force meeting (February 4, 2009), HMA responded to the Task Force's "recommendations" to revise the CTM guidelines through a memo written by CMO, Ron Riner, MD. HMA stated that its next "course of action" for the 2008 CTM guidelines (as revised in 2009), would include HMA management review and distribution to Pro-MED, followed by the HMA hospital ED Directors' review and approval by the Medical Executive Committee (MEC) within 30 days. Although HMA "anticipated a meeting of the Complaint Test Mapping Task Force to review progress and needed adjustments," HMA never sought such a meeting.

323. On February 5, 2009, the Riner Group provided HMA executives and the attendees of the Task Force meeting with revised CTM guidelines. The document attached to the Riner Group's email was titled "CTM updated 2 3 09 true tests only."

324. Upon information and belief, HMA retained another version of the CTM guidelines which included both "true" and "false" guidelines tests. By doing so, HMA allowed its emergency departments to continue to use many of the tests contained in the excessive 2008 CTM guidelines.

325. The 2008 CTM guidelines were in place at all 55 HMA facilities from October 2008 until at least March 19, 2009. Relators believe that during this time, hundreds of thousands of unnecessary tests were ordered for patients in HMA's emergency rooms.

326. Although Relators were advised that HMA would install the revised (2009) CTM guidelines in all HMA facilities after the February 2009 meeting, Relators have no knowledge of whether this has occurred.

327. In fact, Relators believe that HMA did not re-issue to Relators a complete or master set of CTM Guidelines after Relators challenged the HMA/EmCare Master CTM dated October 23, 2008. Further, Relators believe that HMA did not make all of the changes Relator Mason and others requested at the Naples Meeting on February 3, 2009. In fact, rather than paring down the unnecessary tests ordered using CTM, HMA actually ADDED new true tests to some chief complaints after the so-called Task Force meeting in 2009, i.e., a blood culture for a cough with fever.

b. Complaint Test Mapping Abuses Continues After the Florida Task Force Meeting

328. While the February 2009 Naples meeting may have resulted in the removal of some of the most egregious tests to be ordered by HMA's nurses, the revised (2009) CTM guidelines employed by HMA continue to cause the submission of many false claims for hundreds of

unnecessary tests.

329. In particular, Complaint Test Mapping abuses continued even after the February 2009 revisions, including, but not limited to, the tests ordered for the following chief complaints:

- All patients over 55 with abdominal pain receive unnecessary EKGs, which should never be ordered without the benefit of the treating physician's determination;
- All patients with a sore throat receive a complete blood count ("CBC");
- Patients who are pregnant less than 20 weeks and have vaginal bleeding, receive a complete blood count ("CBC") and Type & Screen (which are unnecessary), as well as the Quantitative B-HCG, which should be selected by the physician after the patient assessment;
- Patients who are unresponsive or unconscious receive unnecessary CK, CK-MP; PT, PTT, Troponin, and ABG tests;
- Patients who are in cardiac arrest (and whom would be seen by the physician immediately) have a battery of tests ordered by the triage nurse before the physician sees the patient, including: complete blood count ("CBC"), complete metabolic panel ("CMP"), CPK-MB, CPK Total, Magnesium, PT, PTT, Troponin, ABG, EKG, and Chest x-ray.

330. After the February 3, 2009 meeting until at least August 2010, HMA continued to maintain and mandate Complaint Test Mapping (CTM) that is standardized in Pro-MED for all HMA facilities. These standard HMA CTM tests sets include "true" tests that HMA expects the nurses to order at the time of triage, before the patient is seen by a physician. These mandates continue to the present.

331. When the emergency physician cancels any of these unnecessary tests, HMA subjects them to great pressure for not meeting the corporate testing guidelines benchmark.

332. Since 2003, Relators have received various versions of Pro-MED CTM Guidelines

from HMA. While the CTM Guidelines imposed by HMA differ in some respects, particularly after October 2008, reviewing these detailed lists of tests ordered for every patient with a particular chief complaint has provided Relators with direct knowledge of HMA's scheme to cause the excessive ER tests to be ordered nationwide at HMA facilities. These emergency room testing abuses by HMA result in the submission of false claims to state and federal healthcare programs.

15. HMA's Drive in 2009 and 2010 to Force Emergency Physicians to Adhere to HMA's Corporate Benchmarks for Admissions

333. In 2009, HMA executives continued to harass ED physicians to drive admissions. HMA added action plans and comments in weekly Pro-MED ER Round Reports. When HMA guidelines were not met, action plans were immediately implemented and communicated to HMA corporate officers. There were daily pressures to admit every ER patient 65 and older, even those with the most benign conditions.

334. On January 27, 2009, there was a meeting at Davis Regional between Lake Norman and Davis Regional administrators (Lake Norman CEO, Cowling, and Davis Regional CEO, Metz), the ED Medical Directors (Relator Mason and Dr. Greer), and Relator Folstad to discuss the emergency physicians' concerns and the pressure the HMA hospital CEOs were under to use the Pro-MED system.

335. From January to June 2009, MEMA physicians had resisted using the Pro-MED physician EMR, an inferior and slow product, with the hope that HMA would permit the continued use of a paper T-System physician record. These efforts failed and, on June 1, 2009, the Pro-MED physician EMR (which would allow HMA to run QualCheck) was installed at Lake Norman and Davis Regional.

336. Pro-MED stated in the July 2008 Time Studies and Patient Flow Report that the Pro-MED programs, including the physician EMR, would facilitate a shorter length of stay for the ER

patient. In fact, after the slow Pro-MED physician EMR was installed at Lake Norman, the time for the ER patient to see the physician has increased by 40%. At Lake Norman, ED Flash Meetings began in June of 2009, when Greg Lowe took over as hospital CEO. With these Flash Meetings, HMA increased its pressure to meet corporate benchmarks for admissions and testing.

337. For example, on August 17, 2009, Lynne West, HMA Corporate Director of Emergency, wrote an email to ED nurse managers and ED Directors regarding the Dashboard Reports: "Big declines in > 65 admissions – you know what to do! Start reviewing > 65 by MD report and meeting with your medical director to formulate a new game plan."

338. On December 14, 2009, Angela Marchi wrote an e-mail questioning Relator Folstad about the low performance on several ED benchmarks at Lake Norman. The specific benchmarks that she focused on included: a low admit rate; a high QualCheck override rate; and a low attendings called rate for the ED population in general, and in patients over age 65 in particular. She demanded to know Relators Folstad's plan to "reverse these metrics immediately."

339. In addition, HMA hospital executives implemented an action plan at Davis Regional in early 2010 to increase overall attending called statistics: call the attending for 100% of patients over 65, even when HMA knew that admission was not necessary. An April 7, 2010 notation by Davis Regional's CNO, Robin Clark, on the ER Round Report provides: "We continue to struggle with attending called for all patients. It was discussed and agreed to months ago that attendings would be contacted for all 65+ patients. This was done as a courtesy even if patients do not require admission to assist in continuity of care." (Emphasis added). In contrast, HMA's physicians, including Dr. Gish, Lake Norman's Chief of Staff, have made it clear to Relators that they trust ER physicians to call them only when necessary.

340. HMA admits that the purpose of HMA's benchmark for attendings called was not a legitimate concern for continuity of patient care, but solely to increase hospital admissions. On April

15, 2010, the Chief Nursing Officer at Davis, Robin Clark, RN, conducted the ED Flash Meeting with Relator Folstad. Relator Folstad asked Clark for the true purpose of calling the patient's private attending physician.

341. Clark stated that HMA's sole purpose in imposing the "attendings called" benchmark was not intended as a check on the quality of the MEMA ED physicians' care, nor to provide better communication with the medical staff about their patients. Clark admitted that HMA wanted the patient's attendings called to try to persuade the attending physicians to admit more patients into HMA hospitals.

342. In April 2010, Angela Marchi, VP Operations, Division 1, began to send daily emails to MEMA ED Directors questioning the HMA benchmarks in the ER Round Reports. For example, on April 6, 2010, Marchi wrote to Relator Mason "re: volumes and admissions at Lake Norman not being 'metric':" Marchi's questions included: "Were LWOTs called back? Why testing guidelines low? Why not meet benchmark in calling attending with volume that high?"

343. In a later email to MEMA's Dr. Greer, dated April 8, 2010, Marchi (referencing the 100% benchmark for calling attendings for patients over 65), asked: "Dr. Greer, why are > 65's not being called? This is simply not acceptable."

344. HMA's policies and practices to pressure ED physicians and to interfere with the emergency physicians' treatment decisions resulted in thousands of unnecessary in-patient hospital admissions.

16. HMA Established Revenue-Generating Corporate ED Benchmarks for Testing and Admissions without Support that they Promote the Quality of Patient Care

345. Relators have repeatedly requested that HMA provide them with some evidence-based medical support for the ED benchmarks as they relate to quality emergency care, but HMA has never provided any scientific support for its ED benchmarks.

346. The Pro-MED CTM guidelines and HMA's related testing benchmarks, as implemented, do not benefit either the patient or the ED staff. The Pro-MED CTM guidelines generate medically unnecessary tests. In turn, the patient is subjected to unnecessary pain, discomfort, and inconvenience attendant to unneeded diagnostie studies. The ED staff is preoccupied with unnecessary tests that actually contribute to delays in the ER.

347. Upon information and belief, HMA's other admissions' benchmarks are arbitrary and were not implemented based on established standards of medical care. HMA mandates that patients be admitted without regard to medical necessity actually undermines patient care because these patients are unnecessarily exposed to health risks (i.e., infection and other known complications related to a hospital admission).

348. HMA has required since 2003 that physicians in its EDs call patients' attending physicians at least 30% of the time (75% for Medicare patients) and that ED physicians admit at least 16% of new ED patients (and 75% of Medicare patients). However, as recently as September 2009, HMA lacked any evidence-based support for these benchmarks.

349. HMA established an "ED Core" group in early 2009 after emergency physicians raised concerns with the 2008 CTM guidelines. Before he was fired, Relator Mason participated in the HMA Core Group through two conference calls and two meetings, one in September 2009 and another in February 2010.

350. Relator Mason's efforts to effectuate corporate change on testing and admission levels included his work on the ED Core group at HMA. During the September 22, 2009 meeting, Relator Mason repeated earlier requests for evidence-based support for HMA's ED benchmarks for patient admission and attending called.

351. The minutes from HMA's ED Core Meeting on September 22, 2009 included the following agenda items or action points for the next meeting: "[u]ndertake a search of the

literature for background information and evidence-based information concerning admission rates and call to referring physician rates."

352. HMA executives in attendance who agreed in late 2009 to look for evidence-based support for ED performance benchmarks (which HMA had put in place at least 6 years earlier) included Ronald Riner, MD, HMA's CMO and Stanley D. McLemore, HMA's Senior Vice President – Operations.

353. HMA implemented the Pro-MED's CTM guidelines at all HMA hospital EDs. Pro-MED has blatantly touted the revenue-generating benefit of "consistent utilization" of the testing guidelines. Using HMA's Paintsville hospital as an example, Pro-MED has highlighted and also quantified for HMA the revenues that are gained or lost depending on the EDs adherence to HMA benchmarks for Pro-MED's CTM guidelines.

354. Using Paintsville's $300,000 per month, HMA earns approximately $3.6 million annually at each of HMA hospital EDs as a result of HMA mandates for unnecessary minimum tests ordered through CTM alone. Across the HMA network of 55 hospitals, this translates to $198 million annually from unnecessary tests. Only HMA benefits from the unnecessary charges related to CTM guidelines.

355. Other HMA benchmarks also serve to generate significant revenues for HMA, while placing significant demands on ED physicians' time and detracting from patient care. For example, HMA's mandate that ED physicians call attendings in order to increase admissions means that ED physicians spend precious time on the phone unnecessarily, time that could be spent with patients or documenting their charts.

356. Upon information and belief, HMA's mandates for minimum admission rates result in hundreds of millions of dollars in illegal charges each year. This is in addition to illegal charges related to unnecessary tests.

357. For example, from June 1, 2009 to May 3, 2010 MEMA physicians at Davis Regional initiated QualCheck overrides for 286 patients which HMA Pro-MED software selected for admission, 91 were Medicare, and 48 were Medicaid patients. From May 9, 2009 to May 9, 2010, there were 463 patients at Lake Norman for whom MEMA physicians initiated QualCheck overrides, of which 208 were Medicare and 39 were Medicaid. Had MEMA met HMA's minimum admission rates, based on a conservative minimum charge of $5,000 per admission, Davis Regional and Lake Norman would have caused close to $2 million in damages to the Medicare program alone.

17. MEMA Meets Other HMA Benchmarks Not Focused Solely on Maximizing Revenues

358. Pro-MED reports prepared for HMA also include other data related to the time it takes to process the patient through the ED because: "excessive wait times and lengths of stay in the Emergency Department create frustration for patients and families and often have a negative impact on customer satisfaction and perception of quality of care."

