

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF ARKANSAS

UNITED STATES OF AMERICA,)
THE STATES OF CALIFORNIA,)
COLORADO, CONNETICUT, FLORIDA,)
GEORGIA, ILLINOIS, INDIANA, IOWA,)
LOUISIANA, MARYLAND,)
MASSACHUSETTS, MICHIGAN, MINNESOTA,)
MONTANA, NEVADA, NEW JERSEY,)
NEW MEXICO, NORTH CAROLINA,)
OKLAHOMA, TENNESSEE, TEXAS,)
VERMONT, VIRGINIA and WASHINGTON)
and THE DISTRICT OF COLUMBIA)
ex rel. DENISE AUCOIN and BRENT AUCOIN)

Plaintiffs-Relators,)

v.)

ADVANCED PATHOLOGY SOLUTIONS,)
HISTOLOGY CONNECTIONS, LLC,)
CHIEF EXECUTIVE OFFICER KEVIN)
HANNAH, CHIEF LABORATORY OFFICER)
HUNTER PLEDGER, CHIEF OPERATIONS)
OFFICER DONELL BURKETT, UNITED)
DIGESTIVE, GASTROINTESTINAL)
SPECIALISTS, PREMIER GASTRO)
ASSOCIATES, DIGESTIVE DISEASES)
CENTER OF HATTIESBURG, LLC, MEDICAL)
ASSOCIATES OF NORTHWEST ARKANSAS)
(MANA), DIGESTIVE DISEASE GROUP)
(DDG), GASTROENTEROLOGY ASSOCIATES)
OF CENTRAL GEORGIA,)
GASTROENTEROLOGY ASSOCIATES PA,)
GATEWAY GASTROENTEROLOGY,)
DR. LUIS E. ALVAREZ)
GASTROENTEROLOGY,)
GASTROENTEROLOGY CLINIC OF)
ACADIANA and ALABAMA MEDICAL)
GROUP PC)

Defendants.)

FILED
U.S. DISTRICT COURT
EASTERN DISTRICT ARKANSAS

APR 09 2021

JAMES W. MCCORMACK, CLERK
By: *[Signature]* DEPT. CLERK

Civil Action No. 4:21cv277-BRW

**FILED IN CAMERA AND
UNDER SEAL**

Jury Trial Requested

This case assigned to District Judge *Wilson*
and to Magistrate Judge *Kearney*

COMPLAINT

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This is a False Claims Act *qui tam* action by Relators Denise Aucoin and Brent Aucoin to recover treble damages and civil penalties arising from the actions of Advanced Pathology Solutions (“APS”), Histology Connections LLC, Chief Executive Officer Kevin Hannah, Chief Laboratory Officer Hunter Pledger, and Chief Operations Officer Donell Burkett, and any of their successors or predecessors (**collectively “Defendants”**); and Defendants United Digestive (Atlanta, Georgia), Gastrointestinal Specialists (Shreveport, Louisiana), Premier Gastroenterology Associates (Little Rock, Arkansas), Digestive Diseases Center of Hattiesburg, LLC (Hattiesburg, Mississippi), Medical Associates of Northwest Arkansas or MANA (Fayetteville, Arkansas), Digestive Disease Group or DDG (Greenwood, South Carolina), Gastroenterology Associates of Central Georgia (Macon, Georgia), Gastroenterology Associates PA (Hickory, North Carolina), Gateway Gastroenterology (Chesterfield, Missouri), Dr. Luis E. Alvarez Gastroenterology (New Iberia and Lafayette, Louisiana), Gastroenterology Clinic of Acadiana (Lafayette, Louisiana) and Alabama Medical Group PC (Mobile, Alabama). The Defendant gastroenterology practices are collectively, “**Defendant GIs.**”

I. STATEMENT OF THE CASE

1. Defendants offered anatomic pathology laboratory services to physician practices in at least 40 states.

2. However, Defendants' business model was an unlawful kickback scheme in violation of federal laws.

3. Defendants established on-site labs at physician practices at little to no cost to the physicians. In exchange, the physician practices were required to perform all biopsies of government-insured patients through Defendants' on-site lab and exclusively refer specimens to Defendants to perform the pathology services.

4. Defendants performed pathology services on the biopsies and submitted claims for these services to the government ("the professional component" of the claims).

5. Defendants perpetuated the scheme through ongoing services to the physician practices at little to no cost to the physicians—services such as lab technicians, lab supplies and equipment, office and administrative equipment, shipping services, electronic data systems, and physical storage facilities.

6. In marketing this scheme, Defendants shared a financial statement that predicted the physician practices would make significant extra money in net revenue that would come from billing the government programs for the specimen collections for pathology services ("the technical component of the claims"). The financial statement showed the little amount of money the physician practices were

expected to pay for Defendants' on-site labs, as shown against their expected net earnings.

7. The amounts charged by Defendants for these services were not commercially reasonable or at fair market value. Therefore, they violated laws designed to guard against unlawful kickback schemes in the health care context.

8. The Anti-Kickback Statute and the Stark Law are intended to ensure that judgments of medical providers are not compromised by improper financial incentives and are instead based on the best interests of their patients.

9. While there are "safe harbors" under the Anti-Kickback Statute and "exceptions" under the Stark Law, none applied here.

10. Defendant GIs also benefitted financially from these unlawful kickback arrangements because they were fully outfitted with on-site labs at little to no cost.

11. Further, Defendants had these fraudulent kickback arrangements to ensure exclusive referral streams for pathology services that themselves were unallowable.

12. More particularly, Defendants created a "standing order" for a test called a "special stain." The standing order required Defendants' own pathologists to perform a special stain on every specimen even where no medical necessity determination was made.

13. The Centers for Medicare and Medicaid Services (“CMS”) pays more money to laboratories for special stains than routine stains due to the special nature of the tests and because the pathologist is “double-staining.”

14. According to CMS, special stains should be performed only if a pathologist documents that a routine stain is medically insufficient and should be required in no more than 20 percent of cases. Standing orders for special stains are not allowable. However, Defendants billed the government for special stains in at least 200 percent of cases because they “double-stained” and billed the government at least twice for every specimen pursuant to the standing order.

15. Notably, Defendants further maximized their billings to the government by also duping physician practices.

16. Here is how: While Defendants fraudulently billed the government for the most expensive of the special staining procedures, they pocketed the portion of the money normally paid to the physician practices for the specimen collections (“the technical component of the claim”), in addition to their professional component of the claims. The physician practices had no idea that Defendants were using specimen drawn from their patients to bill for both the technical and professional components (“global billing”) of the costliest of the special stains.

17. In this way, Defendants' scheme was singular in purpose—to maximize billings to the government and enrich themselves financially—and it operated like an efficient assembly line for fraudulent claims to the government (Medicare, Medicaid and TRICARE).

18. The Defendant GIs also billed the government for pathology services even where no medical necessity determination was made. Whenever the Defendant GIs themselves pocketed the money for “the technical component of these claims,” they also enriched themselves at the government's expense.

19. Defendants also set up sham labs in Florida and other States and billed the government for pathology services purportedly performed in those States.

20. Through its fraudulent course of conduct, Defendants knowingly submitted or caused the submission of false or fraudulent claims to the government, in violation of the federal and state False Claims Acts, and the government paid those claims.

21. Victims of this fraud are the United States and the taxpayers. This kind of scheme depletes the funds designed to support and care for older and sick Americans, including members of our military and veterans. The fraud also creates improper inducements that can corrupt the integrity of physician decision-making.

22. The False Claims Act is the appropriate tool to remedy this fraudulent scheme according to the Deputy Assistant Attorney General for the United States Department of Justice: “the False Claims Act has long served as an important vehicle for ensuring compliance with the Anti-Kickback Statute and Stark Law. Indeed, such cases have been at or near the top of the list of cases most frequently pursued by the Department over the last several years.”

<https://www.justice.gov/opa/speech/remarks-deputy-assistant-attorney-general-michael-d-granston-aba-civil-false-claims-act>

II. LEGAL FRAMEWORK

A. Parties

23. Relators allege, based upon personal knowledge, relevant documents, and information, and on information and belief, the facts set forth in this Complaint.

24. Relators were employees of Defendant Advanced Pathology Solutions during the time period alleged in the Complaint.

25. Relators have extensive first-hand knowledge of Defendants’ policies and practices alleged in this Complaint.

26. Relators were retaliated against for raising, objecting to, and opposing fraudulent conduct alleged in this Complaint.

27. Relators have standing to bring this action pursuant to 31 U.S.C. § 3730(b)(1). Prior to becoming aware of any known public disclosure under subsection (e)(4)(a) of 31 U.S.C. § 3730, Relators voluntarily disclosed to the Government the information on which the allegations or transactions in this claim are based; and Relators have knowledge that is independent of and materially adds to any publicly disclosed allegations or transactions that may exist and have voluntarily provided the information to the Government before filing an action. Relators are either entitled to between 15-25 percent of the proceeds that result from this action or any settlement of the claims raised or identified herein, under 31 U.S.C. § 3730(d)(1); or between 25 – 35 percent of the proceeds pursuant to 31 U.S.C. § 3730(d)(2).

28. Prior to filing their complaint, and pursuant to subsection (e)(4)(a) of 31 U.S.C. § 3730, Relators voluntarily disclosed to the Government the information on which the allegations or transactions of their claims are based; and Relators have knowledge that is independent of and materially adds to any publicly disclosed allegations or transactions that may exist and have voluntarily provided the information to the Government before filing an action under this section. 31 U.S.C. § 3730(e)(4)(A). Relators are the original source of these allegations as defined in 31 U.S.C. § 3730(e)(4)(B).

29. Defendant Advanced Pathology Solutions (“APS”) represents itself as

“a CLIA-accredited anatomic and molecular pathology laboratory dedicated to bringing the highest quality pathology services to Gastroenterologists, Podiatrists, Wound Specialists, Pain Specialists, Orthopedists, and Plastic Surgeons.”

30. APS is headquartered in North Little Rock, Arkansas.

31. APS is staffed with at least eight pathologists who are physically located at headquarters in Arkansas.

32. APS has arrangements with over 1,000 physician practices for the provision of pathology services in at least 40 states, including the states named in this Complaint.

33. Defendant Kevin Hannah was the Chief Executive Officer (“CEO”) of APS and worked at APS headquarters during the time period alleged in the Complaint. On information and belief, he holds an ownership interest in APS.

34. Defendant Hunter Pledger is the Chief Laboratory Officer (CLO) of APS and worked at APS headquarters during the time period alleged in the Complaint. On information and belief, he holds an ownership interest in APS.

35. Defendant Donell Burkett is the Chief Operations Officer (COO) of APS and worked at APS headquarters during the time period alleged in the Complaint.

36. Defendant Histology Connections, LLC is based in Little Rock, Arkansas and is co-owned by Defendants Kevin Hannah and Hunter Pledger. It is

a related entity of APS, selling discounted lab equipment to the physician practices for their on-site APS labs. This company is staffed with APS employees.

37. Defendant United Digestive is a gastroenterology practice in Atlanta, Georgia.

38. Defendant Gastrointestinal Specialists is a gastroenterology practice in Shreveport, Louisiana.

39. Premier Gastroenterology Associates PLLC is a gastroenterology practice in Little Rock, Arkansas.

40. Digestive Diseases Center of Hattiesburg, LLC (“DDC-Hattiesburg”) is a gastroenterology practice in Hattiesburg, Mississippi.

41. Medical Associates of Northwest Arkansas (“MANA”) is a gastroenterology practice in Fayetteville, Arkansas.

42. Digestive Disease Group (“DDG”) is a gastroenterology practice in Greenwood, South Carolina.

43. Gastroenterology Associates of Central Georgia is a gastroenterology practice in Macon, Georgia.

44. Gastroenterology Associates PA is a gastroenterology practice in Hickory, North Carolina.

45. Gateway Gastroenterology is a gastroenterology practice in Chesterfield, Missouri.

46. Dr. Luis E. Alvarez Gastroenterology is a gastroenterology practice in New Iberia and Lafayette, Louisiana.

47. Defendant Gastroenterology Clinic of Acadiana is a gastroenterology practice in Lafayette, Louisiana.

48. Defendant Alabama Medical Group PC is a physician practice in Mobile, Alabama.

B. Jurisdiction and Venue

49. This Court has subject matter jurisdiction over the claims asserted in this Complaint, pursuant to the False Claims Act, 31 U.S.C. §§ 3729 *et seq.*, and 28 U.S.C. § 1331.

50. Venue is proper in this judicial district, pursuant to 31 U.S.C. § 3732(a), because one or more defendants may be found, resides, and/or transacts business in this District, or because an act, proscribed by 31 U.S.C. § 3729, occurred in this District.

C. Time Period

51. On information and belief, Defendants' business model, upon which the fraudulent conduct alleged in this Complaint is based, has been in operation since at least as early as 2014.

D. The Laws Violated

1. The Federal False Claims Act

52. The False Claims Act provides, in part: Liability for Certain Acts.

— (1) In general.—[] any person who—

(A) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval

(B) knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim

(C) conspires to commit a violation of subparagraph (A), (B), [] or (G), []

(G) knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the Government, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government, []

is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990 (28 U.S.C. 2461 note; Public Law 104–410 [1]), plus 3 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), (C), (G).

53. Under the False Claims Act, scienter must be demonstrated:

Definitions—For purposes of this section— (1) the terms “knowing” and “knowingly”— (A) mean that a person, with respect to information— (i) has actual knowledge of the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information; and (B) require no proof of specific intent to defraud. 31 U.S.C. § 3729(b)(1)-(2).

54. Under section (b)(2) the term “claim ” — (A) means any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property, that— (i) is presented to an officer, employee, or agent of the United States; or (ii) is made to a contractor, grantee, or other recipient, if the money or property is to be spent or used on the Government’s behalf or to advance a Government program or interest, and if the United States Government— (I) provides or has provided any portion of the money or property requested or demanded; or (II) will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded; []. 31 U.S.C. § 3729(b)(1)-(2).

55. Under the False Claims Act, materiality is defined as “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” 31 U.S.C. § 3729(b)(4); *Universal Health Services, Inc. v.*

United States ex rel. Escobar, et al. 136 S. Ct. 1989 (2016).

2. The Anti-Kickback Statute

56. The Anti-Kickback Statute (AKS) prohibits any person or entity from making or accepting payments to induce or reward any person for referring, recommending or arranging for the purchase of any item for which payment may be made under a federally-funded health care program. 42 U.S.C. § 1320a-7b(b).

57. The AKS does not require persons to have actual knowledge or specific intent to commit a violation. 42 U.S.C. § 1320a-7b(h).

58. The AKS has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals. An opportunity to earn a fee may be sufficient to constitute an inducement, even if payments were reasonable for services.

59. The AKS contains statutory safe harbors that exempt certain transactions from its prohibitions such as contracts for employment or personal services.

60. The federal agency that enforces the AKS – the United States Department of Health and Human Services (“HHS”), Office of Inspector General (“OIG”) – warns that “arrangements between referring physicians and laboratories historically have been subject to abuse,” further stating that “whenever a laboratory offers or gives to a source of referrals anything of value not paid for at fair market

value, the inference may be made that the thing of value is offered to induce the referral of business.”

61. HHS-OIG further cautioned that “we have, on various occasions, repeated our position that arrangements providing free or below-market goods or services to actual or potential referral sources are suspect and may violate the anti-kickback statute, depending on the circumstances.”

62. There is a “personal services safe harbor” under the AKS. The personal services safe harbor applies to payments to an agent as long as: (1) the agency agreement is in writing and signed by the parties; (2) the agreement specifies all of the services that the agent is to provide for the principal; (3) if “the agency agreement is intended to provide the services of the agent on a periodic, sporadic, or part-time basis” then the agreement must specify the intervals and their schedules and charges with specificity; (4) the term of the agreement must be not less than 1 year; (5) the aggregate compensation to the agent must be set in advance, “consistent with fair-market value,” and not be determined “in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties;” (6) the services must not involve promotion of any activity that violates state or Federal law; and (7) the aggregate services contracted for must not exceed those reasonably necessary to accomplish the business purpose of the entity. 42 C.F.R. § 1001.952(d).

63. Compliance with the AKS is a precondition to participation as a health care provider in all federal health care programs (Medicare, Medicaid, TRICARE, VA Health Programs, and the Federal Employees Health Benefits program). Health care providers are required to enter into provider agreements with CMS and certify that they are complying with the Medicare and Medicaid laws, regulations, and program instructions, including the AKS.

64. Compliance with the AKS is also a condition of payment for health care providers under these same health care programs.

65. Similarly, compliance with the AKS is a prerequisite to health care providers' obligations when they receive or retain reimbursement payments from government-funded health care programs.

66. Thus, compliance with these terms is at the essence of the bargain between the government and health care providers and material to the government's payment decision.

67. Further, any party convicted under the AKS must be excluded from federal health care programs and not allowed to bill for services rendered for a term of at least five years. 42 U.S.C. § 1320a-7(a)(1). Even without a conviction, if the Secretary of HHS finds that a provider has violated the AKS, the Secretary may exclude that provider from the federal health care programs for a discretionary period, direct the relevant State agency to exclude that provider from the State

health programs, and impose administrative sanctions of \$50,000 per kickback violation. 42 U.S.C. § 1320a-7(b).

68. The enactment of these various provisions demonstrates Congress' commitment to the fundamental principle that federal health care programs will not tolerate the payment of kickbacks.

69. Furthermore, pursuant to the Affordable Care Act passed in 2010, any claim submitted to a federal health care program that includes items or services resulting from violations of the AKS constitutes a false or fraudulent claim for purposes of the False Claims Act. 42 U.S.C. § 1320a-7b(g)

3. The Stark Law

70. The Stark Law establishes the clear rule that the United States will not pay for designated health services prescribed by physicians who have improper financial relationships with other health care providers. The statute was designed specifically to prevent losses that might be suffered by the Medicare program due to questionable utilization of designated health services.

