FILED
6-16-17
Date
Time
CLERK, U.S. DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA, FLORIDA

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION

UNITED STATES OF AMERICA, *ex rel.* **Geraldine Petrowski** **Plaintiff(s),** **v.** **Epic Systems Corporation,** **Defendant.**	**CIVIL ACTION NO. 8:15CV1408T30EAJ** **FILED UNDER SEAL**

SECOND AMENDED COMPLAINT FOR FALSE CLAIMS ACT VIOLATIONS UNDER 31 U.S.C. § 3729 *et seq.*

The United States of America and the State of Florida, by and through *qui tam* Relator, Geraldine Petrowski ("Relator") brings this action under 31 U.S.C. § 3729 *et seq.* ("False Claims Act") to recover all damages, penalties and other remedies established by the False Claims Act on behalf of the United States and themselves, and would show the following:

I. INTRODUCTION

1. Nationally, Medicaid and Medicare have been subject to fraud and abuse by unscrupulous providers who have put profits above the public good. Those fraudulent schemes have threatened to diminish the quality of care, burdened taxpayers, and degrade the medical profession. Relator alleges extensive improper billing practices and noncompliance issues by Epic Systems Corporation (ESC).
2. This suit concerns fraud perpetrated against the U.S. Government through false and fraudulent billing in order to procure Medicare and Medicaid paid business. As a result

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of this nationwide scheme, Defendant reaped profits far beyond those they would have achieved from legitimate promotion of its business.

II. PARTIES

3. Geraldine Petrowski ("Petrowski" or "Relator") is a citizen of the United States of America and a resident of the state of North Carolina. Relator brings this civil action for violations of 31 U.S.C. § 3729 *et seq*, for herself and for the United States Government pursuant to 31 U.S.C. § 3730(b)(1).

4. Defendant, Epic Systems Corporation ("ESC" or "Defendant"), is a national corporation with its principal place of business in Verona, Wisconsin. ESC conducts extensive business in the Tampa Bay region, the State of Florida and throughout the United States. Epic provides software to the following hospitals in Florida: Florida Hospital, Lee Memorial Hospital, Leon Medical Centers, Martin Health Center, Memorial Healthcare System, Mount Sinai Medical Center, Tampa General Hospital, UF Health and University of Miami Uhealth. Epic Systems Corporation is a privately held healthcare software company. According to the company, hospitals that use its software, hold medical records of 54% of patients in the U.S., and 2.5% of patients worldwide. ESC was founded in 1979 by Judith R. Faulkner. Originally headquartered in Madison, Wisconsin, ESC moved its headquarters to a large campus in the suburb Verona, Wisconsin in 2005, where it now employs more than 8000 people.

5. ESC's market focus is large healthcare organizations. ESC offers an integrated suite of healthcare software centered on a Caché database provided by InterSystems. Their applications support functions related to patient care, including registration and scheduling; clinical systems for doctors, nurses, emergency personnel, and other care

providers, including systems for lab technologists, pharmacists, and radiologists. ESC also offers billing systems for private insurers and Medicare and Medicaid. In total, ESC has 315 customers. This includes 69% of Stage 7 U.S. Hospitals, 71% of Children's Hospitals, and 83% of Stage 7 Clinics.

III. JURISDICTION AND VENUE

6. This action arises under the False Claims Act, 31 U.S.C. § 3729 *et seq.*

7. Jurisdiction over this action is conferred on this Court by 31 U.S.C. 3732(a) and 28 U.S.C. 1331 in that this action arises under the laws of the United States of America.

8. Venue is proper in the United States District Court for the Middle District of Florida, Tampa Division, pursuant to 28 U.S.C. § 1391(b) and (c), and 31 U.S.C. § 3732(a) because the Defendant transacts business in this District, and the practices forming the basis for the Complaint occurred in this District.

