MSO
WASHINGTON, INC

February 12, 2014

U.S. Department of Justice
Office of the Inspector General
Investigations Division
950 Pennsylvania Avenue, N.W.
Room 4706
Washington, DC 20530

I recently learned that lying to a Federal agent is a felony. I am reporting a crime.

This case started with a disgruntled key employee who left my business in 2005. Bruce Brandler is the individual who perpetrated the crime of lying to a Federal Agent(s) under Title 18, Section 1001 of the U.S.C. by providing false information. The information provided seemed credible to the agents resulting in Brandler and his attorney filing a Qui tam complaint (whistleblower) suit in Federal Court on August 3, 2006.

Background:

In November 1988 I concluded my military career of 20 years and returned to the Puget Sound area. As Medical Service Corps Officer in the Air Force I was assigned as the logistics officer, financial controller, squadron commander and hospital administrator. In addition, I had a three year special duty assignment in Seattle, Washington as a Medical Recruiter for the Air Force.

Upon retiring from the military I took a position with an established executive recruiting firm who had an interest in physician recruiting. As the recruiting executive, I developed a number of relationships with local area hospitals and hospital systems outside the area. One of the clients was Puget Sound Hospital in Tacoma, Washington, whose CEO was Bruce Brandler.

I left the executive recruiting firm in 1993 and started a physician practice management company doing business as MSO Washington, Inc. which remains in business to this day. During this time my firm has managed primary care physicians and specialists in OB/GYN, maternal fetal medicine, pediatrics and dermatology. Other medical providers have included physical therapists.

In late 1998 the company embarked on a new practice model providing primary care services in adult family homes, assisted living facilities and memory care units. The name of this was The Home Doctor which soon spread in popularity and within a few years was servicing over 400 homes in the four county area. In 1998 Brandler, the client mentioned before, was terminated as the CEO, at that time the hospital being owned by the Tenet Corporation. Brandler approached me having interest in staying in the local area knowing that there were no hospital CEO positions in the Seattle/Tacoma area. I explained to Brandler that this is a small company and we could not match the salary that he was accustomed to and he was agreeable to take a reduced salary. Brandler expressed a particular interest in The Home Doctor operation and asked to be put in charge of that, which I agreed to. Brandler did an excellent job of helping me recruit physicians and other medical professionals as well as building the business. He brought to my attention the need to have a more formal Medicare/Medicaid compliance program. His background, particularly during his time with Tenet Corporation, prepared him to be the Compliance Officer and he took that position. See Attachment "A", which was the first version of the Medical Compliance Program.

Brandler did an exceptionally good job of keeping up with all of the compliance issues, reviewing medical records for compliance and in particular regarding the level of service being billed for both Medicare and Medicaid and taking appropriate actions with the one or two providers that needed attention to their medical records documentation. It is important to note that Brandler's concern over compliance was first for his own self-interest. This is highlighted in the correspondence with attorney Chris Marsh.

The following attachments are a representative paper trail produced by Brandler.

Attachment B: Memo to Dr. Rynes directing chart reviews for coding and charting.
Attachment C: Memo to Dr. Adams regarding concerns over his coding levels.
Attachment D: Memo to all providers regarding Level 5 coding and ongoing monitoring.
Attachment E: Brandler's response to records audit.
Attachment F: Brandler's memo to all provider focusing on "reasonable and necessary" visits.
Attachment G: Brandler's memo regarding meeting with attorney Chris Marsh.
Attachment H: Undated letter from attorney Chris Marsh regarding issues discussed in meeting.
Attachment I: Additional Brandler memo on Dr. Adams' coding.
Attachment J: List of Brandler HIPAA accomplishments.
Attachment K: Brandler memo to Lisa directing another record audit.
Attachment L: Brandler directing a billing audit.
Attachment M: Brandler directing a records audit at Adult Medicine Associates
Attachment N: Brandler memo to Dr. Shetty on records audit.
Attachment O: Brandler memo to Dr. Spalek on records audit.
Attachment P: Brandler memo to Dr. Gaines on records audit.
Attachment Q: Brandler memo to Phiroce Ishaque, ARNP on records audit.
Attachment R: Brandler memo to Georgia Mohler, ARNP on records audit.
Attachment S: Brandler memo to Dr. Tom Smith on records audit.

Attachment T: Brandler memo to all providers on documentation requirements.
Attachment U: Brandler memo to Dr. Coe from records audit.

There was also concern regarding what was called the Place of Service (POS) which dictated how the individual visit was billed, i.e., the specific CPT codes. He wisely contacted Noridian, the financial intermediary for Medicare in Washington and obtained a Freedom of Information Act request which served as the letter of determination giving The Home Doctor guidance on how to properly bill for these visits. See Attachment "V".

As time went on, Brandler stated on several occasions that he wanted to become a partner in the business. I was open to the idea and made him an offer based upon my financial investment and the fair market value of the current business operation. Brandler countered with an offer of approximately one tenth of my offer. He reasoned that his "sweat equity" more than justified him paying such a small amount. I explained that that was not within financial reality and that he could continue on as an employee. Apparently this affected Brandler more than I had understood at the time and his production went down dramatically. It came to a point that I gave him notice and Brandler departed in October 2005.

Shortly thereafter, I received a letter from his attorney (see Attachment "W") demanding a financial settlement based upon profits. I e-mailed the attorney back explaining that there were no net profits during the entire time that Brandler was on my payroll, further that there would be no money coming or due him. Subsequent to that, Brandler and his attorney filed a qui tam lawsuit in Federal Court on August 3, 2006 (see Attachment "X") in which he alleges that I and twenty three medical providers were guilty of inappropriate billing, providing medically unnecessary services and more.

Further documentation substantiating Brandler's attention to detail regarding compliance is found in Attachment "Y". Not long before departing MSO he conducted an extensive compliance training program for MSO staff and Home Doctor physicians and nurse practitioners.