71. The Stark Law explicitly states that Medicare may not pay for any designated health service provided in violation of the Stark Law. 42 U.S.C. § 1395nn(g)(1). In addition, the regulations implementing the Stark Law expressly require that any entity collecting payment for a healthcare service “performed

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

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

73. In 1993, Congress passed Stark II, which extended the Stark Law to referrals for additional designated health services. Omnibus Reconciliation Act of 1993, P.L. 103-66, § 13562, Social Security Act Amendments of 1994, P.L. 103-432, § 152.

74. The Stark Law prohibits a lab (such as Defendant APS) from submitting a claim to Medicare for “designated health services” that were referred to the lab by a physician with whom the lab has a “financial relationship,” unless a statutory exception applies.

75. “Designated health services” include clinical laboratory services. 42 U.S.C. § 1395nn(h)(6).

76. In pertinent part, the Stark Law provides:

(a) Prohibition of certain referrals

(1) In general

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

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

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

42 U.S.C. § 1395nn(a)(1).

77. A “financial relationship” includes a “compensation arrangement,” which means any arrangement involving any remuneration paid directly or indirectly to a referring physician. 42 U.S.C. §§ 1395nn(h)(1)(A) and (h)(1)(B).

78. The Stark Law and companion regulations contain exceptions for certain compensation arrangements. These exceptions include, among others, “in-office ancillary services” and “personal services arrangements.”

79. To qualify for the Stark Law’s exception for in-office ancillary services, the arrangement must meet the following statutory requirements: (A) the service can be provided in the physician practice; and (B) the person supervising the service is employed or retained by the physician practice, (C) the services are provided “on-

site,” and (D) the services are billed by the appropriate party. 42 U.S.C. §§ 1395nn(b)(2).

80. If a physician practice chooses to operate an on-site lab, the physician practice must furnish the necessary supervision of the lab services with its own employees.

81. It may be permissible for a physician practice to not provide the supervision for an on-site lab and instead contract with a pathology lab to provide consulting services with respect to the establishment and management of ongoing operations, provided that the arrangement with the pathology lab complies with the Stark Law exception for personal service arrangements.

82. To qualify for the Stark Law’s exception for personal services arrangements, the arrangement must meet the following statutory requirements: (A) arrangement terms in writing, (B) written arrangement covers all services to be furnished by lab to physician practice and vice versa, (C) aggregate services are reasonable and necessary, (D) arrangement is for at least a year, (E) compensation does not exceed fair market value. 42 U.S.C. § 1395nn(e)(3)(A)(v).

4. The State False Claims Acts

83. The False Claims Act of numerous states are alleged in this Complaint, including the states California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Louisiana, Maryland, Massachusetts, Michigan,

Minnesota, Montana, Nevada, New Jersey, New Mexico, North Carolina, Oklahoma, Tennessee, Texas, Vermont, Virginia and Washington and the District of Columbia.

III. THE REGULATORY FRAMEWORK

A. The Government Health Care Programs

1. Medicare

84. In 1965, Congress enacted Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.*, to pay the costs of certain health care services for eligible individuals, also known as Medicare. 42 U.S.C. §§ 426, 426a.

85. The other federal and state healthcare programs have similar requirements and have similarly been defrauded by the Defendants, including Medicaid, TRICARE, the VA health programs and the Federal Employee Health Benefits (FEHB) program.

86. The Medicare program consists of four parts: A, B, C and D. Defendants submitted, or caused to be submitted, false claims under Medicare Parts A and B.

87. Medicare Part A provides coverage for hospital costs, services rendered by hospitals, skilled nursing facilities, home health care, and hospice care.

88. Medicare Part B covers the cost of medically necessary services, including provider services, clinical laboratory tests and other medical services and

supplies. 42 U.S.C. §§ 1395j-1395w-4. Most laboratory services are considered Part B services and paid for individually as identified by the appropriate Current Procedural Terminology (“CPT”) code.

89. Medicare provides coverage for items and services that are reasonable and necessary to diagnose or treat an illness or injury or to improve a malformed body member. Payment will be provided if medical necessity is documented and can be substantiated. Standing orders usurp medical necessity determinations and are not allowable.

90. The activities, operations, and contracts of HHS are paid from federal funds. CMS is a division of HHS that is responsible for the administration and supervision of the Medicare and Medicaid programs. To administer Part B Medicare reimbursement claims, HHS contracts with private local insurance companies, known as “carriers” or “fiscal intermediaries,” to receive, review, and pay appropriate reimbursement claims related to services provided to Medicare beneficiaries. 42 U.S.C. § 1395h; 42 C.F.R. §§ 421.3, 421.100.

91. CMS calls these “carriers” Medicare Administrative Contractors or “MACs,” and awards a geographic jurisdiction to process Medicare Parts A and B claims to those MACs.

92. “CMS relies on a network of MACs to serve as the primary operational contact between the Medicare FFS program and the health care providers enrolled in the program.”

93. Among other activities, MACs are responsible for “educat[ing] providers about Medicare FFS [Fee-For-Service] billing requirements,” and “establish[ing] local coverage determinations (LCDs).”

94. Here are the responsible MACs during the relevant time frames:

MAC	YEARS	JURISDICTION
Cahaba Government Benefit Administrators, LLC	2013 - February 2018	Alabama Georgia Tennessee
CGS Administrators, LLC	2013 - 2020	Kentucky Ohio
First Coast Service Options, LLC	2013 - 2020	Florida Puerto Rico
Noridian Healthcare Solutions, LLC	2013 - 2020	Alaska Arizona California Hawaii Idaho Montana Nevada North Dakota Oregon South Dakota Utah Washington Wyoming

National Government Services, Inc.	2013 - 2020	Connecticut Illinois Maine Massachusetts Minnesota New Hampshire New York Rhode Island Vermont Wisconsin
Novitas Solutions, Inc.	2013 - 2020	Arkansas Colorado Delaware District of Columbia Louisiana Maryland New Jersey New Mexico Mississippi Oklahoma Pennsylvania Texas
Palmetto GBA, LLC	2013 - 2020	North Carolina South Carolina Virginia West Virginia
Palmetto GBA, LLC	February 2018 – 2020	Alabama Georgia Tennessee
Wisconsin Physicians Service Government Health Administrators	2013 - 2020	Indiana Iowa Kansas Michigan Missouri Nebraska

2. Medicaid

95. The Medicaid Program provides funding for medical and health-related services for certain individuals and families with low incomes and virtually no financial resources. 42 U.S.C. § 1396, *et seq.* Those eligible for Medicaid include pregnant women, children, and persons who are blind or suffer from other disabilities and who cannot afford the cost of health care. 42 U.S.C. § 1396d.

96. The Medicaid program is a joint federal–state health care program. 42 U.S.C. § 1396b. If a state elects to participate in the program, the costs of Medicaid are shared between the state and the federal government. 42 U.S.C. § 1396a(a)(2). In order to receive federal funding, a participating state must comply with requirements and regulations imposed by the Act.

3. TRICARE

97. TRICARE is a federal health care program that is administered by the Defense Health Agency (“DHA”), which is a component of the United States Department of Defense (“DOD”). TRICARE provides health care insurance for active-duty military personnel, military retirees, and military dependents.

98. TRICARE also requires that appropriate medical records be maintained to substantiate that billed services were actually rendered. Failure to document the care billed will result in denial of payment by TRICARE. 32 C.F.R. § 199.7(b)(3).

B. Requirements for Payment of Claims

99. Medicare providers such as APS have a legal duty to familiarize themselves with Medicare's reimbursement rules, including those delineated in the Medicare Manuals. *Heckler v. Cmty. Health Serv. of Crawford County, Inc.*, 467 U.S. 51, 64-65 (1984). United States Supreme Court Justice Holmes wrote: "Men must turn square corners when they deal with the Government." *Rock Island, A. & L. R. Co. v. United States*, 254 U. S. 141, 254 U. S. 143 (1920). As the Supreme Court has further noted, this observation has its greatest force when a private party seeks to spend the government's money. Protection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law. A health care provider, such as Defendant APS, can expect no less than to be held to the most demanding standards in its quest for public funds. This is consistent with the general rule that those who deal with the Government are expected to know the law. *Heckler v. Commun. Health Svcs.* 467 U.S. 51 (1984).

100. Medicare Provider Agreements require health care providers to certify to the following:

2. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of

any text on this application form, may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.

3. I agree to abide by the Medicare laws, regulations and program instructions that apply to this provider. The Medicare laws, regulations, and program instructions are available through the Medicare contractor. **I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal anti-kickback statute and the Stark law), and on the provider's compliance with all applicable conditions of participation in Medicare.**

6. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and I will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

(emphasis added)

101. Likewise, Medicaid Provider Agreements typically require health care providers to certify:

I understand that any omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicaid to complete or clarify this application may be punishable by criminal, civil or other administrative actions.

I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicaid and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

102. Medicare only pays for Part B services that are actually rendered and are reasonably and medically necessary. 42 U.S.C. § 1395y(a). Part B providers such as Defendant APS also must certify that services are medically necessary. 42 C.F.R. § 424.24(g)(1). Standing orders usurp medical necessity determinations and are unlawful.

103. State Medicaid claims, which are funded in part with federal dollars, are similarly required to cover only medical items and services that are within the scope of the state program and that are medically necessary. 42 U.S.C. § 1395y(a). Again, standing orders usurp medical necessity determinations and are unlawful.

104. TRICARE also does not pay for services that are not authorized by law or that are fraudulently billed. 32 C.F.R. § 199.7(i)(3).

105. As a participant in the Medicare, Medicaid and other federal and state health care programs, APS has a duty to familiarize itself with each health care program's legal requirements and to comply with the False Claims Act.

106. To obtain reimbursement from all government health care programs, health care providers submit a claim form, which is typically done electronically.

107. To submit claims electronically, Medicare providers execute an Electronic Data Interchange Enrollment Form (“EDI form”), in which providers agree to “be responsible for Medicare claims submitted to CMS by itself, its employees, or its agents,” and to “submit claims that are accurate, complete and truthful.”

108. By executing the EDI Enrollment Form, a provider also acknowledges “that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim as required by this Agreement may, upon conviction be subject to a fine and/or imprisonment under applicable Federal law.”

109. For Medicaid payments, providers also certify on Form CMS 1500 that “services were medically indicated and necessary to the health of this patient.” It also contains another “NOTICE” that “the foregoing information is true, accurate and complete ... and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.” CMS 1500, Health Insurance Claim Form,

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS1188854>

110. To obtain TRICARE reimbursement for services from physicians or other authorized health care providers, as with Medicare, the providers must submit a claim form to TRICARE, which lists the procedure code or narrative description for each procedure or service for each date of service. TRICARE claim forms also must bear a signature of the participating provider certifying that the medical care billed for was actually rendered to the government-insured patients. This signature certifies that the specific medical care listed on the claim form was actually rendered to the specific government-insured patients at the level indicated on the claim form. 32 C.F.R. §§ 199.7(b)(2)(ix)(B) & (c).

111. Among the information the provider includes on a CMS 1500 or 837P form are certain five-digit codes, including CPT and Healthcare Common Procedure Coding System (“HCPCS”) codes, that identify the diagnosis, services rendered for which reimbursement is sought, and the unique billing identification number of the “rendering provider” and the “referring provider or other source.” 45 C.F.R. § 162.1002(a)-(b).

112. TRICARE utilizes and incorporates CPT codes to describe the scope of allowable services.

113. Providing accurate CPT and HCPCS codes on claims submission forms is material to, and a condition of, payment for the for all government health care programs.

114. Defendants submitted or caused to be submitted claims for payment to the federal health care programs electronically, upon information and belief, on forms known as a UB-92, HCFA-1450 or UB-04, and CMS-1450, which contain the following certification: “This claim, to the best of my knowledge, is correct and complete [].”

115. Medicare contractors can establish Local Coverage Determinations (LCDs) when they identify over-utilization or aberrant billing patterns for a particular test. These policies specify when Medicare covers a given CPT code.

116. “CMS may automatically deny a claim without manual review if a national coverage decision or LMRP (local medical review policy, also known as a LCD) specifies the circumstances under which the service is denied, or the service is specifically excluded from Medicare coverage by law.” 42 C.F.R. § 410.32(b)(4).

117. Pursuant to all provider agreements between the federal and state governments and Defendants, Defendants must comply with all state and federal regulatory requirements.

C. Reimbursement for Pathology Services

118. “Diagnostic X-ray, laboratory, and other diagnostic tests, including materials and the services of technicians, are covered under the Medicare program.”

119. “[A]s is the case of all diagnostic services, in order to be covered these services must be related to a patient’s illness or injury (or symptom or complaint) and ordered by a physician. A small number of laboratory tests can be covered as a preventive screening service.”

120. Pathologists help identify the possible cause and effect of disease. Common pathology services include the testing and review of blood and urine. More involved pathology services extend to surgical biopsies or pap smears that may require further testing and examination.

121. Two of the most commonly used CPT codes for surgical pathology services are CPT Codes 88304 and 88305.

122. CPT Code 88304 is defined as a Level III surgical pathology that requires gross and microscopic examination for specific diagnoses or conditions. Basically, Medicare will reimburse the removal and evaluation of one slide specimen to diagnose or evaluate a specific condition for a patient.

123. CPT Code 88305 is defined as a Level IV surgical pathology that requires gross and microscopic examination and that Medicare reimburses at a greater amount because it involves the removal and evaluation of more than one slide specimen on the same date of service.

124. Biopsies are common specimens that are billed under these Medicare pathology codes.

125. Pathologists can also apply stains to specimens to help identify abnormalities in the tissue.

126. Medicare reimbursement for CPT Code 88305 also covers those pathology services that involve staining and, in particular, hematoxylin and eosin stains (“H&E stains”).

127. H&E stains are routine aspects of a CPT Code 88305 and help with the diagnosis and evaluation of disease. “H&E staining is included as part of pathology services [and] [i]t is not reasonable and necessary to claim this stain as a special stain.”

128. Typically, an H&E stain is adequate for diagnosing a patient.

129. Medicare also provides for the billing of additional specialized pathology services that can complement an H&E stain but only when medically necessary. Standing orders usurp medical necessity determinations and are unlawful.

130. Pathologists can determine if in addition to a routine H&E stain, a “special stain,” is medically necessary. “Special stains are called ‘special’ because they are dyes used to stain particular tissues, structures or pathogens such as bacteria that may not be visible by routine H&E staining.”

131. Types of special stains include:

- H. pylori and giemsa stains that are billed to the Medicare

program under CPT code 88312

- Alcian blue, PAS, and trichrome stains that are billed to the Medicare program under CPT code 88313
- Immunohistochemistry (IHC) stains that are billed to the Medicare program under CPT code 88342

132. A pathologist should review the specimen with the H&E stain before ordering any special, additional stain for the specimen.

133. Pathologists sometimes refer to the use of these special stains as “double staining” because it is an additional service that is rendered and billed only when the H&E stain alone may be insufficient.

134. Medicare states that special stains are only payable when:

Services are medically necessary so that a complete and accurate diagnosis can be reported to the treating physician/practitioner;

Results of the tests are communicated to and are used by the treating physician/practitioner in the treatment of the beneficiary; and

Pathologist documents in his/her report why additional testing was done.

135. Further, CMS requires that the health care provider “who orders the service must maintain documentation of medical necessity in the beneficiary’s medical record” for that claim to be payable. 42 C.F.R. § 410.32(d)(2).

136. Medicare contractors have issued LCDs about special stains for the evaluation of a number of disease states because of the concern that providers are over-utilizing or incorrectly billing for these services.

137. This documentation requirement was reiterated in the LCDs: “[t]he medical necessity for the special stain or IHC studies, and the results of the stain or IHC, must be documented in the surgical pathology report.”

138. To avoid billing for medically unnecessary claims for special stains, Medicare contractors have issued LCDs to put the health care provider community on notice that they are required to document the reasons for special stains related to gastrointestinal pathology, breast pathology, prostate pathology, lung cancer, certain types of tumors and tumor profiling, skin and peripheral nervous system lesions, and bone marrow samples. Standing orders usurp medical necessity determinations and are unlawful.

139. For services related to gastrointestinal pathology such as those provided by APS, the Medicare LCDs put the health care providers on notice that:

Most normal and abnormal conditions of these organs can be detected by the use of the routine H&E stain alone. Only the pathologist may determine the medical necessity of a special stain.
Ordering special stains of IHC stains prior to review of the routine H&E stain is not reasonable or necessary.

(emphasis added).

140. For instance, gastrointestinal biopsies and nail specimens are evaluated, in part, for the presence of a bacteria known as helicobacter pylori (H. pylori).

141. Typically, H. pylori can be detected through the routine H&E stain that Medicare pays for pursuant to CPT Codes 88304 or 88305. It is not reasonable or necessary to order special stains to detect that bacteria, and if ordered, the pathologist must document the specific reason why after review of the initial stained gastrointestinal biopsies or nail specimens. Standing orders usurp medical necessity determinations and are unlawful.

142. The LCDs put the providers on notice that:

Ordering SPECIAL STAINS or immunostains prior to review of the H&E stain is not reasonable and necessary.

If stains in addition to the H&E stain are needed, specific documentation to justify the need for the SPECIAL STAIN is required in the pathology report.

