UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF TENNESSEE
WINCHESTER DIVISION

UNITED STATES OF AMERICA
and STATE OF TENNESSEE,
ex rel., DARLA LANE **PLAINTIFFS**

V. **CIVIL ACTION NO. 4:07-CV-4**

(MATTICE/CARTER)

MURFREESBORO DERMATOLOGY CLINIC, PLC
and MICHAEL W. BELL, M.D. **DEFENDANTS**

SECOND AMENDED COMPLAINT

Qui tam relator, Darla Lane, by her undersigned attorneys, submits the following as her Second Amended Complaint herein, pursuant to Rule 15(a) of the Federal Rules of Civil Procedure and to a Memorandum and Order granting leave therefor and filed herein on July 8, 2011:

1. This is a civil action brought by the Plaintiff as Relator on her behalf and on behalf of the United States of America and the State of Tennessee against the Murfreesboro Dermatology Clinic, PLC ("the Clinic") and Dr. Michael W. Bell ("Bell") to recover damages and civil penalties on behalf of the United States under the False Claims Act, 31 U.S.C. §§ 3729-3732, as amended by the False Claims Act Amendments

of 1986, and on behalf of the State of Tennessee under the Tennessee Medicaid False Claims Act, Tennessee Code §§ 71-5-181 through 71-5-185d ("Tennessee Medicaid FCA"). Relator Darla Lane ("Lane") brings this civil action under the *qui tam* provisions of both such statutory schemes.

Venue and Jurisdiction

2. This Court has jurisdiction over this action pursuant to 28 U.S.C. § 1345 and 31 U.S.C. §§ 3730(b) and 3732(a), and pendent jurisdiction over the claims arising under the Tennessee Medicaid False Claims Act.

3. Venue is proper in this district pursuant to 28 U.S.C. § 1391(b) and (c) and 31 U.S.C. § 3732(a). Defendants conducted their medical practice in substantial part within this District and Division by virtue of their maintenance of a medical clinic in Winchester, Tennessee during all relevant times, and were otherwise doing business in this District at all times material to this action. The claims set forth in this Second Amended Complaint likewise arose, in part, in this District and Division.

The Parties

4. *Qui tam* relator Lane is a United States citizen and an adult resident of the State of Tennessee, residing in Murfreesboro. Between September of 2002 and March of 2006, Lane was employed by the Defendants as a billing specialist. The conduct by the Defendants as described herein occurred to her personal knowledge on a continual basis throughout all of those months. From information made available to her since her

departure from that employment, and from the admissions made and data presented by the Defendants in the course of discovery in this action, Relator Lane now knows that the Defendants also continually engaged in the conduct described herein at all times since (and including) January 24, 2001. All periods of time between (a) January 24, 2001 and (b) the time when this case shall be tried and submitted for decision shall hereafter be referred to as "the relevant months" (or "the months relevant to this case").

5. Murfreesboro Dermatology Clinic, PLC, is a Tennessee entity owned and controlled by Bell, and operates as a dermatology medical clinic in Tennessee. The principal clinic is located at 1725 Medical Center Parkway, Suite 300, Murfreesboro, Tennessee, where Bell has been served with process. The Clinic also owns and operates at least six "satellite" dermatology clinics located in Winchester, Manchester, McMinnville, Smyrna, Shelbyville and Springhill, Tennessee. All of the conduct by the Defendants described herein took place at and from those seven locations.

6. Dr. Michael W. Bell is a citizen of Canada, whose immigration status in the United States is that of a resident alien. He resides in or near Nashville, Tennessee, owns the Clinic entity, and during the relevant months has practiced dermatology and pathology at and through the Clinic. As the person who during all relevant months has controlled the billing and clinical policies and practices of the Defendant Clinic, Bell individually and knowingly caused the conduct and false claims described herein, intending for those claims to be paid with funds of the United States and of the State of Tennessee. All of the

conduct by Bell alleged herein resulted from breaches by him of the standard of care of a dermatologist and pathologist in the relevant medical community.

The Medicare, Tricare and TennCare Programs

7. The United States, through the Department of Health and Human Services ("HHS") and its component agency, the Center for Medicare and Medicaid Services ("CMS"), administers Title XVIII of the Social Security Act under 42 U.S.C. §§ 1395, et seq. (Medicare Part B Program). The Medicare Part B Program ("Medicare Program") is a 100% federally subsidized health insurance system for disabled persons or persons over the age of 65. The Medicare Program pays for certain specified medically necessary services rendered to patients covered by Medicare Part B. One of the services paid for under Medicare Part B is services by a physician or physician's assistant.

