UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

UNITED STATES *ex rel.* LINDA JAINNINEY, **Plaintiff-Relator,** **vs.** **ANMED HEALTH, formerly known as ANDERSON AREA MEDICAL CENTER, INC.; BLUE RIDGE RADIATION ONCOLOGY, P.A.; WILLIAM V. TOMLINSON, M.D.; ANDERSON RADIATION ONCOLOGY; RAVINDER MALIK, M.D.; ANDERSON AREA CANCER CENTER ONCOLOGY – HEMATOLOGY CLINIC, P.A.; SZABOKS BATIZY, M.D.; RAJEEV MALIK, M.D., NANDAKISHORE PARCHURI, M.D.; ANDERSON EMERGENCY ASSOCIATES, P.A.; THE CHARLOTTE-MECKLENBERG HOSPITAL AUTHORITY d/b/a CAROLINAS HEALTHCARE SYSTEM.** **Defendants.**	**CIVIL ACTION FILE NO.** 1:12-CV-2942 **FILED *IN CAMERA* UNDER SEAL** **Jury Trial Requested**

COMPLAINT

1. This is an action by Relator Linda Jainniney on behalf of herself and the United States Government, to recover penalties and damages from the false statements or records submitted or caused to be submitted by ANMED, formerly known as Anderson Area Medical Center, Inc.; Blue Ridge Radiation Oncology, P.A; William V. Tomlinson, M.D.; Anderson Radiation Oncology; Ravinder Malik, M.D.; Anderson Area Cancer Center Oncology – Hematology Clinic, P.A.; Szaboks Batizy, M.D.; Rajeev Malik, M.D., Nandakishore Parchuri, M.D.; Anderson Emergency Associates, P.A.; The Charlotte-Mecklenberg Hospital Authority d/b/a Carolinas HealthCare System (collectively hereinafter, "Defendants"), to the United States Government in order to obtain payments of federal funds.

JURISDICTION AND VENUE

2. This action arises under the False Claims Act, 31 U.S.C. §§ 3729 *et seq.* (the "FCA").

3. This Court has subject matter jurisdiction over this matter pursuant to 31 U.S.C. § 3732(a) and 28 U.S.C. § 1345.

4. This Court has personal jurisdiction over the Defendants.

5. Venue is proper in this district under 28 U.S.C. §§ 1391(b), and 1391(c), and under 31 U.S.C. § 3732(a). The Defendants transact business within the district, and certain acts proscribed by the FCA occurred within the district.

6. Relator is entitled to and demands a trial by jury.

PARTIES

7. Relator Linda Jainniney is a resident of Georgia and a United States citizen. Relator Jainniney was employed by AnMed (formerly known as Anderson Area Medical Center, Inc.) ("AnMed") as a Manager, Radiation Oncology, from September 2005 through July 13, 2012. Relator Jainniney is an experienced radiation therapist registered with The American Registry of Radiologic Technologists and is a Radiation Oncology Certified Coder with American Medical Accounting and Consulting, Inc in Marietta, Georgia. She received an Associates Degree from the Medical College of Georgia in 1998, and received her Bachelors Degree in Radiation Therapy in 1999.

8. Defendant AnMed is a South Carolina corporation created in 1906. AnMed, on information and belief, with over $500,000,000 in annual revenues is a nonprofit 501(c)(3) corporation providing a full range of inpatient acute care services for medical, surgical, pediatric, obstetric, psychiatric, substance abuse and

rehabilitation patients, as well as specialized care in its intensive care and coronary care units. The AnMed Health System, operates three separately licensed inpatient facilities (i) AnMed Health Medical Center located at the AnMed Health Medical Center Campus, 800 North Fant Street in the City of Anderson (the "Medical Center" or "AnMed Health Medical Center"), (ii) AnMed Health Women's & Children's Hospital located at the AnMed Health North Campus, 2000 East Greenville Street in the City of Anderson, and (iii) the AnMed Health Rehabilitation Hospital (a joint venture with the HealthSouth Corporation) located at the AnMed Health North Campus, 1 Springback Way in the city of Anderson. To support these inpatient services, AnMed Health offers a normal complement of diagnostic and ancillary services. Additionally, AnMed Health offers normal compliment of diagnostic and ancillary services. Additionally, AnMed Health offers outpatient services at D.K. Oglesby Center at the AnMed Health North Campus and has several clinics located in Anderson, Iva, Clemson, Honea Path and Williamston, South Carolina and Hartwell, Georgia. In June 2012, AnMed announced that it was expanding its presence in North Georgia with two new major partnerships in the cities of Elberton and Hartwell. Technical and support employees (including the Relator) working at Defendant

AnMed are employed by Defendant AnMed in Anderson, South Carolina. Defendant AnMed transacts business in the Northern District of Georgia.

9. At all times relevant hereto, Defendant AnMed was enrolled as a participating provider in the Medicare program. In order to enroll in the Medicare Program, Defendant AnMed had submitted a Medicare Enrollment Application, Institutional Providers, Form CMS 855A, in which Defendant AnMed certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

10. Defendant Blue Ridge Radiation Oncology, P.A. ("Blue Ridge") is a South Carolina corporation created in 1998, with its principal place of business at Anderson, South Carolina. Blue Ridge provides radiation treatment for cancer patients and maintains its offices at AnMed Health Cancer Center in Anderson, South Carolina which is part of AnMed.

11. At all times relevant hereto, Defendant Blue Ridge was enrolled as a participating provider in the Medicare program. In order to enroll in the Medicare Program, Defendant Blue Ridge submitted a Medicare Enrollment Application, Clinics/Group Practices and Certain Other Suppliers, Form CMS 855B, in which Defendant Blue Ridge certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

12. Defendant William V. Tomlinson, M.D. ("Tomlinson") is a United States citizen. Tomlinson is the sole owner of Blue Ridge and acts as the Medical Director of the Department of Radiation Oncology and has been on staff at AnMed Health Cancer Center since 1986. At all times relevant hereto, Defendant Tomlinson was enrolled as a participating provider in the Medicare Program. In order to enroll in the Medicare Program, Defendant Tomlinson a Medicare Enrollment Application, Physicians and

Non-Physician Practitioners, Form CMS 8551, in which Defendant Tomlinson certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

13. Defendant Anderson Radiation Oncology ("ARO") is on information and belief a sole proprietorship owned by Ravinder Malik, M.D. which provides radiation oncology services to AnMed Health Cancer Care in Anderson, South Carolina. At all times relevant hereto, Defendant ARO was enrolled as a participating provider in the Medicare Program. In order to enroll in the Medicare Program, Defendant ARO submitted a Medicare Enrollment Application, Clinics/Group Practices and Certain Other Suppliers, Form CMS 855B, in which Defendant ARO certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

14. Defendant Ravinder Malik, M.D. ("Malik") is believed to be a United States citizen. Dr. Malik a radiation oncologist uses the trade name Anderson Radiation Oncology and from 1985 until December 2011, was on staff at AnMed Health Cancer Center.

15. At all times relevant hereto, Defendant Malik was enrolled as a participating provider in the Medicare Program. In order to enroll in the Medicare Program, Defendant Malik a Medicare Enrollment Application, Physicians and Non-Physician Practitioners, Form CMS 8551, in which Defendant Tomlinson certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

16. Defendants Tomlinson and Malik have been the primary radiation oncologists performing radiation oncology services for Defendant AnMed Health since 1986 and 1985, respectively.

17. Anderson Area Cancer Center Oncology – Hematology Clinic, P.A. ("Anderson Oncology") is a South Carolina corporation created in 1990, with its principal place of business in Anderson, South Carolina. Anderson Oncology provides medical oncology treatment for cancer patients and maintains its offices at AnMed Health Care Center in Anderson, South Carolina.

18. At all times relevant hereto, Defendant Anderson Oncology was enrolled as a participating provider in the Medicare Program. In order to enroll in the Medicare Program, Defendant Anderson Radiology submitted a Medicare Enrollment Application, Clinics/Group Practices and Certain Other Suppliers, Form CMS 855B, in which Defendant Anderson Radiology certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.

> 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.

19. On information and belief, Defendant AnMed provided to Defendants Blue Ridge, Anderson Radiation Oncology, Tomlinson and Malik without charge approximately forty percent (40%) of 143,000 square feet of office space with no written lease (plus, without charge to such Defendants other goods and services including staff services, furniture, equipment, supplies, telecommunication and mail equipment and other goods and services which directly benefit such Defendant's practices) dedicated to the Cancer Center on Defendant AnMed's premises at its hospital campus in Anderson, South Carolina, to Defendant's Tomlinson, Blue Ridge, Anderson Radiation Oncology and Malik with free rent in exchange for the exclusive patient referrals which generated in excess of $18,000,000 in revenues in 2011 alone! On information and belief, Anderson Oncology pays Defendant AnMed rent to use and operate its medical oncology practice the AnMed Health Cancer Center facility in Anderson, South Carolina.

20. Such a lease arrangement constitutes the offering, paying, soliciting, and receiving of remuneration in exchange for, or induces the referral of a patient for an item or service covered by federal health care programs, by Defendants AnMed, CHS,

Tomlinson, Blue Ridge, Anderson Radiation Oncology and Malik and is in violation of Medicare/Medicaid Anti-Kickback Statue 42 U.S.C. Section 1302a-7b ("AKS").