(emphasis added)

143. The LCDs further notify Medicare providers that: **“Scientific data demonstrates that the combined number of gastric biopsies requiring SPECIAL STAINS is equal to or less than 20% of biopsies received and examined in a practice, laboratory, or hospital.”** (emphasis added)

144. The scientific evidence that H. pylori can be detected in routine

staining in a majority or at least 80 percent of biopsies is so strong that the LCDs even encourage providers to check their special stain utilization by performing self-audits to ensure that “[t]he ancillary stain code group should be less than 20% of the total gastric biopsies (88305 codes) submitted. **Providers that exceed the 20% criteria may be subject to additional action.**” (emphasis added)

145. CMS, through several of its contractors (MACs) in locations where Defendants submitted claims to the government, put Defendants on notice that special stains are medically necessary when a routine stain was deemed medically insufficient and should be required in no more than 20 percent of cases. However, under the unlawful standing order, Defendants billed the government for special stains in at least 200 percent of cases because they double-stained every specimen and billed at least 2 special stains on every specimen.

146. All pathology services can be billed with technical or professional component modifiers.

147. The technical component of billing for a pathology service involves the preparation of the slide from the specimen collection.

148. The professional component of billing for a pathology service involves the reading of the slide by the pathologist.

149. These CPT codes may also be billed “globally,” meaning that

both technical and professional components are billed together by the same Medicare provider.

D. Requirements for Pathology Labs

150. To establish a pathology lab in any state and bill the government health care programs for pathology services, the lab must adhere to the Clinical Laboratory Improvement Amendments (CLIA), which are administered by CMS. 42 C.F.R. § 493.2

151. Congress passed CLIA in 1988 to strengthen federal oversight of clinical laboratories and ensure accuracy and reliability of test results.

152. CLIA regulates pathology labs that test human specimens to ensure “accurate, reliable and timely patient test results,” regardless of where the test is performed. 42 C.F.R. § 493.2.

153. Pursuant to CLIA mandates, high complexity pathology testing, such as special staining, requires the lab to be staffed with a medical director who “must be qualified to manage and direct the laboratory personnel and performance of high complexity tests and must be eligible to be an operator of a laboratory.” 42 C.F.R. § 493.1441, 493.1443; 42 C.F.R. § 410.33(b) (IDTF supervision requirements).

154. The laboratory director must “be a doctor of medicine or doctor of osteopathy licensed to practice medicine or osteopathy in the State in which

the laboratory is located.” 42 C.F.R. § 493.1443(b)(1)(i)

155. The laboratory director “is responsible for the overall operation and administration of the laboratory, including the employment of personnel who are competent to perform test procedures, record and report test results promptly, accurately and proficiently, and for assuring compliance with the applicable regulations.” 42 C.F.R. § 493.1445

156. Relatedly, the laboratory must have a technical supervisor, clinical consultant, and general supervisor who possess the appropriate licensure in the state where the laboratory is located, plus certain other accreditations, licensure and requirements for certain specialties. 42 C.F.R. §§ 493.1449, 493.1453, 493.1455, 493.1457, 493.1459, 493.1461, 493.1463.

157. While the technical and clinical supervisors need not be on-site at all times when testing is being performed, the supervisor must still be accessible to the laboratory to provide on-site, telephone or electronic consultation. 42 C.F.R. §§ 493.1451 & 493.1457

158. The general supervisor must “provide day-to-day supervision of testing personnel and reporting of test results. In the absence of the director and technical supervisor, the general supervisor must be responsible for the proper performance of all laboratory procedures and reporting of test results.” 42 C.F.R. § 493.1461.

159. Pathologists may act as the supervising physician or medical directors of clinical laboratories.

160. Any location that fails to staff a pathology lab with these required supervising personnel would be in non-compliance with CLIA and ineligible to submit claims to the government health care programs.

IV. THE FRAUD SCHEME

A. The Unlawful Kickback Scheme

161. Defendants knowingly executed fraudulent arrangements with physician practices, offering remuneration in the form of pathology-related services at little to no cost in exchange for exclusive lucrative referral streams for pathology services that themselves were unallowable.

162. Their senior executives planned, marketed, implemented, and maintained these unlawful kickback arrangements, including the Chief Executive Officer, Chief Laboratory Officer and Chief Operating Officer, all named as Defendants.

163. Defendants' unlawful kickback scheme worked like this:

- Defendants established on-site labs for physician practices at little to no cost.
- In exchange, the physician practices were required to perform all biopsies of government-insured patients through the on-site lab and

exclusively refer specimens to Defendants to perform the pathology services.

- Defendants performed pathology services on the biopsies and submitted claims for these services to the government (“the professional component” of the claims).
- Defendants perpetuated the scheme through additional services to the physician practices at little to no cost to the groups, such as lab technicians, lab supplies and equipment, office and administrative equipment, shipping services, electronic data systems, and physical storage facilities.
- In marketing this scheme, Defendants shared a financial statement with physician practices, including Defendant GIs, that predicted they would make significant extra money in net revenue that would come from billing the government programs for the specimen collections for pathology services (“the technical component of the claims”). The financial statement showed the little amount of money the physician practices were expected to pay for on-site labs, as shown against their higher expected net earnings.

164. In short, the physician practices, including Defendant GIs, earned money they otherwise would not have earned but for Defendants’ scheme in the

form of on-site lab operations, and these arrangements were lucrative for Defendants and Defendant GIs. It was a win-win for both parties to the arrangements and tainted the claims paid by the government programs.

165. As part of their scheme, Defendants executed written agreements with physician practices, including Defendant GIs. However, the unlawful kickback arrangements were either contrary to the express terms of the written agreements or outside the terms of the written agreements.

166. On information and belief, Defendants have almost exclusively performed pathology services for at least 1,000 physician practices in multiple States, including the States named in this Complaint.

167. The cost of the services that Defendants provided the physician practices to establish and maintain these on-site labs were not commercially reasonable or at fair market value (“little to no cost”), rendering them unlawful kickbacks.

168. Defendant GIs were as knowledgeable as Defendants that these arrangements were unlawful kickbacks.

169. Further, no AKS Safe Harbor or Stark exception applied to these arrangements, and all claims submitted (or caused to be submitted) by Defendants and Defendant GIs to the government were tainted.

1. Components of the Scheme

170. As described further, there were several components of Defendants' and Defendant GIs' unlawful kickback scheme.

a. On-Site Labs at Little to No Cost

171. Defendants provided consulting services, personnel, equipment, and supplies for start-up and maintenance of on-site labs at little or no cost to the physician practices, including Defendant GIs.

172. In some instances, the written agreements between the parties stated that such costs would be approximately \$10,000. Other times, the written agreements were silent about the costs for these same services.

173. Often Defendants did not always charge the physician practices \$10,000 for the consulting services, as stated by the written agreements. In those few instances where physician practices did pay \$10,000, that amount was not commercially reasonable or fair market value for the services, in violation of the AKS and Stark laws. And no safe harbors or exceptions applied.

174. One contemporaneous fair market valuation showed that the services provided by Defendants to physician practices, including Defendant GIs, would have been more than two times the amount quoted by Defendants (i.e., \$20,000) in the written agreement.

175. Unlawful kickback arrangements with the Defendant GIs are illustrative of the types of unlawful kickbacks provided to other physician practices, as shown below.

176. Defendant United Digestive (Atlanta, Georgia) executed an agreement with Defendants and Defendants charged it no more than \$10,000 for the consulting fees for a new on-site lab.

177. Defendant Gastrointestinal Specialists (Shreveport, Louisiana) executed an agreement with Defendants and Defendants charged them no more than \$10,000 for the consulting fees for a new on-site lab.

178. Defendant Premier Gastro Associates (Little Rock, Arkansas) executed an agreement with Defendants and Defendants charged them no more than \$10,000 for the consulting fees for a new on-site lab.

179. Digestive Diseases Center of Hattiesburg, LLC (“DDC-Hattiesburg”) (Hattiesburg, Mississippi) executed an agreement with Defendants and Defendants charged it no more than \$10,000 for the consulting fees for a new on-site lab.

180. Defendant Medical Associates of Northwest Arkansas (“MANA”) (Fayetteville, Arkansas) executed an agreement with Defendants and Defendants charged them no more than \$10,000 for the consulting fees for a new on-site lab.

181. Defendant Digestive Disease Group (“DDG”) (Greenwood, South Carolina) executed an agreement with Defendants and Defendants charged it no

more than \$10,000 for the consulting fees for a new on-site lab.

182. Defendant Gastroenterology Associates of Central Georgia (Macon, Georgia) executed an agreement with Defendants but did not charge them for consulting services for an existing on-site lab.

183. Defendant Gastroenterology Associates PA (Hickory, North Carolina) executed an agreement with Defendants and Defendants charged it no more than \$10,000 for the consulting fees for a new on-site lab.

184. Defendant Gateway Gastroenterology (Chesterfield, Missouri) executed an agreement with Defendants and Defendants charged it no more than \$10,000 for the consulting fees for a new on-site lab.

185. Defendant Luis E. Alvarez Gastroenterology (New Iberia, Louisiana) executed an agreement with Defendants for \$10,000 in consulting fees. On information and belief, Defendants provided the consulting services for its on-site lab but never collected money for these services.

186. Defendant Gastroenterology Clinic of Acadiana (Lafayette, Louisiana) executed an agreement with Defendants and Defendants charged it no more than \$10,000 for the consulting fees for a new on-site lab.

187. Defendant Alabama Medical Group PC (Mobile, Alabama) executed an agreement with Defendants and Defendants charged it no more than \$10,000 to upgrade its on-site lab.

188. Below are further examples of unlawful kickback arrangements that Defendants had with physician practices.

189. In April 2020, a physician practice in Loganville, Georgia was offered services to establish an on-site lab at little cost and Defendants never intended to collect the fees at all.

190. A physician practice in Leesburg, Florida executed an agreement with Defendants and Defendants provided it consulting services to upgrade an existing on-site lab but charged it only a \$5,000 consulting fee.

191. A physician practice in Tavares, Florida executed an agreement with Defendants in March 2020 and Defendants charged it no more than \$10,000 for consulting fees for a replacement on-site lab with new equipment and training services.

192. A physician practice in Altamonte Springs, Florida executed an agreement with Defendants and Defendants provided it consulting services to upgrade an existing an on-site lab at no cost, per the written agreement between the parties.

193. As explained by the Chief Executive Officer, Defendants provided these services at no cost to the physician practices, including Defendant GIs, even when the written agreement quoted a flat fee of \$10,000, because the kickback arrangement would be lucrative for both parties in the end:

In regards to the consulting fee I know we discussed the ability to be flexible on that since you are not a full build. We have to charge something for proprietary knowledge, however, I did just speak with our CEO and he said he would be happy to waive it. He said 'Bottom line is ourselves and [the practice group] will make a lot of revenue from this partnership, and we do not need to hold it up over a couple thousand dollars.'

I will have a new contract sent over with the removal of the consulting fee before your meeting.

(emphasis added).

194. In marketing its kickback scheme to physician practices, Defendants promised that “APS makes [this set-up] easy” using a “Lean Lab implementation team” for “lab equipment installation, lab staffing, CLIA setup and compliance, and diagnostic experience.” A “Lean Lab” is the term APS used for the on-site labs at the physician practices and is a common industry term.

195. As promised in the written agreements, Defendants designed and installed the on-site labs:

3.2 APS's Performance Obligations.

(a.) **Installation of Lab.** As described in Exhibit A, APS will install and set up the [REDACTED] Histology Lab and, for the term of this Agreement until the Date of Termination, provide or cause to be provided limited software support necessary to electronically link APS's lab and [REDACTED] Histology Lab's systems together for the purposes of providing the Services. APS is the personal property owner and/or license holder of all software and equipment it uses to perform the obligations contained in this Section 3.2(a.).

Exhibit A
Scope of Services

1. **Installation Phase.** APS agrees to assist [REDACTED] with the installation and setup of the [REDACTED] Histology Lab at the Property. APS and [REDACTED] shall mutually agree upon a schedule for the completion of the installation phase of this Agreement.

196. Defendants provided these services to the physician practices, including Defendant GIs, at little to no cost.

197. Defendants ordered and installed the lab equipment for the on-site labs: “APS will uncrate, set up, and validate all of the lab equipment.”

198. Defendants provided these services to the physician practices, including Defendant GIs, at little to no cost.

199. Although there were some upfront costs to physician practices for equipment, Defendants offered used equipment at discounted prices through the affiliated company, Defendant Histology Connections. This option provided Defendants yet another stream of income from the arrangements.

200. Defendants established the on-site lab’s billing processes.

201. Defendants provided these services to the physician practices, including Defendant GIs, at little to no cost.

202. Defendants hired and trained the histology technicians at the on-site labs on the collection, processing and shipment of specimen to Defendants for pathology services:

3.2 APS's Performance Obligations.

(b.) **Training of Histology Technician.** APS will provide training to the [REDACTED] employee selected to serve as the histology lab technician, or otherwise upon [REDACTED] request, provide employment referrals of potential candidates for the [REDACTED] histology lab technician position. APS expressly disclaims any warranty with respect to employment referrals it may provide under this Section 3.2(b.).

203. Defendants provided these services to the physician practices at little to no cost: “APS will train and handle all expenses for this.”

204. Defendants even hired, trained and paid for temporary histology technicians at the on-site labs during the start-up phase: “APS will provide an experienced technician to come to office and work in lab along with your histology technician, until all lab operations are running smoothly (most likely 1-2 weeks).”

205. To sustain its unlawful kickback scheme, Defendants established routine protocols and procedures for the daily operations of the on-site labs:

**Exhibit A
Scope of Services**

3. **Day-to-Day Services.** As described throughout the Agreement, APS will assist and provide [REDACTED] with consulting services necessary for the creation of an in-house Histology Lab. Ultimately, the [REDACTED] Histology Lab will process slides each day per approved protocol initiated by APS. At all times relevant under this Agreement, [REDACTED] shall follow the protocol, which is incorporated herein by reference as currently stated and as may be amended from time-to-time based upon laboratory best practices. All slide folders accompanied with the necessary patient information sheets (requisition sheets, insurance information, and other documents prescribed by APS) will be picked up each afternoon by FedEx or APS courier for delivery to APS at [REDACTED] [REDACTED] expense. Upon arrival at APS, all cases will be reviewed by a board-certified pathologist, and all pathology reports submitted to [REDACTED] that day or next day for viewing. In the event that forces beyond the parties' control prevent the delivery of slides within this timeframe, the parties agree that such slides shall be delivered within a reasonable time thereafter.

206. During its marketing presentation, Defendants promised that their staff would be “on-call” to provide “personalized concierge services for the gastroenterologists and their patients.”

207. As part of its day-to-day involvement in the on-site labs, Defendants provided the physician practices, including Defendant GIs, with daily access to their pathologists by sharing their cell phone numbers and direct emails: to “access your personal pathologists for any laboratory-related question.”

208. Defendants provided these ongoing services for the life of the on-site labs at little to no cost to the physician practices, including Defendant GIs.

209. Defendants prepared and filed the applications of the physician practices for their CLIA certifications required by CMS: “During the validation process, APS will have set up all of the lab manuals, and lab protocols within the CLIA guidelines for the lab.”

210. Defendants provided these services to physician practices, including Defendant GIs, at little or no cost.

211. These services were unlawful inducements and violated the AKS and Stark Law. No “safe harbors” or “exceptions” applied. Therefore, all claims submitted to (and paid by) the government programs were tainted by the unlawful kickbacks.

212. Troublingly, Defendants even flouted CLIA requirements and made false certifications to CMS during the application process because their singular goal was to maximize their billings to the government through these on-site labs. These false certifications are discussed in a separate section below.

b. Lab Supplies at Little to No Cost

213. The written agreements between Defendants and the physician practices, including Defendant GIs, do not mention the provision of lab supplies.

214. Yet, Defendants provided them lab supplies such as formalin jars and slide folders for specimen collection to physician practices: “APS will set up a vendor, for your in house lab, in order to get the APS discounted purchase prices, for ordering and receiving materials for the lab.”

215. Each formalin jar can cost as much as one dollar, plus shipping and delivery costs.

216. Defendants routinely furnished thousands of dollars of formalin jars to physician practices, including Defendant GIs, at little to no cost.

217. In one example, Defendants provided a physician practice with formalin jars based on “a standing order for every other week [for] 200 formalin [jars]” at no cost.

218. Defendants routinely furnished thousands of dollars of slide trays and slide folders (used to collect lab specimens) to physician practices at little to no cost.

219. These supplies were unlawful inducements and violated the AKS and Stark Law. No “safe harbors” or “exceptions” applied. Therefore, all claims submitted to (and paid by) the government programs by Defendants and Defendant GIs were tainted by the unlawful kickbacks.

c. Shipping Services at Little to No Cost

220. The written agreements between Defendants and the physician practices, including Defendant GIs, do not mention the provision of shipping services.

221. Yet, Defendants and the physician practices routinely shipped specimens and lab supplies between their offices, often using costly overnight shipment methods: “APS will set up FedEx pick up each day for the slides to be delivered [from physician practice] to the North Little Rock corporate offices.”

222. Defendants provided shipping services to physician practices, including Defendant GIs, at little to no cost.

223. In one example, Defendants shipped hundreds of free lab supplies for specimen collection (slide folders) to one physician practice at no cost to the physician practice for the expedited shipping method:

After overhearing about the shipping issues with the lab folders, I went ahead and ordered slide folders directly from my rep and had him overnight 240 folders directly to [the physician practice]. This is on my APS lab account, so no charges were made to [the physician practice] for this order.

224. These services were unlawful inducements and violated the AKS and Stark Law. No “safe harbors” or “exceptions” applied. Therefore, all claims submitted to (and paid by) the government programs by Defendants and Defendant GIs were tainted by the unlawful kickbacks.

d. Computers, Office Equipment and IT Services at Little to No Cost

225. The written agreements between Defendants and the physician practices, including Defendant GIs, do not mention the provision of computers, office equipment or information technology (“IT”) services.