The most telling of all documentation preserved is an email from Brandler to Dr. Smith (Attachment "Z") where Brandler states "It does not matter what Medicare knows, since we have nothing to hide, as you know, I am a conservative person who likes to do things "by the book"". Yet Brandler alleges just the opposite in the qui tam complaint.

We were unaware of any filing since the qui tam is filed under seal with the Federal Government for an initial period of time where the government looks at each case, determines whether or not they wish to pursue it and in this case they did intervene. We were presented with subpoenas dated the 5th day of May 2008 requesting a substantial amount of information which was provided to them in the time dictated by the subpoena. I met in about a week later with the U.S. Attorney and my attorney for compliance and another counsel suggested by him who focused on defending qui tam suits.

Conclusion:

Brandler was a good employee who did an exemplary job in his compliance role. His dismissal was a business decision based on other performance issues and economic reality. Brandler was not fired, but his position had to be eliminated. He was told that I was available as a reference.

The qui tam filing is contradictory to the extensive compliance paper trail left by Brandler. During his entire employment with MSO, Brandler consistently focused on insuring that things were done correctly. As he states in the e-mail (Attachment Z) responding to Dr. Tim Smith: *"It does not matter what Medicare knows, since we have nothing to hide, as you know, I am a conservative person who likes to do things "by the book""*. It defies logic that Brandler would have stayed employed had MSO been involved in the activities he claims on page 4 of the qui tam complaint. Further, if Brandler knew of such activities he claims "from his personal observation of the events . ." he had a duty to notify me and the other co-defendants. If Brandler had made these notifications without any response, he had a duty to report the alleged wrongdoings to CMS or file the qui tam while still employed. The attachments show that just the opposite was true, i.e., from seeking legal advice from attorney Chris Marsh, conducting medical records audits for medical necessity, documentation and coding levels. Brandler took prompt corrective action when deficits were found, as in the case of Charles Adams, MD. to resolve the matter. The attached documentation includes numerous annotations that show inconsistences with the qui tam filing.

Brandler and Martin state in para 40 of the qui tam that *"Despite plaintiff's best efforts, medical record documentation for Medicare and Medicaid reimbursements by defendants was woefully and intentionally deficient. As demonstrated above, plaintiff made defendants acutely aware of those deficiencies."* This allegation conflicts with letter and memos sent over several years. To wit, Attachment N to Dr. Shetty stating that Tim (Dr. Smith) was impressed with her efforts adding that she needed "to do a little more documentation to support what you are doing". This is not woefully deficient documentation as alleged.

Brandler and Martin allege in Paragraph 54 wrongdoing in using Place of Service (POS) 12 for billing rather than Places of Service 13 (which did not exist at the time), 14, 32 or 33. Brandler requested and obtained a Freedom of Information Act (FOIA) opinion from Noridian (Medicare) regarding place of service and mentioned above. The answer from John Noel (Attachment V) was "In all of these instances, place of service "12" would be appropriate." I am confident that Brandler had not forgotten this opinion letter yet he and attorney Martin allege misconduct.

In my opinion, Brandler's attorney Warren Martin is equally culpable in this crime. It is certainly suspicious that Martin filed the qui tam after his letter (Attachment W) failed to produce any money for Brandler. On page 2, Martin writes "If I have not heard from you or your attorney by then, I will conclude you are denying him access to these financial records and will proceed with legal process accordingly." In fact, I offered Martin and Brandler access to the records.

Attorney Martin should have proceeded with his legal process in state court but Martin likely knew Brandler had no standing. I now interpret Martin's letter as a threat of extortion.

During the extensive investigation, Brandler and/or Martin told one or more of the investigators that I had extensive funds in European banks. It is my understanding that one or both of the agents spent considerable time investigating the matter. This was another Section 1001 violation and a further waste of Federal agent's time.

This matter was settled in mediation for business expediency. There was never any wrongdoing on my part or by any of the physicians and other medical providers managed by MSO Washington.

This matter needs attention. Disgorgement of all funds received by Brandler and Martin is appropriate and both need to be held accountable for their actions. It is time the truth be known about Brandler and Martin's actions.

I trust that DOJ will pursue this matter with the same enthusiasm as demonstrated in my qui tam investigation. This letter is not, in any manner, critical of DOJ or the local office. My dealings with the U.S. Attorney were always professional.

Please contact me for any help in this matter. The attachments mentioned above will be sent to the address on your web site.

Sincerely,

Charles Plunkett

Supporting documentation regarding Bruce Brandler

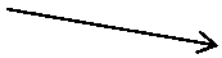
Attachment A

Attention:
There are notations on many of the following attachments.

MSO COMPLIANCE PROGRAM

ADOPTED FEBRUARY 26, 2001

MSO Washington, Inc.
4901 108th St. SW
P.O. Box 98886
Tacoma, Wash 98498-0886



Bruce Brandler
Compliance Officer

MSO COMPLIANCE PROGRAM

I. STATEMENT Of POLICY ON ETHICAL PRACTICES (Policy)

MSO Washington (MSO) has a policy of maintaining the highest level of professional and ethical standards in the conduct of its business. MSO places the highest importance on its reputation for honesty, integrity, and high ethical standards. This Policy is a reaffirmation of the importance of the highest level of ethical conduct and standards.

These standards can be achieved and sustained only through the actions and conduct of all personnel of the company and the providers. Each and every employee, and provider, including management employees, of the company is obligated to conduct himself/herself in a manner to ensure the maintenance of these standards. Such actions and conduct will be important factors in evaluating an employee's judgment and competence, and an important element in the evaluation of an employee for raises and for promotion. Employees and providers who ignore or disregard the principles of this Policy will be subject to appropriate disciplinary actions.