359. HMA's corporate benchmarks from 2003 also include measures reflecting the time it takes to process the patient through the ER ("throughput time"), and other information that can impact on patient satisfaction and quality of care, for example: average length of stay (ALOS), and patients who left without treatment (LWOT) or against medical advice (AMA).

360. Relators understand that some HMA benchmarks, including AMA/LWOT and ALOS can impact on the quality of patient care. For example, an ED patient who waits too long may become so frustrated that they leave without treatment (LWOT) or against medical advice (AMA).

361. Since 2003, the HMA benchmark for ALOS is < 2.0 hours. The national average is about 4.5 hours. The HMA benchmark for LWOT/AMA is < 2.0%. The national average is about

4%.

362. Although HMA touts its testing and admissions benchmark as "quality" indicators, the HMA facilities with the highest performance on these standards often had the highest ALOS. For example, the following facilities as of January 2010 met HMA testing mandates, but were poor performances on true quality indicators: Punta Gorda, number 15 on test guidelines, but number 31 on ALOS (2:29); Natchez, number 1 on test guidelines, number 42 on ALOS (2:51), and ranks 51 or 52 in AMA/LWOT at 3.3%; Sebastian, number 2 on test guidelines, but ranks 29 (2:27) on ALOS; Lebanon, ranks number 4 in test guidelines, but number 32 on ALOS (2:30); Gadsden meets HMA's benchmark for testing guidelines (85.8%), but has an ALOS of 3:27 (making it 53/53 for ALOS, and number 35 for AMA/LWOT at 2.1%.

363. While the hospital ERs staffed by MEMA physicians may not meet HMA's testing and admissions benchmarks, the Lake Norman and Davis ERs have performed well in AMA/LWOT and ALOS. For example, as of January 2010, both facilities were well below HMA's benchmark for AMA/LWOT of < 2%. In addition, the ALOS for both facilities was much shorter than many HMA facilities meeting or exceeding HMA's benchmarks for guidelines tests, (i.e., Natchez and Gadsden) and well below the national average of 4.5 hours.

18. HMA's Efforts to Use Pro-MED's Nurse and Physician Documentation to Increase Facilities Charges through Inflated Patient Acuity

364. When a patient is documented as having a higher acuity, a hospital can bill for higher level of care. For Medicare patients, charges related to Emergeney Room APCs (and/or inpatient DRGs) on the facility side are based on the level of care.

365. Pro-MED generates a level of care for each ER patient. The patient record that MEMA receives to conduct its own billing often included the Orders Summary, which includes the level of care ascribed by Pro-MED for the patient's emergency room care at HMA's facilities.

Other aspects of patient care, including tests and procedures also increase the facilities' charges for ER care.

366. HMA placed great pressure on ER nurses to document patient acuity. Patient charts were reviewed each day by an ED nurse for completeness of nurse documentation.

367. During the time that Newsome was at HMA, the nurse that reviewed nurse documentation was usually Joyce McLean, RN. If there were deficiencies on the nursing documentation, Nurse McLean contacted the nurse to make changes as soon as possible.

368. Relators understand that the acuity for the facility side of ER charges is based in part on the emergency department nurses' documentation. Relators understood that nurse staffing was also based upon these acuity records. Interestingly, HMA had, during the Relators' tenure, cut nursing staff (and continues to cut nursing staff) in both Lake Norman and Davis Regional ERs. This is incongruous with HMA's 2008 and 2009 10-Ks which credit increased acuity with higher hospital revenues.

a. **HMA Boasts Increased Acuity Led to Increased Revenues**

369. Upon information and belief, both extended teaching and critical care are elements that impact on patient acuity, and therefore, the level of care billed by HMA to payors for its facilities charges.

370. In its SEC filings for FYE 12/31/2008, HMA stated that net revenues had increased since third quarter 2008 due, in part, to "increased patient acuity." (Newsome arrived at HMA in Q3 2008). Again, for FYE 12/31/2009, HMA stated that "Net revenue per adjusted admission at our same 2008 hospitals increased approximately 2.4% during the 2009 Calendar Year as compared to the 2008 Calendar Year." HMA cited "increased patient acuity" as a contributing factor.

b. **HMA's Benchmark for Nursing Acuity**

371. Several Pro-MED reports prepared for HMA track "Nursing Acuity Weighted

Mean:" HMA Pro-MED Executive Summary; the Forced Rank Report, with a corporate benchmark of 3.43; the ER Round Reports document nursing acuity as a data element reported each morning and discussed in ED Flash Meetings.

372. The Pro-MED program automatically generates the "patient acuity based on level of service provided and documented." As stated above, the Pro-MED Orders Summary (which lists the Pro-MED CTM tests, the time ordered, any procedures or treatments ordered by the emergency physician), also typically included an ED Level of Care ascribed by Pro-MED. Based on Relators' review of the records provided for beneficiaries of Medicare, Medicaid, and other government health programs, ED level of care ascribed by Pro-MED to most of these patients treated at Lake Norman and Davis Regional was at least three. Relators incorporate by reference the summary of patient chart information attached as Exhibit "A."

373. In June of 2009, Lynne West, Director of Emergency Services, created a list of "Pro-MED opportunities for improvement." An item whieh West ascribed the "Highest Level of Priority" was a request to change Pro-MED's 5-point system that drives the acuity level, a system that is different from the ACEP-accredited acuity criteria: "E&M levels; In Blue; Pro-MED attaches acuity points that drives the level. This is an issue... If the nurse over documents the patient will receive an inappropriate higher level."

c. Inflated Acuity through Over-Documenting Nurses' So-Called "Extended Teaching"

374. The Pro-MED Electronic Nursing Documentation (END) "includes prompts to assure thorough documentation for all areas of assessment and of APC procedures, optimizing billing opportunities." For most patients at Davis Regional and Lake Norman, the Discharge section of the Pro-MED Nurse Documentation report mentions "extended teaching" by the emergency nurses.

375. Relators believe that the documentation of "extended teaching" may be a shortcut or macro entered into the Pro-MED program, possibly related to a Pro-MED prompt, because the term "extended teaching" is misspelled "extending" teaching in the Pro-MED Nurse Documentation report for every Davis Regional and Lake Norman patient record where it appears. For example, 24 of the 28 Medicare, Medicaid, and/or CHAMPUS patients listed in Exhibit "A" to this Complaint have "extended teaching" documented in their charts, either as "extending teaching' in the discharge section of the nurses' record or as "extended teaching" in the points table attached to the Pro-MED Nurse Documentation.

376. Many Lake Norman patient charts have a table of "points" for various tasks included in the Nurse Documentation. Upon information and belief, the points chart is used by Pro-MED to determine the patient acuity, which is automatically generated by the Pro-MED program. In the Nurse Documentation reports for both Lake Norman and Davis Regional patients, the "extended teaching" usually consists of providing routine discharge instructions, which should not add to the patient acuity.

377. Extended teaching, when included in the chart, is always associated with 10 points. Other tasks are assigned far fewer points by Pro-MED for nursing care than extended teaching: neurological or cardiovascular assessment (each 3 points); NG tube insertion (5 points).

378. Upon information and belief, the documentation of "extended teaching" for the majority of HMA patients is another means devised by HMA to fraudulently increase the facilities side charges for ER care.

d. Pro-MED Prompts Physicians to Document for "Critical Care"

379. In the Physician EMR, the Pro-MED software has a prompt for acuity level (critical care) which is similar to the QualCheck prompt, a box that appears instructing the physician to admit the patient. Once the emergency physician selects admission as the disposition, for patients

meeting HMA's corporate criteria, a second box then appears instructing the emergency physician to document Critical Care. Many of the cases where HMA's Pro-MED system recommends Critical Care documentation are as exaggerated and egregious as the recommendations for admissions.

380. Like the admission prompt, this critical care prompt was an invitation by HMA to physicians willing to conspire in the effort to overbill for medical care. Relators believe that EmCare and other emergency physicians would likely have provided HMA with unfounded physician documentation for critical care.

e. Overbilling and Reusing MDIs

381. MEMA physicians at Lake Norman became aware in the summer of 2009 of an HMA policy directing the reuse and multiple billings for each metered dose inhaler ("MDI"). Instead of dispensing the MDI to the patient to take home, the canister was wiped off, a new spacer was added, and the MDI was reused for the next patient. An MDI costs approximately $40 at the local pharmacy and contains 200 metered doses. HMA charged $66.00 per dose, and could bill as much as $13,200 for each $40.00 MDI.

19. Pro-MED Actively Advanced HMA's Efforts to Generate Revenue from Unnecessary Tests and Admissions

382. Since 2003, Pro-MED has implemented at HMA facilities the programs necessary for HMA to gather data on ED tests and admissions, to organize that data, and to facilitate HMA's tight corporate control over medical decisions made by ED physicians.

383. Pro-MED implemented ED software at HMA facilities, including the nurse's EMR and the physician's EMR, as well as the Pro-MED CTM guidelines. All of these programs enable HMA executives to collect ER patient data, to generate unnecessary diagnostic tests using Complaint Test Mapping, and to police ED physicians' decisions to recommend admission to HMA

facilities.

384. In 2006, Pro-MED recommended to HMA a program called "QualCheck," which HMA used to interject minimal corporate admission standards in an attempt to exert greater influence over the ED physicians' medical judgment and to increase unnecessary admissions.

385. In a June 8, 2007 Pro-MED Performance Review Letter, analyzing the ED at Davis Regional, Pro-MED recognized that the Pro-MED CTM guidelines are a means to exert corporate control over emergency physicians' decisions to order tests when it recommended that HMA "review and revise testing guidelines to ensure they meet corporation . . . expectations." In 2008, Pro-MED was instrumental in developing HMA's revised and more outrageous CTM guidelines.

386. On July 28, 2008 Pro-MED issued a Time Studies and Patient Flow Assessment Report. This study, prepared by Pro-MED's COO, Len Strickland, RN and Paul Lindeman, MD, resulted from a recent "meeting with corporate management," and was allegedly conducted after low results on patient/family satisfaction surveys in many HMA ERs which were attributed, in part, to excessive wait times and length of stays."

387. The Pro-MED authors of the Time Study report of July 2008 specifically refer to Complaint Test Mapping as a means to maximize revenue per patient. Using HMA's Paintsville, Kentucky facility as an example, Pro-MED actually quantified for HMA's corporate management the substantial revenues generated by adherence to the Pro-MED CTM guidelines.

388. In this same July 2008 Time Study Patient Flow report, Pro-MED also made the following recommendations for implementing HMA's corporate benchmarks: triage nurses should order the Pro-MED Complaint Test Mapping guidelines tests immediately after triage; HMA's emergency room triage nurses should order guidelines tests 70% of the time within 10 minutes of triage. (The existing HMA benchmark was 67%); HMA should "review and modify practice (testing) guidelines so that number of tests in HMA hospitals is consistent with the standards);"

HMA should "maintain established benchmark (greater than 80% for using practice guidelines overall) to ensure a consistent high quality of care and optimize revenue potential for ancillary services."

389. Following the recommendations of the Pro-MED report of July 2008, HMA both issued revised Complaint Test Mapping (practice guidelines) and demanded that all HMA hospital EDs implement them.

A. HMA Offers Kickbacks (Lucrative Contracts and Cash) to Induce ER Physicians, to Refer or Recommend Patients for Unnecessary In-Patient and Out-Patient Treatment (Diagnostic Tests and Admissions)

390. HMA provides kickbacks to emergency medicine practices who were complying with their benchmarks for unnecessary tests and unnecessary admissions by renewing or awarding them lucrative emergency room professional services contracts. HMA discharges ER physicians who do not meet HMA's performance standards for unnecessary tests and admissions.

391. For example, from at least 2008 until mid-2010, HMA repeatedly threatened MEMA with contract termination for failure to participate in its fraud. Particularly, HMA communicated orally through Division executives and hospital CEOs that if MEMA did not meet HMA's testing and admission benchmarks, HMA would fire MEMA and replace it with a physician group that would.

392. On October 27, 2009, during a meeting at CEO Greg Lowe's office at Lake Norman, Angela Marchi told Relator Folstad that Pro-MED software and testing guidelines were "here to stay," that HMA was not going to change these procedures, and that MEMA must "work with us or you are gone." Marchi added that Relator Folstad needed "to get Dr. Mason under control." At the time Relator Mason was the most vocal critic of HMA's illegal testing and admissions' practices. Relators understood this to mean that if MEMA did not follow the Pro-MED CTM guidelines, implement the Pro-MED physician EMR needed to run QualCheck, and

meet HMA's other ED benchmarks, they would be terminated.

393. Upon information and belief, Defendant EmCare's emergency room physicians have been meeting HMA's benchmarks for Complaint Test Mapping and/or admissions. These include, but are not limited to, EmCare physicians who staff the following HMA facilities: Charlotte Regional in Punta Gorda, Florida; Lehigh Regional, Lehigh Acres, Florida; Pasco Regional Medical Center, Dade City, Florida; Spring Hill Regional, Spring Hill, Florida; Natchez Community Hospital, Natchez, Mississippi.