21. The aforementioned lease arrange between Defendant AnMed and Defendants Tomlinson, Blue Ridge, Malik and Anderson Radiation Oncology constitute the referral of patients where the physician has a "financial relationship" with Defendant AnMed, in violation of the Stark Law, 42 U.S.C. Section 1395nn, *et seq*.

22. Upon information and belief, in presenting claims to the United States or its agents for payment or approval, Defendants AnMed, CHS, Tomlinson, Blue Ridge, Malik and Anderson Radiation Oncology falsely certified that they were not in violation of the AKS or the Stark Law.

23. A false certification of compliance of the AKS and/or the Stark Law creates liability under the FCA and all claims resulting for illegal kickbacks are false claims within the meaning of the FCA.

24. The Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, § 6402(f)(1) (2010), confirms that an underlying violation of the AKS renders a subsequent claim false. Specifically, the AKS now provides that "a claim that includes items or services resulting from a violation of this section constitutes a

false or fraudulent claim for purposes of [the FCA]. *See* PPACA § 6402(f); codified at 42 U.S.C. 1320a-7b(g). The amended thus clarifies that *all* claims for services that were tainted by the payment of a kickback are false claims within the meaning of the FCA.

25. Defendant Szaboks Batizy, M.D. ("Batizy") is, on information and belief, a U.S. citizen and on information and belief is an owner of Anderson Oncology. He resides in South Carolina.

26. At all times relevant hereto, Defendant Batizy was enrolled as a participating provider in the Medicare Program. In order to enroll in the Medicare Program, Defendant Batizy a Medicare Enrollment Application, Physicians and Non-Physician Practitioners, Form CMS 8551, in which Defendant Batizy certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

27. Defendant Rajeev Malik, M.D., the husband of Defendant Malik ("R. Malik"), is, on information and belief, a U.S. citizen and on information and belief is an owner of Anderson Oncology.

28. At all times relevant hereto, Defendant R. Malik was enrolled as a participating provider in the Medicare Program. In order to enroll in the Medicare Program, Defendant R. Malik a Medicare Enrollment Application, Physicians and Non-Physician Practitioners, Form CMS 8551, in which Defendant R. Malik certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

29. Defendant Nandakishore Parchuri, M.D. ("Parchuri") is, on information and belief, a U.S. citizen and on information and belief is an owner of Anderson Oncology.

30. At all times relevant hereto, Defendant Parchuri was enrolled as a participating provider in the Medicare Program. In order to enroll in the Medicare Program, Defendant Parchuri a Medicare Enrollment Application, Physicians and Non-Physician Practitioners, Form CMS 8551, in which Defendant Parchuri certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

31. Anderson Emergency Associates, P.A. ("Anderson Emergency") is a South Carolina corporation created in 1989. Anderson Emergency provides emergency room medicine and maintains its offices at AnMed in Anderson, South Carolina.

32. At all times relevant hereto, Defendant Anderson Emergency was enrolled as a participating provider in the Medicare Program. In order to enroll in the Medicare Program, Defendant Anderson Emergency submitted a Medicare Enrollment

Application, Clinics/Group Practices and Certain Other Suppliers, Form CMS 855B, in which Defendant Anderson Emergency certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
>
> 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.

33. The Charlotte – Mecklenberg Hospital Authority, d/b/a Carolinas Healthcare System ("CHS") is a North Carolina corporation created in 1997. On information and belief, since October 1, 2009, pursuant to a services and affiliation agreement (the "AnMed Services Agreement"), Defendant AnMed appointed CHS as the manager of AnMed. Defendant CMS is one of the leading healthcare organizations in the Southeast and one of the largest public, not-for-profit systems in the nation. It operates more than 30 affiliated hospitals, directly employs more than 1, 900 physicians, and serves patients at more than 600 other care locations including physician practices, freestanding emergency departments, outpatient surgery centers, pharmacies, laboratories, imaging centers and other facilities. CHS also operations 8

cancer centers, a large number of nursing homes and other enterprises that provide home care, medical equipment and hospice services. Altogether, CHS operations comprise more than 6,200 licensed beds and employ more than 48,000 people, with combined net operating revenues during 2011 totaling more than $6.7 billion.

34. At all times relevant hereto, Defendant CHS was enrolled as a participating provider in the Medicare program. In order to enroll in the Medicare Program, Defendant CHS had submitted a Medicare Enrollment Application, Institutional Providers, Form CMS 855A, in which Defendant CHS certified that:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to this supplier. 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 supplier's compliance with all applicable conditions of participation in Medicare.
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> 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.

35. On information and belief, on or about October 2009, a number of AnMed senior management, including Garrick B. Chidester, who is Relator's direct supervisor and who served as Vice President of Network Development of AnMed since January 1999, became employed by Defendant CHS. It is not clear whether he

also remained employed at AnMed since he continued to wear his AnMed badge and his AnMed employee identity card. Mr. Chidester was listed as the 4th most senior executive in AnMed's $112,000,000 Hospital Refunding and Improvement Revenue Bond Prospectus, dated April 27, 2009, just below John Miller, President and Chief Executive Officer, William T. Manson, Executive Vice President and Chief Operating Officer and James Parrish, Vice President of Financial Services. On information and belief, Mr. Chidester reports directly to John Miller, the President and Chief Executive Officer.

36. On information and belief, all Defendants treated and or currently treat patients who reside in the States of Georgia and South Carolina.

GOVERNING REGULATIONS AND BACKGROUND

37. Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395, *et seq.*, establishes the Health Insurance for the Aged and Disabled Program, popularly known as the Medicare program. The Secretary of the United States Department of Health and Human Services ("HHS") administers the Medicare Program through the Centers for Medicare and Medicaid Services ("CMS"), a component of HHS.

38. The Medicare program consists of several parts. Medicare Part A provides basic insurance for the costs of hospitalization and post-hospitalization care.

42 U.S.C. §§ 1395c-1395i-2 (1992). Medicare Part B is a federally subsidized, voluntary insurance program that covers certain non-hospital medical services and products including the treatments at issue in this complaint. 42 U.S.C. §§ 1395(k), 1395(i) and 1395(s). Reimbursement for Medicare claims is made by the United States through CMS. CMS, in turn, contracts with private insurance carriers to administer and pay Medicare Part B claims from the Medicare Trust Fund. 42 U.S.C. § 1395(u). In this capacity, the carriers act on behalf of CMS. 42 C.F.R. § 421.5(b) (1994).

39. In order to receive Medicare funds, enrolled suppliers, including Defendants, together with their authorized agents, employees, and contractors, are required to abide by all the provisions of the Social Security Act, the regulations promulgated under the Act, and all applicable policies and procedures issued by the states.

40. Among the rules and regulations which enrolled suppliers, including Defendants, agree to follow are to: (1) bill Medicare Carriers for only those covered services which are medically necessary; (2) not bill Medicare Carriers for any services or items which were not performed or delivered in accordance with all applicable policies, nor submit false or inaccurate information relating to provider costs or services; (3) not engage in any act or omission that constitutes or results in over--

utilization of services; (4) be fully licensed and/or certified under the applicable state and federal laws to perform the services provided to recipients; (5) comply with state and federal statutes, policies and regulations applicable to the Medicare Program; and (6) not engage in any illegal activities related to the furnishing of services to recipients.

41. Medicaid is a joint federal/state program that provides care for indigent and disabled people. Although the Medicaid program is administered by the states, it is funded in a significant part by the federal government.

42. The Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS") is a government-funded program that provides medical benefits to retired members of the Uniformed Services and to spouses and children of active duty, retired, and deceased members, as well as reservists who were ordered to active duty for thirty (30) days or longer. The program is administered by the Department of Defense and funded by the federal government.

43. The Civilian Health and Medical Program of the Veterans Administration ("CHAMPVA") provides similar benefits for spouses and children of veterans who are entitled to VA permanent and total disability benefits to widows and children of veterans who dies of service-related disabilities. The program is administered by the Department of Defense and funded by the federal government.

44. At all times relevant to this Complaint, Defendants were participating Medicare, Medicaid, CHAMPUS, and CHAMPVA providers. Defendants submitted claims for payment to Medicare, Medicaid, CHAMPUS, and CHAMPVA for services and supplies.

45. At all times relevant to this Complaint, Medicare, Medicaid, CHAMPUS, and CHAMPVA constituted a significant source of revenue for Defendants.

46. All of the conduct alleged in this Complaint is alleged to have occurred "knowingly" or with reckless disregard, as those terms are defined in the False Claims Act, 31 U.S.C. § 3729 and related case law.

THE RADIATION ONCOLOGY SPECIALTY

47. Radiation Oncology is a cancer treatment wherein ionizing radiation is utilized to control malignant cells. The radiation is used to damage the DNA of the malignant cells in hopes of causing the cells to die or reproduce at a slower rate. Radiation Oncology is used as a palliative treatment (where cure is not possible and the aim is for local disease control or symptomatic relief) or as therapeutic treatment (where the therapy has survival benefit and it can be curative).