Although MSO Washington is not a billing company that performs coding nor provides documentation for clinical visits (which is up to the provider) each employee who is materially involved in processing coding and billing has an obligation to familiarize himself or herself with applicable laws and regulations and to adhere at all times to the requirements thereof. Where any question or uncertainty regarding these requirements exists, it is incumbent on, and the obligation of, each employee to seek guidance from a knowledgeable officer of, or attorney for, the company.

In particular, and without limitation, this Policy prohibits each provider from directly or indirectly engaging or participating in any of the following:

1. Improper Claims

Presenting or causing to be presented to the U.S. government or any' other healthcare payor a claim:

a. ***Item or Service Not Provided as Claimed***
For a medical or other item or service that such person knows or should know' was not provided as claimed, including a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that such person knows or should know will result in a greater payment to the claimant than the code such person knows or should know is applicable to the item or service actually provided;

b. ***False Claim***
For a medical or other item or service and such person knows or should know the claim is false or fraudulent;

c. ***Service by Unlicensed Physician or Unlicensed Nurse Practitioner***
For a physician or nurse practitioner's service (or an item or service incident to their service) when such person knows or should know the individual who furnished (or supervised the furnishing of) the service:

i. was not a licensed physician or nurse practitioner;

ii. was licensed as a physician or nurse practitioner, but such license had been obtained through a misrepresentation of material fact (including cheating on an examination required for licensing); or

iii. represented to the patient at the time the service was furnished that the physician or nurse practitioner was certified in a medical specialty by a medical specialty board when the individual was not so certified;

d. *Excluded Provider*
For a medical or other item or service furnished during a period in which such person knows or should know the claimant was excluded from the program under which the claim was made;

e. *Not Medically Necessary*
For a pattern of medical or other items or services that such person knows or should know are not medically necessary;

2. False Statement in Determining Rights to Benefits
Making, using, or causing to be made or used any false record, statement, or representation of a material fact for use in determining rights to any benefit or payment under any healthcare program;

3. *Conspiracy to Defraud*
Conspiring to defraud the U.S. government or any other healthcare payor by getting a false claim allowed or paid;

4. *Provision of Care to Contract HMO Patients*
Knowingly failing to provide covered services or necessary care to members of a health maintenance organization with which the company has a contract;

5. Healthcare Fraud/False Statements Relating to Healthcare Matters
Executing or attempting to execute a scheme or artifice to defraud any healthcare benefit program or to obtain, by means of false, fictitious, or fraudulent pretenses, representations or promises, any of the money or property owned by, or under the custody or control of, any healthcare benefit program;

6. Anti-Referral

Presenting or causing to be presented a claim for reimbursement to any individual, third-party payor, or other entity for designated health services' that were furnished pursuant to a referral by a physician who has a financial relationship with the company, as such is defined in 42 U.S.C. § 1395nn;

7. Anti-Kickback

Except as otherwise provided in 42 U.S.C. § 1320a-7b(b), knowingly and willfully:
a. soliciting or receiving any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind either:

i. in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal healthcare program; or

ii. in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facil-
ity, service, or item for which payment may be made in whole or in part under a federal healthcare program; or

b. offering or paying any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person either:

i. to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal healthcare program; or

ii. to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a federal healthcare program;

8. **Antitrust**

Engaging in any activity, including without limitation being a member of a multiprovider network or other joint venture or affiliation that is in restraint of trade or that monopolizes, or attempts to monopolize, any part of interstate trade or commerce; or

9. **Failure to Report Violations to Compliance Coordinator**

Failing to promptly report to the Compliance Coordinator (as defined below) any instance of noncompliant conduct, including without limitation violations of the standards with respect to the company or any of its employees which is known to such person is subject to discipline.

II. APPOINTMENT OF COMPLIANCE COORDINATOR

A. Compliance Coordinator

In an effort to ensure compliance with this Policy, the company President and owner, Charles Plunkett, is adopting a formal Compliance Program. This program has been reviewed by, and approved by the Medical Director (Richard I. Rynes, M.D.) of MSO's significant service called the Home Doctor. To oversee and implement this program, the owner has appointed its employee, Bruce Brandler, CEO, as its Compliance Coordinator. The company has chosen its Compliance Coordinator based on his or her outstanding record of commitment to honesty, integrity, and high ethical standards, and on the officer's knowledge and understanding of the applicable laws and regulations. The Compliance Coordinator will provide for education and training programs for employees, respond to inquiries from any employee regarding appropriate billing and documentation, and investigate any allegations of possible impropriety.

B. Duties and Responsibilities of the Compliance Coordinator

The duties and responsibilities of the Compliance Coordinator shall include, but are not limited to, the following:

1. working with President, Controller, and general counsel in the preparation and development of, and overseeing the implementation of, written guidelines on specific federal and state legal and regulatory issues and matters involving ethical and legal business practices, including, without limitation, documentation, coding, and billing practices with respect to requests for payments and/or reimbursements from Medicare or any other federally

funded healthcare program, the giving and receiving of remuneration to induce referrals and engagement in certain business affiliations or pricing arrangements that may affect competition;

2. developing and implementing an educational training program for company personnel to ensure understanding of federal and state laws and regulations involving ethical and legal business practices, and providing education to providers including information about billing practices with respect to requests for payments and/or reimbursements from Medicare or any other federally funded healthcare program, the giving and receiving of remuneration to induce referrals and engagement in certain business affiliations or pricing arrangements that may affect competition;

3. handling inquiries by employees regarding any aspect of compliance;

4. investigating any information or allegation concerning possible unethical or improper business practices and recommending corrective action when necessary;

5. providing guidance and interpretation to the President, Controller, and company personnel, in conjunction with the company's legal counsel, on matters related to the Compliance Program;

6. planning and overseeing regular, periodic audits of the company's operations to identify and rectify any possible barriers to the efficacy of the Compliance Program;

7. developing policies and programs that encourage managers and employees to report suspected fraud and other improprieties without fear of retaliation;

8. preparing at least annually a report to the President concerning the compliance activities and actions undertaken during the preceding year, the proposed compliance program for the next year, and any recommendations for changes in the Compliance Program;

9. performing such other duties and responsibilities as the President may request.