394. EmCare physicians also benefit from meeting HMA's ED benchmarks. The unnecessary tests and physician consults, also raise the level of service, whether or not the patient is admitted.

HMA ATTEMPTS TO INDUCE MEMA WITH CASH TO MEET CORPORATE BENCHMARKS

395. MEMA resisted HMA's efforts to employ fraudulent emergency room practices at Lake Norman and Davis Regional. HMA offered MEMA physicians at both facilities cash "awards" to meet its corporate benchmarks. MEMA refused HMA's offers of illegal cash inducements as illegal kickbacks to meet testing and admissions benchmarks.

396. On approximately July 16, 2006, Karen Metz, the then Davis CEO, offered cash incentives to meet HMA's testing and admissions ED benchmarks to Relator Folstad. At the time, he was the ED Medical Director at Davis. In a proposed amendment to the MEMA contract, HMA offered "bonuses" or "awards" of $3,000 per quarter to each emergency physician who met CTM guidelines and attendings called benchmarks.

397. Relator Folstad refused to participate in HMA's incentives aimed at increasing ER tests ordered or patients admitted though the ER because he knew these offers to be illegal. When Relator Folstad told Karen Metz that MEMA could participate only in the incentives related to

quality patient care (LOS and physician exam times), Metz rejected Folstad's suggestion.

398. Greg Lowe became HMA's CEO at Lake Norman in early June, 2009. Shortly thereafter, he offered similar incentives to MEMA. Particularly, on or about June 22, 2009, Lowe sent an email to Relator Mason which stated: "I've attached a proposal similar to one I had in place at my last hospital related to some of the **quality indicators** tracked by Pro-MED. We should discuss what our goals would be set at given historical performance. Let me know your availability."

399. Lowe attached a document to his June 22, 2009 email, which detailed proposed cash payments for participation in HMA's fraud. In practice, HMA offered each MEMA physician $2,000 per quarter for each of six HMA corporate benchmark met, including the following three benchmarks related to patient admissions and tests ordered:

- Physician test guideline adherence: > 80% (complaint test mapping);
- Attending called: > 30%;
- Quality review criteria met: fewer than 35% cases not admitted when picked up by Pro-MED as eligible for admission;

Given the number of MEMA staff members at Lake Norman, these kickbacks offered by CEO Lowe could total $250,000 per year.

400. Like Relator Folstad, Relator Mason refused HMA's offer of incentives related to ER tests and/or admission. Relator Mason also told Lowe that MEMA physicians did not need bribes to strive for excellence in the metrics related to quality patient care. Mason told Lowe that he considered the offer a bribe and that it was "fraud and abuse." In response to Mason's statement, Lowe became very angry, insulted Dr. Mason, denied that they were kickbacks, and said," Everyone does this kinda thing." Lowe added that he had "done it before."

B. **Defendant HMA has Failed to Meet Medicare Conditions of Participation**

401. In order for services at any Defendant HMA's facilities, including Defendant Lake Norman and/or Davis Regional, to qualify for coverage under any federal health care program, it must meet all Medicare conditions of participation (Medicare COPs), including compliance with the federal Anti-Kickback Statute ("AKS").

402. Defendants failed to meet these Medicare COPs because, as alleged herein, Defendants violated the federal Anti-Kickback Statute.

403. In order for Defendant HMA's services to qualify for coverage under state health care programs offered in North Carolina, Florida, Georgia, Oklahoma, Tennessee, and Texas, or other state health programs, including Medicaid, HMA must meet all Medicaid conditions of participation (Medicaid COPs), including compliance with the federal Anti-Kickback Statute.

404. Defendants failed to meet these Medicaid COPs because, as alleged herein, Defendants violated the federal Anti-Kickback Statute and applicable state Anti-Kickback Statutes.

405. Defendants employed unlawful schemes to have ED physicians refer or recommend that patients receive diagnostic testing or other services at Defendant HMA's hospital ER, and/or receive in-patient care at HMA hospitals by paying or offering to pay "kickbacks" to ED physicians and/or physician groups. These schemes and relationships with referring physicians violate the federal Anti-Kiekback Statute and state anti-kickback laws.

406. Compliance with the federal AKS is a condition of payment under Medicare and other Federal health care programs. The federal Anti-Kickback Statute specifically provides that a violation also constitutes a violation of the federal False Claims Act.

407. Defendants have violated and continue to violate the federal FCA by committing

acts to further the submission of claims to federal and/or state health care programs for services related to patient referrals which are tainted by Defendant HMA's federal and state Anti-Kickback Statute violations.

C. Defendant HMA Terminated Relator Folstad, Mason and MEMA's Professional Services Contracts at Lake Norman and Davis Regional in Violation of the Anti-Retaliation Provisions of the Federal False Claims Act, 31 U.S.C. § 3730(h) as well as the North Carolina False Claims Act, §1-613

408. Defendant HMA has violated the anti-retaliation provisions of the federal False Claims Act, 31 U.S.C. § 3730(h) and the North Carolina False Claims Act, G.S. §1-613, by terminating the Relators' contracts for engaging in protected conduct as described herein.

409. Relators MEMA, Mason, Folstad, as well as other emergency physicians employed by or through MEMA who worked at HMA facilities, repeatedly complained to HMA corporate officers and executives, both orally and in writing, about HMA's above-described fraudulent schemes. These complaints were made at every level of HMA's corporate structure, beginning with the hospital CEOs and reaching to HMA CEO Newsome, and Bill Schoen, Chairman of the Board of Directors at HMA.

410. Relators repeatedly warned HMA that ordering unnecessary tests and admitting patients unnecessarily created potential exposure for billing government payors for unnecessary diagnostic tests and admissions.

411. Rather than make difficult and costly changes that would have brought HMA into compliance with Medicare and Medicaid rules and regulations, HMA attempted to silence MEMA and the other Relators. Finally, HMA terminated MEMA's valuable professional services contracts at HMA's Lake Norman and Davis Regional facilities.

1. HMA's Retaliation of the Relators

412. The chronology of events sets forth a compelling account of Defendant HMA's

concerted efforts to exert pressure on the Relators and to coerce them to cooperate in Defendant's fraud.

a. Relators' Exposure of HMA's Early "Quality Reviews" to Push Testing and Admissions

413. Since the early years of MEMA's contract at Lake Norman (1996), HMA has conducted "quality reviews" of patient charts in thinly-veiled attempts to increase HMA revenues through unnecessary tests and patient admissions. These reviews had little to do with evidence-based medicine or the quality of patient care.

414. Soon after MEMA emergency physicians arrived at Lake Norman, HMA sent a consultant, Dr. "Hump" Wood, to perform "quality" chart reviews. Dr. Wood conducted similar "quality" reviews at all HMA EDs. HMA, through Dr. Wood, suggested to MEMA that their emergency physicians should have ordered additional testing, called the patients' private attendings, or recommended patients for admission (at times for ridiculously low-risk patients).

415. Relator Mason reported to P. Paul Smith, HMA's then CEO at Lake Norman, that HMA's "quality reviews" were badly-disguised efforts to generate charges for HMA through unnecessary hospital services. Smith agreed with Dr. Mason. After a couple of years, Dr. Wood's "quality reviews" of MEMA patients at Lake Norman ceased. Defendant HMA has more recently retained additional "quality review" consultants to scrutinize MEMA physicians' ER patient charts. HMA's quality review consultants have each concluded that there were no areas for improvement and that MEMA's work is of the highest quality.

416. For example, in January 2009, HMA retained Lisa Nummi, RN/ CNP to review MEMA patient charts from Lake Norman and Davis Regional. After reviewing 100 charts from each facility, Nummi reported that MEMA physicians at both facilities had provided high quality emergency care and had not discharged any patients that should have been admitted.

417. In December of 2009, in an effort to find some pretense for criticism, HMA retained EmCare physician Michael Wheelis, MD, to conduct a "quality review" of MEMA charts. After reviewing MEMA's charts for Quality Review and QualCheck patients discharged over a four-month period, Dr. Wheelis also found neither deficiencies nor need for improvement.

418. HMA's "quality reviews" show that MEMA physicians rendered appropriate emergency care even though they have largely resisted HMA's pressures to order excessive tests and to admit patients to Lake Norman and Davis Regional unnecessarily.

b. Relators' Refusal to Cooperate with HMA's CTM Guidelines and Admissions Fraud

419. HMA attempted to induce Relators with illegal cash inducements to meet corporate mandates to order unnecessary tests and to recommend that patients be admitted to the hospital unnecessarily. When the Relators refused, HMA intensified its efforts to harass the Relators.

420. Throughout 2009 and into 2010, HMA was unable to persuade or compel MEMA physicians to cooperate with its fraudulent corporate mandates. HMA attempted to silence the Relators, and eventually terminated the Relators' contracts, which were worth approximately $6 million annually, so that Defendant HMA could continue the fraudulent practices which MEMA had uncovered and reported.

421. MEMA's reports to HMA began during the years of "Hump Wood" reviews (approximately 1996 through 1998), when Relator Mason reported to the CEO at Lake Norman, P. Paul Smith, that HMA's "quality reviews" were thinly veiled attempts to generate illegal charges for HMA from unnecessary hospital services. HMA's executive, P. Paul Smith, agreed with Relator Mason.

422. In more recent years, Relators also reported to other HMA executives that HMA's

corporate benchmarks for ordering tests and minimum ER admissions were part of HMA's efforts to gain illegal revenues through unnecessary services. Relators repeatedly reported to HMA that these practices interfered with the ED physicians' independent medical judgment regarding the best treatment for the patient and exposed all to regulatory scrutiny.

423. From the inception of their contracts with HMA, Relators have taken proactive steps to eliminate the effects of HMA's fraudulent schemes at Lake Norman and Davis Regional. HMA punished the Relators for their efforts to comply with state and federal health care program requirements.

424. Since mid-2008, the Relators were told, in not so subtle terms, that their ability to retain their lucrative contracts with HMA depended on their willingness to meet HMA's corporate mandates on diagnostic tests ordered and admissions recommended for ER patients.

425. On December 22, 2008, MEMA's outside compliance counsel wrote a letter to HMA's CMO, Ronald Riner, MD. MEMA's counsel related MEMA's concerns with Pro-MED Complaint Test Mapping and Pro-MED QualCheck, adding that the "physicians questions are legitimate in the current context of overuse in Medicare."

426. In late 2008, Relator Mason also raised concerns with Lynne West, RN, Corporate Director of Emergency Services, that Pro-MED Complaint Test Mapping involved fraud and abuse that put all parties involved at risk.

427. From late 2008, HMA mandated that Relators implement the Pro-MED Physician EMR and 2008 CTM guidelines at Lake Norman and Davis Regional. The Pro-MED EMR was necessary to facilitate HMA's use of Pro-MED's QualCheck software, which HMA used to increase unnecessary admission to its hospitals.

428. After HMA mandated that all EDs use the 2008 CTM guidelines, Relators continued their efforts to minimize the local effects of HMA's testing benchmarks by continuing

to manually cancel unnecessary tests. At the same time, Relator Mason continued his efforts to work with HMA to have the CTM guidelines formally and drastically reduced to bring the number of excessive tests generated to more acceptable levels.

429. In late 2008, Karen Metz, CEO of Davis Regional, contacted Mason and arranged for him to go to HMA corporate headquarters in Naples to work with a group of "concerned" emergency physicians to review the revised CTM guidelines.

c. **Early 2009 – Additional Acts of Retaliation by HMA**

430. In early January, 2009, Relator Mason met with Lake Norman CEO, Mike Cowling and reported that HMA's 2008 CTM guidelines were clearly abusive and interfered with the ED physicians' independent medical judgment. Relator Mason told Cowling that MEMA will not use them. Cowling agreed with Relator Mason that the new CTM guidelines were excessive and meant to generate revenue, not improve quality.

431. CEO Cowling told Relator Mason that his corporate superiors at HMA told Cowling that if MEMA would not use CTM guidelines, Cowling needed to fire MEMA and find a group that would. Cowling added that HMA could "have his job," but Cowling would not tell Mason's group how to practice medicine. (Cowling would resign shortly thereafter, on February 11, 2009.)

432. After the January 4, 2009 meeting, Cowling communicated Relator Mason's fraud and abuse concerns about the 2008 CTM guidelines to HMA corporate, including Vickie Briggs and Britt Reynolds.

433. On January 8, 2009, Relator Mason received a memo from HMA's CMO, Dr. Riner, inviting Mason to a meeting at HMA's Naples, Florida corporate offices to discuss Pro-MED Complaint Test Mapping.

434. On that same date, Lake Norman CEO, Mike Cowling, told Relator Mason that

the HMA executives directed Cowling to implement the 2008 CTM guidelines' program and that there would be "no negotiation."