226. Yet, Defendants provided them with computer laptops pre-installed with APS software to process the lab results and government claims, as accompanied by IT services.

227. Defendants purchased, installed and maintained high quality printers and scanners at the on-site labs:

- “APS will provide a dedicated pathology color printer to the GI clinic and the [ambulatory surgery clinic].”
- “Endoscopy called again today and said that she hasn’t received the ink yet.”

228. Defendants also stocked the physician practices with printer cartridges and other office supplies and equipment and provided routine maintenance of equipment.

229. In summary, Defendants provided computers, software, office equipment and IT and maintenance services to physician practices, including Defendant GIs, at little to no cost.

230. These were unlawful inducements and violated the AKS and Stark Law. No “safe harbors” or “exceptions” applied. Therefore, all claims submitted by Defendants and Defendant GIs to (and paid by) the government programs were tainted by the unlawful kickbacks.

e. Electronic Data Systems at Little to No Cost

231. The written agreements between Defendants and the physician practices, including Defendant GIs, do not mention the provision of electronic data systems.

232. Yet, Defendants provided laboratory information systems (LIS) that stored test orders and clinical results.

233. Further, the LIS allowed physician practices to print the results of pathology reports, which typically cost \$2 for each patient report.

234. Defendants provided LIS and report printouts to physician practices, including Defendant GIs, at little or no cost.

235. These were unlawful inducements and violated the AKS and Stark Law. No “safe harbors” or “exceptions” applied. Therefore, all claims submitted by Defendants and Defendant GIs to (and paid by) the government programs were tainted by the unlawful kickbacks.

f. Physical Storage Facilities at Little to No Cost

236. The written agreements between Defendants and the physician practices, including Defendant GIs, do not mention the use of physical storage facilities for paraffin tissue blocks and slide storage, which require temperature control.

237. Yet, Defendants provided facilities for the storage of thousands of paraffin tissue blocks and slide storage at Defendants’ headquarters.

238. Defendants provided these storage facilities at little to no cost to the physician practices, including Defendant GIs.

239. Recognizing that this free service was improper, at least one physician practice insisted that it would pay for its own storage.

240. These were unlawful inducements and violated the AKS and Stark Law. No “safe harbors” or “exceptions” applied. Therefore, all claims submitted by Defendants and Defendant GIs to (and paid by) the government programs were tainted by the unlawful kickbacks.

g. Histology Technicians at Little to No Cost

241. The written agreements between Defendants and the physician practices, including Defendant GIs, do not mention the provision of histology technicians.

242. Yet, Defendants provided histology technicians at on-site labs during the start-up phase: “She [histology technician] lives in OK and is willing to relocate but will need to give her 2 weeks notice. Then, she would need to move her things to Hickory and also spend a week in LR. **We need to resort to our contingency plan for at least a couple of weeks.**” (emphasis added).

243. Defendants provided these services at little or no cost to physician practices, including Defendant GIs.

244. These were unlawful inducements and violated the AKS and Stark Law. No “safe harbors” or “exceptions” applied. Therefore, all claims submitted

by Defendants and Defendant GIs to (and paid by) the government programs were tainted by the unlawful kickbacks.

2. Knowledge That Kickback Scheme Was Unlawful (Scienter)

245. As discussed extensively throughout this Complaint, Defendants and Defendant GIs knowingly engaged in an unlawful kickback scheme. They were aware that the provision of services and other items not contained in the written agreements were unlawful kickbacks. They were also aware that the provision of services at little to no cost was an unlawful kickback.

246. Defendant United Digestive (Atlanta, Georgia) raised concerns that Defendants' standing order was unlawful and, accordingly, requested that Defendants provide additional staff to remedy the problem. Defendants responded that: "providing additional onsite staff to do the new work could be construed as a 'kickback.'"

247. Despite this knowledge of what constituted an unlawful kickback, Defendants continued to provide consulting and IT services, lab technicians, lab supplies and equipment, office equipment (computers, printers, scanners and supplies), shipping services, software, electronic data systems, and physical storage facilities to physician practices at little to no cost.

248. On information and belief, Defendant United Digestive did not report these unlawful kickbacks to the government and continued to receive remuneration.

249. Further, on information and belief, Defendants knew that the conduct alleged in this Complaint amounted to an unlawful kickback scheme and they took measures to prevent discovery of the scheme by the government.

3. No Exceptions to The Kickback Scheme Applied

250. As shown, Defendants' kickback scheme is a violation of the Anti-Kickback Statute and Stark law and Defendants and Defendant GIs cannot avail themselves of any safe harbors or exceptions. These laws and their safe harbors and exceptions are described more fully above.

251. Under the Anti-Kickback Statute, the personal services safe harbor applies to payments to an agent as long as: (1) the agency agreement is in writing and signed by the parties; (2) the agreement specifies all of the services that the agent is to provide for the principal; (3) if "the agency agreement is intended to provide the services of the agent on a periodic, sporadic, or part-time basis" then the agreement must specify the intervals and their schedules and charges with specificity; (4) the term of the agreement must be not less than 1 year; (5) the aggregate compensation to the agent must be set in advance, "consistent with fair-market value," and not be determined "in a manner that takes into account the

volume or value of any referrals or business otherwise generated between the parties;” (6) the services must not involve promotion of any activity that violates state or Federal law; and (7) the aggregate services contracted for must not exceed those reasonably necessary to accomplish the business purpose of the entity. 42 C.F.R. § 1001.952(d).

252. Under the Stark Law, an on-site lab to a physician practice (such as APS), may qualify for the Stark Law’s exception for personal service arrangements if: (A) all arrangement terms are in writing, (B) the written arrangement covers all services to be furnished by lab to physician practice and vice versa, (C) aggregate services are reasonable and necessary, (D) the arrangement is for at least a year, (E) compensation does not exceed fair market value. 42 U.S.C. § 1395nn(e)(3)(A)(v).

253. Defendants provided physician practices, including Defendant GIs, consulting services, personnel, equipment, and supplies for start-up and maintenance of on-site labs at little or no cost to the physician practices.

254. While some written agreements between the parties addressed certain consulting services, and included a stated fee of \$10,000, that fee was often not charged to the physician practice or it was significantly reduced. Even if paid in some instances, \$10,000 was not commercially reasonable or fair market value for the services.

255. Further, Defendants' provision of lab technicians, lab supplies and equipment, office and administrative equipment, shipping services, electronic data systems, and physical storage facilities were not included in the written agreements.

256. For these reasons, Defendants' arrangements do not meet the personal services safe harbor or exception under the AKS or Stark law because portions of the arrangements were not in writing signed by the parties and those portions (consulting fees) that were in writing were not consistent with fair market value.

257. Therefore, all claims submitted to the government were tainted by these unlawful kickback arrangements, in violation of the False Claims Act.

258. On information and belief, Defendants and Defendant GIs knowingly submitted hundreds of thousands of false or fraudulent (tainted) claims to the government and knowingly failed to return overpayments of tainted claims.

B. The Standing Order Usurped Medical Judgment

259. As shown, Defendants' sole focus was to maximize government billings through their on-site labs at physician practices. Defendants' kickback scheme was accompanied by the submission of false claims to the government for excessive special stains.

260. Defendants effectuated this part of their scheme through use of a “standing order” for special stains, which operated much like an efficient assembly line at a factory designed to maximize government billings.

261. Special stains billed under CPT Codes 88312, 88313 and 88342 (and other CPT codes) were far more lucrative for Defendants than routine (H&E) stains billed under CPT Codes 88304 and 88305 because the government paid more money for these claims. Here are the costs to the government for these CPT codes in 2019:

CPT CODE	MEDICARE “GLOBAL” REIMBURSEMENT RATES (2019)
88304	\$41.08
88305	\$70.28
88312	\$101.99
88313	\$73.88
88342	\$108.48

262. Special stains are scientifically required in only limited situations. “Special stains are called ‘special’ because they are dyes used to stain particular tissues, structures or pathogens such as bacteria that may not be visible by routine H&E staining.”

263. More particularly, Defendants implemented a standing order to conduct special stains on all specimens taken from patients even where no medical necessity determination was made by a pathologist or physician. In this way, Defendants used the standing order to usurp medical judgment.

264. Defendants directed their own in-house histology technicians and pathologists to use “special stain protocol sheets” to order special stains and bill the government programs for these special stains:

- “1 HP IHC” or 1 H. pylori special stain per gastrointestinal biopsy, or
- “1 HP-IHC unstained and baked slide per patient required if from the stomach, body, antrum, fundus, gastric, or cardia region.”

265. The standing order substituted for the judgment of the pathologists, in violation of the requirements of the government programs: the physician “who orders the service must maintain documentation of medical necessity in the beneficiary’s medical record” for that claim to be payable. 42 C.F.R. § 410.32(d)(2).

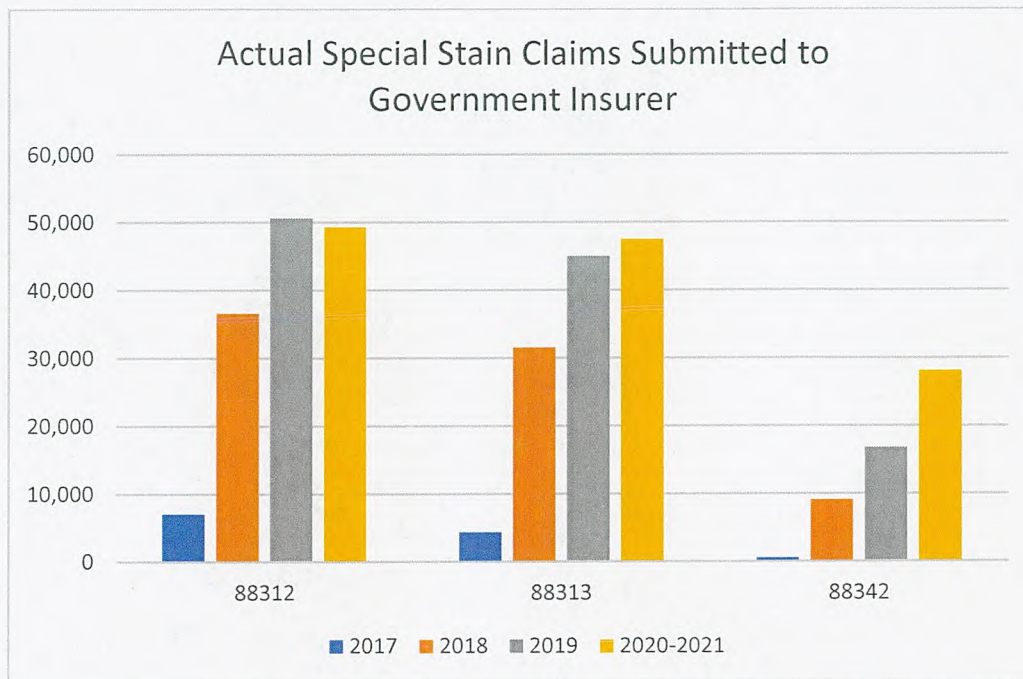
266. Defendants’ standing order significantly increased billings to the government for pathology services in which no medical necessity determination was made, particularly with respect to gastroenterologist practices because of the sheer volume of biopsies the gastroenterologists performed.

267. Defendants performed special stains on all biopsies even when a determination of medical necessity had not been made and fraudulently billed the government for all these special stains because that was the purpose of the standing order.

268. In one example, Defendants used a limited number of specimens from the same Medicare patient, to perform multiple special stains, which led to false claims submitted to the government. That example is illustrative of the thousands of specimens that Defendants excessively stained and billed the government for.

269. To illustrate the excessive billing to the government under the standing order for a single patient, Defendants billed Medicare for hematoxylin and eosin stains under CPT code 88304 or 88305 for H&E, and then billed the government again for three special stains under these additional CPT codes: multiple giesma (CPT code 88312), Alcian Blue PAS (CPT code 88313), and IHC (CPT code 88342).

270. As this demonstrative shows, with the standing order in place, billings for special stains for which no medical necessity determination had been made continued to significantly increase for all three CPT codes, resulting in a dramatic increase in government insured billings of 300 to 500 percent from 2017 to the present.



271. Defendants’ use of the standing order created an efficient assembly line for fraudulently billing the government for pathology services even where no medical necessity determination had been made. The physician practices, including the Defendant GIs, provided the biopsies and prepared the slides (“the technical component”). The Defendants received the slides and performed the reading of the slides (“the professional component”) and ordered special stains on virtually every specimen under the standing order.

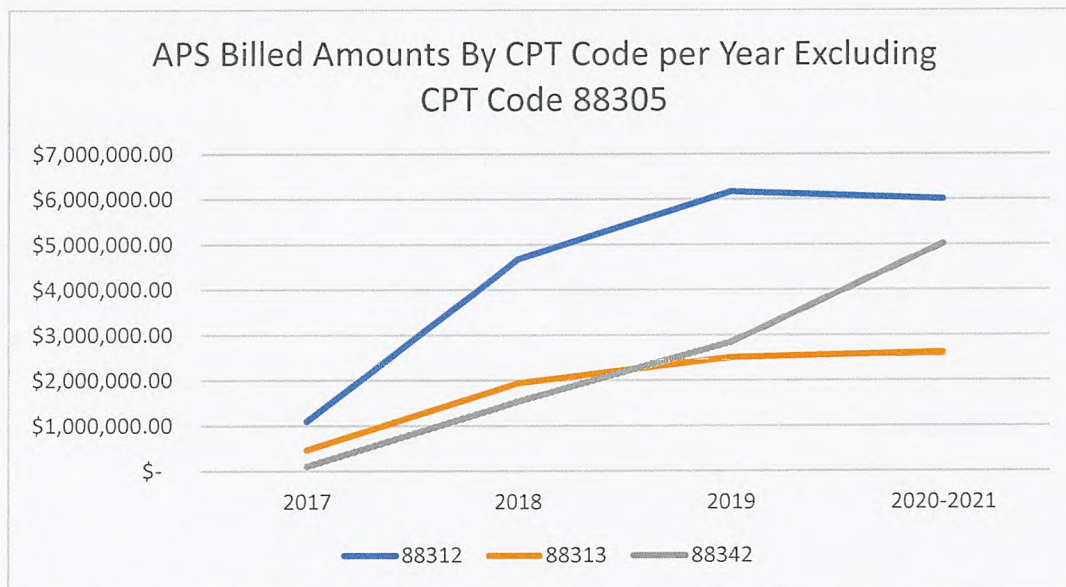
272. Often, more than one special stain was performed on a single specimen.

273. No one questioned or second-guessed Defendants because their own pathologists did not need authorization from an independent physician to conduct a

special stain. Further, Defendants provided financial incentives to their pathologists to comply with the standing order.

274. The physician practices billed for the technical component of the services (histology technician's preparation of the slides) and Defendants billed for the professional component of the services (pathologist reading of the slide), making these arrangements lucrative for both parties at the expense of the government.

275. Defendants billed the government-insured programs for special stains in these amounts since 2017: over \$17 million for CPT Code 88312, over \$7 million for CPT Code 88313 and over \$9 million for CPT Code 88342.



276. Notably, Defendants further maximized their billings to the government by often duping the physician practices.

277. Here is how: While Defendants fraudulently billed the government for the most expensive of the special staining procedures (CPT Code 88342), they often pocketed the portion of the money normally paid to the physician practices for the specimen collections (“the technical component of the claim”). Many physician practices had no idea that Defendants were using specimen drawn from their patients to bill for their portion of the billing.

278. In this way, for the claims that were the costliest to the government (CPT Code 88342), Defendants billed the government and pocketed the money normally paid to the physician practices (“the technical component of the claim”) and the money paid to them (“the professional component of the claim”). This is called “global” billing and Defendants reaped greater financial benefits from its fraud scheme by global billing of CPT Code 88342.

279. Certain physician practices such as the Defendant GIs also knowingly billing the government for the technical component of claims under the unlawful standing order. Below are some examples of such claims submitted to (and paid by) the Medicare program.

280. Defendant United Digestive (Atlanta, Georgia) billed the government at least \$2.2 million for the technical component of claims for one year alone (2019).

281. Defendant Gastrointestinal Specialists (Shreveport, Louisiana) billed

the government at least \$1.18 million for the technical component of claims for one year alone (2020).

282. Defendant Premier Gastro Associates (Little Rock, Arkansas) billed the government at least \$860,000 for the technical component of claims for one year alone (2020).

283. Digestive Diseases Center of Hattiesburg, LLC (“DDC-Hattiesburg”) (Hattiesburg, Mississippi) billed the government at least \$538,000 for the technical component of claims for one year alone (2019).

284. Defendant Medical Associates of Northwest Arkansas (“MANA”) (Fayetteville, Arkansas) billed the government at least \$486,000 for the technical component of claims for one year alone (2019).

285. Defendant Digestive Disease Group (“DDG”) (Greenwood, South Carolina) billed the government at least \$355,000 for the technical component of the claims for one year alone (2020).

286. Defendant Gastroenterology Associates of Central Georgia (Macon, Georgia) billed the government at least \$307,000 for the technical component of claims for one year alone (2020).

287. Defendant Gastroenterology Associates PA (Hickory, North Carolina) billed the government at least \$305,000 for the technical component of claims for one year alone (2019).

288. Defendant Gateway Gastroenterology (Chesterfield, Missouri) billed the government at least \$61,000 for the technical component of claims for one year alone (2020).

289. Defendant Luis E. Alvarez Gastroenterology (New Iberia, Louisiana) billed the government at least \$347,000 for the technical component of claims for one year alone (2020).

290. Defendant Gastroenterology Clinic of Acadiana (Lafayette, Louisiana) billed the government at least \$500,000 for the technical component of claims for one year alone (2020).