8. Physicians and their clinics are required to enter into a contract, or "provider agreement," with HHS in order to participate in the Medicare program. Dr. Bell indeed expressly represented to Medicare in signing his Medicare Enrollment Application entitling him to Medicare payments during the period concerned in this litigation as follows:

> (A) "I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the (Clinic) listed on this application."
>
> (B) "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. . . ."

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

9. The United States, through the Department of Defense Military Health System, also administers a health care insurance program known as Tricare (formerly known as the Civilian Health and Medical Program of the Uniformed Services, or "CHAMPUS"), which pays for medical care rendered to U. S. military personnel, military retirees, and their dependents, including some members of the Reserve Component. The Defendants also made claims to Tricare pursuant to the billing schemes described above, intending for Tricare to pay such claims with funds of the United States Treasury.

10. The State of Tennessee maintains a federally-approved Medicaid program to reimburse health care charges made by physicians for the treatment of many Tennessee citizens not covered by Medicare, a program known as TennCare and described by the CMS at http://www.cms.hhs.gov/medicaid/1115/tnfact.pdf. Claims to TennCare for reimbursement and payment submitted by physicians and their clinics, including the Defendants in this case, are claims made and presented to the State of Tennessee, within the meaning of the Tennessee Medicaid False Claims Act, and also cause claims to be made to the United States, as the United States pays some portion of each claim submitted or presented to Tenncare for payment.

11. Physicians, including Defendant Bell, apply to participate in the Tenncare program, pursuant to the provisions of 1200-13-1-.05 of the Tennessee Bureau of Tenncare/Medicaid, and agree as a condition of participation in the Tenncare program that any claim for reimbursement will include an implied certification, as a condition of continued participation and as a condition of payment as to any such claim, that the physician has complied with all Medicaid policies and regulations and has provided the medical assistance represented by the claim at or above recognized standards of medical practice. All of the acts and patterns of conduct alleged below as to Bell and the Clinic were conducted contrary to, and inconsistent with, recognized standards of medical practices.

12. All claims to Medicare, Tricare and Tenncare resulting from the unlawful practices and false statements described hereafter were made to those payors, seeking to get those governmental payors to pay the Defendants in reliance on those claims, through the submission of "Health Insurance Claim Forms" referred to as "HCFA 1500 forms" or "CMS Form 1500s" with a first (or "front") page reflected on Exhibit A hereto and a second (or "back") page reflected on Exhibit B hereto. As Exhibit B reflects, Defendant Bell (or another physician employed by and on behalf of the Defendant Clinic) expressly certified to the governmental payor on the face of and as a material part of each such claim submission that "the services shown on this form were medically indicated and necessary for the health of the patient. . . ." (42 C.F.R. § 424.32). Each such claim was

presented on behalf of the Defendants by a billing preparation team which (during the periods of her employment) included the Relator, and were physically submitted directly to the payors by an employee of the Defendant Clinic named Leslie Moore, working at the time of all such claims submissions at the principal Clinic office location of 1725 Medical Center Parkway, Suite 300, Murfreesboro, Tennessee.

13. Defendant Bell is board certified both in dermatology and in pathology, and controlled the billing patterns and practices of the Clinic with respect both to dermatological and pathology services.

First False Claims Pattern:
Clinic Practice of Conducting Lab Tests of All Skin Material Removed from all Patients (including Material Removed for "Cosmetic" Reasons and otherwise "Benign" Conditions) and Falsely Certifying All Resulting Pathology Tests as "Medically Indicated" (and "Medically Necessary")

14. In order to get paid on false claims for pathology services which the Clinic's own clinical records demonstrated were not medically indicated or medically necessary, Bell established and the Clinic maintained throughout the relevant months a clinical and billing practice of sending to Bell for a laboratory (or "pathology") test by Bell, purportedly for the purpose of testing for evidence of cancer, every tissue, skin tag, or other skin-related material removed from every patient of the Clinic. (This practice of the Clinic shall hereafter be referred to as the "Clinic's test-everything laboratory referral practice.")

15. Throughout the relevant months, the Defendants knew that no medical

journal, no medical textbook, and no other peer-reviewed literature published for physicians recommended or justified the Clinic's test-everything laboratory referral practice. Indeed, the Defendants knew that the practice disregarded medical indications for real risks of cancer, and was designed to create additional billings for medically unnecessary laboratory tests undertaken under the Defendants' control.

16. False pathology claims resulting from the Clinic's test-everything laboratory referral practice were made by the Defendants to Medicare, Tenncare and Tricare using procedural "pathology" billing codes 88304, 88305 (most often), 88312, 88313, and 88342 (hereafter referred to collectively as the "laboratory claims"). The laboratory claims most frequently made to those government payors was under the 88305 procedure code, for which the Defendants claimed that they were entitled to be paid $130.00 for each such claim.