C. *Compliance Committees*

The Compliance Coordinator may create one or more committees to advise the Compliance Coordinator and assist in the implementation of the Compliance Program. Each committee may have one or more members, who may be company employees, independent contractors, or other interested parties, and such members shall serve at the pleasure of the Compliance Coordinator. The purpose of providing for such committees is to allow the company and the Compliance Coordinator to benefit from the combined perspectives of individuals with varying responsibilities in the company such as, by way of example only and not obligation, operations, finance, audit, human resources, utilization review, social work, discharge planning, medicine, coding, and legal, as well as employees and managers of key operating units.

D. *Reporting by Compliance Coordinator*

In general, recommendations from the Compliance Coordinator regarding compliance matters will be directed to the appropriate officer or manager of the company. If the Compliance Coordinator is not satisfied with the action taken in response to his or her recommendations, he or she will report such concern to the President. In no case will the company endeavor to conceal company or individual wrongdoing.

E. *Establishment of a Hotline*

The Compliance Coordinator shall have an open-door policy with respect to receiving reports of violations, or suspected violations, of the law or of the Policy and with respect to answering employee questions concerning adherence to the law and to the Policy. In addition, the company shall establish a hotline to the Compliance Coordinator for such reporting or questions. **The telephone number for the hotline is 253-984-7247 ext. 13.**

Telephone calls to the hotline may come from company employees, patients of the company or others, whether or not affiliated with the company. All information reported to the hotline by any employee in accordance with the Compliance Program shall be kept confidential by the company to the extent that confidentiality is possible throughout any resulting investigation; however, there may be a point at which an employee's identity may become known or may have to be revealed in certain instances when governmental authorities become involved. Under no circumstances shall the reporting of any such information or possible impropriety serve as a basis for any retaliatory actions to be taken against any employee, patient, or other person making the report to the Compliance Coordinator or the hotline. The telephone number for the hotline, along with a copy of the Compliance Program, shall be posted in conspicuous locations throughout the company.

III. EDUCATIONAL PROGRAM

A. *Purpose of Educational Program*

The Compliance Program promotes the company's policy of adherence to the highest level of professional and ethical standards, as well as all applicable laws and regulations. The company will make available appropriate educational and training programs and resources to ensure that all employees are thoroughly familiar with those areas of law that apply to and affect the conduct of their respective duties.

B. *Responsibility for Educational Program*

The Compliance Coordinator, in conjunction with the company's legal counsel, is responsible for implementation of the educational program. The program is intended to provide each employee of the company with an appropriate level of information and instruction regarding ethical and legal standards. Education and training of all employees shall be conducted at least annually. The determination of the level of education needed by particular employees or classes of employees will be made by the Compliance Coordinator. Each educational program presented by the company shall allow for a question and answer period at the end of such program. The providers will receive education at their medical staff meetings.

C. *Subject Matter of Educational Program*

The educational program shall explain the applicability of pertinent laws, including, without limitation, applicable provisions of the False Claims Act (31 U.S.C. § 3729), the civil and criminal provisions of the Social Security Act (42 U.S.C. § 1320a-7a and § 1320a-7b, respectively), the patient antidumping statute (42 U.S.C. § 1395dd), laws pertaining to the provision of medically necessary items and services that are required to be provided to members of an HMO with whom the company contracts (42 U.S.C. § 1320a-7(b)(6)(D)), criminal offenses concerning false statements relating to healthcare matters (18 U.S.C. § 1035), the criminal offense of healthcare fraud (18 U.S.C. § 1347), the federal anti-referral laws (42 U.S.C. § 1395nn), the anti-kickback laws

(42 U.S.C. § 1320a-7b(b)), and the Sherman Antitrust Act (15 U.S.C. §§ 1, 2 and 18). As additional legal issues and matters are identified by the Compliance Coordinator, those areas will be included in the educational program. Each education and/or training program conducted hereunder shall reinforce that strict compliance with the law and with the company's Policy is a condition of employment with the company.

D. Training Methods

Brandler

Different methods may be used to communicate information about applicable laws and regulations to company employees, as determined by the Compliance Coordinator. The company may conduct training sessions regarding compliance, which may be mandatory for selected employees. The seminars will be conducted by the Compliance Coordinator, legal counsel for the company, or, where appropriate, by company managers or consultants. The Compliance Coordinator may require that certain employees or representatives of the company attend, at the company's expense, publicly available seminars covering particular areas of law. The company's orientation for new employees will include discussions of the Compliance Program and an employee's obligation to maintain the highest level of ethical and legal conduct and standards.

While the company will make every effort to provide appropriate compliance information to all employees, and to respond to all inquiries, no educational and training program, however comprehensive, can anticipate every situation that may present compliance issues. Responsibility for compliance with this Compliance Program, including the duty to seek guidance when in doubt, rests with each employee and provider of the company.

IV. EMPLOYEE OBLIGATIONS

The Compliance Program imposes several obligations on company employees, all of which will be enforced by the standard disciplinary measures available to the company as an employer. Adherence to the Compliance Program will be considered in personnel evaluations.

A. Employee Obligations

1. ***Reporting Obligation.*** Employees must immediately report to the Compliance Coordinator any suspected or actual violations (whether or not based on personal knowledge) of applicable law or regulations. Any employee making a report may do so anonymously if he or she so chooses. Once an employee has made a report, the employee has a continuing obligation to update the report as new information comes into his or her possession. All information reported to the Compliance Coordinator by any employee in accordance with the Compliance Program shall be kept confidential by the company to the extent that confidentiality is possible throughout any resulting investigation; however, there may be a point where an employee's identity may become known or may have to be revealed in certain instances when governmental authorities become involved. Under no circumstances shall the reporting of any such information or possible impropriety serve as a basis for any retaliatory actions to be taken against any employee making the report.