291. Defendant Alabama Medical Group PC (Mobile, Alabama) billed the government at least \$228,000 for the technical component of claims for one year alone (2020).

292. In short, the on-site labs were part of Defendants' efficient assembly line for fraudulently billing the government. The standing order allowed them to bill the government for pathology services even where no medical necessity determination had been made, compounding the losses to the government programs from the kickback scheme, while enriching themselves financially.

1. Knowledge That Standing Order Was Unlawful (Scienter)

293. CMS, through its contractors, put the pathology industry on notice that orders from pathologists for special stains on specimens from biopsies are

ordinarily deemed not medically necessary and, more particularly, that special stains for gastric and stomach biopsies should be medically necessary in only about 20 percent of cases.

294. However, as shown by the chart (below) reflecting Defendants' billings to the government on CPT codes for special stains, Defendants billed the government for special stains in at least 200 percent of cases because they billed at least two special stains on every patient biopsy.

295. To further put the pathology industry on notice to avoid billing for special stains without the appropriate medical judgment, CMS required pathologists to provide written documentation to support the medical necessity for billing both a routine H&E stain and a special stain under CPT codes 88312, 88313 and 88342. 42 C.F.R. § 410.32(d)(2) (the physician "who orders the service must maintain documentation of medical necessity in the beneficiary's medical record" in order for that claim to be payable.). CMS made clear that use of a standing order was prohibited.

296. Despite these government measures to prevent the kind of overbilling alleged in this Complaint, Defendants incentivized and pressured everyone to stain more and bill the government more: their sales force, their own pathologists and the physician practices themselves, including Defendant GIs.

297. Defendants pressured their sales force—the boots on the ground who marketed the on-site lab arrangements to physician practices.

298. Defendants tracked the weekly and monthly statistics showing the volume of stains (and special stains) and dollars billed to government for each of their physician practices. This is how Defendants paid commissions to their sales representatives, the higher the stain volume and government billings, the higher the bonuses.

299. If these figures were not at a high enough level to be considered acceptable by the Defendant Chief Executive Officer, the sales force was threatened.

Subject: target list

From: kevinhannah@apaths.net

To: [REDACTED]

Date Sent: Tuesday, September 8, 2020 11:54:27 AM GMT-04:00

Date Received: Tuesday, September 8, 2020 11:54:25 AM GMT-04:00

I WANT THE GODDAMN SALES TARGET LISTS FOR THE REPS TODAY!

IF THEY DON'T WANT TO UPDATE THE LIST, I DON'T GIVE A SHIT!

K

300. The Chief Executive Officer meted out inducements as well as pressure:

“The Buffalo Plains” have got off to a good start by increasing the daily specimen count by 10 per day, from 23 to 33 daily. Nice job [REDACTED]. She has also got a signed deal in Arizona which will soon take her daily

increase to around 50 per day. [REDACTED], the leader of the “Thug-ville” mafia, over in Little Rock is still looking to make about a million dollars in commissions this year but will have a steep climb to look for growth. That’s what you get when your [sic] doing north of 430 specimens per day.

You guys are all rock stars, and I am proud to have all of you out there on the team. Happy Hunting!

301. Defendants also induced their pathologists to bill more. They were paid a commission based on the number of special stains they ordered and billed the government.

302. In turn, the pathologists pressured physician practices to increase the number of biopsies performed on patients because more biopsies led to more special stains performed and billed to the government. This pressure was compounded by the fact that physician practices often deferred to the expertise of the pathologists.

303. Pathologists provided presentations to physician practices “to increase their biopsy rates,” encouraging physician practices to order multiple biopsies to evaluate gastroenterology problems to “maximize your clinical results.”

304. For example, for every potential gastrointestinal biopsy site (e.g., stomach, upper gastrointestinal tract, lower gastrointestinal tract), Defendants recommended at least 2, and sometimes as many as 7, biopsies be taken in a single anatomical structure (such as the colon) to generate the “highest diagnostic yield.”

305. In fact, one of Defendant’s highest-billing physician practices was Defendant United Digestive (Atlanta, Georgia). This Defendant GI performed thousands of gastrointestinal biopsies annually and raised concerns about Defendants’ standing order for special stains in the fall of 2019.

306. Being called out by one its physician practices further put Defendants on notice that its billing practices were leading to false or fraudulent submissions of claims to the government for special stains:

Just to keep everyone in the loop, last week [Defendant COO] Donell, [APS employee], and I were onsite at [Defendant United Digestive] Thursday and I stayed for Friday. The purpose of the trip was to switch the [Defendant United Digestive on-site] lab to the new workflow in the LIS. This LIS change was made specifically at their request to move from standing orders for special stains based on specimen location to having all special stains ordered by a pathologist following initial review of H&E. . . . In brief, new workflow will be they send H&E slides one day, cases are screened and special stains are ordered, and special stains are sent the next day.

As [Defendant United Digestive] has also talked about self reporting over use of special stains to medicare and accused us of intentional overutilization, I think we

need to be cautious about how we proceed with them from a risk management perspective. [APS employee]r wanted me to respond [] about the concerns [] expressed on call Friday.

(emphasis added)

307. This same physician practice also put Defendants on notice that its standing order for special stains was “not in compliance with the Palmetto [government contractor] LCD [local coverage determination].”

308. In response, Defendants purportedly changed its “special stain protocol sheets,” to order special stains only “after an initial review by an APS pathologist.”

309. However, the changes in written policy were not implemented because Defendant United Digestive terminated its on-site lab arrangement with Defendants in February 2020, following a meeting “to understand your [APS] stain protocol and clinical justification for us of special stains.”

310. On information and belief, Defendant United Digestive did not voluntarily disclose these overpayments to the government and is liable for knowingly submitting or causing the submission of false claims for pathology services under the standing order.

311. Further, Defendants’ own histology technicians and pathologists raised concerns about the impropriety of the standing order with management. In

one instance, a histology technician declined an offer of employment at an on-site lab of a physician practice because she knew the standing order was unlawful.

312. Yet, Defendants remained undeterred despite being provided notice from the government, its contractors, its own employees, and some of its physician practices that its standing order for special stains was unlawful and causing the government to pay for claims for which no medical necessity determination was made.

313. Defendants standing order remained in place:

H. PYLORI IHC= HP IHC

GI SPECIAL STAINS: *****1 HP IHC per case*****

314. Defendants continued to bill the government for special stains under the unlawful standing order in 2020 and 2021, as shown by these examples. In each example below for the different physician practices, the percentage of special stains performed far exceeded 20 percent.

315. Defendant Premier Gastroenterology Associates (Little Rock, Arkansas) (1-2020 through 1-2021)

CPT Code	No. of claims to the government	Percentage of special stains	Claims to the government (dollars)
88305 (routine)	6,767		\$395,072
88312 (special)	1,862	28%	\$92,847
88313 (special)	3,853	57%	\$94,884

88342 (special)	1,576	23%	\$278,069
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316. A physician practice in Leesburg, Florida (6-2020 through 12-2020)

CPT Code	No. of claims to the government	Percentage of special stains	Claims to the government (dollars)
88305 (routine)	5,016		\$283,493
88312 (special)	2,061	41%	\$130,407
88313 (special)	2,871	57%	\$96,750
88342 (special)	883	18%	\$149,065

317. Defendant Gastrointestinal Specialists in Shreveport, Louisiana (1-2020 through 1-2021)

CPT Code	No. of claims to the government	Percentage of special stains	Claims to the government (dollars)
88305 (routine)	7,405		\$426,036
88312 (special)	2,344	32%	\$116,917
88313 (special)	3,667	50%	\$277,621
88342 (special)	2,055	28%	\$364,931

318. In one example, on June 9, 2020, Defendants notified a physician practice (potential partner) that they would conduct special stains on every biopsy:

Stain assignment is to be followed according to APS staining protocols. A chart was provided. *Please refer to GI Protocol SV-8.0*

- ALL upper gi biopsies receive alcian blue/pas (this is in EVERY case).
- ALL gastric biopsies receive giemsa.

319. In another example, a physician practice refused to contract its pathology services to Defendants because of Defendants' excessive practices stating: "[t]he numbers of bottles are exaggerated for our center productivity. We also do not utilize a large number of special stains which are one of the major revenue generators."

320. Rather than stopping its fraudulent billing practices, Defendants even more aggressively marketed the financial benefits of its kickback scheme ("no cost at all") and standing order "we allow you to do special stains as part of our protocol"):

Equipment – I spoke with my Chief Lab Officer and he said we can do an even swap for the stainer you would need to do special stains. **So, no cost at all** and we currently have what is needed readily available.

Special Staining – The biggest difference between [competitor pathology group] and APS is the fact that **we allow you to do special stains as part of our protocol. This is revenue that [competitor pathology group] is enjoying today**, we actually make this more fair and enable you to benefit instead.

I would be happy to fly one of our 10 GI Fellowship Trained Pathologists and my manager in for dinner so you can ask any questions you would like. . . . At the end of the day, we have a program that is more of a WinWin and I am confident you will enjoy the concierge service we provide.

(emphasis added).

321. In summary, Defendants knowingly submitted thousands of false or fraudulent claims for special stains under the standing order, and the government paid those claims.

C. Sham Pathology Labs in Florida, California and Louisiana

322. Under the Clinical Laboratory Improvement Amendments (CLIA), administered by CMS, clinical laboratories (like APS) must be certified by CMS before they can accept human samples for diagnostic testing.

323. Defendants established pathology labs to bill the government for claims in certain states, including Florida, California and Louisiana.

324. To establish a pathology lab in any state and bill the government for pathology services, the pathology lab must meet certain requirements under CLIA. 42 C.F.R. § 493.2

325. As part of its push to maximize billings to the government, Defendants made fraudulent certifications on their CLIA applications that certain of their labs met CLIA standards for pathology services in Florida, California and Louisiana when they did not.

326. As Defendants well knew, CLIA required that a lab identify the medical director who is responsible for oversight of the daily operations.

1. Sham Florida Lab

327. Defendants rented office space in Winter Garden, Florida and then moved to a Lake Worth, Florida location and billed the government for pathology services at both locations.

328. However, Defendants did not establish a lab at either location. Both were empty offices where no pathology services were performed, as shown by this image.



329. Defendants “set it up to look legit.”

330. To that end, Defendants falsely certified in their CLIA application that Dr. Zheng Ping was the medical director of the Florida pathology lab located at Lake Worth, Florida.

331. While Dr. Ping is a pathologist at Defendant APS, he worked in the Little Rock, Arkansas lab and never even visited either Florida location.

332. No clinical staff worked at the Winter Garden or Lake Worth address and there were no lab operations at either location. In fact, no pathology specimens were collected, processed, or evaluated at either address.

333. However, Defendants submitted numerous claims for pathology services to the government and used Florida addresses when doing so.

334. The office spaces in Florida served as part of Defendants' assembly line for fraudulent claims to the government.

335. As a result, all claims for pathology services submitted to (and paid by) the government from the Winter Garden and Lake Worth, Florida addresses are false or fraudulent claims.

2. Sham California Lab

336. Defendants rented office space in Elk Grove, California and billed the government for pathology services at this location.

337. However, Defendants did not establish a lab at this location.

338. Instead, the Elk Grove location was nothing more than a room in the dental office of the husband of an APS employee. The office had no lab operations and no Medical Director.

339. However, Defendants submitted numerous claims for pathology services to the government and used the dental office address when doing so.

340. The dental office space in Elk Grove served as part of Defendants' assembly line for fraudulent claims to the government.

341. As a result, all claims for pathology services submitted to (and paid by) the government from the Elk Grove, California address are false or fraudulent claims.

3. Louisiana Labs with No Medical Directors

342. Defendants established pathology labs in Monroe, Louisiana and Shreveport, Louisiana and billed the government for pathology services at both locations.

343. The Monroe lab was planned as a stand-alone lab and the Shreveport lab was on-site at a physician practice.

344. Defendants knew that CLIA required that every pathology lab be headed by a medical director who was responsible for oversight of the daily operations.

345. Defendants completed CLIA applications and certifications for both locations where pathology services were performed.

346. However, there was no medical director to oversee either the Monroe stand-alone lab or the Shreveport on-site lab, contrary to Defendants' CLIA certifications.

347. Further, Defendants falsely certified that a physician in their employ at the Little Rock, Arkansas location was also the medical director for the Shreveport location. When the physician learned that Defendants falsely named her as the medical director in Shreveport on the CLIA certification, she objected to this false certification and resigned.

348. Yet, on information and belief, Defendants used both the Monroe and the Shreveport locations to bill the government for pathology services, in violation of CLIA.

349. Both labs in Louisiana served as part of Defendants' assembly line for fraudulent claims to the government.

350. On information and belief, Defendants submitted numerous claims for pathology services to the government from the Monroe and Shreveport locations, which had no medical director, in violation of CLIA.

351. As a result, all claims for pathology services submitted to (and paid by) the government from the Shreveport, Louisiana and Monroe, Louisiana locations are false or fraudulent claims.

V. MATERIALITY

352. Defendants and Defendant GIs knew that compliance with the Anti-Kickback Statute and Stark law was material to the government's decision to pay claims for pathology services. Defendants and Defendant GIs also knew that truthful records and statements in support of claims for pathology services were material to the government's decision to pay these claims.

353. Defendants and Defendant GIs also knew that submitting claims under the standing order where no medical necessity determination had been made was material to the government's decision to pay claims. Defendants and Defendant GIs also knew that truthful records and statements in support of claims for pathology services were material to the government's decision to pay these claims.

354. Further, Defendants and Defendant GIs knew that truthful statements on CLIA certifications were material to the government's decision to pay claims for pathology services. Defendants and Defendant GIs also knew that truthful records and statements in support of claims for pathology services were material to the government's decision to pay these claims.

355. Some of the factors in evaluating materiality under the False Claims Act include (a) statutory, regulatory, and contractual language, (b) whether the violations go to the heart of the benefit of the bargain, (c) whether the violations were serious and material and not merely technical or minor infractions of rules, (d) the government's actions relative to similar violations, (e) whether any reasonable person would attach importance to Defendants' and Defendant GIs' choice of actions, and (f) Defendants' and Defendant GIs' knowledge relative to these factors. All these factors demonstrate materiality in this case and have been addressed throughout this complaint.

356. Defendants and Defendant GIs knowingly submitted or caused to be submitted thousands of false or fraudulent claims and used false records and statements in support of false or fraudulent claims for pathology services in violation of laws designed to prevent unlawful kickback schemes and subject to a standing order whereby no medical necessity determination was made.

357. More specifically, Defendants and Defendant GIs knowingly engaged in unlawful arrangements with physician practices that were in violation of the Anti-Kickback Statute and Stark Law and no "safe harbor" or "exceptions" applied. Therefore, all claims for pathology services to the government were tainted because of the unlawful kickbacks.

358. Further, Defendants and Defendant GIs knowingly submitted claims for special stains pursuant to a “standing order” whereby special stains were performed on all specimens even where no medical necessity determination was made. In turn, those fraudulent claims were submitted to the government and the government paid those claims.

359. CMS recognized that, because special stains can be ordered and billed by a pathologist without the need for an order from the treating physician, there was the potential for waste, fraud and abuse of special stains.

360. Accordingly, CMS required the pathologist to first review the stained specimen under less costly CPT Codes 88304 and 88305 and to also document the medical necessity for a special stain. Use of a standing order was prohibited.

361. CMS, through its contractors, put Defendants on sufficient notice that performing and billing for special stains in more than 20 percent of cases was likely to be improper. Yet, Defendants knowingly maintained the standing order.

362. Therefore, Defendants and Defendant GIs knowingly submitted or caused to be submitted thousands of false or fraudulent claims and used false records and statements in support of false or fraudulent claims for special stains.

363. Finally, Defendants knowingly set up sham laboratories in Florida and other States in violation of CLIA requirements.

364. The United States Department of Justice has enforced the False Claims Act in other instances of similar unlawful kickback arrangements between physicians and pathology laboratories.

365. In one example, the Laboratory Boston Heart Diagnostics Corporation paid \$26.67 million to resolve False Claims Act allegations involving payments for patient referrals in violation of the Anti-Kickback Statute and the Stark Law and claims improperly billed to federal health care programs for laboratory testing.

<https://www.justice.gov/usao-edca/pr/laboratory-pay-2667-million-settle-allegations-kickbacks-physicians#:~:text=Laboratory%20to%20Pay%20%2426.67%20Million%20to%20Settle%20Allegations%20of%20Kickbacks%20to%20Physicians,-SACRAMENTO%2C%20Calif.&text=The%20Anti%2DKickback%20Statute%20prohibits,and%20other%20federally%20funded%20programs>.

366. The United States Department of Justice has also enforced the False Claims Act in a similar fraud scheme where a pathology laboratory was overbilling the government for special stains.

367. In one example, a pathology lab paid a False Claims Act settlement for medically unnecessary special stains and the government's press released stated:

[P]athology practices apply stains to specimens to allow pathologists to identify abnormalities in the tissue. These

stains include a routine hemotoxylin and eosin (H&E) stain and other special stains for various purposes. Among other things, the complaint alleges that a pathologist should review the specimen with the routine H&E stain before any special stain is used on the specimen. Special stains are billed separately to government healthcare programs. The government considers the use of special stains before the analysis of the routine H&E stained specimen to be medically unnecessary.

<https://www.justice.gov/usao-wdnc/pr/hickory-pathology-lab-agrees-pay-united-states-601000-settle-false-claims-act>

368. Further, the United States Department of Justice has supported False Claims Act enforcement where a Defendant violated CLIA requirements similar to the CLIA allegations in this Complaint, namely that Defendants operated sham labs in Florida and other States.