17. The Clinic's test-everything laboratory referral practice required all materials removed from patients for solely cosmetic reasons - reasons having nothing to do with any complaint, evidence, or diagnosis indicating a risk of cancer - to be subjected to a pathology service or laboratory test in order to cause a charge to be made to Medicare, Tenncare and/or Tricare, using the laboratory claims or codes. Many such cosmetic removal procedures were acknowledged by the Defendants as having been rendered solely for cosmetic reasons by the Defendants' use of a procedural code "A9270" to describe the removal procedure itself as *not* medically indicated or medically necessary, but made only

for cosmetic reasons (and for which the patient was financially responsible). Representative false laboratory claims included (but were not limited to) the claims to Medicare identified on Exhibit D, the claims to Tenncare identified on Exhibit E, and the claims to Tricare identified on Exhibit F. (Exhibits D, E and F will be electronically filed herein within 14 days of the production by the Defendants to the Plaintiff of relevant claims data that are the subject of long-standing discovery requests by the Plaintiff.)

18. The Clinic's test-everything laboratory referral practice also required a laboratory test (purportedly for cancer), and thus the charging of a laboratory code, of all materials removed from patients as a result of a diagnosis of what medical practitioners in the Clinic had themselves previously diagnosed as a "benign" condition (including the finding of a "benign lesion"), which by definition was inconsistent with evidence of, or a finding of a risk of, cancer. The Defendants nevertheless instructed billing employee Leslie Moore to represent, and she did represent to Medicare with respect to all laboratory claims for all laboratory tests during a substantial portion of the relevant months, that all such laboratory tests of material removed from "benign" conditions were medically necessary, in part through use as a part of all Medicare claims of the term "KX" as an abbreviation for medically necessary. Those representations were false, and were made with reckless disregard for the actual clinical judgments of "benign" conditions which had been made by practitioners within the Clinic.

19. As the Defendants knew throughout the relevant months, benign skin

lesions typically do not require removal or destruction at all except for cosmetic reasons, though in rare instances they can become irritated or traumatized, with pain and bleeding. Indeed, as the Clinic's own description of Medicare policies concerning non-billable cosmetic procedures admitted (as reflected on Exhibit G hereto), it would be "rare" in actual clinical practice for any destruction or removal of a benign lesion to be medically necessary in the first place.

20. Representative false laboratory claims resulting from the laboratory testing by Bell of "benign lesion" materials, which had **not** been the subject of any "biopsy" removal procedure resulting from actual observations of medical indications of a risk of cancer (and charged as a "biopsy" procedure using procedural codes 11100, 11101, 11755, 69100, 40490, or 67810), included (but were not limited to) the claims to Medicare identified on Exhibit H hereto, the claims to Tenncare identified on Exhibit I hereto, and the claims to Tricare identified on Exhibit J hereto.

21. A material and legally necessary part of each such false laboratory claim presented and made by the Defendants was the Defendants' false certification to the government payors that each such laboratory claim was "medically indicated" and was "medically necessary," when in fact the Defendants knew that such certifications as to all such claims were false when made, since the tested material had been removed from patients for cosmetic reasons or as a consequence of a "benign" condition.

22. Indeed, as a material part of each and every such false laboratory claim

made on behalf of the Defendants to Medicare, Tricare and Tenncare on CMS 1500 claims forms using all such five-digit laboratory codes throughout the relevant period, Bell and the Defendant Clinic expressly made and used, in order to and with an intent to cause the governmental payors to pay each such claim, an explicit representation that Bell (or another physician on behalf of the Defendant Clinic) had made a good faith professional inquiry into the actual medical basis for each such laboratory claim and had determined as to each such individual claim that in truth "the services shown on this form were medically indicated and necessary for the health of the patient," among other certifications. (Exhibit B hereto reflects that certification as it appeared on each such claim form.) Federal regulations required that as a part of each claim such a certification must have been made by a physician "who has knowledge of the case." (42 C.F.R. § 424.24(g)). All such certifications were individually made by Bell, or otherwise on behalf of the Defendant Clinic.

23. Each such explicit certification was false, as to each of the laboratory claims described above. The Defendants knew each of those certifications was false, and intentionally and knowingly used them to get all such claims paid, intending that they should be relied on to cause such payments to be made. As a result of the Clinic's test-everything laboratory referral practice, each such certification made during the relevant months was false when made and each such laboratory claim made during the relevant months was knowingly false and fraudulent within the meaning of 31 U.S.C. § 3729(b) of

the False Claims Act and § 71-5-182(b) of the Tennessee Medicaid False Claims Act. The truth of such representations having been a prerequisite to the Defendants' entitlement to be paid on all such claims under all such codes, their falsity rendered all such claims legally false. All such false claims resulted in damages to the United States and to the State of Tennessee in the amounts of the payments of each and every such claim.