IV. PRELIMINARY STATEMENT

9. Relator, was employed by WakeMed Health from September 2008 to June 2014. From September 2008 to September 2012, Relator, Petrowski worked with the compliance team as a Compliance Review Specialist. From September 2012 to June 2014, Relator, was the Supervisor of Physician's Coding, and served as the hospital liaison regarding ESC's implementation of its software at WakeMed Health.

10. Relator, has firsthand knowledge of Defendant's Epic software which has been provided to various hospitals which incorrectly bills anesthesia charges.

11. On behalf of WakeMed Health, in implementing Epic billing system, Relator travelled to Verona, WI for a week of training for Epic's Resolute Billing Charge Capture system. After training, Relator became certified by ESC as a Charge Capture Analyst for Epic's

2012 and 2014 systems in order to more readily assist Epic's implementation of its software with its customer and Relator's employer WakeMed Health. As part of this effort, Relator was involved in deciding which CPT codes to load, ensuring that pricing was correct, and verifying that documentation was completed and it triggered the correct code which mapped to the same code on the claim form. Additionally, she set up several work queues so that Relator's coding staff would be able to receive their assigned work each day.

12. Relator, worked vigorously to ensure that the ESC software code regarding anesthesia billing and procedure coding complied with Medicare and Medicaid guidelines. It was during this process that Relator, began to develop major concerns in regard to incorrect billing practices that were driven by the ESC billing software.

13. Effective January 1, 2012, Medicare changed its billing and reimbursement practices regarding anesthesia services and through the 5010claim form requested units to be billed in actual minutes, instead of 1 unit equaling 15 minutes. Some hospitals continue to bill with 15 minutes representing 1 unit, as in the example below. Under the new regulations, base units were reported and billed on the claim form. The new regulations provided that only the physician's actual time on the procedure should be submitted/billed on the claim form. Because the reimbursement protocol would automatically add-in and reimburse for the appropriate base unit associated with the medical procedure performed, base units should not be reported on the claim form.. The claim form reflecting this change for such billing was changed from form 4010 to form 5010. ESC's software, however, allowed hospitals to set up their anesthesia billing modules to include the sum of the actual time, plus the base unit time to be reported on the claim form.-This resulted in the provider

being reimbursed twice for the base unit component.

14. Relator went so far as providing examples to ESC representatives illustrating this unlawful practice. Initially, Relator's advice went unheeded, as she was told by ESC that "all other hospitals are billing base units."

15. Relator, met with ESC representatives again after determining that their software's default protocol for anesthesia incorrectly billed base units which resulted in a double reimbursement to the provider of base units. Relator finally succeeded in forcing ESC to take out the base units submission from the hospital's anesthesia billing module, but once again was told that they have "built all other systems with this feature included".

16. Relator believes and has tested ESC's software to prove that it is designed to incorrectly bill in violation of federal Medicare and Medicaid regulations. Furthermore, even though Relator, specifically advised ESC of this, their response was simply "everybody bills base units" and then failed to correct the billing software. It was only after Relator, Petrowski, reiterated her direction to fix this software setting that ESC relented and fixed it only for the WakeMed Health facility.

17. Accordingly, absent challenge/intervention such as provided by Relator on behalf of WakeMed Health and Hospitals, it is probable that most of ESC's software customers (Exhibit A) are using ESC's Epic billing software as written to double bill anesthesia.

V. SPECIFIC FRAUD PERPETRATED BY EPIC SYSTEMS CORPORATION

Md Anderson Cancer Center Anesthesia Bill

18. Relator has reviewed John Doe's medical bill in order to further confirm the incorrect billing of anesthesia by Epic's billing software. The Anesthesia Bill (Exhibit B) was for the anesthesia used for a removal of a prostate at MD Anderson Cancer Center at the

University of Texas on June 14, 2016. MD Anderson is currently a EPIC software user hospital.

19. Relator states that the time units are determined by using the total time in minutes actually spent performing the procedure. Although fifteen minutes is equivalent to one (1) time unit of anesthesia in Exhibit B, the provider billed 28 units of CPT code 00865, which is the equivalent to 420 minutes, *Id.* at 2 and accounts for seven hours of billed anesthesia. In the anesthesia Procedure Summary (Exhibit C) however, it states the anesthesia start time as 07:08 AM and anesthesia stop time as 11:57AM, which is a total of 4 hours and 49 minutes, which should only account for a total of 19 billed units. This results in the overbilling of 9 units, or 2 hours and 15 minutes.