369. In a declined qui tam case against a Florida oncology group, the United States Department of Justice filed a statement of interest in support of a relator, arguing that government agencies cannot possibly catch all fraud, so penalties are high specifically to deter bad conduct and recoup the government's cost of fighting fraud. Defendant in this case falsely certified compliance with CLIA, just as alleged in this Complaint.

<https://www.law360.com/articles/1364203/fla-lab-tells-11th-circ-1-2m-fca-fines-are-excessive>

370. These cases demonstrate that Defendants' and Defendant GIs' same or similar conduct alleged in this Complaint was material to the Government's decision to pay claims.

371. The facts alleged in the Complaint show that Defendants and Defendant GIs were well aware of the statutory and regulatory requirements of the Anti-Kickback Statute and Stark Law and the CLIA requirements for laboratories, and that the standing order for special stains was unlawful; and, further, that the violations alleged in this Complaint were material to the Government's decision to pay.

372. Defendants and Defendant GIs also well knew that the unlawful conduct alleged in this Complaint went to the very heart of the bargain under for the payment of claims for pathology services. CMS expects and requires that claims be paid only for accurate and truthful claims and claims that are not tainted by unlawful kickbacks.

373. CMS's statutory and programmatic requirements for complete, accurate and truthful reporting during the claims submission process and its insistence that claims not be tainted by unlawful kickback arrangements go directly to the "essence of the bargain." These requirements are neither "minor nor insubstantial."

374. Defendants' and Defendant GIs' violations of the statutory,

regulatory, and programmatic requirements were serious and material, leading to actual or potential harm, and were made with at least reckless disregard of the seriousness of their violations.

375. Defendants' and Defendant GIs' violations were not immaterial or inadvertent technical mistakes in processing paperwork, or simple and honest misunderstanding of the rules, terms and conditions, or certification requirements. Rather, Defendants and Defendant GIs knowingly failed to comply with material legal obligations and certifications.

376. Defendants and Defendant GIs knew that they were submitting or causing to submit false or fraudulent claims for pathology services, including tainted claims, and false or fraudulent statements, records, and tainted claims for government health care funds, which the government paid to them.

377. Further, the Department of Justice has repeatedly and publicly stated its intention to use the False Claims Act to remedy knowing violations of the Anti-Kickback and Stark Laws, as well as the pursuit of medically unnecessary claims and false certifications of CLIA requirements.

378. In short, there is ample evidence to show that Defendants knew or should have known that their violations had the natural tendency to influence the Government's decision to pay the claims for laboratory services and that any reasonable person would attach importance to Defendants' choice of action.

VI. UNLAWFUL RETALIATION

379. Relators repeatedly and consistently informed management of concerns related directly to the allegations set forth in the Complaint. Relators were troubled that Defendants were engaged in unlawful practices alleged in this Complaint. Relators also feared job security and the legal propriety of Defendants' actions.

380. Yet, Relators were reprimanded and retaliated against by Defendants when raising concerns related to, and objecting to, Defendants' fraudulent course of conduct alleged in this Complaint. Relators repeatedly and consistently informed management of concerns related directly to the allegations set forth in the Complaint. Relators were troubled that Defendants were engaged in unlawful practices alleged in this Complaint. Relators also feared job security and the legal propriety of Defendants' actions.

381. Both Relators were terminated on December 21, 2020, because of lawful acts by Relators to stop one or more violations of the False Claim Act and lawful acts by Relators in furtherance of an action under 31 U.S.C. § 3730.

382. Relator Ms. Aucoin repeatedly questioned the legality and information provided by Defendants regarding the government overbilling alleged in this Complaint.

383. Notably, once the Georgia and Florida labs were established, Relator Ms. Aucoin was bombarded with increasing complaints from patients who received unreasonably costly bills for pathology services.

384. As Ms. Aucoin brought these complaints to the attention of Defendants and expressed her concerns, Defendants ignored them or brushed them aside. In fact, Defendants only response were to waive the patient copay or other fees to avoid raising too many red flags.

385. The work environment at APS became increasingly more hostile. Defendants intentionally excluded Ms. Aucoin from meetings and business decisions for the sales team. Continued seclusion placed her in the untenable position of having to handle sale representative problems and client billing problems with little to no help or support from Defendants.

386. As a result of this increasing pressure, Ms. Aucoin was physically exhausted and emotionally stressed and she saw several physicians to help her manage this stress. Ms. Aucoin was prescribed several medications to help her cope.

387. Due to Defendants' retaliatory conduct, Ms. Aucoin was terminated from her position at APS on December 21, 2022.

388. Now after being gone from APS, Ms. Aucoin is no longer on any medication but still feels that she has post-traumatic stress disorder from having worked for Defendants.

389. Below are some specific events that occurred, which are relevant to the retaliation allegations in this Complaint.

390. From October 26-28, 2019, during the ACG Conference in San Antonio, Texas, the Chief Executive Officer of Defendant United Digestive remarked to Ms. Aucoin that Defendants “were full of it”—that what they were doing with “overstaining” (i.e., the standing order) was illegal “no matter how they try to spin it.” This was the first time that Ms. Aucoin truly appreciated that what Defendants were telling their employees was not for the medical benefit of the patient but purely for their own personal financial gain.

391. Relator Brent Aucoin was also in attendance at the ACG Conference in San Antonio, Texas from October 26-28, 2019. This was also Mr. Aucoin’s first exposure to being informed that Defendants were not conducting business as honestly and ethically as the sales force believed. After the conversation between Ms. Aucoin and Defendant United Digestive’s CEO, the Defendant GI’s CEO approached Defendant COO Donell Burkett and Mr. Aucoin could see the animated and hostile conversation from a short distance. Immediately after the conversation ended, COO Burkett remarked to Mr. Aucoin: “well that ass chewing

wasn't any fun, I really wasn't prepared for that." Mr. Aucoin learned from Ms. Aucoin later that same day that United Digestive's CEO had called out Defendants for excessive staining (i.e., billing the government for pathology services under the standing order). This was the first dawning for Mr. Aucoin that Defendants may have been providing misleading information to the sales force.

392. On November 25, 2019, Ms. Aucoin was included on an email from one physician to the Defendants describing a meeting between the physician and Defendants whereby the physician requested that changes relating to the "overstaining" practice be made.

393. However, the changes suggested by Defendants still did not meet the physician's standards and even further caused concern on the part of the physician. The physician stated that APS really needed to be careful because "overstaining" and overbilling was occurring. This was the first time that Ms. Aucoin was brought into this conversation and in which the physician's perspective was brought to her attention. Notably, this was also the last time that Ms. Aucoin would be included in any discussions with this particular physician practice.

394. Defendants' standing order for special stains nevertheless remained in place.

395. On April 1, 2020, Defendants received the first written complaint from this same physician whereby they directly questioned Defendants' standing

order for special stains. The Defendants continued to brush off these complaints and remarked that the physician practice made too much money because of the standing order to demand the order be revoked. Ms. Aucoin was aware of Defendants' indifference to these complaints and concerns being raised.

396. On or around July 23, 2020, Ms. Aucoin became more involved with the billing function at APS. As a result, she started to appreciate Defendants' overbilling practices were more widespread than simply one physician practice. At around this same time, Defendants also stopped waiving fees for patient beneficiaries who complained about excessive bills they were receiving for pathology services. This led to a significant increase in complaints from patients as they were more impacted by Defendants' excessive practices.

397. Ms. Aucoin raised these issues with the Defendant CEO and Defendant CFO, but they ignored her concerns. It was during this time that Ms. Aucoin also came to learn that the government was being billed for special stains for all patients and not only 19-40 percent of stains as she had been earlier told by the Defendant CEO and COO.

398. Around this same time, Defendants began to limit Ms. Aucoin's sales territory, which was accompanied by a loss of 60 percent in commissions.

399. Between July and October 2020, less and less information was being directed to Ms. Aucoin and more work was diverted to other less qualified

employees. During this same period, patient complaints about excessive and costly bills for pathology services continued to place increasing pressure on Ms. Aucoin who felt responsible for these patients.

400. Between September 30 to October 20, 2020, Ms. Aucoin received complaints from another physician practice, which was getting significant push-back from patients who had excessive pathology bills, which their insurers refused to cover. Despite seeking answers from Defendant CEO, her requests for assistance went ignored. Instead, the Defendant CEO retaliated by making Ms. Aucoin a pariah among the employees at APS.

401. Further, on Oct 20, 2020, the CEO substituted Ms. Aucoin's signature for his signature on a billing agreement with the same physician practice, attempting to turn over responsibility for the billing to Relator. The same event occurred with Mr. Aucoin—on October 22, 2021, Defendant CEO and Defendant COO substituted Mr. Aucoin's signature for their signatures on a billing agreement with a physician practice, attempting to turn over responsibility for the billing to Relator.

402. Further, on October 26, 2020, one physician approached relators with an offer to encourage them to leave APS and develop their own lab services. No steps were taken by either Relator to respond to this offer. On November 2, 2020,

Defendant CEO confronted Relators with knowledge of this offer, which Relators did not deny.

403. Between November 30 and December 3, 2020, Ms. Aucoin was in Little Rock, Arkansas to train a new sale representative. During this visit, no one interacted with Ms. Aucoin outside of work hours and the visit was noticeably different than any other meeting or visit because Ms. Aucoin felt unwelcomed. This caused her anxiety, which manifested physically and mentally.

404. A sales team meeting was scheduled for December 3, 2020, and Ms. Aucoin was excluded. Ms. Aucoin spoke up and said she felt that she was being excluded from the team. Nothing was further said to her.

405. On December 21, 2020, Ms. Aucoin received a phone call from the Human Resources Department that she was being terminated. The spurious reason given was because Relators were building a competitive lab, which was untrue. Again, no such steps to build a competitive lab were taken by Relators.

406. Relator Brent Aucoin was also terminated on this same date, December 21, 2020.

407. No severance package was given to Relator Brent Aucoin and Relators' family of six (including four children) had their health insurance stopped on that same day. Defendants also cut Mr. Aucoin's final commission check by about \$10,000. Mr. Aucoin had won "Sales Rep of the Year for 2020" and was

awarded the President Clubs trip but was never provided the trip nor awarded a financial payout equivalent to the cost of the trip.

408. Defendants paid Ms. Aucoin through January, but she did not receive her manager's bonus expected for the fourth quarter.

409. Earlier, Defendants had withheld 30 percent of both Relators' income for April, May and June 2020, in response to the start of the COVID pandemic. This same withholding occurred as to all GI sales representatives. However, in an email, Defendant CEO said the amount that was withheld would be paid back to the employees by the end of 2020. Yet, Defendants never repaid these withheld amounts to Relators.

410. Relators were reprimanded and retaliated against by Defendants when raising concerns related to, and objecting to, Defendants' fraudulent course of conduct alleged in this Complaint.

411. Defendants retaliated against Relators because of lawful acts by Relators to stop one or more violations of the False Claim Act and lawful acts by Relators in furtherance of an action under 31 U.S.C. § 3730.

412. For the reasons set forth in this Complaint, Relators are entitled to double 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, and all other remedies and recompense

allowable under 31 U.S.C. § 3730(h) and the various States' retaliation provisions alleged in this Complaint.

413. Defendants retaliated against Relators because of lawful acts by Relators to stop one or more violations of the False Claim Act and lawful acts by Relators in furtherance of an action under 31 U.S.C. § 3730.

414. For the reasons set forth in this Complaint, Relators are entitled to double 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, and all other remedies and recompense allowable under 31 U.S.C. § 3730(h) and the various States' retaliation provisions alleged in this Complaint.

VII. COUNTS

COUNT I

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

415. The allegations in the preceding paragraphs are incorporated by reference.

416. Defendants and Defendant GIs knowingly presented or caused to be presented false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A).

417. The United States paid for claims that otherwise would not have been allowed.

418. Because of these false or fraudulent claims, Defendants and Defendant GIs are jointly and severally liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act, and liable for all other relief authorized by the statute.

419. As a result of Defendants' and Defendant GIs' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT II

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

420. The allegations in the preceding paragraphs are incorporated by reference.

421. Defendants and Defendant GIs knowingly made, used or caused to be made or used, false records or statements material to false or fraudulent claims, in violation of 31 U.S.C. § 3729 (a)(1)(B).

422. The United States paid for claims that otherwise would not have been allowed.

423. Because of these false or fraudulent claims, Defendants and Defendant GIs are jointly and severally liable to the United States for incurred

damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act, and liable for all other relief authorized by the statute.

424. As a result of Defendants' and Defendant GIs' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT III

**Federal False Claims Act:
31 U.S.C. § 3729(a)(1)(C)
Conspiracy**

425. The allegations in the preceding paragraphs are incorporated by reference.

426. Defendants and Defendant GIs knowingly conspired to commit a violation of the False Claims Act, in violation of 31 U.S.C. § 3729 (a)(1)(C).

427. The United States paid for claims that otherwise would not have been allowed.

428. Because of these false or fraudulent claims, Defendants and Defendant GIs are jointly and severally liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act, and liable for all other relief authorized by the statute.

429. As a result of Defendants' and Defendant GIs' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT IV

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

430. The allegations in the preceding paragraphs are incorporated by reference.

431. Defendants and Defendant GIs knowingly made, used, or caused to be made or used, false records or statements material to an obligation to pay or transmit money or property to the Government, or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the Government, in violation of 31 U.S.C. § 3729 (a)(1)(G).

432. The United States paid for claims that otherwise would not have been allowed.

433. Because of these false or fraudulent claims, Defendants and Defendant GIs are jointly and severally liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act, and liable for all other relief authorized by the statute.

434. As a result of Defendants' and Defendant GIs' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT V

**Federal False Claims Act Based on Anti-Kickback Statute
31 U.S.C. § 3729(a)(1)(A), (B), (C), (G); 42 U.S.C. § 1320a-7b(b)**

435. The allegations in the preceding paragraphs are incorporated by reference.

436. Defendants and Defendant GIs knowingly presented or caused to be presented numerous false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729 (a)(1)(A), (B), (C), (G).

437. By virtue of the kickbacks (in violation of the Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b)), misrepresentations, and submissions (or causing the submissions) of non-reimbursable claims described above, Defendants and Defendant GIs knowingly presented or caused to be presented false or fraudulent claims for the improper payment of claims on behalf of federal health care program beneficiaries.

438. The United States, unaware of the falsity or fraudulent nature of the claims that Defendants and Defendant GIs caused, paid for claims that otherwise would not have been allowed. Defendants' and Defendant GIs' representations were material to the government's decision to pay the claims for pathology services.

439. Because of these false or fraudulent claims, Defendants and Defendant GIs are jointly and severally liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act, and liable for all other relief authorized by the statute.

440. As a result of Defendants' and Defendant GIs' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT VI

Federal False Claims Act Based on Stark Laws 31 U.S.C. § 3729(a)(1)(A), (B), (C), (G); 42 U.S.C. § 1395nn

441. The allegations in the preceding paragraphs are incorporated by reference.

442. Defendants and Defendant GIs knowingly presented or caused to be presented numerous false or fraudulent claims for payment or approval in violation of 31 U.S.C. § 3729 (a)(1)(A), (B), (C), (G).

443. By virtue of the unlawful self-referrals (in violation of the Stark Laws, 42 U.S.C. § 1395nn, misrepresentations, and submissions (or causing the submissions) of non-reimbursable claims described above, Defendants and Defendant GIs knowingly presented or caused to be presented false or fraudulent claims for the improper payment of claims on behalf of federal health care program beneficiaries.

444. The United States, unaware of the falsity or fraudulent nature of the claims that Defendants and Defendant GIs caused, paid for claims that otherwise would not have been allowed. Defendants' and Defendant GIs' representations

were material to the government's decision to pay the claims for pathology services.

445. Because of these false or fraudulent claims, Defendants and Defendant GIs are jointly and severally liable to the United States for incurred damages resulting from such false claims, trebled, plus civil penalties for each violation of the Act, and liable for all other relief authorized by the statute.

446. As a result of Defendants' and Defendant GIs' violations, the United States has suffered damages in an amount to be determined at trial.

COUNT VII

Retaliation of Relators in Violation of False Claims Act 31 U.S.C. § 3730(h)

447. The allegations in the preceding paragraphs are incorporated by reference.

448. Relators engaged in lawful acts in furtherance of efforts to stop one or more violations of 31 U.S.C. § 3729.

449. Because of Relators' lawful acts, Relators were subjected to retaliation by Defendants.

450. Relators were unlawfully retaliated against by Defendants and for engaging in protected activity, namely for raising, objecting to and refusing to participate in fraudulent conduct alleged in this Complaint.

451. Defendants' retaliation against Relators was a violation of 31 U.S.C. § 3730(h).

452. As a consequence of Defendants' violations of 31 U.S.C. § 3730(h), Relators suffered damages.

453. Relators are entitled to damages sustained as a result of the retaliation, including litigation costs and reasonable attorneys' fees, and all other remedies and recompense allowable under 31 U.S.C. § 3729(h).

454. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under DC ST § 2-381.04.

COUNT VIII
California False Claims Act,
Cal. Gov't Code § 12650, et seq.

455. The allegations in the preceding paragraphs are incorporated by reference.

456. Relators also bring this action on behalf of the State of California, against Defendants and Defendant GIs under the California False Claims Act ("FCA"), Cal. Gov't Code § 12652(c).

457. Defendants and Defendant GIs violated the provision of the California FCA, Cal. Gov't Code § 12651(a)(1), which creates liability for any person who

“[k]nowingly presents or causes to be presented a false or fraudulent claim for payment or approval.”

458. Defendants and Defendant GIs violated the provision of the California FCA, Cal. Gov’t Code § 12651(a)(2), which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim.”