2. ***Acknowledgment Statement.*** Each employee must complete and sign from time to time an Acknowledgment Statement to the effect that the employee fully understands the Compliance Program, and acknowledges his or her commitment to comply with the Program as an employee of the company. Each Acknowledgment Statement shall form a part of the personnel file of each employee. It shall be the responsibility of each manager to ensure that all employees under his or her supervision have executed such an acknowledgment.

B. Company Assessment of Employee Performance Under Compliance Program

1. ***Violation of Applicable Law or Regulation.*** If an employee violates any law or regulation in the course of his or her employment, the employee will be subject to sanctions by the company.

2. ***Other Violation of the Compliance Program.*** In addition to direct participation in an illegal act, employees will be subject to disciplinary actions by the company for failure to adhere to the principles and policies set forth in this Compliance Program. Examples of actions or omissions that will subject an employee to discipline on this basis include, but are not limited to, the following:

a. a breach of the company's Policy;

b. failure to report a suspected or actual violation of law or a breach of the Policy;

c. failure to make, or falsification of, any certification required under the Compliance Program;

d. lack of attention or diligence on the part of supervisory personnel that directly or indirectly leads to a violation of law; and/or

e. direct or indirect retaliation against an employee who reports a violation of the Compliance Program or a breach of the Policy.

3. ***Possible Sanctions.*** The possible sanctions include, but are not limited to, termination, suspension, demotion, reduction in pay, reprimand, and/or retraining. Employees who engage in intentional or reckless violation of law, regulation, or this Compliance Program will be subject to more severe sanctions than accidental transgressors. Providers' violations will be asked to correct them or leave the company.

C. Employee Evaluation

Employee participation in, and adherence to, the Compliance Program and related activities will be an element of each employee's annual personnel evaluations including, without limitation, annual personnel evaluations of company supervisors and managers. As such, it will affect decisions concerning compensation, promotion, and retention.

D. Nonemployment or Retention of Sanctioned Individuals

The company shall not knowingly employ any individual, or contract with any person or entity, who has been convicted of a criminal offense related to healthcare or who is listed by a federal agency as debarred, excluded, or otherwise ineligible for participation in federally funded healthcare programs. In addition, until resolution of such criminal charges or proposed debarment or exclusion, any individual who is charged with criminal offenses related to healthcare or proposed for exclusion or debarment shall be removed from direct responsibility for, or involvement in, documentation, coding, billing, or competitive practices. If resolution results in conviction, debarment, or exclusion of the individual, the company shall terminate its employment of such individual.

V. RESPONSE TO REPORTS OF VIOLATIONS

Physician Acknowledgment-Compliance

The undersigned physician (Physician) acknowledges that he or she has received and reviewed MSO's Compliance Program, including its Statement of Policy on Ethical Practices (Policy). Physician fully understands the company Policy and Compliance Program and is committed to comply with the company Policy and Compliance Program as long as Physician has an active agreement with the company. When Physician has a concern about a possible violation of company Policy, Physician will promptly report the concern to the Compliance Coordinator in accordance with the Compliance Program.

Physician acknowledges that the company may furnish to all physicians and their staff, from time to time, training in the federal requirements for determining, accurately documenting, and supporting the principal and secondary diagnoses and the major procedures performed on the patient, as attested by Physician in the medical record pursuant to 42 CFR § 412.46. Such training shall be furnished for one or more of the following purposes: (1) to promote compliance with the Physician's obligations under 42 C.F.R. § 412.46, (2) to promote compliance with company Policy pursuant to the Compliance Program, and/or (3) to satisfy the training standard imposed on the company under proposed 42 C.F.R. § 482.125(c) for the company's continued participation in the Medicare and Medicaid programs.

Physician and company each acknowledges that such training is not intended to, and will not, induce referrals from Physician to the company. To the extent that such training may be deemed to constitute remuneration or compensation under any applicable law or regulation, the benefit resulting from such training to the Physician is consistent with fair market value of the services rendered by the Physician in documenting and attesting to the medical records which support the company's billings. The term of this arrangement is at least one year and shall continue thereafter as long as Physician has an active agreement at the company.

Date_____ Physician's signature_____

Printed name of Physician_____

Acknowledgment-Compliance

The undersigned independent contractor, or employee of independent contractor, as the case may be, (Contractor) acknowledges that he or she has received and reviewed MSO's Compliance Program, including its Statement of Policy, on Ethical Practices (Policy).

Contractor fully understands the company Policy and Compliance Program and is committed to comply with the company Policy and Compliance Program as long as Contractor (or Contractor's employer, as the case may be) is engaged by the company. When Contractor has a concern about a possible violation of company Policy, Contractor will promptly report the concern to the Compliance Coordinator in accordance with the Compliance Program.

Date_____ Contractor's signature _____

Printed name of Contractor_____

Attachment B

Memorandum

To: Richard I. Rynes, M.D.

From: Bruce Brandler, CEO No: 1

Date: 2/20/2001

Re: Audit of Coding and Charting

I'm enclosing a selection of charts for you to audit and determine compliance with proper coding guidelines.

Please let me know if these charts, by random, are properly documented and support the level of code submitted.

Thanks for your review.

Attachment C

Memorandum

Note: Brandler's focused attention on correct coding.

To: Charles Adams, M.D.

CC: Charles Plunkett

From: Bruce Brandler

Date: 2/20/2001

Re: Coding

This memo is to document our previous conversations in which I have stated that I am not comfortable in how you code. Specifically, I have problems with how you lack justification and documentation for a level 4 or 5.