Per Medicare Claims Processing Manual, Chapter 12, Section 140.3.2 provides the following guidance:

> Anesthesia time means the time during which a qualified nonphysician anesthetist is present with the patient. It starts when the qualified nonphysician anesthetist begins to prepare the patient for anesthesia services in the operating room or an equivalent area and ends when the qualified nonphysician anesthetist is no longer furnishing anesthesia services to the patient, that is, when the patient may be placed safely under postoperative care. Anesthesia time is a continuous time period from the start of anesthesia to the end of an anesthesia service.

CPT code 55866, for a laparoscopic prostatectomy, has a corresponding anesthesia CPT code of 00865, which was billed by the anesthesiologist. The number of base units assigned to CPT code 00865 is seven. As Medicare's guidance states that anesthesia time begins when the anesthesia personnel "begins to prepare the patient for anesthesia" and ends "when the patient may be safely placed under postoperative care", MD Anderson may be additionally billing two units to account for time prior to the actual initiation of

anesthesia and time after the stop time of anesthesia. Per Novitas Solutions, the Medicare contractor for Texas, where MD Anderson is located, only "*the actual anesthesia time in minutes*" is reported on the claim form.

Epic System Corporation Procedural Handbooks on Billing Anesthesia

20. The Epic Handbook on Billing Anesthesia indicates that Epic continues to improperly include base units in its billing protocol thereby resulting in overbilling to payors including Medicare and Medicaid. In Epic's ESC Anesthesia Billing Self Study Guide, (p.55), it indicates that base units should be included for claim processing (Exhibit D). Further, in ESC's Billing Descriptions, (p. 9) it indicates that the base units are built into the pricing for the claims. (Exhibit E).

21. These Epic software-generated bills incorrectly and unlawfully include base units in bills for anesthesia services thereby resulting in the double payment to the provider for base units for every anesthesia service bill provided under ESC's Epic software billing system. This unlawful billing protocol has resulted in the presentation of hundreds of millions of dollars in fraudulent bills for anesthesia services being submitted to Medicare and Medicaid as false claims.

VI. CLAIM FOR RELIEF
COUNT I
FALSE CLAIMS ACT VIOLATION (31 U.S.C. § 3729(a)(1)(A))

1. Relator incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth in this paragraph.

2. As set forth above, Defendant knowingly, or acting with deliberate ignorance and/or reckless disregard of the truth, made false representations about the software it provided which led to fraudulent double billing of anesthesia.

3. As set forth above, Defendant knowingly, or acting with deliberate ignorance and/or reckless disregard of the truth, presented and or caused to be presented, a false or fraudulent claim for payment or approval in connection with the Medicare and Medicaid reimbursement for anesthesia.
4. Defendant's material omission of the fact that its software billed for base units and actual time of anesthesia used, led to influencing the fraudulent billing to Medicare and Medicaid.
5. By virtue of the acts described above, and in violation of 31 U.S.C. § 3729(a)(1)(A), for each fraudulent bill submitted to the Government for reimbursement, defendant knowingly, or acting with deliberate ignorance and/or reckless disregard of the truth, presented and or caused to be presented a fraudulent claim for payment or approval.
6. Pursuant to the False Claim Act 31 U.S.C. § 3729(a)(1), Defendants are liable to the United States under the treble damages and civil penalty provision for a civil penalty of not less than $5,000 and not more than $10,000 for each of the false or fraudulent claims herein, plus three (3) times the amount of damages which the government has sustained because of Defendant's actions.