Second False Billing Pattern: False "Modifier -25" Office Consultation Charges

24. The Defendants during the relevant months knew that any claim or charge to Medicare, Tricare and Tenncare of (or resulting from) of a "Modifier 25" (or "Modifier -25", or "025 Sep. E & M on same day") code amounted to a representation that on the same day of a surgical procedure (which was the subject of a separate procedural claim or charge), the medical practitioner at the Clinic had been required by medical indications to spend more time consulting with or advising the patient concerning that procedure than would ordinarily or typically have been required or spent by a physician in order to conduct the procedure itself. Similarly, the Defendants knew that the "Modifier 25" was only medically indicated, medically necessary, and truthful when it described a consultation service to the patient (on the same day as a separately-compensated surgical procedure) which was above and beyond the usual preoperative and postoperative care associated with the procedure performed. Any legally proper and truthful "Modifer -25" claim would communicate the occurrence of a significant and identifiable evaluation and management service by that physician, identifiably separate from the evaluation and

management involved in the administration of the dermatology procedure itself (and therefore not compensated by the separate code peculiar to the procedure itself). Defendants' use of a Modifier 25 code resulted in an additional charge or claim for office consultation (through an additional charge of a code beginning with the digits "992").

25. By its very nature, therefore, an additional consultation claim resulting from proper and medically accurate uses of a Modifier 25 claim would be used no more than fifty percent of the time a procedure is performed. In fact, the Defendants used and charged a Modifier 25 code a substantial majority of the time they also asserted a claim for a surgical procedure.

26. The Defendants throughout the relevant months, in disregard of the actual medical necessity of unusual or additional consultation time or services accompanying surgical procedures, devised and executed a pattern and plan of consulting with patients about a surgical procedure on the day of an initial office visit concerning that procedure, and then scheduling the procedure itself for a later day, and then charging a second office consultation (or "evaluation and maintenance") claim on the day of the procedure itself through routinely charging a Modifier 25 (resulting in the second such consultation claim). The Defendants undertook and executed this billing pattern and scheme with a fraudulent purpose of getting compensated by Medicare, Tenncare and Tricare effectively twice (or, typically, three times) for the same consultation service associated with the surgical procedure. The scheme would result in one consultation ("E & M") claim on the day of the

initial consultation, a second claim for the procedure itself (which separately compensated the Defendants for the consultation typical of conducting that procedure), and a third claim for a second consultation (which resulted from routine charging on the day of the procedure of a “Modifier 25" code). This pattern or scheme of claiming compensation two times (or, effectively, three times) for the same consultation about the same procedure was undertaken and executed in reckless disregard of the actual medical indications and medical necessities of such multiple or duplicative patient consultations.

27. Representative false consultation (“E & M”, or “992–“) claims caused by this pattern of double-billing for surgery-related consultations included (but were not limited to) the claims to Medicare identified on Exhibit K hereto, the claims to Tenncare identified on Exhibit L hereto, and the claims to Tricare identified on Exhibit M hereto. All such false claims result from Modifier 25 codes employed by the Defendants within thirty days of having earlier charged the same patient with a separate and original consultation code concerning the same surgical procedure for which the Modifier 25 charge was also made.

28. In the course of and as a legally necessary part of making each such false claim and false communication to Medicare, Tenncare and Tricare of a “Modifier 25", the Defendants falsely represented on the claim form (of the kind reflected on Exhibits A and B hereto) that the medical provider had made a good faith professional inquiry into the actual medical basis for each such additional claim for additional consultation services,

and had determined as a result of that inquiry that as to each such individual claim "the services shown on this form were medically indicated and necessary for the health of the patient."

29. In truth, however, the claim forms resulting from the double-billing scheme described above so completely corrupted the integrity of *all* of those certifications of medical necessity that the resulting claims forms were not accurate.

30. As a result of that pattern and practice, each and every such claim or representation that Bell or the Clinic was entitled to an additional payment for a patient consultation resulting from a "Modifier -25" adjustment, made to Medicare, Tenncare or Tricare as to a patient who had already been the subject of a "consultation" (or "E & M") charge within the thirty-day period prior to the surgical procedure and accompanying "Modifier 25" charge, was knowingly false and fraudulent within the meaning of 31 U.S.C. § 3729(b) of the False Claims Act and § 71-5-182(b) of the Tennessee Medicaid False Claims Act, and was knowingly used by the Defendants in order to get false claims paid (and such claims were in fact paid in reliance on those certifications). The truth of that certification that such additional consultation charges were "medically indicated" and "medically necessary" having been a prerequisite to the Defendant Clinic's entitlement to be paid in response to each such claim, the falsity of each such assertion rendered each such claim legally false.