Since I am not a physician, I tried to understand your rationale for higher coding levels, however, based on the coding table that we reviewed, your records do not seem to support 4's and 5's, and that is why I have repeatedly addressed this subject with you.

Many of your Adult Family Home patients may indeed have numerous problems, but it is the **complexity** of your medical decision-making that is the subject of concern. You need to review outside records, involve other professionals, and perhaps have the patient admitted to a hospital or have major surgery to support a level 5, for example. If this is not required for your patient, and/or if it is absent from your record, then a 5 does not appear to be warranted—at least in my opinion.

You have the responsibility to support a higher code, whether a 4 or 5, and we will rely on you for this effort.

Thank you.

Attachment D

INTEROFFICE MEMORANDUM

To: All Home Doctor Practitioners

From: Bruce Brandler

Subject: Coding

Date: 2/20/2001

cc: Charles Plunkett

I have some concerns about the subject of coding, and to be on the safe side, I discussed this issue with Dr. Rynes. As a result of our conversation, we believe it would be appropriate to remove level 5 from the computer.

The reason for the above action is due to our concern of matching our patient population's complexity of care with the support needed to justify a 5 or another high coding level. Although we do treat sick and complex patients, coding rules must be strictly followed.

We will also monitor 3's and 4's in an effort to ensure that you are coding accurately.

Thanks for your support in this matter.

Attachment E

Note: This survey was conducted by a UHC employee (Holly Dutton, RN).

Contined focus on quality and compliance by Brandler.

Memorandum

To: Holly Dutton, RN

From: Bruce Brandler

Date: 2/20/2001

Re: Recent Site Visit/MSO Washington, Inc.

Thanks for the recent site visit, and thanks for your patience in teaching me this crazy business of ours.

As discussed, I am sending you several documents to substantiate our compliance with various assessment standards. If I have left anything out, please let me know—since I am sure that you will anyhow. Afterall, you did not achieve the pinnacle of the PCW corporate ladder without fine attention to detail!

As you saw during our meeting, we are light-years ahead of our past performance, however, we are obviously not yet where we want to be. To assist me, I will have Billie Beckman, RN as my key UM person, and she will need a learning curve as Chris had over this past year.

Please let me know if I can be of assistance.

Regards,

Bruce

HOME DOCTOR MEDICATION AUDIT
SELECTION OF PATIENTS FROM DR. ADAMS' LIST OF CLIENTS N=45

Purpose

Since the Home Doctor services many elderly patients, and those taking a diverse array of medications, it is vital that the physician have this information at their ready use in order to provide the best care possible. An accurate listing of medications helps to ensure proper dosages, it creates a greater alert to possible adverse drug interactions, and it adds to overall risk management. Additionally, it improves the Home Doctor communication with those in the field, and thus increases its customer service.

Objective

To determine the degree of alignment between the medication list of the physician provider and the medication list generated by the facility. That is, does the doctor have an accurate listing of meds in their chart, or by Atlas, as compared to the Medication Administration Record (MAR) held in the facility?

Method

Phone calls were placed to the facilities Dr. Adams services in order to have them fax their MAR. The facility was asked to send their current med record as part of a study being done on medications. This study, or audit, was designed to obtain data in two categories: one category was to determine how many patient records had MARs different than what we had; two, how many patient medication records did we have that was different than the MARs at the facility.

Results

There was a high degree of compliance from the facilities for their med record. A total of 45 med records were received in our office within a four-day period. On a few records, however, the facility erroneously sent the Atlas generated Summary of the Patient Visit, which does contain a med list, but since we already have that information, it was discarded.

There were 11 patient MARs (24%) that lacked medications listed in the Atlas med list. There were 18 patients (40%) who did not have medications in Atlas that was listed in their MAR.

HOME DOCTOR MEDICATION AUDIT
SELECTION OF PATIENTS FROM DR. ADAMS' LIST OF CLIENTS N=45 (Cont.)

Assessment

It was interesting to see that the facilities are very proactive in wanting to do a good job with their patients when it comes to medications. This was seen in both their quick responsiveness to this data, and from their comments on the phone. There were statements such as, "I am glad that you are doing this study." Another person said that "this was good information to know, and she would send out her MAR as soon as possible."

Medications are of critical importance, and the facilities are held accountable to proper dispensing and accurate medical records in this regard. They have many "watchdog" groups over them, such as State Licensing, and other parties see their records, such as outside providers, home health, etc. Hence, aside from their personal concern, issues such as licensing and sanctions are also at stake.

The Home Doctor is also very interested in quality healthcare delivery, and this is why this study was done. It was created to provide outstanding service, and strong communication with caregivers in the field.

The results of the study verified why the one of the Home Doctor providers had some concerns. It showed that the facilities are not capturing all the med requests from the doctor, and even more disturbing is that Atlas is not obtaining all the med data that the facility has on each patient. Neither 25% nor 40% is acceptable, and corrective actions will be taken.

Conclusion

The physicians will be asked to compare their medication information with the information in the MAR. Differences will be noted and corrections made. The facility will also be asked to change their records to reflect what the doctor has ordered.

Since revealing information was obtained from this study, other studies are being planned. One will be a study of Coumadin compliance, and the information will similarly be utilized and shared.

Attachment F

The Home Doctor®
4903-A 108th Street SW
P.O. Box 98886
Tacoma WA 98498-0886
Telephone 253-984-1098
Fax 253-984-1101

To: All Providers

From: Bruce Brandler, Compliance Officer

Subject: Documentation to Support Medical Necessity

Date: May 18, 2001

I thought it would be helpful to remind all the providers about Medicare's Medical Necessity Criteria to justify patient visits, and to support the need for scheduling of re-visits.

For medical services to be considered "reasonable and necessary," I have attached a few pages from our Medicare Manual. Please review this information.