459. Defendants and Defendant GIs violated the provision of the California FCA, Cal. Gov’t Code § 12651(a)(7), which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the state or to any political subdivision, or knowingly conceals or knowingly and improperly avoids, or decreases an obligation to pay or transmit money or property to the state or to any political subdivision.”

460. Pursuant to the California FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Cal. Gov’t Code § 12651(a)(1).

461. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

462. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

463. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Cal. Gov. Code § 12651, unlawfully retaliated against Relators.

464. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all relief allowable under Cal. Gov. Code § 12653.

COUNT IX

Colorado Medicaid False Claims Act, Colo. Rev. Stat. §§ 25.5-4-303.5, et seq.

465. The allegations in the preceding paragraphs are incorporated by reference.

466. Relators also bring this action in the name of the State of Colorado, against Defendants and Defendant GIs pursuant to the Colorado Medicaid False Claims Act, Colo. Rev. Stat. § 25.5-4-306.

467. Defendants and Defendant GIs violated the provision of the Colorado FCA, Colo. Rev. Stat. § 25.5-4-305(1)(a), which creates liability for any person who "[k]nowingly presents, or causes to be presented, to an officer or employee of the state a false or fraudulent claim for payment or approval."

468. Defendants and Defendant GIs violated the provision of the Colorado FCA, Colo. Rev. Stat. § 25.5-4-305(1)(b), which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim.”

469. Defendants and Defendant GIs violated the provision of the Colorado FCA, Colo. Rev. Stat. § 25.5-4-305(1)(f), which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state in connection with the ‘Colorado Medical Assistance Act,’ or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state in connection with the ‘Colorado Medical Assistance Act.’”

470. Pursuant to the Colorado FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Colo. Rev. Stat. § 25.5-4-305(1).

471. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

472. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Colo. Rev. Stat. §§ 25.5-4-303.5, et seq., unlawfully retaliated against Relators.

473. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all relief allowable under Colo. Rev. Stat. §§ 25.5-4-303.5, et seq.

COUNT X

Connecticut False Claims Act, Conn. Gen. Stat. §§ 4-274, et seq.

474. The allegations in the preceding paragraphs are incorporated by reference.

475. Relators also bring this action in the name of the State of Connecticut, against Defendants and Defendant GIs pursuant to the Connecticut False Claims Act, Conn. Gen. Stat. § 4-277.

476. Defendants and Defendant GIs violated the Connecticut FCA, Conn. Gen. Stat. § 4-275(a)(1), which provides that no person shall "[k]nowingly present, or cause to be presented, a false or fraudulent claim for payment or approval under a state-administered health or human services program."

477. Defendants and Defendant GIs violated the provision of the Connecticut FCA, Conn. Gen. Stat. § 4-275(a)(2), which provides that no person shall "[k]nowingly make, use or cause to be made or used, a false record or

statement material to a false or fraudulent claim under a state-administered health or human services program.”

478. Defendants and Defendant GIs violated the provisions of the Connecticut FCA, Conn. Gen. Stat. § 4-275(a)(7), which provides that no person shall “[k]nowingly make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state under a state-administered health or human services program.”

479. Defendants and Defendant GIs violated the provision of the Connecticut FCA, Conn. Gen. Stat. § 4-275(a)(8), which provides that no person shall “[k]nowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the state under a state-administered health or human services program.”

480. Pursuant to the Connecticut FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by the law. Conn. Gen. Stat. § 4-275(b).

481. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

482. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Conn. Gen. Stat. §§ 4-274, et seq., unlawfully retaliated against Relators.

483. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all relief allowable under Conn. Gen. Stat. §§ 4-274, et seq.

COUNT XI

District of Columbia False Claims Act, D.C. Code Ann. §§ 2.381.01, et seq.

484. The allegations in the preceding paragraphs are incorporated by reference.

485. Relators also bring this action in the name of the District of Columbia, against Defendants and Defendant GIs under the District of Columbia False Claims Act, D.C. Code Ann. § 2-381.03(b)(1).

486. Defendants and Defendant GIs violated the provision of the D.C. FCA, D.C. Code Ann. § 2-381.02(a)(1), which creates liability for any person who “[k]nowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.”

487. Defendants and Defendant GIs violated the provision of the D.C. FCA, D.C. Code Ann. § 2-381.02(a)(2), which creates liability for any person who

“[k]nowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.”

488. Defendants and Defendant GIs violated the provision of the D.C. FCA, D.C. Code Ann. § 2-381.02(a)(6), which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the District, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the District.”

489. Pursuant to the D.C. FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Defendants and Defendant GIs are thus liable to the District for statutorily defined damages sustained because of the acts of Defendants and Defendant GIs and civil penalties. D.C. Code Ann. § 2-381.02(a).

490. During and by virtue of Relators employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

491. Defendants, with actual knowledge of Relators’ lawful acts in furtherance of this action and efforts to stop Defendants’ violations of DC ST § 2-381.02, unlawfully retaliated against Relators.

492. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under DC ST § 2-381.04.

COUNT XII

Florida False Claims Act, Fla. Stat. § 68.081, et seq.

493. The allegations in the preceding paragraphs are incorporated by reference.

494. Relators also bring this action on behalf of the State of Florida, against Defendants and Defendant GIs under the State of Florida's False Claims Act ("FCA"), Fla. Stat. § 68.083(2).

495. Defendants and Defendant GIs violated the provision of the Florida FCA, Fla. Stat. § 68.082(2)(a), which creates liability for any person who "[k]nowingly presents or causes to be presented a false or fraudulent claim for payment or approval."

496. Defendants and Defendant GIs violated the provision of the Florida FCA, Fla. Stat. § 68.082(2)(b), which creates liability for any person who "[k]nowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim."

497. Defendants and Defendant GIs violated the provision of the Florida FCA, Fla. Stat. § 68.082(2)(g), which creates liability for any person who

“[k]nowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to the state, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state.”

498. Pursuant to the Florida FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Fla. Stat. § 68.082(2).

499. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

500. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

501. Defendants, with actual knowledge of Relators’ lawful acts in furtherance of this action, unlawfully retaliated against Relators.

502. As a direct and proximate result of Defendants’ retaliatory actions, Relators suffered damages and are entitled to all allowable relief under Fla. Stat. §§ 68.088 and 112.3187(9).

COUNT XIII

**Georgia False Medicaid Claims Act,
O.C.G.A. § 49-4-168, et seq.**

503. The allegations in the preceding paragraphs are incorporated by reference.

504. Relators also bring this action in the name of the State of Georgia, against Defendants and Defendant GIs pursuant to the State of Georgia False Medicaid Claims Act (“FMCA”), O.C.G.A. § 49-4-168 et seq.

505. Defendants and Defendant GIs violated the provision of the Georgia FMCA, O.C.G.A. § 49-4-168.1(a)(1), which creates liability for any person who “[k]nowingly presents or causes to be presented to the Georgia Medicaid program a false or fraudulent claim for payment or approval.”

506. Defendants and Defendant GIs violated the provision of the Georgia FMCA, O.C.G.A. § 49-4-168.1(a)(2), which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim.”

507. Defendants and Defendant GIs violated the provision of the Georgia FMCA, O.C.G.A. § 49-4-168.1(a)(7), which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit property or money to the Georgia Medicaid program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit property or money to the Georgia Medicaid program.”

508. Pursuant to the Georgia FMCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. O.C.G.A. § 49-4-168.1(a).

509. As a result of Defendants' and Defendant GIs' violations, the State has suffered damages in an amount to be determined at trial.

510. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

511. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of O.C.G.A. § 49-4-168, et seq., unlawfully retaliated against Relators.

512. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all relief allowable under O.C.G.A. § 49-4-168, et seq.

COUNT XIV

Illinois False Claims Act, 740 Ill. Comp. Stat. 175/1, et seq.

513. The allegations in the preceding paragraphs are incorporated by reference.

514. Relators also bring this action on behalf of the State of Illinois, against Defendants and Defendant GIs under the Illinois False Claims Act (“FCA”), 740 Ill. Comp. Stat. 175/4(b).

515. Defendants and Defendant GIs violated the provision of the Illinois FCA, 740 Ill. Comp. Stat. 175/3(a)(1)(A), which creates liability for any person who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.”

516. Defendants and Defendant GIs violated the provision of the Illinois FCA, 740 Ill. Comp. Stat. 175/3(a)(1)(B), which creates liability for any person who “knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.”

517. Defendants and Defendant GIs violated the provision of the Illinois FCA, 740 Ill. Comp. Stat. 175/3(a)(1)(G), which creates liability for any person who “knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the State.”

518. Pursuant to the Illinois FCA, based on Defendants’ and Defendant GIs’ material non-disclosures and other wrongful acts and omissions set forth

above, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. 740 Ill. Comp. Stat. 175/3(a).

519. As a result of Defendants' and Defendant GIs' violations, the State has suffered damages in an amount to be determined at trial.

520. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

521. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of 740 ILCS §§ 175/3, unlawfully retaliated against Relators.

522. As a direct and proximate result of Defendants retaliatory actions, Relators suffered damages and are entitled to all allowable relief under 740 ILCS 175/4(g)(1) and (2).

COUNT XV

Indiana Medicaid False Claims and Whistleblower Protection Act, Ind. Code § 5-11-5.7, et seq.

523. The allegations in the preceding paragraphs are incorporated by reference.

524. Relators also bring this action on behalf of the State of Indiana, against Defendants and Defendant GIs under the State of Indiana False Claims and Whistleblower Protection Act (“FCA”), Ind. Code § 5-11-5.7-4(a).

525. Defendants and Defendant GIs violated the provision of the Indiana FCA, Ind. Code § 5-11-5.7-2(a)(1), creates liability for any person who “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.”

526. Defendants and Defendant GIs violated the provision of the Indiana FCA, Ind. Code § 5-11-5.7-2(a)(2), creates liability for any person who “knowingly makes, uses, or causes to be made or used, a false record or statement that is material to a false or fraudulent claim.”

527. Defendants and Defendant GIs violated the provision of the Indiana FCA, Ind. Code § 5-11-5.7-2(a)(6)(A)-(B), which creates liability for any person who “(A) makes, uses, or causes to be made or used, a false record or statement concerning an obligation to pay or transmit money or property to the state; or (B) conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state.”

528. Pursuant to the Indiana FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Ind. Code § 5-11-5.5-2(b).

529. As a result of Defendants' and Defendant GIs' violations, the State has suffered damages in an amount to be determined at trial.

530. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

531. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Ind. Code Ann. § 5-11-5.5-2, unlawfully retaliated against Relators.

532. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under Ind. Code Ann. § 5-11-5.5-8.

COUNT XVI

Iowa False Claims Act, Iowa Code § 685.1, et seq.

533. The allegations in the preceding paragraphs are incorporated by reference.

534. Relators also bring this action on behalf of the State of Iowa, against Defendants and Defendant GIs under the State of Iowa False Claims Act ("FCA"), Iowa Code § 685.3(2)a.

535. Defendants and Defendant GIs violated the provision of the Iowa FCA, Iowa Code § 685.2(1).a, which creates liability for any person who

“[k]nowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.”

536. Defendants and Defendant GIs violated the provision of the Iowa FCA, Iowa Code § 685.2(1).b, which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.”

537. Defendants and Defendant GIs violated the provision of the Iowa FCA, Iowa Code § 685.2(1).g, which creates liability for any person who “[k]nowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state.”

538. Pursuant to the Iowa FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Iowa Code § 685.2(1).

539. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

540. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

541. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of IA Code Ann. § 685.2, unlawfully retaliated against Relators.

542. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under IA Code Ann. §§ 685.3(6)(a) and (b).

COUNT XVII

Louisiana Medical Assistance Programs Integrity Law, La. Rev. Stat. Ann. § 46:437.1, et seq.

543. The allegations in the preceding paragraphs are incorporated by reference.

544. Relators also bring this action on behalf of the State of Louisiana's medical assistance programs, against Defendants and Defendant GIs under the State of Louisiana Medical Assistance Programs Integrity Law ("FCA"), La. Rev. Stat. Ann. § 46:439.1.A.

545. Defendants and Defendant GIs violated the provision of the Louisiana FCA, La. Rev. Stat. Ann. § 46:438.3.A, which states that "[n]o person shall knowingly present or cause to be presented a false or fraudulent claim."

546. Defendants and Defendant GIs violated the provision of the Louisiana FCA, La. Rev. Stat. Ann. § 46:438.3.B, which states that "[n]o person shall

knowingly engage in misrepresentation or make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim.”

547. Defendants and Defendant GIs violated the provision of the Louisiana FCA, La. Rev. Stat. Ann. § 46:438.3.C, which states that “[n]o person shall knowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the medical assistance programs, or to knowingly conceal, avoid, or decrease an obligation to pay or transmit money or property to the medical assistance programs.”

548. Pursuant to the Louisiana FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. La. Rev. Stat. Ann. § 46:438.6.

549. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

550. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

551. Defendants, with actual knowledge of Relators’ lawful acts in furtherance of this action and other efforts to stop Defendants’ violations of La. Rev. Stat. Ann. § 46:437.1, et seq., unlawfully retaliated against Relators.

552. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all relief allowable under La. Rev. Stat. Ann. § 46:437.1, et seq.

COUNT XVIII

Maryland False Health Claims Act, Md. Code Ann. Health-Gen. § 2-601, et seq.

553. The allegations in the preceding paragraphs are incorporated by reference.

554. Relators also bring this action on behalf of the State of Maryland, against Defendants and Defendant GIs under the State of Maryland False Health Claims Act ("FCA"), Md. Code Ann. Health-Gen. § 2-604(a)(1).

555. Defendants and Defendant GIs, violated the provision of the Maryland FCA, Md. Code Ann. Health-Gen. § 2-602(a)(1), which states that a person may not "[k]nowingly present or cause to be presented a false or fraudulent claim for payment or approval."

556. Defendants and Defendant GIs violated the provision of the Maryland FCA, Md. Code Ann. Health-Gen. § 2-602(a)(2), which states that a person may not "[k]nowingly make, use, or cause to be made or used a false record or statement material to a false or fraudulent claim."

557. Defendants and Defendant GIs violated the provision of the Maryland FCA, Md. Code Ann. Health-Gen. § 2-602(a)(7), which states that a person may

not “[k]nowingly make, use, or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or other property to the State.”

558. Defendants and Defendant GIs violated the provision of the Maryland FCA, Md. Code Ann. Health-Gen. § 2-602(a)(8), which states that a person may not “[k]nowingly conceal, or knowingly and improperly avoid or decrease, an obligation to pay or transmit money or other property to the State.”

559. Defendants and Defendant GIs violated the provision of the Maryland FCA, Md. Code Ann. Health-Gen. § 2-602(a)(9), which states that a person may not “[k]nowingly make any other false or fraudulent claim against a State health plan or a State health program.”

560. Pursuant to the Maryland FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Md. Code Ann. Health-Gen. § 2-602(b).

561. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

562. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

563. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Md. Code Ann., Gen. Prov. § 8-102, unlawfully retaliated against Relators.

564. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under Md. Code Ann., Gen. Prov. § 8-107(a)-(b).

COUNT XIX

The Commonwealth of Massachusetts False Claims Act, Mass. Ann. Laws Ch. 12, § 5A, et seq.

565. The allegations in the preceding paragraphs are incorporated by reference.

566. Relators also bring this action on behalf of the Commonwealth of Massachusetts, against Defendants and Defendant GIs under the Massachusetts False Claims Act ("FCA"), Mass. Ann. Laws ch. 12, § 5C(2).

567. Defendants and Defendant GIs violated the provision of the Massachusetts FCA, Mass. Ann. Laws ch. 12, § 5B(1), which creates liability for any person who "knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval."

568. Defendants and Defendant GIs violated the provision of the Massachusetts FCA, Mass. Ann. Laws ch. 12, § 5B(2), creates liability for any

person who “knowingly makes, uses or causes to be made or used a false record or statement material to a false or fraudulent claim.”

569. Defendants and Defendant GIs violated the provision of the Massachusetts FCA, Mass. Ann. Laws ch. 12, § 5B(9), which creates liability for any person who “knowingly makes, uses or causes to be made or used a false record or statement material to an obligation to pay or to transmit money or property to the commonwealth or a political subdivision thereof, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the commonwealth or a political subdivision thereof.”

570. Pursuant to the Massachusetts FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Mass. Ann. Laws ch. 12, § 5B(a).

571. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

572. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

573. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of M.G.L.A. 12 § 5B to 5O, unlawfully retaliated against Relators.

574. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under M.G.L.A. 12 § 5J.

COUNT XX

Michigan Medicaid False Claims Act, Mich. Comp. Laws Serv. § 400.601, et seq.

575. The allegations in the preceding paragraphs are incorporated by reference.

576. Relators also bring this action in the name of the State of Michigan, against Defendants and Defendant GIs under the State of Michigan Medicaid False Claims Act ("FCA"), Mich. Comp. Laws Serv. § 400.610a(1).

577. Defendants and Defendant GIs violated each of the following provisions of the Michigan FCA, Mich. Comp. Laws Serv. § 400.603(1)-(3):

"(1) A person shall not knowingly make or cause to be made a false statement or false representation of a material fact in an application for Medicaid benefits.

(2) A person shall not knowingly make or cause to be made a false statement or false representation of a material fact for use in determining rights to a Medicaid benefit.

(3) A person, who having knowledge of the occurrence of an

event affecting his initial or continued right to receive a Medicaid benefit or the initial or continued right of any other person on whose behalf he has applied for or is receiving a benefit, shall not conceal or fail to disclose that event with intent to obtain a benefit to which the person or any other person is not entitled or in an amount greater than that to which the person or any other person is entitled.”