COUNT II
FALSE CLAIMS ACT VIOLATION (31 U.S.C. § 3729(a)(1)(B))

7. Relator incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth in this paragraph.
8. As set forth above, Defendant knowingly, or acting with deliberate ignorance and/or reckless disregard of the truth, made false representations about the software it provided which led to fraudulent double billing of anesthesia.
9. As set forth above, Defendant knowingly, or acting with deliberate ignorance and/or

reckless disregard of the truth, presented and or caused to be presented, a false or fraudulent claim for payment or approval in connection with the Medicare and Medicaid reimbursement for anesthesia.

10. Defendant's material omission of the fact that its software billed for base units and actual time of anesthesia used, led to influencing the fraudulent billing to Medicare and Medicaid.

11. By virtue of the acts described above, and in violation of 31 U.S.C. § 3729(a)(1)(B), for each fraudulent bill submitted to the Government for reimbursement, defendant knowingly, or acting with deliberate ignorance and/or reckless disregard of the truth, presented and or caused to be presented a fraudulent claim for payment or approval.

12. Pursuant to the False Claim Act 31 U.S.C. § 3729(a)(1), Defendants are liable to the United States under the treble damages and civil penalty provision for a civil penalty of not less than $5,000 and not more than $10,000 for each of the false or fraudulent claims herein, plus three (3) times the amount of damages which the government has sustained because of Defendant's actions.

COUNT III
FALSE CLAIMS ACT VIOLATION (31 U.S.C. § 3729(a)(1)(G))

13. Relator incorporates by reference the allegations in each of the preceding paragraphs as if fully set forth in this paragraph.

14. As set forth above, Defendant knowingly, or acting with deliberate ignorance and/or reckless disregard of the truth, made false representations about the software it provided which led to fraudulent double billing of anesthesia.

15. As set forth above, Defendant knowingly, or acting with deliberate ignorance and/or reckless disregard of the truth, presented and or caused to be presented, a false or

fraudulent claim for payment or approval in connection with the Medicare and Medicaid reimbursement for anesthesia.

16. Defendant's material omission of the fact that its software billed for base units and actual time of anesthesia used, led to influencing the fraudulent billing to Medicare and Medicaid.

17. By virtue of the acts described above, and in violation of 31 U.S.C. § 3729(a)(1)(G), for each fraudulent bill submitted to the Government for reimbursement, defendant knowingly, or acting with deliberate ignorance and/or reckless disregard of the truth, presented and or caused to be presented a fraudulent claim for payment or approval.

18. Pursuant to the False Claim Act 31 U.S.C. § 3729(a)(1), Defendants are liable to the United States under the treble damages and civil penalty provision for a civil penalty of not less than $5,000 and not more than $10,000 for each of the false or fraudulent claims herein, plus three (3) times the amount of damages which the government has sustained because of Defendant's actions.

VII. PRAYER FOR RELIEF

19. WHEREFORE, the Relator respectfully requests that judgment be entered in its favor and against Defendants as follows:

    a. On Count One, Two and Three (False Claim Act), a judgment against all Defendants for treble damages and civil penalties for the maximum amount allowed by law;

    b. That the Relator's *qui tam*, Plaintiff, in Counts I - III, be awarded the maximum amounts allowed pursuant to the False Claim Acts or any other applicable provision of law of the states on behalf those claims are brought;

c. For an award of costs pursuant to 31 U.S.C. § 3729(a);

d. For such further relief that this Court deems appropriate.

VIII. DEMAND FOR JURY TRIAL

20. Pursuant to Federal Rule of Civil Procedure 38, Relator demands a trial by jury for all issues so triable as a matter of right.

[Signature on Next Page]

Dated: June 8, 2017

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing has been hand delivered by courier to: Clerk, U.S. District Court 801 North Florida Avenue Tampa, Florida 33602 and mailed; postage prepaid, U.S. First Class Certified Mail, this 8th day of June 2017 to:

U.S. Attorney's Office 400 North Tampa Street, Room 329 Tampa, Florida 33602	Office of the Attorney General **U.S. Department of Justice** 950 Pennsylvania Avenue, N.W. Washington, D.C. 20530-0001

By: /s/ David J. Linesch, Esq.
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