Although the scheduling software in Atlas defaults automatically to a 5 week follow-up, many of you have stretched this to 8, 10, or 12 weeks, and that is appropriate, since you need to clinically justify each visit. There are also some patients who have no follow-up date, unless the facility faxes us the appointment schedule.

Overall, the key is documentation.

Charles will soon be addressing a means to document follow-up care in the Plan section of the medical record. He will be giving you specific guidance for documentation.

Thank you.

genuine financial hardship for a particular patient, they may be unlawfully inducing that patient to purchase items or services from them. If attempts to collect the coinsurance and/or deductible fail, the provider may write these charges off on a case-by-case basis where the beneficiary can prove financial hardship.

PAYMENT FLOOR

Under the Omnibus Reconciliation act of 1993 (OBRA), the Health Care Financing Administration (HCFA) imposed a payment floor for Medicare payments. For claims filed electronically, payment can be made as early as the 14th day after the date of receipt. Paper claims can be paid as early as the 27th day after the date of receipt.

INTEREST PAYMENTS

The Health Care Financing Administration requires Medicare to pay interest on claims submitted with complete information when not paid by the 30th day after the date of receipt.

Interest is not required on claims:

- requiring external investigation or development;
- for which no payment is due; or
- which are full denials.

The rate of interest is determined by the Treasury Department on a six-month basis. Medicare will calculate the interest rate using the following formula:

Interest payment = Reimbursement amount **x** rate **x** days **divided** by 365

Interest will not be paid on claims which are appealed if the original claim did not include interest. If a claim is partially denied, interest will be paid only on the reduced amount.

Interest on an adjusted claim will be recalculated based on the new reimbursement amount using the original claim's interest rate and elapsed days. The following formula will be applied to determine the amount of interest a provider is paid for an adjusted claim:

$$\text{Interest} = \frac{\text{Corrected reimbursement amount}}{\text{Original reimbursement amount}} \times \text{original interest paid}$$

REASONABLE AND NECESSARY

Section 1862 (a)(1)(A) of Medicare Law, written in 1963, states that Medicare will cover "services which are reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." The term, "reasonable and necessary" applies to the determination of whether a diagnosis or

treatment by a provider is considered appropriate or inappropriate, based on the medical community's perception and understanding of the diagnosis and/or treatment plan. Reasonable and necessary takes into account the medical condition, the patient, the doctor, the family, medical support services and a host of other things. There are, granted, certain gray areas where different physicians have differing views, but there are other areas where nearly all agree. It is these not-so-gray areas that Medicare is concerned about.

To be considered reasonable and necessary, items and services must be established as safe and effective. That is, the items and services must be:

- Consistent with the symptoms or diagnosis of the illness or injury under treatment.
- Necessary and consistent with generally accepted professional medical standards (i.e., not still experimental or investigational).
- Not furnished primarily for the convenience of the patient, the attending physician, or other physician or supplier.
- Furnished at the most appropriate level, which can be provided safely and effectively to the patient.

Medical necessity also includes the judgment of whether or not modalities of treatment are considered investigational and/or experimental. With rare exceptions, experimental or investigational procedures are not payable. Those procedures or treatment modalities that are considered to be outmoded or outside of accepted medical practice are not considered reasonable and necessary and, therefore, are not payable.

Documentation on both the claim form and in the office or hospital medical record should justify the services rendered as medically necessary. When the documentation on the claim form clearly reveals the necessity for the service, the service is considered a covered benefit. When the medical necessity is unclear, the claim may be delayed until further information can be obtained to clarify the need for services.

PREAUTHORIZATION

Under Medicare law, payment for services and supplies is based upon the reasonability and necessity of the services performed or supplied, and is determined on a case-by-case basis.

Each week, Medicare receives several referral forms and/or requests from providers for preauthorization of services. It is not necessary to send these forms to Medicare, as we are unable to preauthorize coverage of an anticipated service or supply.

If you are in doubt as to whether Medicare will cover a service or supply for a specific patient you should first check to see if there is anything printed on the subject in Medicare B News. You may also safeguard yourself by having the beneficiary sign a waiver of liability form prior to having the service performed. A waiver holds the beneficiary liable for the service should it be denied as not reasonable and necessary.

Attachment G

Memorandum

To: Personal File

From: Bruce Brandler

Date: 2/20/2001

Re: Meeting with Attorney

This is to document our meeting today with Chris Marsh.

I told Charles that I want to get a healthcare attorney to go over all the business arrangements he has with the Home Doctor and Secure Horizons. I told him that it is important, and that in order for me to continue, I have to have things done legally and appropriately. He agreed.

Although I am not an attorney, over these past months that I have been aboard, I have learned more about this business, and I therefore have strong concerns about how Charles has created projects, provided documentation, and structured arrangements. This included leases, medical directorship, and so forth.

As a result of my concerns, we went over the structure of the company; we discussed transactions, and we addressed referral and compensation patterns. I told Chris my concerns about these matters, and that he needs to see if we can reconfigure anything that may not be in accordance with either Safe Harbors, Medicare Statutes, False Claims Act, etc.

Chris took copies of various agreements, and he said that he would get back with us for possible solutions. I asked him if I should leave the company since I do not want to be associated with something that is wrong, but he said that I was new and not a part of creating the company and its operations, and therefore I should wait to see what he comes up with.

Note: Brandler was apparently satisfied that the company (MSO) was operating appropriately, he stayed on the payroll.

Attachment H

CHRISTOPHER MARSH
attorney at law

Note: undated letter relating to Attachment G. Chris Marsh is a well know Medicare/Medicaid compliance attorney.

Charles Plunkett
Bruce Brandler
MSO Washington, Inc.
4901 108th Street SW
Tacoma, WA 98498-0886

RE: Medicare Place of Service

Charles and Bruce:

I write once again regarding the rules on place of service and procedural billing codes related to home care and domiciliary care visits, particularly as they relate to residents in non-private residence, or institutional, living arrangements, such as boarding homes, adult family homes or group homes.