435. Meanwhile, MEMA physicians at Lake Norman and Davis Regional continued their efforts to reduce the number of unnecessary tests ordered by reviewing ordered tests, making sure the ED physician had the tests needed, then cancelling the tests they concluded were not medically necessary. In an effort to help Dr. Mason defend their decisions to cancel Pro-MED tests when challenged by HMA, Relator Mason asked his physicians at Lake Norman to document their reasons for cancelling tests. Dr. Folstad and the other MEMA physicians at Davis Regional also documented their reasons for cancelling tests.

436. Approximately one to two weeks before the February 3, 2009 meeting in Naples, Florida, Relator Mason discussed the CTM guidelines over the telephone with HMA CMO Riner. Mason reported that the 2008 CTM guidelines constituted fraud and abuse. Dr. Riner responded that he would leave HMA if the CTM guidelines were not revised.

437. On January 23, 2009, Relator Mason met with Lisa Nummi, RN, CNP, a quality consultant for HMA. He reported to Nummi MEMA's concerns that the Pro-MED CTM software was employed to perpetrate fraud and that "unnecessary tests were being ordered for revenue generation." Ms. Nummi agreed. In an email dated January 26, 2009, Ms. Nummi stated that she reported MEMA's concerns about fraud and abuse to Dr. Riner, HMA's CMO.

438. On January 27, 2009, Relators Mason and Folstad attended a meeting at Davis Regional between Lake Norman and Davis Regional administrators (CEO Cowling from Lake Norman and Karen Metz from Davis Regional) and ED medical directors to discuss "concerns and the pressure the HMA hospital CEOs were under to use the [Pro-MED] system."

439. In June of 2009, MEMA rejected HMA's second offer of incentives to induce compliance with HMA ED testing and admissions benchmarks.

d. Relators MEMA and Mason Notify HMA CEO Newsome that HMA's ER Practices Involve Fraud and Abuse

440. Thereafter, on August 18, 2009, Relator Mason wrote an email to HMA CEO Newsome and reported that HMA's 2008 CTM guidelines require that ER physicians order an egregiously excessive volume of tests and amounted to fraud and abuse, that would put all involved "at risk under any regulatory review."

441. Relator Mason also explained that the Pro-MED physician EMR program causes excessive delays in moving patients through the ER, which negatively impacts patient care. Relator Mason enclosed letters from his partners, who echoed Mason's concerns, as well as their own concerns that the implementation of HMA's benchmarks interfere with the ED physicians' independent judgment regarding the best care for the patient.

442. On August 25, 2009, Relators Mason and Folstad, with Dr. Greer, MEMA Medical Director at Davis, met with Greg Lowe, CEO at Lake Norman, HMA Division 1 President, Britt Reynolds, and Division 1 Vice President Angie Marchi. When the attendees took their seats, the first words Britt Reynolds uttered were: "If this meeting is anything about Medicare compliance and fraud and abuse, this meeting is over, and we will need to bring our attorneys." It is clear that MEMA expressed grave concerns that HMA's program would create fraudulent claims.

443. At the same time, Reynolds also stated "You [MEMA] are our best ER group in the entire corporation and in our highest revenue-generating hospital, and we are not going to blow up this hospital by getting rid of you. We do not want EmCare in here." Reynolds also told MEMA that HMA was going to correct the problems with the Pro-MED Physician EMR and provide the emergency physicians with a patient medical record that works. Reynolds stated that Angie Marchi and Relator Mason would be sent to Florida to work on revising the Pro-MED

Physician EMR. Two months later, MEMA was told that they must implement the Pro-MED Physician EMR "as is" or be terminated.

e. HMA Terminates MEMA for Not Meeting HMA Corporate Benchmarks for Testing and Admissions and Replaces them with Physicians Groups who will Cooperate with HMA's Testing and Admissions Goals

444. After Relators refused HMA's offer of illegal incentives, HMA continued to threaten Relators with contract termination. For example, HMA communicated through hospital CEO Lowe that if Relators did not meet HMA ED benchmarks, HMA would fire them and replace them with physicians that would.

445. HMA also repeatedly put Relators' emergency medical care under close scrutiny and applied additional pressure on MEMA through a pretextual "Quality Review." From late December 2009 until February 2010, HMA subjected MEMA to quality review by Defendant EmCare's Dr. Wheelis. Relators believe that HMA used the EmCare review as a means to harass them for not cooperating with HMA's efforts to generate revenues through unnecessary tests and hospital admissions, as well as to attempt to find grounds to terminate MEMA for cause.

446. Dr. Wheelis specifically requested from MEMA all QualCheck overrides and Discharge Quality Review reports for four months for both Lake Norman and Davis Regional EDs. Quality Review and QualCheck patients are those "recommended" for admission through Pro-MED software employed by HMA. After reviewing MEMA's "Quality Review" and "QualCheck" charts for patients discharged over a four-month period, Dr. Wheelis found neither deficiencies nor need for improvement. In fact, Dr. Wheelis gave MEMA high praise for both quality of care and charting -- the two core services MEMA agreed to provide under its professional services

agreements with HMA.

447. Dr. Wheelis told Relators Mason and Folstad, and a group of other MEMA physicians from Lake Norman and Davis Regional, in the presence of HMA's then-CEO at Lake Norman, Greg Lowe, that MEMA ED physicians provided excellent care. Dr. Wheelis added: "If I wreck going back to Charlotte tonight, I hope that one of your doctors takes care of me."

448. HMA's quality consultants, including EmCare's Dr. Wheelis, found that MEMA's emergency care was of the highest quality and that there was no need for improvement. HMA's quality reviews show that MEMA's refusal to order unnecessary tests or to recommend unnecessary admission did not negatively impact the quality of the emergency care MEMA rendered to its ED patients.

449. In January 2010, Relator Mason refused to recommend that the Lake Norman MEC approve the 2009 Pro-MED CTM guidelines. He was silent, rather than vote against approval, in order to avoid inciting the wrath of Lake Norman CEO, Greg Lowe. Lowe was angry that MEMA did not "fall in line" and approve HMA's Pro-MED CTM guidelines.

450. In the winter and spring of 2010, Relator Mason repeatedly reported to HMA's CEO at Lake Norman that the HMA reviews of ER data were attempts to have ER physicians order tests and admit patients unnecessarily. In response, Lowe frequently threatened to cancel MEMA's contract and get a group that would comply with HMA's ER agenda.

451. On May 3, 2010, HMA's hospital executives at Lake Norman provided notice, both orally and in writing, to MEMA's President, Relator Folstad that HMA was terminating the Lake Norman contract with Relator MEMA effective November 3, 2010. HMA later revised this notice to reflect a termination date of October 29, 2010.

452. On that same date, HMA's hospital executives at Davis provided similar notice to MEMA's President, Relator Folstad, that it was terminating the Davis Regional contract with

Relator MEMA effective August 31, 2010. HMA terminated Relators' contracts "without cause" and as a direct result of Relators' and MEMA's doctors' refusal to participate in HMA's blatant fraud.

453. HMA's May 3, 2010 notice of termination to Relators stated that it was terminating the Lake Norman and Davis Regional professional services contracts without cause based on "philosophical differences." In fact, HMA lacked cause to terminate Relators because the services Relators contracted to provide - emergency medicine and creating a record of that care - were of the highest quality.

454. Upon information and belief, HMA contacted Defendant EmCare on or before May 3, 2010 and awarded it the professional services contract to staff the ER at Lake Norman. EmCare was awarded the lucrative Lake Norman contract, at least in part, because EmCare physicians are viewed as a group that will cooperate with HMA's benchmarks for ordering CTM guidelines tests and admissions.

455. On July 28, 2010, Todd Dixon, Lake Norman Chief Operating Officer, attended the staff meetings for the Lake Norman Imaging Department. Dixon "reviewed some of the things the [hospital] administration is doing to improve the hospital's business." Mr. Dixon discussed new emergency physicians and hospitalists groups who would be starting at Lake Norman on November 3, 2010 (the termination date on the MEMA contract).

456. HMA's hospital COO stated that the emergency physicians and internists have been "carefully selected," they come from the same company, and they "come to the hospital with new thought processes and a willingness to work as a team." Mr. Dixon stated that HMA anticipates "an immediate increase in volume because of these changes" in emergency physicians and hospitalists groups.

457. EmCare's physicians, who replaced Relators at HMA's Lake Norman, order tests

to meet HMA's CTM guidelines benchmarks, and they recommend admissions to HMA where other EmCare hospitalists will also benefit from professional fees for treating patients once admitted.

458. The contract with HMA's Lake Norman generated revenues for MEMA of approximately $270,000 per month. MEMA earned approximately $200,000 per month through their contract with HMA's Davis Regional. Combined, MEMA earned approximately $6 million annually from their HMA contracts. Relators would have continued to earn these fees had HMA not terminated them for engaging in protected conduct. In addition, MEMA will incur $2.3 million in annual increased staffing costs as a result of HMA's illegal termination of the Lake Norman and Davis contracts.

HMA SLANDERS RELATORS MEMA, MASON AND FOLSTAD

459. The Relators' reputations in the community and good names and professional standing have been tainted in their medical community as other professionals speculate as to the reasons for their abrupt termination. In some cases, HMA has slandered Relators' in the medical community.

460. For example, within days of the May 3, 2010 termination notices issued by HMA's Davis Regional and Lake Norman, two members of the Lake Norman Board of Directors, Dr. David Hillsgrove and Dr. Herb Wettreich, approached Dr. Mason. They told him that Greg Lowe had told the Lake Norman Board of Directors that MEMA was terminated because it was not committed to HMA's quality program and MEMA was not committed to improving their patient satisfaction scores.

461. The week after the terminations, Drs. Folstad and Mason met with Lake Norman Board Chairman Randy Marion, who confirmed what Drs. Hillsgrove and Wettreich had told Dr. Mason: that Greg Lowe had told the Lake Norman Board of Directors that MEMA was fired

because they refused to use HMA's quality system.

462. Defendants HMA and/or Lake Norman told numerous other physicians in their community that MEMA was terminated because of its failure to commit to HMA's quality program and their patient satisfaction scores, despite 14 years of never having their quality questioned and patient satisfaction scores that had previously been at the top of their division.

463. On August 26, 2010, Relator Mason sent an email to HMA's CEO at Lake Norman, Greg Lowe, regarding the pending transition at Lake Norman from MEMA emergency physicians. In the email, Relator Mason notified HMA's hospital CEO that MEMA had "heard both by rumor and direct conversation with others that you and your staff have made some disparaging remarks about MEMA regarding our quality and patient satisfaction." Relators received no response whatsoever from Lake Norman or HMA to the Relators' statement that disparaging statements had been made by HMA's employees.

464. On November 3, 2010, Relators again wrote to HMA's hospital CEO at Lake Norman regarding the slanderous remarks about MEMA's discharge that continued to be made, even after the August 26, 2010 letter:

> We have been hearing an increasing number of rumors about why we were discharged. At first, we tried to ignore them, but they have continued. In an effort to avoid unnecessary rumors or anything that may hurt MEMA or our physicians' chances of replacing our HMA contracts, we request that no further inaccurate rumors be circulated, directly or indirectly, throughout the medical community.
>
> As you know, we feel very strongly that we were terminated because we failed to follow the practices and procedures that were imposed on us to order unnecessary tests for patients that we treated and to admit patients when we found no medical necessity to do so.
>
> We understand that HMA has decided to go another way and to employ physicians who will be more compliant with your corporate practices. As of today you are free to do whatever you

> like in your emergency rooms. Our concern is simple. We do not want our good names or our good reputations, which we covet, in any way besmirched by rumor mills, innuendo, inferences, or other factors that we find inappropriate and, frankly, distasteful.

Again, neither HMA nor its hospital CEO responded to the Relators' letter.

465. HMA terminated MEMA's contracts without cause and as a direct result of MEMA's repeated refusal to participate in HMA's fraud and abuse practices.

466. HMA's incentive to terminate MEMA's contract is clearly revealed in the report by its consultant, Pro-MED: each HMA hospital where MEMA refused to implement HMA's standard Complaint Test Mapping (practice guidelines) was losing, at a minimum, $300,000 per month.

467. Since at least 2008, Relators repeatedly told HMA that HMA's mandates for ordering unnecessary tests and recommending unnecessary admissions interfere with the ED physicians' independent medical judgment regarding necessary care to meet their patients' best interests.

468. Throughout the second half of 2008, all of 2009 and the first four months of 2010, HMA repeatedly threatened MEMA that if its physicians would not comply with HMA's corporate mandates for tests ordered and patients admitted to the hospital, it would fire MEMA and replace them with another emergency physician group that would do what HMA wished.

469. By May 3, 2010, HMA had already contracted with EmCare to replace MEMA ED physicians at Lake Norman, and HMA had already contacted another group to take over the ED at Davis Regional.

2. HMA's Termination of MEMA Violates the Anti-Retaliation Provisions of the Federal False Claims Act as well as the North Carolina False Claims Act

470. The facts set forth above meet the elements required to establish a prima facie case of retaliation pursuant to 31 U.S.C. § 3730(h). The facts set forth above also establish a

prima facie case of retaliation under Section 1-613 of the North Carolina False Claims Act. Both of these statutes extend anti-retaliation protections to contractors and agents, as well as employees.