Third False Billing Pattern - Charging for Cosmetic Procedures

31. As the Defendants knew throughout the relevant months, numerous dermatological procedures and services are regarded by Medicare, Tricare and TennCare as "cosmetic" in nature, and as not properly the subject of any allowable or lawful claim for reimbursement by Medicare, Tricare or TennCare, unless and until the condition requiring the procedure or service is accompanied by an authentic patient complaint of being medically necessary as defined by the Defendants' own memorandum attached as Exhibit G hereto.

32. The general prohibition on any physician's entitlement to payments for "cosmetic surgery and related services" has certain exceptions related to true medical necessity. (42 CFR § 411.15(h)). The prohibition and those exceptions are described in the governing Medicare Benefit Policy Manual as follows:

> Cosmetic surgery or expenses incurred in connection with such surgery is (sic) not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.

Medicare Benefit Policy Manual, Chap. 16, Sec. 120.

33. In reckless disregard of this prohibition on entitlement to reimbursement from Medicare, Tricare or Tenncare for removals or destruction of skin materials for cosmetic reasons, the Defendants billed all three such government insurers for cosmetic procedures not meeting the standards of medical necessity described in the above two

paragraphs (and in Exhibit G), as to conditions which the Defendants themselves had diagnosed or observed to be without medical necessity justifying any such removal or destruction.

34. Representative false claims for services rendered only as to cosmetic conditions included (but were not limited to) the claims to Medicare identified on Exhibit N hereto, the claims to Tenncare identified on Exhibit O hereto, and the claims to Tricare identified on Exhibit P hereto.

35. As a material part of each and every claim made on behalf of the Defendants to Medicare, Tricare and Tenncare on CMS 1500 claims forms for all such cosmetic services, Bell and the Defendant Clinic expressly made and used, in order to and with an intent to cause the governmental payors to pay each such claim, an explicit representation that Bell (or another physician or physician's assistant on behalf of the Defendant Clinic) had made a good faith professional inquiry into the actual medical basis for each such claim and had determined as to each such individual claim that in truth "the services shown on this form were medically indicated and necessary for the health of the patient," among other certifications. (Exhibit B hereto reflects that certification as it appeared on each such claim form.) Federal regulations required that as a part of each claim such a certification must have been made by a physician "who has knowledge of the case." (42 C.F.R. § 424.24(g)). All such certifications were individually made by Bell or otherwise on behalf of the Defendant Clinic. During substantial periods of time during the

relevant months, the Defendants instructed billing employee Leslie Moore to communicate, and she did communicate, to Medicare with each such claim the term "KX", which also represented that the claim was the result of a medically necessary procedure. All such "KX" representations of medical necessity with respect to such cosmetic conditions were false when made as a part of each such claim to Medicare.

36. The Defendants knew each of those certifications was false, and intentionally and knowingly used them to get all such false claims paid, intending that they should be relied on (and they were relied on) to cause such payments notwithstanding the presumptively cosmetic nature of each such procedure. Each such certification that each such condition was "medically indicated" and necessary was a representation that the procedure was covered and payable, notwithstanding the exclusion applying to cosmetic procedures, and caused a payment to be made to the Defendants.

COUNT 1

Claim By and on Behalf of the United States under the False Claims Act Relating to Laboratory Charges from the Defendants' "Test-Everything Laboratory Referral Practice" (Presenting False Claims)

37. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

38. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

39. By virtue of the acts described above, and in particular with respect to Paragraphs 14 through 23, with respect to the "Clinic's test-everything laboratory referral practice", Defendants knowingly presented false or fraudulent claims for payment by Medicare, Tenncare and Tricare for pathology or laboratory services not medically necessary because they were known by Defendant Bell to be of material that had not been the subject of a medically necessary biopsy, had been removed for cosmetic purposes, and/or had been diagnosed as benign, or knowingly caused false or fraudulent claims for payments for such laboratory claims to be presented, to officials of the United States Government throughout the relevant months and in violation of 31 U.S.C. § 3729(a)(1), as amended.

40. By virtue of those false claims presented or caused to be presented by Defendants, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT II

Claim By and on Behalf of the United States under the False Claims Act Relating to Laboratory Charges from the Defendants' "Test-Everything Laboratory Referral Practice" (Using False Statements or Records)

41. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

42. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

43. By virtue of the acts described above, and in particular with respect to Paragraphs 14 through 23, with respect to the Defendants' "test-everything laboratory referral practice" Defendants knowingly made and used, and caused to be made and used, throughout the relevant months, false records, certifications and statements in order to get false and fraudulent claims paid or approved by Medicare, Tenncare and Tricare, in violation of 31 U.S.C. § 3729(a)(2), as amended.