48. Among others, Medicare, TRICARE, the VA's Purchased Care Program, and Medicaid provides coverage for X-ray therapy and other radiation therapy services,

including radium therapy and radioactive isotope therapy, and materials and the services of the therapists administering the treatment.

49. The Radiation Oncology service codes are considered "Radiology" services by Medicare, TRICARE, VA's Purchased Care program, and Medicaid and are therefore subject to the same general payment regulations as diagnostic radiology services, with specific requirements set forth by Medicare, TRICARE, the VA's Purchased Care Program, and Medicaid for some Radiation Oncology services.

50. Medicare, TRICARE, the VA's Purchased Care Program, and Medicaid will only pay for medical services when they are "reasonable and necessary" for the "diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

51. Medicare, TRICARE, the VA's Purchased Care Program, and Medicaid assigns the technical component of all diagnostic radiology services a required level of physician supervision in order to be considered "reasonable and necessary." There are three levels of supervision as follows:

> a. General Supervision – The procedure is done under the physician's direction and control and the physician is not required to be present during the procedure. The physician is personally responsible for the training of the personnel performing the procedure and for the maintenance of the equipment and supplies utilized.

b. Direct Supervision – The physician does not have to be in the room when the procedure is performed but must be in the office and immediately able to provide assistance and direction during the procedure.

c. Personal Supervision – The physician must be in the room when the procedure is performed.

52. Radiation Oncology services provided by non-physician personnel require direct supervision of a physician. Title 42, Code of Federal Regulation, Section 410.32 *et seq.* Accordingly, a Radiation Oncologist does not have to be in the room when certain Radiation Oncology services are performed by non-physician personnel, but must be in the office suite and immediately available to provide assistance and/or direction during the procedure Title 42, Code of Federal Regulations, Section 410.32(b)(3)(ii).

53. The immediate availability of a physician by phone does not constitute direct supervision of services nor can they be "off campus" in the case of provider based departments of hospitals. The rationale is that the lack of physician availability represents a quality concern and risk to both the patient and the hospital. The Center for Medicare and Medicaid Services ("CMS"), a branch of the U.S. Department of Health and Human Services is the federal agency which administers, among others, Medicare and Medicaid. CMS has not specifically defined "immediate" in terms of distance but has stated that the physician or practitioner should not be so physically far

away from the main campus or from the location where the hospital outpatient services are being furnished that he/she could not intervene right away.

54. CMS requires the supervising physician or nonphysician practitioner to be able to immediately step in and perform the procedure not just in the event of an emergency but also to furnish assistance and direction throughout the performance of the procedure. CMS has indicated that the supervising physician or nonphysician practitioner must also be a person who is "clinically appropriate" to supervise the services and procedures and unless a non-radiation oncologist physician or a nonphysician practitioner has within his or her State scope of practice, licensure, training and hospital-granted privileges the ability to perform the service or procedure, this would not meet the supervision requirements.

55. Additionally, for Radiation Oncology services to be considered "reasonable and necessary" by Medicare, TRICARE, the VA's Purchased Care Program, or Medicaid, the services must be ordered by a "treating physician" of the beneficiary.

56. A "treating physician" is "the physician who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary's specific medical problem." A Radiation Oncologist is considered a "treating physician" by all programs.

57. A treating physician's order may be delivered in one of three ways: by a written document signed by the treating physician; by a phone call from the treating physician to the testing facility, documented by both the treating physician and the testing facility in their respective medical record on the patient; or by an e-mail from the treating physician to the testing facility. If the treating physician's order is not signed by him, the physician must document in his medical record that he wants the test performed.

58. Claims submitted to the Medicare, TRICARE, the VA's Purchased Care Program, and Medicaid program for reimbursement are to be paid in accordance with the applicable statute, the Code of Federal Regulations, and Rules and Regulations as promulgated by each program administrator. The Rules and Regulations are distributed by the program administrator to the Medicare, TRICARE, the VA, and Medicaid carrier, who in turn distributes the rules and regulations to the providers. The program administrators also provide rules and regulations to providers via its internet website.

59. Claims are submitted for payment utilizing the CMS-1500. During all times set out in this complaint, providers have been required to submit these CMS-1500 forms electronically.

60. When filing the electronic equivalent of the CMS-1500, a provider certifies that:

> …the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

(hereafter "Medicare Certifications").

61. CMS mandates that Radiation Oncology providers utilize the Healthcare Common Procedure Coding System ("HCPCS") to indicate the medical services rendered when submitting claims to Carriers. HCPCS is a uniform method for health care providers and medical suppliers to report professional services, procedures, and supplies. The medical services codes of the HCPCS are known as "Common Procedure Terminology" Codes a/k/a "CPT Codes".

62. During all relevant times hereto, Radiation Oncology services performed and/or directly supervised by a radiation oncologist have been billed to Medicare utilizing CPT Codes 77261 – 77799 (Radiation Oncology service codes).

63. Medicare will make up to two payments for most Radiation Oncology procedures performed on an outpatient basis when the procedures qualify as "reasonable and necessary" – a technical component for performing the procedure and a professional component for reviewing the results.

64. The type of fee being claimed by a provider for a particular Radiation Oncology procedure is indicated by either the use or absence of a modifier with the applicable CPT Code when completing the CMS 1500 claim form. The modifier "TC" is utilized for the technical component of a service. Modifier "26" is utilized for the professional component. The absence of a modifier with the CPT Code for the procedure indicates the physician personally performed both the technical and professional portions of the procedure.

65. Beginning not later than September 2005 and continuing at least until the present, the Defendants devised a scheme by which they:

a. billed or caused others to bill Medicaid, Medicare, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs for unreasonable, unnecessary, or medically improper radiation diagnosis and treatments provided to patients without complying with the regulations, protocols, and requirements for reimbursement as established by Medicaid Medicare, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs.

b. disguised the unavailability of the treating Defendants Tomlinson and Malik to directly supervise or perform the necessary diagnosis and radiation

treatment by failing to maintain true and accurate schedules of the Defendant doctors' whereabouts and their then-present inability to properly supervise radiation diagnosis and treatment, so as to conceal, to perpetuate and to avoid discovery of their collective scheme;

c. treated or caused to be treated patients improperly without either the direct supervision or personal involvement of radiation oncologists, knowing that radiation diagnosis, simulation and treatment requires a radiation oncologist's direct supervision or personal involvement and using templates to build documentation for CPT Codes.

d. performed and caused others to perform medically unnecessary procedures and testing on certain patients, including but not limited to simulations, dosimetry calculations, and other radiation oncology tests and procedures;

e. generated or caused to be generated patient records reflecting that the Defendant doctors were providing correct or timely supervision of clinic staff, including but not limited to physicists, dosimetrists, radiation therapists, and radiation nurses, by appearing to timely monitor patients' progress by signing or causing to have signed blank records reflecting patient reviews whether actually reviewed or not, but not dating the signatures to avoid demonstrating when or even if a review was

conducted (this scheme was facilitated by using dictation to make it appear that physicians were present when in fact they were not, preparing treatment prescriptions after therapy had been initiated and by signing blank prescription sheets and instructing staff to check off items as services are performed);

f. created, and caused others to create, false records to justify and support claims submitted to Medicaid, Medicare, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs including false medical records and false business records;

g. concealed, and caused others to conceal from Medicaid, Medicare, CHAMPUS, CHAMPVA,TRICARE, the VA's Purchased Care Program and other federal programs certain material information concerning the manner in which the radiation treatments were being prescribed, ordered and administered;

h. submitted and caused others to submit false and fraudulent claims for payment to Medicaid, Medicare, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs, including claims relating to medically unnecessary services, procedures, and testing.

66. Defendant Tomlinson, an employee of Defendant Blue Ridge, served as radiation Chief Medical Officer for AnMed Cancer Center at least between 2005 and

the present. His duties included directly supervising the physicist, dosimetrist, radiation therapists and other support staff in the diagnosis, simulation and radiation treatment, recruiting qualified radiation oncologists to substitute for him or Defendant Malik when either was unavailable, supervising the maintenance of the medical records, ensuring quality control, and executing other documents on behalf of AnMed and Blue Ridge.

67. Defendant Malik, an employee of Defendant Anderson Radiation Oncology, served as the other fulltime radiation oncologist for Defendant AnMed between at least September 2005 and December 2011. Her duties included directly supervising the physicist, dosimetrist, radiation therapists, and other support staff in the diagnosis simulation, and radiation treatment, supervising the maintenance of the medical records, ensuring quality control, and executing other documents on behalf of AnMed and Anderson Radiology Associates.

THE FRAUD SCHEME

A. Lack of Physician Supervision/Lack of Valid Physician Order in Radiation Oncology Department.

68. In September 2005, Defendant AnMed hired Relator as Manager of Radiation Oncology to manage employees, treat patients as a radiation therapist, and to

supervise and be responsible for healthcare compliance issues for AnMed Health Radiation Oncology at the AnMed Health Cancer Center at 2000 East Greenville Street, Anderson, South Carolina. The AnMed Health Cancer Center holds itself out to the public as a multi-specialty department consisting of medical, radiation and gynecologic oncologists, general surgeons, radiologists, plastic surgeons, gastroenterologists, urologists, and pathologists (See 2011 brochure attached as Exhibit "A").