471. Relators repeatedly used words to Defendants HMA, Lake Norman and Davis Regional which were sufficient to put any Defendant on notice that Relators were involved in protected activities.

472. Relators continually protested HMA's illegal conduct over a period of many months, both orally and in writing. Relators objected to HMA practices requiring ED physicians at HMA hospitals to order unnecessary tests and to admit patients unnecessarily, as well as HMA's interference with the ED physicians' independent medical judgment regarding the most appropriate treatment and care for ED patients and that HMA's practices constituted fraud. MEMA also told HMA that its incentives to meet HMA "quality" benchmarks constitute illegal inducements for ED physicians to order tests and to admit patients at HMA facilities. While HMA repeatedly tried to silence Relators, particularly Relator Mason, Relators received confirmation from a number of HMA hospital and corporate executives that their fraud concerns were legitimate.

473. Relators provided written notice to Defendants HMA, Lake Norman, and Davis Regional that they were involved in protected activities. These included, but were not limited to, Relators' December 2008 letter to HMA's CMO, Dr. Ron Riner, as well as letters to HMA's CEO, Newsome, in August of 2009. HMA executives acknowledged that they had received such notice including on August 25, 2009, when HMA's Division I President, who reports directly to CEO Newsome, stated to Relators Folstad and Mason that, if Relators were going to discuss "fraud and abuse, the meeting is over."

474. Despite HMA's admitted knowledge of its fraudulent practices, no one at HMA

would make necessary corporate changes to its policies and procedures regarding tests ordered in the ER and patients admitted through the ER. Consequently, because Relators refused both to ignore HMA's fraud and illegal schemes, and to participate in them with HMA, they were harassed and then their contracts were terminated.

475. Defendant HMA violated the anti-retaliation provisions of both the federal False Claims Act, 31 U.S.C. § 3730(h), and the North Carolina False Claim Act, § 1-613, when it terminated MEMA's professional services contracts for engaging in protected activity.

476. Pursuant to 31 U.S.C. § 3730(h) and North Carolina G.S. § 1-613, Relators are entitled to "all relief necessary to be made whole," including "reinstatement with the same seniority status that the employee, contractor or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination including litigation costs and reasonable attorneys' fees."

D. EmCare's Conspiracy with Defendant HMA

477. As detailed above, EmCare physicians have conspired with HMA to cause HMA to submit illegal claims for unnecessary tests and admissions. EmCare's conduct includes its complicity to create and implement HMA's CTM guidelines, as well as its physicians' willingness to meet HMA's testing and admission benchmarks.

478. For example, EmCare physicians helped HMA to create the CTM guidelines.

479. In addition, when HMA emergency physicians and ED directors voiced grave concerns about the excessive nature of the 2008 CTM guidelines, EmCare's executive, Terry Meadows, MD, instructed emergency physicians at HMA hospitals to use the excessive CTM guidelines. HMA's CMO, Dr. Riner, relayed these instructions to the emergency physicians in his November 2008 memo, and directed ED physicians at HMA hospitals to comply with Dr.

Meadows' instructions.

480. When the CTM Task Force met to revise the 2008 CTM guidelines, Defendant EmCare's physicians were silent observers rather than active participants in bringing the CTM guidelines closer to acceptable levels.

481. Further, Defendant EmCare has conspired with HMA by ordering unnecessary CTM guidelines tests and by meeting HMA's testing and admissions benchmarks at facilities staffed by EmCare Physicians.

482. HMA has paid, and EmCare has accepted, kickbacks to Defendant EmCare, at least in part, to induce EmCare physicians to recommend or refer patients to HMA facilities for services which are paid by federal and state health care programs. These kickbacks include EmCare's retention of existing lucrative HMA contracts, as well as HMA's awarding new ER contracts to EmCare. For example, HMA has awarded the Lake Norman ER and hospitalists contracts to Defendant EmCare as a financial inducement to EmCare to refer patients for hospital services, including ER testing and admissions.

483. It is clear from the statements made by HMA's hospital COO Todd Dixon during July 2010 staff meetings for the Lake Norman Imaging Department, that Defendant EmCare has conspired with HMA. Dixon stated that HMA expects that the EmCare physicians (both emergency physicians and the internists with admitting privileges) had been "carefully selected" by HMA based on their willingness to cooperate with HMA. Dixon added that, in July of 2010, before the EmCare physicians saw a single patient at Lake Norman, HMA anticipated "an immediate increase in volume" after the EmCare physicians arrival at Lake Norman ER. (Emphasis added). Upon information and belief, HMA has placed EmCare emergency physicians at other HMA facilities based upon their willingness to cooperate with HMA's ED policies and admissions and testing benchmarks.

484. This increase in the volume of tests expected by HMA once EmCare emergency physicians were in place at Lake Norman's ER has, in fact, occurred. Upon information and belief, EmCare's collective contracts at HMA facilities are worth tens of millions of dollars annually.

485. Defendant EmCare's physicians also benefit from unnecessary testing and from meeting HMA's benchmarks for calling attending physicians. These unnecessary diagnostic tests and consults increase the complexity of care and allow the emergency physician to bill for a higher E&M level for their professional services.

486. Relators Folstad, Mason, and MEMA have illustrated through the above allegations that from 2003 to the present, Defendant HMA, HMA facilities, including, but not limited to, Davis Regional and Lake Norman, and the EmCare Defendants engaged in conduct which violates the federal FCA and the false claims acts of the States of North Carolina, Florida, Georgia, Oklahoma, Tennessee and Texas.

COUNT I (U.S. EX REL. MASON, FOLSTAD AND MEMA V. HMA, LAKE NORMAN, DAVIS REGIONAL, AND EMCARE DEFENDANTS) – VIOLATION OF THE FEDERAL FALSE CLAIMS ACT 31 U.S.C. § 3729(a)(1)(A), (B), and (G)

487. Relators re-allege ¶¶ 1-486 as though fully set forth herein.

488. Claims submitted by Defendant HMA's facilities nationwide, including, but not limited to, Defendants Lake Norman and Davis Regional, to federally- or state- funded health care programs (including Medicare, Medicaid, etc.) related to out-patient and in-patient services (ER tests, ancillary services, and admissions) that were not medically necessary constitute violations of the federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A).

489. Claims submitted by Defendant HMA's facilities nationwide, including, but not limited to, Defendants Lake Norman and Davis Regional, to federally- or state- funded health

care programs (including Medicare and Medicaid) for out-patient services, including emergency room services, where the severity of care was inflated or supported by unnecessary tests are false and fraudulent and violate the federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A).

490. Claims submitted by Defendant HMA's facilities nationwide, including, but not limited to, Defendants Lake Norman and Davis Regional, to federally- or state- funded health care programs (including Medicare and Medicaid) for unnecessary admissions and for the unnecessary tests that imply that the admission is medically necessary are false and violate the federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A).

491. Claims submitted by Defendant HMA's facilities, including, but not limited to, Defendants Lake Norman and Davis Regional, to federally- or state- funded health care programs (including Medicare, Medicaid, etc.) related to tainted referrals (those stemming from violations of the federal Anti-Kickback Statute) also constitute violations of the federal False Claims Act, 31 U.S.C. § 3729(a)(1)(A).

492. Defendant HMA, directly or through its facilities nationwide, including, but not limited to, Defendants Lake Norman and Davis Regional, offered and/or provided incentives to emergency physicians and/or their physicians' groups to induce improper referrals of services to Defendant HMA's facilities.

493. Through these emergency physicians at HMA facilities nationwide, HMA facilities received referrals or recommendations for health services to beneficiaries of federally-funded health care programs in violation of the federal Anti-Kickback Statute.

494. Defendants' violations of the federal Anti-Kickback Statute give rise to liability under the federal False Claims Act.

495. As a prerequisite to participating in federally-funded health care programs, Defendants expressly certified (or, through their participation in a federally-funded program,

impliedly certified) their compliance with the federal Anti-Kickback Statute.

496. Defendant HMA, through its facilities nationwide, violated the federal False Claims Act by submitting claims for reimbursement from federal health care programs, including Medicare and Medicaid, knowing that it was ineligible for the payments demanded due to federal Anti-Kickback Statute violations. Defendant HMA's Anti-Kickback Statute violations included the following: illegal remuneration through incentives offered and/or paid to emergency physicians and/or physicians' groups in the various HMA facilities; and the awarding and/or maintaining of lucrative contracts for emergency room services with emergency physicians and/or emergency physicians' groups based upon their willingness to participate in HMA's scheme to bill federal healthcare programs for unnecessary tests and/or admissions.

497. Defendant HMA, through its facilities nationwide, violated the federal False Claims Act by submitting claims for reimbursement from state health care programs, including Medicaid, knowing that it was ineligible for the payments demanded due to federal Anti-Kickback Statute violations associated with illegal remuneration paid to emergency room physicians through incentives and contracts based upon participation in HMA's scheme.

498. Each claim submitted by Defendant HMA, through its facilities nationwide, to a federally or state-funded health care program (including Medicare, Medicaid, etc.) for a service provided to a patient based on the referral or recommendation of an emergency physician who accepted HMA's inducements is false because it is tainted by an illegal kickback.

499. Defendant HMA, directly or through its facilities, and Defendant EmCare knowingly made, used, or caused to be made or used, false records or statements to cause the United States to pay or approve false or fraudulent claims, in violation of 31 U.S.C. § 3729(a)(1)(B). The false records or statements were: false certifications of necessity; false records of physician and/or nursing services related to extended teaching and/or critical care; and

certifications and representations of full compliance with all federal and state laws, including, but not limited to, the federal Anti-Kickback Statute.

500. Defendant HMA, directly or through its facilities nationwide, and Defendant EmCare made or caused to be made such false certifications and representations in agreements under state and federal health care programs, including Medicare and Medicaid, to ensure that these programs would reimburse for services HMA or EmCare provided to beneficiaries of these programs.

501. Defendant HMA, directly or through its facilities nationwide, knowingly made, used, or caused to be made or used, false records or false statements to conceal, avoid, or decrease an obligation by HMA facilities to pay or transmit money or property to the United States, in violation of the federal False Claims Act, 31 U.S.C. § 3729(a)(1)(G).

502. The Patient Protection and Affordable Care Act, (PPACA) 42 U.S.C. § 1128J(d), which Defendant HMA has violated, requires that Defendant HMA self-report and return Medicare and Medicaid overpayments within 60 days of identification.

503. The false records or statements were: the false certifications of medical necessity; and certifications and representations of full compliance with all federal and state laws, including, but not limited to, the federal Anti-Kickback Statute.

504. All of the Defendants' conduct described in this Complaint was knowing, as that term is used in the federal False Claims Act.

WHEREFORE, Relators request the following relief:

A. Judgment against Defendants for three times the amount of damages the United States has sustained because of their actions, plus a civil penalty of $11,000 for each violation of the federal False Claims Act;

B. 25% of the proceeds of this action if the United States elects to intervene, and 30% if it does not;

C. Their attorneys' fees, litigation and investigation costs, and expenses;

D. Such other relief as the Court deems just and appropriate.

COUNT II (U.S. EX REL. MASON, FOLSTAD AND MEMA V. HMA, LAKE NORMAN, DAVIS REGIONAL, AND EMCARE DEFENDANTS) – VIOLATION OF THE FEDERAL FALSE CLAIMS ACT 31 U.S.C. § 3729(a)(1)(C) CONSPIRACY

505. Relators re-allege ¶¶ 1-504 as though fully set forth herein.

506. Defendants HMA and EmCare, through their concerted efforts to carry out Defendant HMA's fraudulent schemes to bill for unnecessary tests and admissions, conspired to defraud the federal government by getting false or fraudulent claims (including those related to unnecessary services, as well as those claims related to referrals tainted by violations of the federal Anti-Kickback Statute) allowed or paid by the government in violation of the federal False Claims Act, 31 U.S.C. § 3729(a)(1)(C).

WHEREFORE, Relators request the following relief:

A. Judgment against Defendants for three times the amount of damages the United States has sustained because of their actions, plus a civil penalty of $11,000 for each violation of the federal False Claims Act;

B. 25% of the proceeds of this action if the United States elects to intervene, and 30% if it does not;

C. Their attorneys' fees, litigation and investigation costs, and expenses;

D. Such other relief as the Court deems just and appropriate.

COUNT III (MASON, FOLSTAD AND MEMA V. HMA, LAKE NORMAN AND DAVIS REGIONAL) – RETALIATION UNDER THE FEDERAL FALSE CLAIMS ACT 31 U.S.C. § 3730(h)

507. Relators re-allege ¶¶ 1-506 as though fully set forth herein.

508. Defendants violated the anti-retaliation provisions of the federal False Claims Act, 31 U.S.C. § 3730(h), when it retaliated against Relators and ultimately terminated their professional services contracts for Relators' engaging in the protected conduct deseribed herein.