44. The false claims for payment presented or caused to be presented by Defendants include all claims submitted by Defendants to Medicare, Tenncare or Tricare since January 24, 2001, for pathology or laboratory services not medically necessary because they were known by Defendant Bell to be of skin material that had not been the subject of a medically necessary biopsy, had been removed for cosmetic purposes, and/or had been diagnosed as benign.

45. By virtue of the false statements and records used by the Defendants as a material and legally necessary part of all such laboratory claims, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented since January 24, 2001, and other monetary relief as appropriate.

COUNT III

Claim By and on Behalf of the United States under the False Claims Act Relating to False "Modifier 25" Duplicative Charges for Office Consultations Incident to Surgical Procedures (Presenting False Claims)

46. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

47. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

48. By virtue of the acts described above, and in particular with respect to Paragraphs 24 through 30, with respect to the Defendants' pattern of multiple charges for patient consultations through "Modifier 25" charges, the Defendants knowingly presented false or fraudulent claims for payment by Medicare, Tenncare and Tricare, or knowingly caused false or fraudulent claims for payment to be presented, to officials of the United States Government throughout the relevant months and in violation of 31 U.S.C. § 3729(a)(1), as amended.

49. The false claims for payment presented or caused to be presented by Defendants include all office consultation (or "E & M" codes beginning with "992") resulting from the Defendants' use of a "Modifier 25" code within thirty days of an earlier such office consultation charge for consultation with the same patient, as a part of charges during the relevant months to Medicare, Tenncare or Tricare.

50. By virtue of such false claims presented or caused to be presented by

Defendants, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT IV

Claim By and on Behalf of the United States under the False Claims Act Relating to False "Modifier 25" Duplicative Charges for Office Consultations Incident to Surgical Procedures (Using False Statements or Records)

51. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

52. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

53. By virtue of the acts described above, and in particular with respect to Paragraphs 24 through 30, with respect to the Defendants' pattern of multiple charges for patient consultations through "Modifier 25" charges, the Defendants knowingly presented false or fraudulent claims for payment by Medicare, Tenncare and Tricare, or knowingly made and used, and caused to be made and used, throughout the relevant months, false records and false statements in order to get false and fraudulent claims paid or approved by Medicare and Tricare, in violation of 31 U.S.C. § 3729(a)(2), as amended.

54. The false claims for payment presented or caused to be presented by Defendants include all office consultation (or "E & M" codes beginning with "992")

resulting from the Defendants' use of a "Modifier 25" code within thirty days of an earlier such office consultation charge for consultation with the same patient.

55. By virtue of the false statements and records used by the Defendants, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented since January 24, 2001, and other monetary relief as appropriate.

COUNT V

Claim By and on Behalf of the United States under the False Claims Act Relating to Claims for Cosmetic Services (Presenting False Claims)

56. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

57. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

58. By virtue of the acts described above, and in particular with respect to Paragraphs 31 through 36, with respect to the Defendants' pattern of charging Medicare, Tenncare and Tricare for services concerning material removed only for cosmetic reasons, Defendants knowingly presented false or fraudulent claims for payment by Medicare, Tenncare and Tricare, or knowingly caused false or fraudulent claims for payment to be

presented, to officials of the United States Government in violation of 31 U.S.C. § 3729(a)(1), as amended.

59. The false claims for payment presented or caused to be presented by Defendants include all claims submitted by Defendants since January 24, 2001 for which the diagnosis code utilized by the Defendants revealed a cosmetic condition, including but not limited to code "702.19" (for non-inflamed Seborrheic Keratosis) and "216 (or 216 followed by a digit and a supplementary number, for benign neoplasm or benign lesion).

60. By virtue of the false claims presented or caused to be presented by Defendants since January 24, 2001, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT VI

Claim By and on Behalf of the United States under the False Claims Act Relating to Claims for Cosmetic Services Using False Statements or Records)

61. This is a claim under the False Claims Act, 31 U.S.C. §§ 3729-33, as amended.

62. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

63. By virtue of the acts described above, and in particular with respect to Paragraphs 31 through 36, describing the Defendants' pattern of charging Medicare,

Tenncare and Tricare for services regarding conditions diagnosed by the Defendants themselves as cosmetic-related, Defendants knowingly made and used, and caused to be made and used, false records and false statements in order to get false and fraudulent claims paid or approved by Medicare, Tenncare and Tricare, in violation of 31 U.S.C. § 3729(a)(2), as amended.