69. Defendant AnMed hired Relator knowing that she had no billing or compliance experience as she had been the chief therapist to a radiation oncologist name Dr. Narendra Shah in Athens, Georgia from September 2001 through September 2005. Relator was expected to continue to act as a radiation therapist in addition to being primarily responsible to supervise and assure healthcare compliance issues for Defendant AnMed Health at a salary of $76,000. It became apparent throughout her employment with Defendant AnMed that her role to oversee and ensure AnMed's compliance with healthcare laws was essentially window dressing that Defendants AnMed and CHS did not "want to rock the boat" and do anything to undermine or antagonize its most profitable group which grossed over $18,000,000 in 2011 alone! Over time, it became clear to Relator that she had from the beginning been set up by

Defendant AnMed to fail in her compliance responsibilities.

70. Relator noticed immediately upon being hired that at least 30% of the time that tests and therapy were administered when Defendant Tomlinson and Defendant R. Malik were not present on campus, they were offsite at the gymnasium, having lunch somewhere, away at meetings, on vacation or otherwise leaving the hospital early for the day, and that tests and therapy were instead administered only by staff. When these radiation oncologists were off campus the staff knew as the automobiles of these physicians were parked directly in front of the facility in plain view. Sometimes during the entire day, there was no radiation oncologist physician present. These treatment services include, but are not limited, to CPT Codes 77413 (linac complex 6-10), 77280 (simple simulation), 77418 (IMRT treatment delivery, 77421 (image guided radiotherapy), 77334 (complex treatment device), 77414 (linac complex 11-19), 77014 (ct for radiation therapy planning), 77290 (complex simulations), 77404 (linac simple 11-19), 77331 (micro dosimetry, and 77417 (port film).

71. Beginning from the first date of Relator's employment in September 2005, the Defendants maintained contracts with and among each other whereby Defendant AnMed provided technical and provider support and Defendant Blue Ridge

and Anderson Radiology Oncology provided the services of Defendants Tomlinson and Malik as authorized radiation oncologists in the treatment by Defendants Tomlinson and Malik of patients referred for radiation treatment. Beginning on or about 2010, Defendant CHS began acting as the exclusive manager of the day-to-day operations of AnMed Cancer Center, which includes diagnosis, preparation, and radiation treatment and the submission of claims to Medicaid for services rendered to patients and certain top management of AnMed also became employees of CHS including Relator's immediate supervisor Garrick Chidester.

72. On information and belief, the contracts between AnMed and CHS created a quality control system to be managed by CHS and to be administered jointly with CHS and would comply with all regulatory and legal requirements. Specifically, all Defendants promised to comply with all radiation oncology regulations and not bill if the requirements were not maintained.

73. Relator's compliance training by AnMed consisted primarily of being sent once every two years to a coding, billing, documentation and compliance training seminar sponsored by well-known radiation consultant Jim Hugh at American Medical Accounting & Consulting, Inc. ("AMAC") in Atlanta, Georgia; attending periodic AnMed Manager Compliance Workshop meetings at Defendant AnMed; and attending

quarterly compliance round tables with Defendant CHS beginning in late 2009 or early 2010 for the 15 radiation oncology centers under Defendant CHS' umbrella and supervision.

74. Upon her arrival at AnMed, Relator quickly began to observe many compliance deficiencies and attempted to notify Defendants to correct them.

75. Relator observed patients being treated without a physician present on a continued basis. For example, patients were often treated in the morning, at lunch and on Fridays when no physician was present. At least once a month on Fridays, patients were treated when Tomlinson was away in the next county at the monthly tumor conference

76. In accordance with AnMed's Code of Conduct attached hereto as Exhibit "B", on or about January 2006, Relator brought this lack of radiation oncologists and a supervisor on the premises to the attention of Leigh Kennedy, the internal audit/corporate compliance officer at AnMed and in an email dated January 13, 2006 was told by Leigh Kennedy, that Robin Bowen (now Darby) who was the business office manager at AnMed (who reported directly to Ken Walters, who directly reported to Jerry Parrish, CFO at AnMed) researched this issue on the CMS website, "we are fine" while at the same time acknowledging guidelines depended on the specialty.

77. In December 2007, Relator noticed and advised Defendant AnHealth and the therapy staff that IGRT films (CPT Code 77421) were not being checked, approved and documented daily by Defendants Tomlinson and Malik. This issue was specifically discussed at length with the therapy staff on December 14, 2007. However, in spite of Relator's efforts, nothing seemed to change.

78. By email dated December 10, 2008, Relator continued to question the Defendant's billing practices concerning physician supervision and the interpretation provided by Robin Bowen.

79. In fact, by fax dated February 11, 2009, Relator sent additional information and materials to prove her case of lack of physician supervision from Jim Hugh at AMAC and the AMAC Bulletin Board which also included CMS-1404-FC-CMS-3887-F-CMS-3835-F-1 to Oleen Bowen

80. On or about May 26, 2009, in coordination with the Defendant AnMed Health Quality Coordinating Council, Relator and physicist Jeff Brock documented with respect to Item 7 of Medicare's Physician Supervision Requirements:

> Medicare has clarified its position on Physician Supervision in a hospital outpatient setting. In order to meet the direct supervision requirement, the supervising physician must be present on the same hospital campus and immediately available to furnish assistant and direction throughout the performance of the procedure. The staff will no longer deliver radiation therapy without a Radiation Oncologist on campus. The staff

and physicians will work together to maintain a schedule that allows us to meet these requirements.

81. Relator believing she was being ignored by Defendants and concerned about patient care and legal liability, continued to voice her concerns to Defendants about the lack of physician supervision. On January 15, 2010, she sent an email about her continuing concerns to Garrick Chidester and a posting on Jim Hugh's AMAC bulletin board supporting her concerns. Mr. Chidester thought enough of her concerns that he asked Relator to forward to both Jerry Parrish, V.P. of Financial Services at Defendant AnMed and Robin Bowen at Defendant AnHealth.

82. In a number of meetings, at various times, Relator brought to the Defendants' attention a number of serious compliance violations including Defendants Tomlinson and Malik not timely checking IGRT films of patients and lack of physician supervision.

83. Relator also brought these issues to the attention of Shannon Brock, the personal billing professional of Dr. Tomlinson and Dr. Malik.

84. Incredibly, in January 2010, Shannon Brock provided Relator with a series of emails between her and consultant D. Scott Simmons, President of Eagle Consulting wherein she asked (anmedhealth@bellsouth.net) whether "Rad Onc must be in the department when rad. Tx is given…..Then they cannot have lunch, days off,

whatever". Mr. Simmons by email of January 18, 2010 responded "If you really want to live by the letter of the lawyers they have it correct on a national level for your setting-question really is what is your risk level in Anderson, SC-most likely pretty low as long as patients are taken care of well-which I know he does-no coverage is a problem of course".

85. It was at one of those annual training seminars sponsored by Jim Hugh in Atlanta on March 25, 2010, that Relator learned from Jim Hugh that it is considered healthcare fraud to bill for radiation oncology services without the requisite physician supervision and creates serious potential for criminal and civil liability and that Defendant AnMed and Defendants Blue Ridge, Anderson Radiation Oncology, Tomlinson and Malik must refund any charges billed and received related thereto.

86. Upon her return from the seminar, Relator emailed her direct supervisor, Garrick Chidester, Vice President at Defendant AnMed and or Defendant CHS of this major compliance infraction. Chidester responded to Relator's email by saying, "Do not send things like this by email. This could be used in discovery."

87. Within one to two weeks after sending her email, Garrick Chidester came back to Relator and said, "I spoke to the physicians and they stated that there is no problem with physician supervision and that Linda is exaggerating."

88. In May 2010, Garrick Chidester asked Relator to ask other radiation oncology groups how they handled physician supervision. On May 3, 2010, Relator called a number of other radiation oncology practices in surrounding areas and counterparts including Vicki Reich at the Levine Cancer Institute (which is CHS affiliated) and Meredith Gay at Cancer Center of the Carolinas Seneca, each who unequivocally confirmed to her that if no radiation oncology physician is present, Medicaid/Medicare patients are not treated. Relator promptly reported these findings to Chidester.

89. Not satisfied with the results of meeting with her direct supervisor or the patronizing and sarcastic tone of her supervisor and concerned about patient care and liability issues, Relator directly approached both Defendants Malik and Tomlinson at the nurse's station about their lack of physician supervision and the applicable laws and liability and both doctors responded, "We have both done this 20 years and we are not going to change our practice."

90. Following this confrontation, Defendant's Malik and Tomlinson commenced being extremely abusive to Relator. They sought repeatedly on a regular basis to publicly intimidate, demean, and harass her in front of AnMed staff and in front of Garrick Chidester for reporting their unlawful and unethical behavior.

91. Not satisfied with the lack of response by AnMed to her reporting of fraud, concerned about the safety of patients, quality of care issues and fearing criminal and civil liability to herself and her employer, Relator also raised issues of lack of physician supervision with the CHS Compliance Round Table at one of their quarterly meetings in 2011.