509. Pursuant to 31 U.S.C. § 3730(h), Relators are entitled to "all relief necessary to be made whole," including "reinstatement with the same seniority status that the employee, contractor or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination including litigation costs and reasonable attorneys' fees."

WHEREFORE, Relators pray for judgment against the HMA Defendants as follows:

A. That judgment be entered for Relators and against Defendant HMA for violating 31 U.S.C. § 3730(h);

B. That Relators shall receive from the HMA Defendant two times back pay, interest on the back pay, special damages, attorneys fees and costs, as authorized by 31 U.S.C. § 3730(h);

C. That Relators be granted such other and further relief as the court deems just and proper.

COUNT IV (NORTH CAROLINA EX REL. MASON, FOLSTAD AND MEMA V. HMA, LAKE NORMAN, DAVIS REGIONAL AND EMCARE DEFENDANTS) – NORTH CAROLINA FALSE CLAIMS ACT N.C. Gen. Stat. § 1-605 et. seq.

510. Relators re-allege ¶¶ 1-509 as though fully set forth herein.

511. This is a claim for damages and penalties under the North Carolina False Claims

Act.

512. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the North Carolina State Government for payment or approval.

513. By virtue of the acts described above, Defendants knowingly made, used or caused to be made or used false records and statements, and omitted material facts to induce the North Carolina State Government to approve or pay such false and fraudulent claims. The Defendants also conspired to commit violations of the North Carolina False Claims Act.

514. The North Carolina State Government, unaware of the falsity of the records, statements and claims made, used, presented or caused to be presented by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' illegal inducements.

515. By reason of the Defendants' acts, the State of North Carolina has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

516. The State of North Carolina is entitled to the maximum penalty of $11,000 for each and every false or fraudulent claim, record or statement made, used, presented or caused to be made, used or presented by Defendants.

517. Defendants also violated the anti-retaliation provisions of the North Carolina False Claims Act, N.C. Gen. Stat. § 1-613, when they retaliated against Relators and ultimately terminated their professional services contracts for Relators' engaging in the protected conduct described herein.

518. Pursuant to North Carolina Gen. Stat. § 1-613, Relators are entitled to "all relief necessary to be made whole," including "reinstatement with the same seniority status that the employee, contractor or agent would have had but for the discrimination, two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a

result of the discrimination, including litigation costs and reasonable attorneys' fees."

WHEREFORE, Relators request the following relief:

A. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the North Carolina Medicaid program has sustained because of Defendants' actions, plus a civil penalty of not less than $5,500 and not more than $11,000 for each violation of North Carolina Gen. Stat. § 1-607;

B. That this Court enter judgment against Defendants in favor of Relators in an amount equal to two times back pay, interest on the back pay, special damages, attorneys fees and costs, as authorized by Gen. Stat. § 1-607; and that Relator MEMA be granted such other and further relief as the court deems just and proper.

COUNT V (FLORIDA EX REL. MASON, FOLSTAD AND MEMA V. HMA AND EMCARE DEFENDANTS) - FLORIDA FALSE CLAIMS ACT
Fla. Stat. Ann. § 68.082(2)

519. Relators re-allege ¶¶ 1-518 as though fully set forth herein.

520. This is a claim for treble damages and penalties under the Florida False Claims Act, Fla. Stat. § 68.082(2).

521. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the Florida State Government for payment or approval.

522. By virtue of the acts described above, Defendants knowingly made, used or caused to be made or used false records and statements, and omitted material facts to induce the Florida State Government to approve or pay such false and fraudulent claims.

523. The Florida State Government, unaware of the falsity of the records, statements and claims made, used, presented or caused to be presented by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' illegal inducements.

524. By reason of the Defendants' acts, the State of Florida has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

525. The State of Florida is entitled to the maximum penalty of $10,000 for each and every false or fraudulent claim, record or statement made, used, presented or caused to be made, used or presented by Defendants.

WHEREFORE, Relators request the following relief:

A. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the State of Florida has sustained because of Defendants' actions, plus a civil penalty of $10,000 for each violation of Fla. Stat. Ann. § 68.082(2).

COUNT VI (GEORGIA EX REL. MASON, FOLSTAD AND MEMA V. HMA AND EMCARE DEFENDANTS) - GEORGIA STATE FALSE MEDICAID CLAIMS ACT Ga. Code Ann. § 49-4-168.1 (a)(1) and (2)

526. Relators re-allege ¶¶ 1-525 as though fully set forth herein.

527. This is a claim for treble damages and penalties under the Georgia State False Medicaid Claims Act.

528. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the Georgia State Government for payment or approval.

529. By virtue of the acts described above, Defendants knowingly made, used or caused to be made or used false records and statements, and omitted material facts to induce the Georgia State Government to approve or pay such false and fraudulent claims.

530. The Georgia State Government, unaware of the falsity of the records, statements and claims made, used, presented or caused to be presented by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' illegal inducements.

531. By reason of the Defendants' acts, the State of Georgia has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

532. The State of Georgia is entitled to the maximum penalty of $11,000 for each and every false or fraudulent claim, record or statement made, used, presented or caused to be made, used or presented by Defendants.

WHEREFORE, Relators request the following relief:

A. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the Georgia Medicaid program has sustained because of Defendants' actions, plus a civil penalty of not less than $5,500 and not more than $11,000 for each violation of Ga. Code Ann. § 49-4-168.1 (a)(1) and (2).

COUNT VII (OKLAHOMA EX REL. MASON, FOLSTAD AND MEMA V. HMA AND EMCARE DEFENDANTS) - OKLAHOMA MEDICAID FALSE CLAIMS ACT 63 Oklahoma Statutes Annotated § 5053 et. seq.

533. Relators re-allege ¶¶ 1-532 as though fully set forth herein.

534. This is a claim for damages and penalties under the Oklahoma Medicaid False Claims Act.

535. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the Oklahoma State Government for payment or approval.

536. By virtue of the acts described above, Defendants knowingly made, used or caused to be made or used false records and statements, and omitted material facts to induce the Oklahoma State Government to approve or pay such false and fraudulent claims. The Defendants also conspired to commit violations of the Oklahoma Medicaid False Claims Act.

537. The Oklahoma State Government, unaware of the falsity of the records, statements and claims made, used, presented or caused to be presented by Defendants, paid and

continues to pay the claims that would not be paid but for Defendants' illegal inducements.

538. By reason of the Defendants' acts, the State of Oklahoma has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

539. The State of Oklahoma is entitled to the maximum penalty of $10,000 for each and every false or fraudulent claim, record or statement made, used, presented or caused to be made, used or presented by Defendants.

WHEREFORE, Relators request the following relief:

A. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the Oklahoma Medicaid program has sustained because of Defendants' actions, plus a civil penalty of not less than $5,000 and not more than $10,000 for each violation of 63 Oklahoma Statutes Annotated § 5053.1.B;

B. That this Court enter judgment against Defendant HMA in favor of Relators for attorneys' fees and costs, as authorized by 63 Oklahoma Statutes Annotated § 5053.4, and that Relators be granted such other and further relief as the court deems just and proper.

COUNT VIII (TENNESSEE EX REL. MASON, FOLSTAD AND MEMA V. HMA AND EMCARE DEFENDANTS) - TENNESSEE MEDICAID FALSE CLAIMS ACT Tenn. Code Ann. § 71-5-182(a)(1)(A) and (B)

540. Relators re-allege ¶¶ 1-539 as though fully set forth herein.

541. This is a claim for treble damages and penalties under the Tennessee Medicaid False Claims Act.

542. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the Tennessee State Government for payment or approval.

543. By virtue of the acts described above, Defendant knowingly made, used or caused to be made or used false records and statements, and omitted material facts to induce the

Tennessee State Government to approve or pay such false and fraudulent claims.

544. The Tennessee State Government, unaware of the falsity of the records, statements and claims made, used, presented or caused to be presented by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' illegal inducements.

545. By reason of the Defendants' acts, the State of Tennessee has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

546. The State of Tennessee is entitled to the maximum penalty of $10,000 for each and every false or fraudulent claim, record or statement made, used, presented or caused to be made, used or presented by Defendants.

WHEREFORE, Relators request the following relief:

A. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the State of Tennessee has sustained because of Defendants' actions, plus a civil penalty of $10,000 for each violation of Tenn. Code Ann. § 71-5-182(a)(1)(A) and (B).

COUNT IX (TEXAS EX REL. MASON, FOLSTAD AND MEMA V. HMA AND EMCARE DEFENDANTS) - TEXAS MEDICAID FRAUD PREVENTION ACT Texas Code § 36.001, et. seq.

547. Relators re-allege ¶¶ 1-546 as though fully set forth herein.

548. This is a claim for treble damages and penalties under the Texas Medicaid Fraud Prevention Act.

549. By virtue of the acts described above, Defendants knowingly presented or caused to be presented, false or fraudulent claims to the Texas State Government for payment or approval.

550. By virtue of the acts described above, Defendants knowingly made, used or caused to be made or used false records and statements, and omitted material facts to induce the

Texas State Government to approve or pay such false and fraudulent claims.

551. The Texas State Government, unaware of the falsity of the records, statements and claims made, used, presented or caused to be presented by Defendants, paid and continues to pay the claims that would not be paid but for Defendants' illegal inducements.

552. By reason of the Defendants' acts, the State of Texas has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

553. The State of Texas is entitled to the maximum penalty of $10,000 for each and every false or fraudulent claim, record or statement made, used, presented or caused to be made, used or presented by Defendants.

WHEREFORE, Relators request the following relief:

> A. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the State of Texas has sustained because of Defendants' actions, plus a civil penalty of $10,000 for each violation of Texas Code § 36.002.

COUNT X (MEMA V. HMA AND EMCARE) – TORTIOUS INTERFERENCE WITH A CONTRACTUAL RELATIONSHIP

554. Relator/Plaintiff MEMA re-alleges ¶¶ 1-553 as though fully set forth herein.

555. Plaintiff MEMA had valid contracts with Defendants Lake Norman and Davis Regional for the exclusive provision of emergency services.

556. Defendants HMA and EmCare knew that these contracts were in place since 1996 and 2000, respectively. In fact, HMA's executives continually threatened Relators to cause the termination of these contracts in retaliation for Relators' refusal to cooperate with HMA's fraud, and/or Relators' efforts which constituted protected conduct.

557. Defendants HMA and EmCare intentionally induced Defendants Lake Norman and Davis Regional to terminate the contracts with MEMA.

558. Defendants HMA and EmCare acted without justification, in that Defendants' motives were not reasonably related to protecting a legitimate business interest. In fact, Defendants' motives, to further a scheme to defraud federal and state government-sponsored health programs across the country, actually undermine Defendants' legitimate business interest.

559. Defendants' conduct caused actual damage to Plaintiff MEMA.

WHEREFORE, Plaintiff MEMA requests the following relief:

A. That this Court enter judgment against Defendants and in favor of Plaintiff MEMA in an amount equal to the damages MEMA has sustained because of Defendants' actions;

B. That this Court assess and enter judgment against Defendants in favor of Plaintiff MEMA for punitive damages pursuant to N.C. Gen. Stat. § 1D;

C. Such other and further relief as the court deems just and proper.

COUNT XI (MASON, FOLSTAD AND MEMA V. DEFENDANTS HMA, LAKE NORMAN AND DAVIS REGIONAL) - DEFAMATION AND SLANDER PER SE

560. Relators/Plaintiffs re-allege ¶¶ 1-559 as though fully set forth herein.

561. Following the Notice of Termination which Defendants provided to Relators on May 3, 2010, Defendants caused injury to Plaintiffs MEMA, Mason, and Folstad by making false statements concerning the Plaintiffs to third persons, including, but not limited to:

- Statements by HMA's Lake Norman CEO, Greg Lowe, to the Lake Norman Board of Directors that the Plaintiffs were replaced because they did not want to practice quality medicine and they refused to use HMA's quality program;
- Defendants HMA, Lake Norman, and/or Davis Regional told numerous other physicians that Plaintiffs were terminated because of its failure to commit to HMA's quality program and because of Plaintiffs' patient satisfaction scores.

562. Each of these statements was false and touched the Plaintiffs in their special trade or occupation.

563. Defendants made these statements in bad faith, with malice, and with a direct intent to harm Plaintiffs, and with reckless disregard for their rights. Defendants were aware at the time that they made these statements that they were false.

564. Defendants made these statements knowing that they would cause great harm to the Plaintiffs, including great harm to their reputations.

565. Defendants' conduct amounts to slander per se because these oral communications amount to allegations that impeach Plaintiffs in their business, or profession.