64. The false claims for payment presented or caused to be presented by Defendants with the use of false certifications of medical necessity and medical indications include all claims submitted by Defendants since January 24, 2001 for which the diagnosis code utilized by the Defendants revealed a cosmetic condition, including but not limited to code "702.19" (for non-inflamed Seborrheic Keratosis) and "216 (or 216 followed by a digit and a supplementary number, for benign neoplasm or benign lesion).

65. By virtue of the false statements and records used by the Defendants, the United States has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT VII

Claim By and on Behalf of Tennessee under the Tennessee FCA Relating to Laboratory Charges from the Defendants' "Test-Everything Laboratory Referral Practice" (Presenting False Claims)

66. This is a claim under the Tennessee False Claims Act, Tennessee Code §§ 71-5-181 through 71-5-185d, as amended.

67. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

68. By virtue of the acts described above, and in particular with respect to Paragraphs 14 through 23 with respect to the Defendants' "test-everything laboratory referral practice," Defendants knowingly presented false or fraudulent claims for payment by Tenncare, or knowingly caused false or fraudulent claims for payment to be presented, to officials of the United States Government in violation of Tennessee Code § 71-5-182(a).

69. The false claims for payment presented or caused to be presented by Defendants include all claims submitted by Defendants to Tenncare since January 24, 2001, for pathology or laboratory services not medically necessary because they were known by Defendant Bell to be of material that had not been the subject of a medically necessary biopsy, had been removed for cosmetic purposes, and/or had been diagnoses as benign.

70. By virtue of the false claims presented or caused to be presented by Defendants, Tennessee has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented,

and other monetary relief as appropriate.

COUNT VIII

Claim By and on Behalf of Tennessee under the Tennessee FCA Relating to Laboratory Charges from the Defendants' "Test-Everything" Laboratory Referral Practice" (Using False Statements or Records)

71. This is a claim under the Tennessee False Claims Act, Tennessee Code §§ 71-5-181 through 71-5-185d, as amended.

72. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

73. By virtue of the acts described above, and in particular with respect to Paragraphs 14 through 23, with respect to the Defendants' "test-everything laboratory referral practice" Defendants knowingly made and used, and caused to be made and used, false records and false statements in order to get false and fraudulent claims paid or approved by Tenncare, in violation of Tennessee Code § 71-5-182(b).

74. The false claims for payment presented or caused to be presented by Defendants include all claims submitted by Defendants to Tenncare since January 24, 2001, for pathology or laboratory services not medically necessary because they were known by Defendant Bell to be of skin material that had not been the subject of a medically necessary biopsy, had been removed for cosmetic purposes, and/or had been diagnoses as benign.

75. By virtue of the false statements and records used by the Defendants,

Tennessee has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT IX

Claim By and on Behalf of Tennessee under the Tennessee FCA Relating to False "Modifier -25" Duplicate Charges for Office Consultations (Presenting False Claims)

76. This is a claim under the Tennessee False Claims Act, Tennessee Code §§ 71-5-181 through 71-5-185d, as amended.

77. Plaintiff realleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

78. By virtue of the acts described above, and in particular with respect to Paragraphs 24 through 30, regarding the Defendants' pattern of multiple charges for patient consultations through "Modifier 25" charges, the Defendants knowingly presented false or fraudulent claims for payment by Tenncare, or knowingly caused false or fraudulent claims for payment to be presented, to officials of Tennessee in violation of Tennessee Code § 71-5-182(c).

79. The false claims for payment presented or caused to be presented by Defendants include all claims submitted by Defendants during the relevant months for office consultations (or "E & M" codes beginning with "992") resulting from the

Defendants' use of a "modifier 25" code within thirty days of an earlier such office consultation charge for consultation with the same patient.

80. By virtue of the false claims presented or caused to be presented by Defendants, Tennessee has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT X

Claim By and on Behalf of Tennessee under the Tennessee FCA (Using False Statements or Records)

81. This is a claim under the Tennessee False Claims Act, Tennessee Code §§ 71-5-181 through 71-5-185d, as amended.

82. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

83. By virtue of the acts described above, and in particular with respect to Paragraphs 24 through 30, with respect to the Defendants' pattern of multiple charges for patient consultations through "Modifier 25" charges, the Defendants knowingly made and used, and caused to be made and used, false records and false statements in order to get false and fraudulent claims paid or approved by Tenncare, in violation of Tennessee Code § 71-5-182(b).

84. The false claims for payment made with use by the Defendants of the knowingly false certifications of "medically indicated" and "medically necessary" include

all office consultation (or "E & M codes beginning with "922") resulting from the Defendants' use of a "Modifier 25" code within thirty days of an earlier such office consultation charge for consultation with the same patient.