92. Vicki Reich (who is the AVP of the Levine Cancer Institute) and who heads up the CHS Compliance Round Table and Gail Satterfield who was at the time President of the Society of Radiation Oncology Administrators agreed whole heartedly with Relator's concerns about this health care fraud. Vicki Reich responded in the meeting, "Our physicians work at my leisure, if they don't cooperate, I ask for a new one."

93. Following the meeting and in further performance of her designated compliance duties, Relator again approached her immediate supervisor, Garrick Chidester with her concerns about a number of continuing compliance issues including the continued lack of physician supervision and the resulting liability to AnMed and harm to patients.

94. After that meeting, Garrick Chidester told Relator that "he had sat down with Defendants Malik and Tomlinson and asked that they be present when radiology services were provided."

95. The situation became increasingly uglier and more harassing for Relator. Defendant Malik did in fact curse, yell and scream in public, declaring, "Tell Linda [Jainniney] it wasn't fair for the hospital to tell her [Dr. Malik] when she could and should not be there." This statement was overheard by a number of Defendant AnMed employees including nurse Mary Jane Hanna and physicist Jeff Brock.

96. Still concerned about the issue and that her reports to Defendants AnMed, Malik, and Tomlinson and her supervisor, Garrick Chidester had fallen on deaf ears and that she was increasingly working in a very hostile environment and work place, Relator approached Wanda Whitener, the Chief Compliance Officer, Director of Compliance at AnMed.

97. In late 2011, at the request of Wanda Whitener, Defendant CHS ordered a 30 patient compliance audit which found, among other things, a zero compliance for physician orders (the "2011 CHS Audit.") This was the first internal audit ever of the department since Relator's arrival in 2005! The 2011 CHS Audit further reported that all sheets for physician orders had been signed by Defendant Tomlinson in blank, a

violation of applicable law and further, that staff had been instructed to just fill in and check boxes that they thought appropriate, without any specific individual direction or guidance by Defendants Tomlinson and Malik. Relator had struggled to try to have the physicians write physician orders since her arrival. In addition, the audit found that none of the physician orders were time stamped as required by CMS since June 2009. [See CMS Manual Pub 100-07]. However, despite Relator's protestations, this audit did NOT measure or audit physician supervision as CMS was unwilling to address that issue!

98. Relator discussed the problems at length on numerous occasions with Defendant Tomlinson and Malik's personal profession biller, Shannon Brock.

99. In response to the 2011 CHS Audit, and to Relator's amazement and disgust, Defendant AnMed and CHS ordered a new compliance plan for the first quarter of 2012 which intentionally omitted any criteria for measuring compliance with the physician orders or physician supervision rules. As part of Defendants continuing fraud and cover-up, this audit only measured whether "physicians were educated on supervision" not the more pressing and relevant issue of physician non-compliance. In sharp contrast, Relator learned that the Ambulatory Care's compliance plan for the same period did in fact continue to measure physician orders! This compliance default

symbolized the Defendants' direct slap in the face to Relator's efforts and their obvious continuing cover-up. It was again clear to Relator that no one would listen and worse, that the Defendants had made a concerted business decision not to enforce compliance at the most basic level.

100. In December 2011, Defendant Malik retired. Around the time of her resignation, Defendant Tomlinson in a further act of defiance and contempt stopped attending special simulations (CPT 77280) (from the approximate daily lunch period of 1:00 - 2:00 p.m.) for patients further exacerbating the situation. Concerned, beaten down and exasperated, Relator emailed Garrick Chidester at this time and advised him "Dr. Malik just left my office angry that we are now allowing sims [simple simulations] to be done in the absence of a physician. She feels that we have done this to cater to Dr. Tomlinson, but would have never considered doing this for her. She is going to write a letter to Mr. Miller. I know that she is only here for another week, but I have just had about enough of her outbursts and profanity."

101. Relator again protested to her immediate supervisor, Garrick Chidester who incredibly told Relator in physicist Jeff Brock's presence, "While Dr. Tomlinson is practicing alone we are going to give him leeway."

102. Relator's stress, intimidation, and lack of support to addressing the compliance, potential criminal and civil liability, and safety issues from Defendant's AnMed, CHS and Tomlinson had gotten so out of control that the December 12, 2011 compliance workshop notes mentioned that they "want a procedure established for physician education to go to Dr. Tomlinson (because Linda is so beaten down)."

103. To further whitewash the fraud and problems and undermine and discredit Relator, Defendants AnMed and Tomlinson hired Susan Vannoni and her company, Radiation Oncology Consulting, LLC to perform a patient chart – billing review of AnMed's radiation oncology department. Relator learned that Susan Vannoni was told not to audit physician supervision or lack of physician orders. Incredibly, when questioned by Relator of this issue and conspicuous omission from the review, Ms. Vannoni replied, "that she had no firsthand knowledge that it was a problem".

104. Relator approached Susan Vannoni on the Defendants' continuing problem with the lack of physician supervision, Ms. Vannoni responded that Relator should keep quiet or risk losing her job! Ms. Vannoni recounted a story from her past work history where she got fired for reporting a similar problem. Relator was shocked by Ms. Vannoni's response and clear message and as the primary breadwinner in her family, Relator continued to fear being terminated at any time!

105. Ms. Vannoni told Relator and the other staff that, "You can't do special dosimetry measurements [on every patient] on a blanket every day basis, this is special!" She also noted that there were no physician orders or any documented medical necessity. On information and belief, Defendants stopped billing for special dosimetry measurements (77331) based on Ms. Vannoni's report but never reimbursed any payor.

106. Ms. Vannoni also noted to Relator templated verbiage by physicians which had been observed, noted and cautioned for years by Relator. When a documentation is worded exactly like or similar to previous entries, the documentation is referred to as cloned documentation. Relator had warned the Defendants that whether cloned documentation is handwritten or in the form of a preprinted template, that cloning of documentation can be considered misrepresentation of the medical necessity requirement for coverage of services and could lead to denial of services rendered due to lack of specific, individual information for each patient. According to an October 11, 2011 Statement from CMS "Identification of this type of documentation will lead to a denial of service for lack of medical necessity and recoupment of all overpayments made."

107. Perhaps indicative of AnMed's casual and flagrant attitude toward compliance, Relator received a memo on May 20, 2010 from AnMed Executive Vice president Mike Tillerson in connection with physician signature requirements for Medicare and Medicaid orders, which while observing that CMS had as of April 1, 2010, began refusing payment for all services if requests were not authenticated by the ordering physician. Ignoring the fact that a date and timestamp were also necessary for authentication, Tillerson suggested that physicians "purchase a rubber stamp and have your name printed on all lab/service requests, and circle your name and sign."

B. Lack of Physician Supervision/Lack of Valid Physician Orders in Medical Oncology Department.

108. In connection with the findings of the 2011 CHS Audit ordered by Wanda Whitener, the AnMed Chief Compliance Officer and Director of Compliance, and Relator's ongoing attempts to get various Defendants to correct the various issues cited by such audit and independently by Relator, Relator learned from her counterpart, Cyndi Simmons, that Defendant's AnMed and CHS were also aware that the Medical Oncology Department, staffed by Defendants R. Malik, Batizy and Parchuri also had a serious chronic long-term problems with physician orders whereby time-stamping orders for such procedures such as chemotherapy infusion treatments (including the

early morning time) and that physicians in that department were not timing stamping orders. Similarly, Relator also learned from Pat Eberhardt, Nurse Navigator, that there were also physician supervision problems whereby medical oncologist were not present when chemotherapy infusions began each morning. Relator also learned from Cyndi Simmons that the physician order problems were supposedly "corrected" by the end of 2011 but that patients continued to be treated in the early morning without a physician present. Relator does not believe that any improper billing was ever refunded to any payor!

C. Lack of Physician Supervision by Defendants Anderson Emergency Associates, P.A. and others in Emergency Room.

109. In the course of her reporting the lack of physician supervision in Radiation Oncology and her increasingly hostile and toxic work environment and AnMed liability issues, Relator learned in May 2012 at an AnMed compliance roundtable that Defendants AnMed and CHS were aware that there was a significant billing fraud in the AnMed Emergency Room. "From the beginning of time" as it was stated. During that roundtable, Defendants executives stated that Defendants AnMed and Anderson Emergency had billed payors as if an emergency room doctor had seen the patient, even though in many cases, the patient was seen at best by a licensed nurse

practitioner or physician assistants. This problem Relator learned was similar to the problem she had experience in her department. Relator learned that sometime in 2012 when Defendant AnMed hired LogixHealth, a new billing company based in Bedford, Massachusetts for the Emergency Room to replace the prior billing company, LogixHealth had refused to bill at least 524 ER of payor accounts as if they were actually seen by a physician until "documentation was provided". According to the Compliance Workshop Meeting Notes of a meeting attended by Relator on May 17, 2012, these 524 claims were being held "pending documentation from the physicians that they observed patients seen by a nurse practitioner or physician assistant, not just reviewed and agreed with the findings. This pertains to compliance of the ER physicians with their Anderson Emergency contract regarding lower reimbursement rates for nurse practitioners and physician assistants." The practice was effected and payors were billed as a direct result of the attending physician signing the charts as if they themselves had seen every patient. It was clear to Relator that Defendants AnMed, CHS or Anderson Emergency never refunded such improper charges to any payor and, further, that Defendants would do nothing about the billing fraud in her department!