578. Defendants and Defendant GIs violated the provision of the Michigan FCA, “400.604 Furnishing of goods or services; kickbacks or bribes; payments or rebates for referrals; felony; penalty, which states: “A person who solicits, offers, or receives a kickback or bribe in connection with the furnishing of goods or services for which payment is or may be made in whole or in part pursuant to a program established under Act No. 280 of the Public Acts of 1939, as amended, who makes or receives the payment, or who receives a rebate of a fee or charge for referring an individual to another person for the furnishing of the goods and services is guilty of a felony, punishable by imprisonment for not more than 4 years, or by a fine of not more than \$30,000.00, or both.”

579. Defendants and Defendant GIs violated the provision of the Michigan FCA, Mich. Comp. Laws Serv. § 400.607(1), which states that “[a] person shall not make or present or cause to be made or presented to an employee or officer of this state a claim under the social welfare act, 1939 PA 280, MCL 400.1 to 400.119b, upon or against the state, knowing the claim to be false.”

580. Defendants and Defendant GIs violated the provision of the Michigan FCA, Mich. Comp. Laws Serv. § 400.607(3), which states that “[a] person shall not knowingly make, use, or cause to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state pertaining to a claim presented under the social welfare act.”

581. Pursuant to the Michigan FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Mich. Comp. Laws. Serv. § 400.612.

582. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

583. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

584. Defendants, with actual knowledge of Relators’ lawful acts in furtherance of this action and other efforts to stop Defendants’ violations of Mich. Comp. Laws Serv. § 400.601, et seq., unlawfully retaliated against Relators.

585. As a direct and proximate result of Defendants’ retaliatory actions, Relators suffered damages and are entitled to all relief allowable under Mich. Comp. Laws Serv. § 400.601, et seq.

COUNT XXI

**Minnesota False Claims Act,
Minn. Stat. §§ 15C.01, et seq.**

586. The allegations in the preceding paragraphs are incorporated by reference.

587. Relators also bring this action on behalf of the State of Minnesota and its political subdivisions, against Defendants and Defendant GIs under the State of Minnesota False Claims Act, Minn. Stat. § 15C.05(a).

588. Defendants and Defendant GIs violated each of the following provisions of the Minnesota FCA, Minn. Stat. § 15C.02(a), which create liability for any person who:

“(1) knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(2) knowingly makes or uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [or]

...

(7) knowingly makes or uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the state or a political subdivision, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the state or a political subdivision.”

589. Pursuant to the Minnesota FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Minn. Stat. § 15C.02(a).

590. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

591. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of M.S.A. § 15C.02, unlawfully retaliated against Relators.

592. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under M.S.A. § 15C.145.

COUNT XXII

Montana False Claims Act, Mont. Code Ann. § 17-8-401, et seq.

593. The allegations in the preceding paragraphs are incorporated by reference.

594. Relators also bring this action on behalf of the State of Montana, against Defendants and Defendant GIs under the State of Montana False Claims Act ("FCA"), Mont. Code Ann. § 17-8-406(1).

595. Defendants and Defendant GIs violated each of the following provisions of the Montana FCA, Mont. Code Ann. § 17-8-403(1), which create liability for any person who:

“(a) knowingly presents or causes to be presented a false or fraudulent claim for payment or approval;

(b) knowingly makes, uses, or causes to be made or used a false record or statement material to a false or fraudulent claim; [or]

...

(g) knowingly makes, uses, or causes to be made or used a false record or statement material to an obligation to pay or transmit money or property to a governmental entity or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to a governmental entity.”

596. Pursuant to the Montana FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Mont. Code Ann. § 17-8-403(2).

597. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

598. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

599. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Mont. Code Ann. § 17-8-403, unlawfully retaliated against Relators.

600. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under Mont. Code Ann. § 17-8-412.

COUNT XXIII

Nevada Submission of False Claims to State or Local Government Act, Nev. Rev. Stat. § 357.010, et seq.

601. The allegations in the preceding paragraphs are incorporated by reference.

602. Relators also bring this action on behalf of the State of Nevada, against Defendants and Defendant GIs under the State of Nevada Submission of False Claims to State or Local Government Act ("FCA"), Nev. Rev. Stat. § 357.080(1).

603. Defendants and Defendant GIs violated each of the following provisions of the Nevada FCA, Nev. Rev. Stat. § 357.040(1), which create liability for any person who:

“(a) Knowingly presents or causes to be presented a false or fraudulent claim for payment or approval.

(b) Knowingly makes or uses, or causes to be made or used, a false record or statement that is material to a false or fraudulent claim.

...

(f) Knowingly makes or uses, or causes to be made or used, a false record or statement that is material to an obligation to pay or transmit money or property to the State or a political subdivision; or

(g) Knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the State or a political subdivision.

604. Pursuant to the Nevada FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Nev. Rev. Stat. § 357.040(2).

605. As a result of Defendants' and Defendant GIs' violations, the State has suffered damages in an amount to be determined at trial.

606. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

607. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Nev. Rev. Stat. § 357.040, unlawfully retaliated against Relators.

608. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under Nev. Rev. Stat. § 357.250.

COUNT XXIV

New Jersey False Claims Act, N.J. Stat. Ann. § 2A:32C-1, et seq.

609. The allegations in the preceding paragraphs are incorporated by reference.

610. Relators also bring this action in the name of the State of New Jersey, against Defendants and Defendant GIs pursuant to the State of New Jersey False Claims Act ("FCA"), N.J. Stat. Ann. § 2A:32C-5.b.

611. Defendants and Defendant GIs violated each of the following provisions of The New Jersey FCA, N.J. Stat. Ann. § 2A:32C-3, which create liability for any person who:

"a. Knowingly presents or causes to be presented to an employee, officer or agent of the State, or to any contractor, grantee, or other recipient of State funds, a false or fraudulent claim for payment or approval;

b. Knowingly makes, uses, or causes to be made or used a false record or statement to get a false or fraudulent claim paid or approved by the State;

...

g. Knowingly makes, uses, or causes to be made or used a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State."

612. Pursuant to the New Jersey FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. N.J. Stat. Ann. § 2A:32C-3.

613. As a result of Defendants' and Defendant GIs' violations, the State has suffered damages in an amount to be determined at trial.

614. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

615. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action, unlawfully retaliated against Relators.

616. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under NJSA 2A:32C-10.

COUNT XXV

New Mexico Medicaid False Claims Act, N.M. Stat. Ann. § 27-14-1, et seq.

617. The allegations in the preceding paragraphs are incorporated by reference.

618. Relators also bring this action on behalf of the State of New Mexico, against Defendants and Defendant GIs under the State of New Mexico Medicaid False Claims Act ("FCA"), N.M. Stat. Ann. § 27-14-7.B.

619. Defendants and Defendant GIs violated each of the following provisions of the New Mexico FCA, N.M. Stat. Ann. § 27-14-4, which create liability for any person who:

“A. presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing that such claim is false or fraudulent;

B. presents, or causes to be presented, to the state a claim for payment under the Medicaid program knowing that the person receiving a Medicaid benefit or payment is not authorized or is not eligible for a benefit under the Medicaid program;

C. makes, uses or causes to be made or used a record or statement to obtain a false or fraudulent claim under the Medicaid program paid for or approved by the state knowing such record or statement is false; [or]

...

E. makes, uses or causes to be made or used a record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state, relative to the Medicaid program, knowing that such record or statement is false.”

620. Pursuant to the New Mexico FCA, Defendants and Defendant GIs are thus liable to the State for statutorily defined damages sustained because of the acts of Defendants and Defendant GIs and such other relief as authorized. N.M. Stat. Ann. § 27-14-4.

621. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

622. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

623. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action, unlawfully retaliated against Relators.

624. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under N.M.S.A. § 44-9-11.

COUNT XXVI

North Carolina False Claims Act, N.C. Gen. Stat. § 1-605, et seq.

625. The allegations in the preceding paragraphs are incorporated by reference.

626. Relators also bring this action on behalf of the State of North Carolina, against Defendants and Defendant GIs under the State of North Carolina False Claims Act ("FCA"), N.C. Gen. Stat. § 1-608(b).

627. Defendants and Defendant GIs violated each of the following provisions of the North Carolina FCA, N.C. Gen. Stat. § 1-607(a), which create liability for 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.

...

(7) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the State.”

628. Pursuant to the North Carolina FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. N.C. Gen. Stat. § 1-607(a).

629. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

630. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

631. Defendants, with actual knowledge of Relators’ lawful acts in furtherance of this action and efforts to stop Defendants’ violations of N.C. Gen. Stat. §§ 1-607, unlawfully retaliated against Relators.

632. As a direct and proximate result of Defendants’ retaliatory actions, Relators suffered damages and are entitled to all allowable relief under N.C.G.S.A. § 1-613.

COUNT XXVII

**Oklahoma Medicaid False Claims Act,
Okla. Stat. Tit. § 63-5053, et seq.**

633. The allegations in the preceding paragraphs are incorporated by reference.

634. Relators also bring this action in the name of the State of Oklahoma, against Defendants and Defendant GIs pursuant to the State of Oklahoma Medicaid False Claims Act (“FCA”), Okla. Stat. tit. § 63-5053.2(B).

635. Defendants and Defendant GIs violated each of the following provisions of the Oklahoma FCA, Okla. Stat. tit. § 63-053.1(B), which create liability for any person who:

“1. Knowingly presents, or causes to be presented, to an officer or employee of the State of Oklahoma, a false or fraudulent claim for payment or approval;

2. Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the state;

... or

7. Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the state.”

636. Pursuant to the Oklahoma FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized under the statute.

637. As a result of Defendants' and Defendant GIs' violations, the State has suffered damages in an amount to be determined at trial.

638. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

639. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Okla. Stat. Tit. § 63-5053, et seq., unlawfully retaliated against Relators.

640. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all relief allowable under Okla. Stat. Tit. § 63-5053, et seq.

COUNT XXVIII

Tennessee Medicaid False Claims Act, Tenn. Code Ann. § 71-5-181, et seq.

641. The allegations in the preceding paragraphs are incorporated by reference.

642. Relators also bring this action in the name of the State of Tennessee, against Defendants and Defendant GIs under the Tennessee Medicaid False Claims Act ("FCA"), Tenn. Code Ann. § 71-5-183(b)(1).

643. Defendants and Defendant GIs violated each of the following provisions of the Tennessee FCA, Tenn. Code Ann. § 71-5-182(a)(1), which create liability for any person who:

“(A) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval under the Medicaid program;

(B) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim under the Medicaid program; [or]

(C) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money, or property to the state, or knowingly conceals, or knowingly and improperly, avoids, or decreases an obligation to pay or transmit money or property to the state, relative to the Medicaid program.”

644. Pursuant to the Tennessee FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Tenn. Code Ann. § 71-5-182(a).

645. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

646. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

647. Defendants, with actual knowledge of Relators’ lawful acts in furtherance of this action, unlawfully retaliated against Relators.

648. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under Tenn. Code Ann. § 4-18-105.

COUNT XXIX

Texas Medicaid Fraud Prevention Act, Tex. Hum. Res. Code § 36.001, et seq.

649. The allegations in the preceding paragraphs are incorporated by reference.

650. Relators also bring this action in the name of the State of Texas, against Defendants and Defendant GIs under the State of Texas Medicaid Fraud Prevention Act ("FCA"), Tex. Hum. Res. Code § 36.101(a).

651. Defendants and Defendant GIs violated each of the following provisions of the Texas FCA, Tex. Hum. Res. Code § 36.002, which create liability for any person who, *inter alia*:

"(1) knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;

(2) knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;

(3) knowingly applies for and receives a benefit or payment

on behalf of another person under the Medicaid program and converts any part of the benefit or payment to a use other than for the benefit of the person on whose behalf it was received;

...

(12) knowingly makes, uses, or causes the making or use of a false record or statement material to an obligation to pay or transmit money or property to this state under the Medicaid program, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to this state under the Medicaid program; or

(13) knowingly engages in conduct that constitutes a violation under Section 32.039(b).”

652. Pursuant to the Texas FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Tex. Hum. Res. Code § 36.052.

653. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

COUNT XXX

Vermont False Claims Act, Vt. Stat. Tit. 32, 630, et seq.

654. The allegations in the preceding paragraphs are incorporated by reference.

655. Relators also bring this action in the name of the State of Vermont, against Defendants and Defendant GIs under the State of Vermont False Claims Act (“FCA”), Vt. Stat. Ann. tit. 32, § 632(b).

656. Defendants and Defendant GIs violated each of the following provisions of the Vermont FCA, Vt. Stat. Ann. tit. 32, § 631, which state that no person shall:

- “(1) knowingly present, or cause to be presented, a false or fraudulent claim for payment or approval;
- (2) knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim;
- ...
- (8) enter into a written agreement or contract with an official of the State or its agent knowing the information contained therein is false;
- (9) knowingly make, use or cause to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the State; [or]
- (10) knowingly conceal or knowingly and improperly avoid or decrease an obligation to pay or transmit money or property to the State;

657. Pursuant to the Vermont FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Vt. Stat. Ann. tit. 32, § 631(b).

658. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

659. During and by virtue of Relators’ employment with Defendants, Relators obtained direct and independent knowledge of Defendants’ unlawful conduct alleged in this Complaint.

660. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and efforts to stop Defendants' violations of 32 V.S.A. § 631, unlawfully retaliated against Relators.

661. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under 32 V.S.A. §

COUNT XXXI

The Commonwealth of Virginia Fraud Against Taxpayers Act, Va. Code Ann. § 8.01-216.1, et seq.

662. The allegations in the preceding paragraphs are incorporated by reference.

663. Relators also bring this action on behalf of the Commonwealth of Virginia, against Defendants and Defendant GIs under the Commonwealth of Virginia Fraud Against Taxpayers Act ("FCA"), Va. Code Ann. § 8.01-216.5(A).

664. Defendants and Defendant GIs violated each of the following provisions of the Virginia FCA, Va. Code Ann. § 8.01-216.3(A), which create liability for 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;

...

7. Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit

money or property to the Commonwealth or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Commonwealth.”

665. Pursuant to the Virginia FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Va. Code Ann. § 8.01-216.3(A).

666. As a result of Defendants' and Defendant GIs' violations, the State has suffered damages in an amount to be determined at trial.

667. During and by virtue of Relators' employment with Defendants, Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

668. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and efforts to stop Defendants' violations of VA Code Ann. § 8.01-216.3, unlawfully retaliated against Relators.

669. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all allowable relief under VA Code Ann. § 8.01-216.8.

COUNT XXXII

**Washington State Medicaid Fraud False Claims Act,
Wash. Rev. Code § 74.66.005, et seq.**

670. The allegations in the preceding paragraphs are incorporated by reference.

671. Relators also bring this action on behalf of the State of Washington, against Defendants and Defendant GIs under the Washington State Medicaid Fraud False Claims Act (“FCA”), Wash. Rev. Code § 74.66.050(1).

672. Defendants and Defendant GIs violated each of the following provisions of the Washington FCA, Wash. Rev. Code § 74.66.020(1), which create liability for any person who:

“(a) Knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval;

(b) Knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim; [or]

...

(g) Knowingly makes, uses, or causes to be made or used, a false record or statement material to an obligation to pay or transmit money or property to the government entity, or knowingly conceals or knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the government entity.”

673. Pursuant to the Washington FCA, Defendants and Defendant GIs are liable to the State for treble damages, civil penalties, and all other relief authorized by law. Wash. Rev. Code § 74.66.020(1).

674. As a result of Defendants’ and Defendant GIs’ violations, the State has suffered damages in an amount to be determined at trial.

675. During and by virtue of Relators’ employment with Defendants,

Relators obtained direct and independent knowledge of Defendants' unlawful conduct alleged in this Complaint.

676. Defendants, with actual knowledge of Relators' lawful acts in furtherance of this action and other efforts to stop Defendants' violations of Wash. Rev. Code § 74.66.005, et seq., unlawfully retaliated against Relators.

677. As a direct and proximate result of Defendants' retaliatory actions, Relators suffered damages and are entitled to all relief allowable under Wash. Rev. Code § 74.66.005, et seq.

WHEREFORE, Relators, on behalf of Relators and the United States, pray:

- (a) That the Court enter judgment against Defendants and Defendant GIs in an amount equal to three times the amount of damages the United States has sustained because of Defendants' and Defendant GIs' actions, plus a civil penalty of any amount within the applicable statutory ranges, for each violation;
- (b) That Relators be awarded an amount that the Court decides is reasonable for recovering the proceeds of the action, including but not necessarily limited to the civil penalties and damages, on behalf of the United States, which, pursuant to the False Claims Act, shall be at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim if the Government intervenes and

proceeds with the action, and not less than 25 percent nor more than 30 percent of the proceeds of the action or settlement of the claim if the Government does not intervene;

- (c) That Relators receive all relief necessary to make Relators whole for Defendants' violations of 31 U.S.C. § 3730(h);
- (d) That the Court order Defendants to awards Relators front pay in lieu of reinstatement;
- (e) That Relators receive an award of two times back pay, including the value of lost benefits and equity;
- (f) That Relators receive an award of compensatory damages in an amount to be proven at trial for the economic, reputational, and emotional harm Relators experienced as a result of Defendants' unlawful conduct;
- (g) That Relators receive an award of punitive damages in an amount sufficient to punish Defendants' for their willful and malicious conduct and deter future, similar violations;
- (h) That judgment be entered against Defendants and Defendant GIs jointly and severally, in the amounts to be determined at trial; and
- (i) That Relators be awarded all costs and expenses incurred, including reasonable attorneys' fees; and

(j) That the Court order such other relief as is appropriate.

Trial by jury is hereby requested.

Dated: April 9, 2021

Respectfully submitted,

Renee Brooker

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