85. By virtue of the false statements and records used by the Defendants, Tennessee has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XI
Claim By and on Behalf of the United States under the False Claims Act Relating to Claims for Cosmetic Services
(Presenting False Claims)

86. This is a claim under the Tennessee False Claims Act, Tennessee Code Sections 71-5-181 through 71-5-185d, as amended.

87. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

88. By virtue of the acts described above, and in particular with respect to Paragraphs 31 through 36, with respect to the Defendants' pattern of charging Tenncare for services concerning material removed only for cosmetic reasons, Defendants knowingly presented false or fraudulent claims for payment by Tenncare, or knowingly caused false or fraudulent claims for payment to be presented, to officials of Tennessee, in violation of Tennessee Code Section 71-5-182(a).

89. The false claims for payment presented or caused to be presented by Defendants include all claims submitted to Tenncare by Defendants since January 24, 2001 for which the diagnosis code utilized by the Defendants revealed a cosmetic condition, including but not limited to code "702.19" (for non-inflamed Seborrheic Keratosis) and "216 (or 216 followed by a digit and a supplementary number, for benign neoplasm or benign lesion).

90. By virtue of the false claims presented or caused to be presented by Defendants since January 24, 2001, Tennessee has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

COUNT XII

Claim By and on Behalf of the United States under the False Claims Act Relating to Claims for Cosmetic Services (Using False Statements or Records)

91. This is a claim under the Tennessee False Claims Act, Sections 71-5-181 through 71-5-185d, as amended.

92. Plaintiff re-alleges and incorporates by reference paragraphs 1 through 36 as though fully set forth herein.

93. By virtue of the acts described above, and in particular with respect to Paragraphs 31 through 36, describing the Defendants' pattern of charging Tenncare for services regarding conditions diagnosed by the Defendants themselves as cosmetic-related,

Defendants knowingly made and used, and caused to be made and used, false records and false statements in order to get false and fraudulent claims paid or approved by Tenncare, in violation of 31 U.S.C. § 3729(a)(2), as amended.

94. The false claims for payment presented or caused to be presented by Defendants with the use of false certifications of medical necessity and medical indications include all claims submitted by Defendants to Tenncare since January 24, 2001 for which the diagnosis code utilized by the Defendants revealed a cosmetic condition, including but not limited to code “702.19" (for non-inflamed Seborrheic Keratosis) and “216 (or 216 followed by a digit and a supplementary number, for benign neoplasm or benign lesion).

95. By virtue of the false statements and records used by the Defendants, Tennessee has suffered actual damages and is entitled to recover three times the amount by which it is damaged, plus civil money penalties of not less than $5,500 and not more than $11,000 for each of the false claims presented or caused to be presented, and other monetary relief as appropriate.

PRAYER FOR RELIEF

WHEREFORE, the United States demands and prays that judgment be entered in favor of the United States:

1. On Counts I - VI, under the Federal False Claims Act, against Defendants for treble the amount of the United States' actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record;

2. For all costs of this civil action; and

3. For such other and further relief as the Court deems just and equitable.

WHEREFORE, the State of Tennessee demands and prays that judgment be entered in favor of the State of Tennessee:

1. On Counts VI - XII, under the Tennessee Medicaid False Claims Act, against Defendants for treble the amount of Tennessee's (or Tenncare's) actual damages (including investigative costs), plus civil penalties as are allowable by law for each false claim or record;

2. For all costs of this civil action; and

3. For such other and further relief as the Court deems just and equitable.

WHEREFORE, Relator Darla Lane demands and prays that judgment be entered in her favor:

1. On Counts I - VI, under the Federal False Claims Act, for a percentage of all civil penalties and damages obtained from Defendants pursuant to 31 U.S.C. § 3730, reasonable attorneys' fees, and all costs incurred against Defendants;

2. On Counts VI-XII, under the Tennessee Medicaid FCA, for a percentage of all civil penalties and damages obtained from Defendants on behalf of Tennessee, pursuant to Tennessee Code § 71-5-183, reasonable attorneys' fees, and all costs incurred against Defendants; and

3. Such other relief as the Court deems just and proper.

Respectfully submitted,

DARLA LANE, RELATOR

By her attorneys,
PIGOTT REEVES JOHNSON, P.A.

/s/ Brad Pigott
Brad Pigott (MS Bar No. 4350)

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CERTIFICATE OF SERVICE

I, Brad Pigott, certify that the foregoing Second Amended Complaint was served this day, via ECF and U.S. mail, postage prepaid, on the following:

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This, the 22nd day of July, 2011.

/s/ Brad Pigott
Brad Pigott