110. Relator also learned from attending the January 19, 2012 AnMed Compliance Workshop meeting that many of the CT Scans performed in the ER were denied for having a valid diagnosis that meets the required medical necessity.

D. Lack of Physician Supervision and Documented Medical Necessity for Image-Guided Radiation Therapy and CPT Code 77421 in Radiation Oncology Department.

111. Physicians have long used radiation therapy to treat cancerous tumors. The goal of radiation therapy is to deliver the target dose of radiation to the affected area, while minimizing the amount of radiation delivered to surrounding body areas. One of the principal factors affecting this issue is the proper positioning of the patient on the treatment unit at the time the radiation is administered.

112. In recent years and specifically with respect to Defendants since 2005, physicians have increasingly utilized a process known as Image-Guided Radiation Therapy ("IGRT") in order to more precisely target the delivery of radiation to affected areas. Under IGRT, the patient is placed on the treatment unit, where he is subjected to imaging procedures, such as ultrasounds, CTs, or stereoscopic x-rays. After the images are reviewed, the patient's position is adjusted as necessary to allow for precise

delivery of radiation to the tumor, while minimizing the amount of radiation delivered to adjacent body areas.

113. When used properly, IGRT helps ensure that the patient is properly aligned in the treatment unit before the radiation treatment is delivered. If used improperly, IGRT may both reduce medical efficacy (by failing to deliver the target dose to the tumor) and negatively impact patient health (by delivering excess radiation to adjacent areas).

114. CMS uses several CPT Codes which allow physicians to be paid for their actions in guiding the delivery of therapy during IGRT procedures, and has specified the required level of physician supervision for each code. This code has both a professional and a technical component. The level of physician supervision required depends on the type of imaging technology used — ultrasound, CT, or stereoscopic X-rays. A description of these CPT Codes and their corresponding supervision levels is as follows:

CPT Code	Description	Supervision
76950	Ultrasonic guidance for replacement therapy fields	General
77014	Computed tomography guidance for placement of radiation therapy fields	Direct

77421	Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy	Personal

115. The level of supervision for CPT Code 77421 was changed from personal to direct, effective for services on or after January 1, 2009 – in the July Update to the 2009 Medicare Physician Database Fee Schedule (Terminal 1748, change Request 6484, May 29, 2009).

116. Thus, where ultrasound is used, the physician need only provide "general" supervision, including the training of the nonphysician personnel performing the procedure, and need not be present in the office. When CT is used, the physician must provide "direct" supervision – i.e., he must be present in the office suite and immediately available to provide assistance, but need not be in the procedure room.

117. When stereoscopic x-rays are used, however, the physician must provide "personal" supervision, which means that he "must be in attendance in the room during the performance of the procedure." This requirement reflects the heightened need for real-time physician involvement in the review of stereoscopic x-ray images and the repositioning of the patient based on such review before radiation is administered. If

the physician is not present in the room, then the stereoscopic x-ray guidance is deemed not reasonable and necessary, and the service is not payable by Medicare.

118. As Manager of Radiation Oncology for Defendant AnMed, Relator has first-hand knowledge of Defendants AnMed, Blue Ridge, Tomlinson, Anderson Radiation Oncology and Malik's practices with respect to IGRT procedures. All such procedures are performed at the AnMed Cancer Center in Anderson, South Carolina, where Relator's office is located. Relator had daily contact with the two Defendant radiation oncologists based at the AnMed Cancer Center, as well as with the therapists and administrative staff at such center. Based on the Defendant AnMed records available to Relator for example, from fiscal year October 2008 through 2011 approximately (using a conservative 65% federal patient mix) 5,571 IGRT procedures were performed and the technical component billed by Defendant AnMed at the AnMed Cancer Center, of approximately $2,730,509 was billed to Medicare, Medicaid, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs during this period. These procedures are done routinely without documented medical necessity daily on patients.

119. Since CPT Code 77421 was adopted in 2006, AnMed has almost never had a physician present during an IGRT procedure. To the contrary, IGRT procedures

are universally performed by radiation therapists with no real-time involvement from the radiation oncologist, who would be in his office treating other patients, or elsewhere off campus.

120. In addition, there was no medical necessity specific to each patient documented by Defendants Tomlinson and Malik as required by CMS. Instead, non-specific boiler-plate templates were often used. See for example Exhibit "C".

121. At no time was the physician called to the treatment area to approve the IGRT prior to treatment. Rather the physician would on a regular basis review and sign the images at least several days later! Attached as Exhibit "D" by way of example only is a summary of the initials of 10 patients between 2009 and 2012, where Defendants Tomlinson and Malik did not review IGRT images prior to the next consecutive treatment as required by CMS. The Varian software which captures and records the IGRT images clearly shows the time and date of the image acquisition and the subsequent time and date of the physician review. The software also shows the time and date of each patient treatment documenting treatment by Defendants AnMed, Tomlinson and Malik prior to image approval by Defendants Tomlinson and Malik.

122. IGRT should not be billed professionally unless the physician looks at the images real time (or before the next treatment session) and makes adjustments prior to treatment.

123. In most cases, the physicians again treat the patient not having even reviewed the prior images until several days later. Indeed, many times CPT Code 77421 has been billed when the physician was away on vacation or out of the office that day.

124. Defendants AnMed, Blue Ridge, Tomlinson, Anderson Radiation Oncology, Malik and CHS are fully aware of the personal supervision requirement with respect to CPT Code 77421. Indeed, the American Society for Therapeutic Radiology and Oncology ("ASTRO") and the American College of Radiology ("ACR") publish an annual reference book called "ASTRO/ACR Guide to Radiation Oncology Coding," which Defendants receive, and which discusses the requirement of personal supervision. Moreover, ASTRO (of which Dr. Tomlinson is a member) has published for its members a PowerPoint presentation entitled "Documentation and Billing of IGRT," which expressly discusses the necessity for personal supervision with respect to CPT Code 77421.

125. In addition, Relator has repeatedly advised the Defendants AnMed, CHS

and in particular Drs. Tomlinson and Malik, they are not in compliance with Medicare and the other listed federal providers supervision requirements.

126. Based on AnMed records available to Relator, Relator estimates that, since 2005, AnMed has billed Medicare and the other listed federal providers over $7,000,000 under CPT Code 77421. The charge of $601 per IGRT multiplied by approximately 42 treatments amounts to improper billing of over $25,000 per patient! All of these claims are medically unnecessary due to the lack of personal supervision by a physician and lack of physician orders, and thus not payable by Medicare and the other listed federal providers. Moreover, the failure to provide required physician supervision in the critical process of patient adjustment prior to radiation treatment raises significant issues of patient safety and medical efficacy.

E. In Vivo Dosimetry ("IVD's") or Basic Dosimetry Calculations and Measurements (77331) Ordered on Every Patient by Defendants Tomlinson and Malik/No Medical Necessity Documented in Radiation Oncology Department.

127. Relator observed that Defendants Tomlinson and Malik routinely instructed staff to perform IVD (microdosimetry or 77331 in field dose measurement) on a per port basis for all patients ($304 each) unless they are breast tangent, IMRT

patients or electron patients. For example a patient with 4 treatment ports will receive four such microdosimetry charges per treatment plan.

128. Based on AnMed records available to Relator, since 2005, approximately $13,868,400 of such 77331 microdosimetry services were billed by Defendant AnMed for the technical component to Medicare, Medicaid, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs. This does not include the professional component for these charges billed by among others, Defendants Blue Ridge, Tomlinson, and Malik.

129. After Relator joined Defendant AnMed, Relator questioned Defendant Tomlinson and was told a story by Defendant Tomlinson of a patient he treated who received the wrong energy of radiation and that he did this routinely to all patients to "cover himself."

130. Relator discussed this practice with Jim Hugh at AMAC in March 2011, and Mr. Hugh advised Relator that this procedure which verifies the radiation dose delivered seemed unusual as the radiation machines are routinely tested and are very accurate on delivering the chosen dosage. Mr. Hugh explained that the physician must document medical necessity. Based on Dr. Tomlinson's comment and her observations about Defendants' other wrongful reporting practices, Relator does not believe the

Defendant physicians have ever documented medical necessity with respect to this procedure!

131. Proof of these standing orders for microdosimetry can be found in the Radiation Oncology Staff Meeting Notes, dated March 9, 2011, prepared by chief physicist Jeff Brock. All therapy staff was present.

132. Relator, on information and belief, has learned that Defendants AnMed, Blue Ridge and Tomlinson no longer order and perform this service yet have made no attempt to reimburse Medicare, Medicaid, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs for these previously billed medically unnecessary services.

F. No Physician Orders by Defendants Tomlinson and Malik for Blocks or Treatment Devices (77332, 77333, 77334 and 77338) in Radiation Oncology Department.

133. Relator in her many meetings with Garrick Chidester on lack of physician orders and physician supervision that neither Defendants Tomlinson nor Malik ever ordered blocks or treatment devices (77332, 77333 or 77334 for patients) but these charges were falsely billed. These orders were not in the order chart. The blocks/treatment devices are called "MLC" for IMRT (77338) and are billed one per

treatment plan with IMRT patients having two treatment plans ($1,764 x 2). The 2011 CHS Audit revealed 0% compliance physician orders further demonstrating to Defendants Relator's concerns.