WHEREFORE, Plaintiffs MEMA, Folstad, and Mason request the following relief:

A. That this Court enter judgment against Defendants and in their favor in an amount equal to the damages MEMA has sustained because of Defendants' actions;

B. That this Court assess and enter judgment against Defendants and in their favor for punitive damages pursuant to N.C. Gen. Stat. § 1D;

C. Such other and further relief as the Court deems just and proper.

COUNT XII (MASON, FOLSTAD AND MEMA V. DEFENDANTS HMA, EMCARE, LAKE NORMAN, AND DAVIS REGIONAL) - NORTH CAROLINA UNFAIR AND DECEPTIVE TRADE PRACTICES ACT ("UDTPA") (N.C. Gen. Stat. § 75-1.1)

566. Relators/Plaintiffs re-allege ¶¶ 1-565 as though fully set forth herein.

567. As recited above, Defendants engaged in unfair or deceptive acts or practices, including, but not limited to the following:

a) conducting the operations of HMA hospitals in the State of North Carolina in a manner which compelled physicians and physician groups, hospital staff and hospital

administrators to participate in Defendants' deception of government health care programs, private insurers, and consumers related to the ordering of unnecessary tests and the provision of unnecessary out-patient and in-patient services at HMA hospitals;

b) incentivizing or attempting to incentivize physicians to cooperate with Defendants' fraudulent practices;

c) retaliating against physician practices, including Plaintiff MEMA, and physicians, including Plaintiffs Folstad and Mason, and staff who would not cooperate with Defendants' fraudulent practices;

d) causing the submission of false claims for unnecessary medical services (ER testing, outpatient services, in-patient admissions) to state and local government health care programs, as well as to private insurers;

e) making false and malicious statements about Plaintiffs.

568. Defendants' conduct constitutes unfair or deceptive acts or practices in or affecting commerce in North Carolina because it involves other market participants, including consumers and public and private insurers, as well as other competitor facilities. Defendants' unfair or deceptive practices caused patients to be treated at HMA hospitals rather than by other providers. Defendants' unfair and/or deceptive practices caused government and/or private insurers, as well as the patients themselves, to be billed for unnecessary hospital services, and/or the revenues generated by HMA's unfair or deceptive practices affect the investment decisions of shareholders and other participants in publicly-traded and privately-held companies, including HMA and its competitors.

569. Defendants' conduct proximately caused actual injury to the Plaintiffs.

WHEREFORE, Plaintiffs MEMA, Folstad, and Mason request the following relief:

A. That this Court assess damages and enter judgment against Defendants and in favor of the Plaintiffs in an amount equal to three times the damages they have sustained because of Defendants' actions pursuant to N.C. Gen. Stat. § 75-16;

B. That this Court assess and enter judgment against Defendants and in favor of the Plaintiffs for punitive damages pursuant to N.C. Gen. Stat. § 1D;

C. That this Court enter judgment against Defendants and in favor of Plaintiffs for attorneys' fees;

D. Such other and further relief as the Court deems just and proper.

DEMAND FOR A JURY TRIAL

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

This the 9th day of January, 2013.

Respectfully submitted,

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EXHIBIT A

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
1.	Champus/Healthnet	Foot Injury (Mild)	Lake Norman Army patient treated by MEMA physician Thomas Mason, MD, on November 2, 2008. An x-ray of the right foot was ordered using Pro-MED prior to physician assessment as indicated (on page 7), under "Laboratory Tests." The entry "R foot" (meaning x-ray, right foot) indicates that the order for the right foot x-ray was sent at 08:45, which was ten minutes before the physician assessment conducted at 08:55 (see page 8). After he evaluated the patient, Dr. Mason determined the medically necessary tests, cancelled the right foot x-ray, and ordered "R calcaneus" (heel x-ray). The order for this medically necessary test was sent at 08:59. Dr. Mason reviewed the R os calcis (heel) x-ray and discussed it with the radiologist. Because we do not have the billing sheet for this patient, we do not know whether the right foot x-ray was actually cancelled in HMA's hospital system, or whether it was billed for. However, the Nurse Documentation report by Pro-MED includes 5 points for the X-Ray Department. Upon information and belief, Champus/Healthnet was billed for the tests ordered before the physician assessed the patient. In addition, upon information and belief, Champus/Healthnet may have been billed for a right foot x-ray that was not performed or preformed unnecessarily. Pro-MED ascribed 31 points on the Nursing Documentation report for this patient's ED care, including 5 for "X-ray."
2.	Medicaid	Kidney Stones	Davis Regional patient treated by MEMA physician Steve Folstad, MD, on November 1, 2008, with the following pertinent times: presented at 18:24; was triaged at 18:55; tests were ordered using Pro-MED at 19:04; physician assessment was conducted at 19:05. On page 5, Dr. Folstad notes the "order time" for several tests, including a urinalysis as 19:20, however on page 11, which is the Pro-MED Order summary, the urinalysis has a host time of 19:04. Then, a second urinalysis appears on the Order Summary with a host time of 19:25, presumably after Dr. Folstad assessed the patient, determined the medically necessary tests, and ordered the test, not realizing it had already been ordered at triage. The result is not only a fraudulent test ordered at triage by a

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
			nurse, but also double billing, because the physician was not aware that the test has already been ordered. Upon information and belief, Medicaid was billed for the tests ordered before the physician assessed the patient. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
3.	Medicaid DNC	Abdominal Pain-Generalized	Davis Regional patient treated by MEMA physician Edmund D'Orazio, MD, on November 6-7, 2008, with the following pertinent times: presented at 22:40; was triaged at 22:44; urinalysis was ordered using Pro-MED at 22:48; physician assessment was conducted at 01:35. On page 10, the Pro-MED Order Summary, shows a urinalysis (UA) being ordered twice: the first US has a host time of 22:48, almost three hours prior to the physician assessment time of 1:35, and the second time the UA was ordered at 1:54, after Dr. D'Orazio assessed the patient and determined the medically necessary tests. The result is not only a fraudulent test ordered at triage by a nurse, but also double billing, since the physician is not aware that the test has already been ordered. Upon information and belief, Medicaid was billed for the tests ordered before the physician assessed the patient. The nursing notes state that "extending teaching was moderate, extensive," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
4.	Humana MCare Choice PPO	Psychiatric	Davis Regional patient treated by MEMA physician Harry Little, MD, on November 7, 2008 with the following pertinent times: presented at 13:59; was triaged at 14:06; tests were ordered using Pro-MED at 14:14; physician assessment was conducted at 14:30. On page 10, the Pro-MED Order Summary, shows a battery of five tests were ordered 15 minutes prior to Dr. Little's assessment time. Then, the very same five tests appear again with host time of 14:44, after Dr. Little assessed the patient and determined the medically necessary tests. The physician assessment occurred within 31 minutes of the

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
			patient's presentation at the ER. This shows the difficulty in avoiding the ordering of Pro-MED tests before the physician assessment under the HMA/Pro-MED system which requires the tests be ordered immediately after triage. Dr. Little, not aware which tests were ordered at triage, ordered the tests for a second time after his assessment. The result is not only a fraudulent test ordered at triage by a nurse, but also double billing, since the physician is not aware that the test has already been ordered. Upon information and belief, Humana MCare was billed for the tests ordered before the physician assessed the patient.
5.	Medicaid DNC	Flank Pain	Davis Regional patient treated by MEMA physician Harry Little, MD, on November 9, 2008, with the following pertinent times: presented at 13:10; was triaged at 13:12; tests were ordered using Pro-MED at 13:16; physician assessment was conducted at 13:20. On page 14, the Pro-MED Order Summary there is a urinalysis with a host time of 13:16, the same test appears on the Order Summary with a host time of 14:04, after the physician assessed the patient and determined the medically necessary tests. Dr. Little's assessment occurred **within 20 minutes of the patient's presentation at the ER.** This shows the difficulty in avoiding the ordering of Pro-MED tests before the physician assessment under the HMA/Pro-MED system which requires the tests be ordered immediately after triage. The result is not only a fraudulent test ordered at triage by a nurse, but also double billing, since the physician is not aware that the test has already been ordered. Upon information and belief, Medicaid was billed for the tests ordered before the physician assessed the patient. Pro-MED ascribed a Level 4 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
6.	Medicaid DNC	Sore Throat without Fever	Davis Regional patient treated by MEMA physician Edmund D'Orazio, MD, on November 10-11, 2008, with the following pertinent times: presented at 11:57; was triaged at 12:26; a Rapid Strep test was ordered using Pro-MED at 12:32; physician assessment was conducted at 13:45, more than an hour after the host time for the strep test on the Pro-MED Order Summary (see page 10). Upon information and belief, Medicaid was billed for the test ordered before the physician assessed the patient. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
7.	Medicaid MC	Fever >100.4 (2-16 years old)	One year-old Davis Regional patient treated by MEMA physician Edmund D'Orazio, MD, on November 15, 2008, with the following pertinent times: presented at 22:33; was triaged at 22:33; tests were ordered using Pro-MED at 23:05. On page 8, the Nurse Documentation section it is noted at 23:20 that "Parents cursing staff because triage labs and x-ray ordered for fever evaluation. Labs and x-rays cancelled until evaluation by Dr. D'Orazio." Though the nurse notes that the physician cancelled the labs, there is no indication on the Pro-MED Order Summary that these tests were ever cancelled. This patient chart undermines HMA and Pro-MED statements that the CTM guidelines and policies adopted by HMA for their use will lead to greater patient satisfaction. Upon information and belief, Medicaid was billed for the tests which were not initially ordered by the physician. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
8.	Champus/Tricare/ Region 2	Psychiatric	Davis Regional patient treated by MEMA physician, Frank Klanduch MD, on November 18, 2008, with the following pertinent times: presented at 18:09; was triaged at 18:14; tests were ordered using Pro-MED at 18:18 and 18:45, physician assessment was conducted at 19:20. On page 10, the Pro-MED Order Summary, shows four tests were ordered 18:18 (CMP, ETOH, CBC hemogram, and urine drug abuse screen), and before the physician assessed the patient and determined the medically necessary test, at 18:45, the same four tests were ordered again (plus two other tests). Not only is there double billing apparent on this patients chart, but the patient was not assessed by a physician before any of the ten tests were ordered. Upon information and belief, Champus/Tricare was billed for the tests which were not initially ordered by the physician. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up procedures, which is generally part of routine discharge instructions.
9.	Medicare B & Medicaid MC	Abdominal Pain-Lower, Female Childbearing	Davis Regional patient treated by MEMA physician, Edmund D'Orazio, MD, on. November 26, 2008, with the following pertinent times: presented at 00:41; was triaged at 00:42; tests were ordered using Pro-MED at 00:59, physician assessment was conducted at 01:30. On page 11, the Pro-MED Order Summary, both a urinalysis and a urine pregnancy were ordered at 00:59, and then the urinalysis and the urine pregnancy appear a second time on the Order Summary at 1:59, presumably after Dr. D'Orazio examined the patient and determined the medically necessary tests. The result is not only a fraudulent test ordered at triage by a nurse, but also double billing, since the physician is not aware that the test has already been ordered. Upon information and belief, Medicare and/or Medicaid were billed for the tests ordered before the physician assessed the patient. The nursing notes state that "extending teaching was focused on medication administration and follow-up care," both of which are generally part of routine discharge instructions.

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
10.	Medicare B	Hematuria	Davis Regional patient treated by MEMA physician, Stephen Folstad, MD, on November 28, 2008, with the following pertinent times: presented at 20:14; was triaged at 20:26; tests were ordered using Pro-MED at 20:51, physician assessment was conducted at 22:15. This chart provides another example of HMA using Pro-MED CTM to have nurses select a chief complaint and automatically order tests. It also shows that HMA causes tests to be ordered twice when the physicians is not aware what tests have been ordered by triage nurse prior to their assessment. A first urinalysis appears on the Pro-MED Order Summary at 20:51 (see page 13). On page 7, after the physician assessed the patient and determined the necessary tests, unaware of the first tests ordered, he ordered a second urinalysis at 22:29. Upon information and belief, Medicare B was billed for the tests ordered before the physician assessed the patient. Pro-MED ascribed a Level 4 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate."
11.	Medicaid MC	Back Pain-Lower (Childbearing)	Davis Regional patient treated by MEMA physician, Edmund D'Orazio, MD, on. November 28, 2008, with the following pertinent times: presented at 13:41; was triaged at 13:58; tests were ordered using Pro-MED at 14:03, physician assessment was conducted at 15:36. (See page 6). The Pro-MED Order Summary (page 9) shows that three tests were ordered at triage, more than an hour and a half before the physician assessed the patient: HCG Qualitative (Urine), CBC, and Urinalysis. Of the three tests that were ordered at triage using the CTM, the physician would never order the CBC even after assessing the patient. Upon information and belief, Medicaid was billed for the tests which were ordered before the physician assessed the patient, including the clearly unnecessary CBC. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
			part of routine discharge instructions.
12.	Medicaid DNC	Abdominal Pain-Lower, Female Childbearing	Davis Regional patient (same as Patient 3 on this chart) treated by MEMA physician, Edmund D'Orazio, MD, on November 30, 2008, with the following pertinent times: presented at 12:04; was triaged at 12:08, tests were ordered using Pro-MED at 12:13, physician assessment was conducted at 13:30. On page 4, on the Physician Order Procedure Form, in the "laboratory tests" several tests section, under "order time" there is a note that says "triage" next to CBC and UA (urinalysis). Although the CMP is also circled, the note taker was likely mistaken and meant to circle "BMP" which had also been ordered at triage (the CMP was never ordered). The "host time" on the Pro-MED Order Summary (page 10) for all of the tests is 12:13, more than one hour prior to Dr. D'Orazio's notes assessment time of 13:30 (see page 5). Even after he assessed the patient, Dr. D'Orazio would never have ordered the CBC or the BMP for this patient. Upon information and belief, Medicaid was billed for the tests which were ordered before the physician assessed the patient, including the unnecessary CBC and BMP. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
13.	Medicare B	Lower Leg Swelling (No Known Injury)	Davis Regional patient treated by MEMA physician Stephen Folstad, MD, on December 14, 2008, with the following pertinent times: presented at 11:06; was triaged at 11:23; tests were ordered using Pro-MED at 11:32; physician assessment was conducted at 12:05. The Pro-MED Order Summary (pages 13-17) shows seven tests with order times of 11:32, a half hour prior to Dr. Folstad's assessment time of 12:05, which is noted on page 8. After assessing the patient, Dr. Folstad determined that four tests were medically necessary: CBC, Uric Acid, D Dimer, and x-ray right foot. These have host times of 12:27

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
			or later. The following six tests ordered through Pro-MED CTM were not necessary, even after the physician assessed the patient: BNP, EKG, US Doppler Ext. Ven. Uni., CMP, Urinalysis, X Chest 2 Views. As the unnecessary pro-MED tests are neither on the physician's Order Procedure Form nor on the Physician Exam record (where the results are normally notes), Relator Folstad believes that he likely tried to cancel the tests ordered at triage. Upon information and belief, Medicare B was billed for the tests ordered before the physician assessed the patient. Pro-MED ascribed a Level 4 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
14.	Medicaid DNC	Back Injury-Lower/Childbearing	Davis Regional patient treated by MEMA physician Stephen Greer, MD, on December 8, 2008, with the following pertinent times: presented at 18:37; was triaged at 19:17; tests were ordered using Pro-MED at 19:25; physician assistant assessment was conducted at 20:11. On page 8, Peggy O'Neal, RN has noted "labs per computer input." On the Pro-MED Order Summary (page 11) both a urinalysis and a urine pregnancy test appear with order times of 19:25. No tests were necessary, particularly a pregnancy test for a patient who was 7-months pregnant. Upon information and belief, Medicaid was billed for the tests which were ordered before the physician assessed the patient and which were ultimately unnecessary. Pro-MED ascribed a Level 3 to this patient's care , based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
15.	Medicaid MC	Congestion-Cough, Fever	Davis Regional patient treated by MEMA physician Stephen Folstad, MD, on December 25, 2008, with the following pertinent times: presented at 19:57; was triaged at 20:30; tests were ordered using Pro-MED at 20:36; physician

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
			assessment was conducted at 20:45 (within 6 minutes of the Pro-MED CTM tests being ordered). On page 5, under the laboratory tests Dr. Folstad has written "cancel labs + x-ray." However, on page 10, the Pro-MED Order Summary all of the tests still appear with order times of 20:36, before the "time seen" of 20:45 noted by Dr. Folstad. Upon information and belief, Medicaid was billed for the tests which were ordered before the physician assessed the patient and which were ultimately unnecessary. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate."
16.	Medicaid DNC	Congestion-Cough, Fever	Davis Regional patient treated by MEMA physician Stephen Folstad, MD, on December 25, 2008, with the following pertinent times: presented at 1:23; was triaged at 1:51; tests were ordered using Pro-MED at 2:03; physician assessment was conducted at 2:20. As he had with Patient 20, Dr. Folstad has written "cancel bloodwork" under the laboratory section of the physician's Order Procedure Form (see page 5). However, all three tests ordered at triage, including the two Dr. Folstad instructed to cancel, appear on the Pro-MED Order Summary (see page 9). Upon information and belief, Medicaid was billed for the tests which were ordered before the physician assessed the patient and which were ultimately unnecessary. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate."
17.	Medicaid DNC	Vaginal Bleeding (Pregnant <20 Weeks)	Davis Regional patient treated by MEMA physician Stephen Folstad, MD, on December 14, 2008, with the following pertinent times: presented at 11:19; was triaged at 11:40; tests were ordered using Pro-MED at 11:46; physician assessment was conducted at 12:30. On page 5, Dr. Folstad has written "cancel" for the following tests: Urine HCG, Type& Screen, OB Ultrasound. However, all of the tests for which Dr. Folstad wrote cancel appear on the Pro-MED Order Summary (see page 12), which was printed at 14:59, more than two hours after Dr. Folstad instructed that the tests be cancelled. Dr. Folstad did not

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
			see the patient until 12:30 (see page 6), forty five minutes after the tests were ordered, making it extremely difficult for the emergency physician to cancel tests which HMA directed nurses to order at triage. Upon information and belief, Medicaid was billed for the tests which were ordered before the physician assessed the patient and which were ultimately unnecessary. Pro-MED ascribed a Level 3 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
18.	Medicaid MC	Ankle Injury (Mod-Severe)	Davis Regional patient treated by MEMA physician Stephen Greer, MD, on March 28, 2009, with the following pertinent times: presented at 5:58; was triaged at 5:58; tests were ordered using Pro-MED at 6:07; physician assistant assessment was conducted at 6:20. On page 12, the Pro-MED Order Summary, an ankle x-ray appears with an order time of 6:07. On page 6, Dr. Greer notes the patient's time seen as 6:20 and on page 5, Dr. Greer orders an ankle x-ray at 6:25. This patient, who was assessed by a physician within 22 minutes of presenting to the ER (well within HMA's goal of <27 min) still had tests inappropriately ordered by a triage nurse before being assessed by the physician. Upon information and belief, Medicaid was billed for the tests which were ordered before the physician assessed the patient. Pro-MED ascribed a Level 4 to this patient's ED care, based in part on the diagnostic tests listed. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
19.	Medicaid NC	Abdominal Pain- Nausea, Vomiting	Lake Norman patient treated by MEMA physician Todd Hanson, MD, on January 16, 2009, with the following pertinent times: presented at 21:26; was triaged at 21:28; tests were ordered using Pro-MED at 21:30; physician assessment was conducted at or near the time of 23:10 noted by Dr. Hanson for

Patient Identifier	Payor	Chief Complaint	Fraudulent Charges
			the "GI cocktail." Within two minutes of triage, the Pro-MED program ordered a battery of the tests (see pages 12-15), including amylase, lipase, CBC, CMP, UA (see page 9). Relators do not believe that Dr. Todd Hansen would have ordered these tests based on his history and exam. Relator Folstad knows that it is not Todd's handwriting on the order form where is says "Amylase, Lipase, UA, CBC, CMP" on the Order Procedure Form (page 9). In the fall of 2008, Dr. Mason asked the nurses at Lake Norman to start writing down the tests they were forced to order by the HMA/EmCare Pro-MED CTM Guidelines, because the emergency physicians we did not routinely look in the computer (this was before the ProMed physician EMR was in place at Lake Norman). Relators believe that the nurses wrote the tests on the order sheet under the "medical necessity" section after they ordered them in Pro-MED CTM. This patient should have received a GI Cocktail, improved, and been discharged. However, the physician had to wait until 23:33, when the unnecessary CMP was reported, before he could discharge her. Also, he then had to deal with the mildly elevated liver enzymes, which didn't need to be ordered in the first place. This patient chart is a good example of how the CTM guidelines actually slow and negatively impact patient care, as well as cause unnecessary charges for ER care and/or subsequent follow-up with a primary care physician. Upon information and belief, Medicaid was billed for the tests ordered before the physician assessed the patient. Pro-MED ascribed 24 points on the Nursing Documentation report for this patient's ED care, including 5 for "labs" and 5 for "specimens collected."
20.	Medicaid NC	CONGESTION – COUGH FEVER	Lake Norman patient (seven-month-old infant) treated by MEMA physician Alvin J. ("Tagg") Murn, MD, on November 15, 2008, with the following pertinent times: presented at 17:11; was triaged at 17:26; chest x-rays were ordered using Pro-MED at 17:35, physician assessment was conducted at 18:02. This child had a fever of 99.1 for only two hours. Upon information and belief, Medicaid was billed for the x-rays which were ordered before the

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			physician assessed the patient, and which were unnecessary. Pro-MED ascribed 28 points on the Nursing Documentation report for this patient's ED care, including 5 for X-Ray" and 10 points for "extended teaching."
21.	Medicaid NC CA Access	Abdominal Pain >55 yrs of age	37 year old Lake Norman patient treated by Relator Mason on November 2, 2008. An improper chief complaint of abdominal pain >55 yrs of age was selected by the triage nurse. Not only was the patient under 55 (she was 37), but she was suffering from a labial abscess. Because MEMA physicians had instructed the emergency nurses not to automatically order tests from the CTM, this patient avoided undergoing a plethora of tests in HMA's CTM guidelines for this incorrect chief complaint.
22.	Medicaid NC	Vomiting Blood (Reported/Mild)	Lake Norman patient treated by Relator Mason on November 2, 2008 whom the emergency physician concluded had psychological issues, but the triage nurse selected the chief complaint of vomiting blood. Because MEMA physicians had instructed the emergency nurses not to automatically order tests from the CTM, this patient avoided undergoing unnecessary tests in HMA's CTM guidelines for this incorrect chief complaint.
23.	Medicare A	Hyperglycemia-Diabetes	This patient presented to Lake Norman on November 19, 2008 and was treated by Relator Mason. The chief complaint selected at triage was hyperglycemia-diabetes, but the patient was suffering from gout. Dr. Mason treated and discharged the patient without any labs. However, on page 6 of the Nurse Documentation, the patient was accessed 5 points for labs. According to the 2008 CTM guidelines, there are at four true tests that could have been performed which were neither necessary nor ordered at any time by the physician. The patient charts notes that a bedside glucose test was administered. The patient was assigned 10 points for extended teaching. The nurses notes states that "extending teaching" was moderate and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions. The patient presented at triage at 15:02 and was discharged from the ER by 16:10.

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24.	Medicaid NC	Fever >100.4 (2-16 years old)	This patient presented to Lake Norman on November 29, 2008 and was treated by Relator Mason. After accessing the patient, Relator Mason provided him with a prescription and sent him home without any testing. On page six, the nurse documentation sheet, the patient was assigned 10 points for extended teaching. The nurse's notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
25.	Medicaid NC CA Access	Vomiting and Diarrhea-Ped (Mild)	This patient presented to Lake Norman on December 4, 2008 and was treated by Relator Mason. After assessing the patient, Relator Mason discharged the patient, who did not need any diagnostic studies. The nurse documentation chart, at page five, includes 10 points for extended teaching. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
26.	Medicaid MC	Hand Injury (mild)	Davis Regional patient treated by MEMA physician Frank A Klanduch, MD, on November 1, 2008, with the following pertinent times: presented at 11:37; was triaged at 11:51; an x-ray of the hand (minimum 3 views) was ordered using Pro-MED at 11:54. This hand x-ray test is marked "False" in HMA's CTM guidelines, meaning that it should not have been ordered automatically by the Pro-MED program when the chief complaint was selected at triage. Dr. Klanduch conducted the physician assessment at 12:15, which shows an injury to the right wrist. He then ordered a right forearm x-ray, which appears on the Pro-MED Order Summary with a host time of 13:29. Dr. Klanduch had to review both of these tests, only one of which was necessary. This patient's nursing record also states that "extending teaching was moderate."
27.	Medicaid	Cough with Fever	Lake Norman patient treated by Relator Mason on March 1, 2009, with the following pertinent times: presented at 8:31; was triaged at 8:31, a chest x-ray was ordered and performed at 8:35, 20 minutes before the emergency physician

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			assessed the patient at 8:55. The emergency physician assessed the patient and determined that he had a cold, a condition which required no tests. The nurse documentation chart includes 10 points for extended teaching. The nursing notes state that "extending teaching was moderate," and that the patient was given instructions on follow-up care and medication administration, both of which are generally part of routine discharge instructions.
28.	Medicaid	Abd Pain –Epigastric <55	This patient presented to Lake Norman on March 25, 2009 and was treated by Relator Mason, with the following pertinent times: presented at 9:41; was triaged at 9:47, and the following tests were "ordered at triage" using HMA's Pro-MED CTM: CBC, CMP, Lipase, and EKG. The emergency physician assessed the patient at 10:17 and determined that she was suffering from hemorrhoids. The nurse documentation chart includes 10 points for extended teaching. The nursing notes state that "extending teaching focused on medication administration, follow-up procedures," both of which are generally part of routine discharge instructions.

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Relator's Severed Second Amended Qui Tam Complaint for Violations of Federal and State False Claims Acts and the Anti-Kickback Statutes has been served on the following in the manner listed below:

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