G. Falsely Billing for Services Provided by a Newly Hired Radiation Oncologist in Radiation Oncology Department.

134. Relator has recently learned that a new radiation oncology physician, Dr Leander Cannick III, formerly a resident Physician at the Medical University of South Carolina, Charleston, has been recently been hired by Blue Ridge to work at AnMed Health Cancer Center.

135. Relator has learned that Defendant's AnMed, BlueRidge and Tomlinson are billing payors for the services performed by Dr. Cannick for patients.

136. The dictation records of Dr. Cannick which were reviewed by Relator clearly shows that Dr. Cannick is actually the physician treating these patients!

FALSE AND FRAUDULENT CLAIMS AND STATEMENTS

137. The Defendants in turn submitted claims to Medicaid, Medicare CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs to which they were not entitled.

138. To conceal their unlawful conduct and avoid having to make mandatory refunding payments made on the false claims, the Defendants also falsely certified, in violation of 31 U.S.C. § 68.082(2)(g), that the services identified in their billings were provided in compliance with state law. The false certifications were part of Defendants' unlawful scheme to defraud Medicaid, Medicare, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs.

139. The Defendants submitted and caused to be submitted false claims to Medicaid, Medicare, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs for payment including:

a. submitting claims for payment falsely certifying that the claims were for services performed on the dates indicated that were both medically necessary and reasonable;

b. falsely representing and causing others to falsely represent that the various medical services provided to patients were properly supervised;

c. concealing and causing others to conceal and not disclose the fact that diagnosis, simulations and radiation treatment were not directly supervised by the Defendant doctors identified on the billings, knowing that such disclosures would result in the denial of those claims;

d. creating and causing others to create medical records that contained false entries, false diagnoses, and other false information; and

e. creating business records that contained false information to create the appearance that the Defendant doctors were properly performing their duties and properly supervising the treatments they certified that they had supervised.

140. As a result of the Defendants' false and fraudulent claims for reimbursement, funds were paid to Defendants to which they were not entitled during the period September 2005 through the present.

141. In so doing, Defendants presented, or caused to be presented, these claims with actual knowledge of their falsity, or in deliberate ignorance or reckless disregard that such claims were false and fraudulent.

142. Relator has documented that, among other dates, by way of example only, Defendants AnMed, BlueRidge, Dr. Tomlinson or Dr. Malik submitted or caused to be submitted on over 200 days from 2005 to July 2012 (when they were absent from the treatment premises, some or all of the day and where there was no physician supervision) false claims for Radiation Oncology services allegedly provided on,

including but not limited to the following dates - in chronological order listed by procedure, coverage and CPT Code attached hereto as Exhibit "E".

143. With respect to the above dates in the preceding paragraph and with further specificity, Exhibit "F" identifies over 80 patients (by patient initials) for approximately 60 days alone in 2012 who received Radiation Oncology services at AnMed on dates and times when no physician was present. The example also provides the CPT Code billing number of services Dr. Tomlinson or Dr. Malik submitted or caused to be submitted to Medicaid, Medicare, CHAMPUS, CHAMPVA, TRICARE, the VA's Purchased Care Program and other federal programs for payment:

144. By way of further example and particularity, Defendants made claims on the Medicare program for Radiation Oncology services purportedly rendered to Patient #67 at AnMed on May 9, 2012 and June 7, 2012. As with all the other dates listed, the physicians were not present at AnMed on such dates for CPT Code procedures 77418 (IMRT treatment delivery) and 77421 (image guided radiotherapy). With respect to these claims and as noted above, Defendant AnMed billed Medicare at least $2,942 for Radiation Oncology services purportedly rendered to Patient #67 for which they were not entitled. In addition, Defendant Tomlinson and Blue Ridge separately billed Medicare for additional amounts for which they were not entitled.

145. By way of further example and particularity, Defendants made claims on the Medicare/Medicaid program for Radiation Oncology services purportedly rendered to Georgia resident Patient #75 at AnMed on February 23, 2012 and March 30, 2012. As with all the other dates listed, the physicians were not present at AnMed for the simple simulation (77280-$601 per date) on such dates. The last two digits of the patient chart number is 39 With respect to these claims and as noted above, Defendant AnMed billed Medicare/Medicaid $1,202 for Radiation Oncology services purportedly rendered to Patient #75 for which they were not entitled. In addition, Defendant Tomlinson and Blue Ridge separately billed Medicare for additional amounts for which they were not entitled. In addition, as generally with all charts where there was no physician supervision, Defendants Tomlinson and Blue Ridge falsified medical chart dictation after the fact for the March 30, 2012 date of service to make it appear that he was present on that date of service. He omitted to do any medical dictation to cover up his lack of physician supervision on February 23, 2012. In addition as previously described herein, neither simple simulation was ordered by the physician as required.

146. Relator has documented evidence of patients resident in Georgia who were billed by Defendants AnMed. Tomlinson, Blue Ridge, Anderson Radiation

Oncology and Malik for radiation oncology services, including simple simulations (77280), pm linac complex 06-10 (77414), on various dates from 2005-2012 when no physician was present.

H. Retaliation by Defendants Against Relator Jainniney.

147. Relator's continued attempts to perform her duties, report and seek to correct compliance problems and prevent healthcare fraud by Defendants, who at first maintained deaf ears and permitted Defendant's Tomlinson and Malik harassment of Relator, continued to take a serious toll on Relator.

148. As described herein, Relator complained repeatedly about the unlawful actions of the Defendants and told them that they were all incurring significant criminal and civil liability.

149. Yet instead of improving over time, things became worse. Defendant AnMed did little or nothing to correct these issues and even aided in the cover-up of the practices, other than a few "meetings" Relator's supervisor, Garrick Chidester, claimed he had with Defendants Tomlinson and Malik. In fact, as described herein, in response to the 2011 CHS Audit, Defendant CHS removed physician orders from the criteria to be reviewed in 2012!

150. In fact, sometime in mid 2011, in an obvious attempt to cover up the problems and legal liability, Garrick Chidester told Relator, "don't audit patient treatment charts, it's not a valuable use of time." It was clear that Defendant's AnMed and CHS didn't want to touch the highly profitable golden goose radiation oncology practice.

151. After returning from the 2011 AMAC Jim Hugh Compliance Seminar in Atlanta, Relator typed her handwritten notes on the compliance issues discussed, many of which she had discussed with Defendants AnMed, Tomlinson, Malik and AnMed staff. She handed copies to each of them to reinforce the recurring issues to be addressed and immediately rectified. Included in these notes was a notation from Jim Hugh to "contact attorney and voluntarily disclose past physician supervision non-compliance to keep from being barred from Medicare."

152. Defendants Tomlinson and Malik would scream and curse at Relator and make personally disparaging comments to her in front of other AnMed employees and supervisors, including Garrick Chidester.

153. On one occasion, Defendant Malik screamed and cursed at Relator when Relator approached her about a lack of physician supervision and resulting legal liability to the Defendant and angrily shouted at Relator, "It wasn't fair for the hospital

to tell her when she should and shouldn't be there." This was witnessed by AnMed employees Mary Jane Hanna and Jeff Brock.

154. Things got increasingly ugly for Relator. Defendant Tomlinson became even more abusive and threatening to Relator as a result of her numerous reports of wrongdoing and the CHS Corporate Compliance Corrective Action Plan Template prepared by Relator and submitted on January 25, 2012 to Marion Bacot and Wanda Whitener of Defendant AnMed addressing Dr. Tomlinson's lack of physician orders and charge accuracy.

155. Despite her continued complaints to her supervisor Garrick Chidester, the harassment and intimidation continued. Consequently, Relator became extremely concerned that she would be terminated for reporting the healthcare fraud, wrongdoing by Defendants and warning of the potential criminal and civil liability of such actions.

156. It became increasingly clearer to Relator that the handwriting was on the wall, namely, that Relator would likely lose her job for repeatedly reporting the healthcare fraud and criminal and civil liability. Defendant AnMed was seeking to muzzle her at best and create grounds to terminate or demote her. Relator received her 2011 annual review on October 20, 2011 and received a low score of 74, inexplicably down from 88 the year before in 2010 and a score of 90 in 2009.

157. Relator never failed to perform the duties for which she was hired.

158. All the while, Relator maintained a positive and professional relationship with the AnMed and CHS clinical, professional and office staff.

159. When Defendant Malik retired soon after the 2011 CHS Audit showing 0% compliance for physician orders (leaving Defendants with only one radiation oncologist to treat all patients), Relator advised AnMed and Garrick Chidester that Defendant Tomlinson stopped being present for simple simulations, he became even more abusive defiant, threatening and menacing to Relator.

160. Garrick Chidester's reply gave Relator "the chills" and told her, "While Dr. Tomlinson is practicing alone we are going to give him leeway," leaving Relator with a full understanding that Defendants would do nothing about his conduct and further instilling the fear that if she continued reporting these violations she would lose her job.

161. Further evidence of this intimidation and harassment and threats can be found in the December 15, 2011 Compliance Workshop meeting notes, where it was noted that there needed to be a procedure established for physician education to go to Dr. Tomlinson (because Linda was getting beaten down).

162. Relator even tried to involve and obtain the support of Gail Satterfield at CHS on some of the issues and forwarded them an email on the issue of physician supervision on February 2, 2012 from the SATRO users group.

163. It became crystal clear to Relator from the lack of support, inaction and complicity of Defendants AnMed and CHS to her reporting wrongdoing and warnings of civil and criminal liability for healthcare fraud by Defendant AnMed's continued tolerance and continued abuse and harassment from Defendants Tomlinson and Malik before her "retirement" and their tolerance and tacit encouragement of the increasingly abusive and threatening behavior by Defendants Tomlinson and Malik that Relator was at real risk of immediate termination.

164. It was clear to Relator that Defendant AnMed (and CMS who received approximately $5,000,000 a year (plus reimbursement of salaries) to manage Defendant AnMed) would not take any action that could jeopardize or undermine the performance or operation of the highest grossing, most profitable money machine at Defendant AnMed, yielding total revenue of over $18,000,000 in 2011 generated from the two radiation oncologists from the Radiation Oncology Department. Rather, its business decision on rectifying the problems was to throw Relator under the bus due to her repeated whistleblowing of the Defendants' healthcare fraud. ***In fact, the***

Radiology Oncology practice, run solely by physician Defendants Tomlinson and Malik generated a whopping total of approximately $890,000,000 in total revenue for Defendant AnMed alone during Relator's employment from 2005 to 2011 inclusive!

165. In response to the continued acrimony over Relator's continued concerns and the 0% compliance on physician orders raised by the 2011 CHS Audit, Dr. Tomlinson sought out Susan Vannoni of Radiation Oncology Consulting, LLC to give him a clean bill of health. At Defendant Tomlinson's request, Defendants AnMed willingly agreed to split the cost of this report with Defendant Tomlinson. It is interesting to note that Vannoni had also been hired to issue a review of billing procedures for Blue Ridge, a clear conflict of interest!

166. Vannoni had previously commented on February 2, 2012 in a SATRO user group chatroom (SATRO is a Yahoo discussion group for the radiation oncology staff in physician practices or hospital departments primarily in the Southern United States), "Why doesn't anyone understand the importance of Radiation Oncologist supervision. That is why a radiologist is trained and is the primary one supervising what goes on in the clinic…period…end of discussion." Relator hoped that Vannoni

would be an advocate for pointing out these healthcare violations and civil and criminal liability associated with them.

167. Relator had spoken with Vannoni at length about the 2011 CHS Audit findings and physician supervision issues and Relator's concerns about continued healthcare fraud and civil and criminal liability.

168. Instead, to Relator's shock and amazement, when Relator raised these issues with Vannoni, Vannoni admonished Relator of a similar thing happening to Vannoni earlier in her career and that Vannoni had spoken out and had gotten fired.

169. Relator clearly understood what the clear message being conveyed by the hired gun consultant hired by Defendants AnMed, Blue Ridge and Tomlinson was. Either be quiet about the continuing healthcare fraud or be fired!

170. No longer able to live in continued fear of immediate termination and being thrown under the bus by Defendants in case of a CMS audit or otherwise, and suffering continued severe emotional stress, sleep deprivation and exhaustion from her continued efforts which affected her personal and professional life. Relator resigned her position on June 13, 2012, and accepted a position for a 25% pay cut in salary at the Medical College of Georgia in Augusta, Georgia where she had previously worked.

As the primary breadwinner for her family, she has at great expense and toll moved her family to Augusta, Georgia.

171. In one of Relator's exit interviews in June 2012 with her Supervisor Garrick Chidester, Chidester acknowledged that "we had let you down" by not properly addressing the many healthcare fraud issues of Defendants that Relator had brought to Defendant's attention and for "leaving her alone" and not "adding a manager" to help Relator get Defendants in compliance and address the abusive behavior by Defendants Tomlinson and Malik.

172. Incredibly, Chidester event asked Relator to "put together a memo" before she left on all the healthcare fraud and compliance issues that her successor would have to deal with even though all these issues had been raised multiple times with him and Defendants in personal meetings and group meetings, by e-mail and through the most recent 2011 CHS Audit.

173. Chidester, while repeatedly acknowledging and apologizing for the harassment and intimidation that Defendant AnMed and he permitted against Relator, callously and defensively joked to Relator, "No one takes Dr. Tomlinson seriously."

174. Relator again met with Garrick Chidester on June 22, 2012, at his request. Chidester acknowledged the 0% compliance on physician orders in the 2011

CHS Audit and acknowledged, "I got to fix it." He admitted that since Relator had put in her resignation notice, he had sat down with Defendant Tomlinson and told him that, "You are still not in compliance with simulations and (physician) orders." Chidester admitted that the problems detailed by Relator, "never got fixed," and that he put Relator "in the middle." Chidester also admitted that in response to being told about Relator's resignation and the ongoing problems identified by Relator, Defendant Tomlinson stated, "She is more of a problem than asset," and that "she should be fired immediately."

175. Incredibly, Chidester also acknowledged that, "I know what the issues are and I don't blame you that you want to leave."

176. Trying to rationalize and explain away the harassment and retaliation that Relator had experienced and as a result of calling attention and trying to correct the compliance, fraud and abuse issues, from Defendants Tomlinson and Malik and the absence of support and complicity from Defendants AnMed and CHS, Chidester stated that, "Doctors are like professional athletes, they are hard to find so you have to put up with their crap."

177. Defendants AnMed and CHS posted an advertisement on AnMed's website (www.anmed.org) for Relator's replacement on or about June 18, 2012. A copy of that advertisement is attached as Exhibit "G".

COUNT I
FALSE CLAIMS ACT VIOLATIONS

178. The prior allegations of this Complaint are incorporated herein by reference.

179. Defendants, by and through their agents, officers and employees, presented and caused to be presented to officers or employees of the United States false or fraudulent claims for payment or approval, in violation of 31 U.S.C. § 3729(a)(1).

180. Defendants, by and through their agents, officers and employees, presented or caused to be presented to officers and employees of the United States false records or statements to get false claims paid in violation of 31 U.S.C. § 3729 (a)(2).

181. Defendants, by and through their agents, officers and employees, conspired to defraud the United States Government by getting false or fraudulent claims allowed or paid in violation of 31 U.S.C. § 3729(a)(3).

182. The United States has been damaged as a result of Defendants' violations of the False Claims Act in an amount to be proven at trial. The United States is

entitled to this sum as reimbursement for monies obtained by the Defendants for fraudulent claims submitted to the United States.

183. The United States is entitled to three times the total damages sustained as a result of Defendants' violations of 31 U.S.C. § 3729(a).

184. The United States is entitled to a civil penalty of between $5,500 and $11,000 as required by 31 U.S.C. § 3729(a) for each of Defendant's false and/or fraudulent claims.

185. Relator is entitled to reasonable costs and attorneys' fees pursuant to 31 U.S.C. § 3730 (d)(1).

COUNT II
RETALIATION

186. The prior allegations of this Complaint are incorporated herein by reference.

187. As set forth at length above, Relator Jainniney was harassed, intimidated and threatened in employment and feared imminent discharge in retaliation for protected activities including investigating and opposing fraudulent practices of Defendants, in violation of 31 U.S.C. § 3730(h).

188. Pursuant to this statute, Relator Jainniney is entitled to be reinstated at the same level of seniority she would have enjoyed absent Defendants' illegal acts; an

award of two times the amount of back pay (including bonus) plus interest; compensation for special damages including emotional distress; and litigation costs and reasonable attorneys' fees.

PRAYER FOR RELIEF

WHEREFORE, Relator prays that:

(a) Defendants each be assessed a civil penalty of not less than $5,500 nor more than $11,000 for each act committed in violation of the False Claims Act;

(b) Defendants each be held jointly and severally liable for three times the actual damages suffered by the Federal Government as a result of the Defendants' violations of the False Claims Act;

(c) Relator Jainniney be awarded not less than 15 per cent nor more than 30 per cent of any proceeds resulting from this action or any resulting settlement, pursuant to 31 U.S.C. § 3730(d);

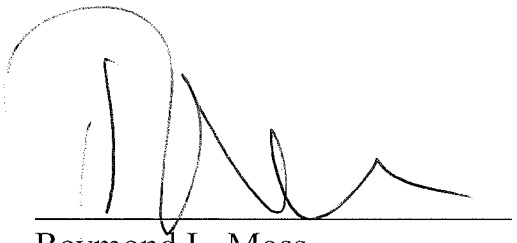
(d) Relator Jainniney be awarded all damages and any other compensatory amounts necessary against Defendant AnMed to make Relator Jainniney whole from Defendants' retaliation pursuant to 31 U.S.C. § 3730(h);

(e) Defendants each be assessed jointly and severally an additional sum sufficient to compensate Relator Jainniney for all expenses of litigation incurred in this action, including reasonable attorney's fees;

(f) Defendants AnMed and CHS be ordered to reinstate Relator Jainniney with the level of seniority she would have enjoyed but for the retaliation; and

(g) Any and all other relief as the Court deems just and proper.

Respectfully submitted this 24th day of August, 2012.



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