CMS has issued Publication 100-04, Transmittal 168 (copy attached) which replaces prior instructions. The Transmittal specifies that the Home Service codes, CPT 99341 through 99350, may be used to bill only for services provided to a patient in the patient's own private residence and "not in any type of facility."

The distinction, if any, between a "private residence" (that might be nonetheless in a facility) and a "private residence" that is "not any type of facility" still seems open. Though there is still no absolute certainty, for me at least, with respect to what exactly is a private residence, the rules coordinating CPT codes with place of service clearly contemplate that only certain CPT codes may be billed for services provided to any patient in any institutional facility which are generally considered as "custodial care facilities" (whether or not that facility could, as we have previously discussed and analyzed, be considered the patient's "home"), and that no Home Service codes can be billed for services provided to any patient in "any type of facility."

It may be time for another letter to CMS to clarify whether there are any instances where POS 12 ("home") can be in "any type of facility." However, I understand from Charles that as you enter into arrangements with payers such as Evercare who have contracted with Medicare, the MSO W managed physicians will be receiving reimbursement from the payer (on a capitated or FFS participating provider basis) and not billing Medicare directly, so that the billing issue becomes one for your payer as it directly bills Medicare or receives Medicare reimbursement. It may pay, though, to make sure the payer is billing correctly for physician home visits.

Let's discuss if you have any remaining questions on this issue.

Very truly yours

Christopher Marsh
encl CMS Pub. 100-04, Transmittal 168; HGSA Memo

2940 72nd Ave SE
Mercer Island, WA 98040
206.236.1131
206.624.2805
chrismarsh@attbi.com

Attachment I

Memorandum

To: Personal File

From: Bruce Brandler

Date: 2/20/2001

Re: Coding

Since Dr. Adams has been with the Home Doctor for a long time, and since he has said that he knows coding, I met with him today. He said that the Home Doctor sees a lot of 3s and 4s, but the doctors need to document more that they are seeing these higher levels.

He said that if you have to think about it, then you treated it . I went over the coding audit, and he looked at the 3 key areas of coding and said that 3s and 4s are warranted due to the complexity of the patient.

I explained that Home Doctor patients don't come to us as in the case of a doctor's office, but he said that due to that fact, and since they can't drive themselves, many of them have numerous problems. If they were more mobile and healthy, they likely would not opt for the Home Doctor.

I also showed him the clinical examples from the CPT book, and he further asserted that they do see many 3s and 4s.

Attachment J

Note: Brandler is highlighting all that "he" did to keep the company in compliance.

To: HIPAA File

From: Bruce Brandler

Date: 4/24/2003

Re: Actions Taken

To be in compliance with the HIPAA timelines, I have thus far achieved the following:

- Attended a HIPAA training course and sent our CIO to training.
- Created a comprehensive manual on HIPAA Documentation and Implementation.
- We distributed the notice of privacy and acknowledgment, and explained how they are to be used. These are now being given out to patients.
- HIPAA has been mentioned at various medical staff meetings, and this was first mentioned in July of 2001 when I became the Privacy Officer.
- I created Business Associate Agreements and sent them out.
- I questioned our CIO, Andrew, on the EDI and Security requirements and our software contractor is working on the new requirements.
- We have done audits utilizing questionnaires to determine where we are and what we need to do to improve greater privacy and confidentiality.
- We held training for providers and employees.
- We are using confidentiality statements for employees and non-employees.]

Your role in HIPAA

- Be alert and educated on HIPAA issues
- Report any possible violations and comment on any improvements needed
- Adhere to policies and procedures on HIPAA
- If uncertain, be proactive and ask questions and share concerns

Attachment K

The Home Doctor®

Phone: (253) 981-7247
FAX: (253) 588-8244
e-mail: jbj@mso-wa.com

Mailing Address: P.O. Box 98886
Tacoma, WA 98498-0886

To: Lisa

From: Bruce

Date: 1/15/2002

Re: Coding Audit

Dr. Rynes is going to once again perform an audit on coding. Therefore, please randomly pull two charts from each Home Doctor practitioner and give them to me next Monday.

Thanks.

cc: Dr. Rynes

Attachment L

MSO
WASHINGTON, INC

Note: Brander's continued attention to correct billing and coding.

An Integrated Healthcare Company

To: Wayne Nelson

From: Bruce Brandler

Subject: Chart/Billing Audit

Date: March 31, 2004

I would like to do another chart audit of the providers. Please have someone randomly select 4 bills from each provider in the company. This includes all doctors and nurse practitioners.

We need to do this audit as part of the requirements of a billing company, as well as our compliance plan. It also serves as good feedback to the provider.

Thanks for your help.

Adult Medicine Associates
The Home Doctor
Medical Billing
Documentation Management
Medical Legal Exams

4901 108th Street SW
Post Office Box 98886
Tacoma, WA 98498-0886
Tel: 253.984.7247
Fax: 253.588.8244
www.mso-wa.com

Attachment M

MSO
WASHINGTON, INC

An Integrated Healthcare Company

To: Compliance File

From: Bruce Brandler

Date: 7/27/2004

Re: Random Coding Check

I had some charts pulled from Adult Medicine Associates to spot check coding from physicians. It appeared that Dr. Caldwell had various 3's and 4's. Dr. Phillips had 3's and 4's, and Dr. Abolins had 2's, 3's, and 4's. I will next determine how the doctors turn in their billing information, to ensure that they are doing the billing properly.

Adult Medicine Associates
The Home Doctor
Medical Billing
Documentation Management
Medical Legal Exams

4901 108th Street SW
Post Office Box 98886
Tacoma, WA 98498-0886
Tel: 253.984.7247
Fax: 253.588.8244
www.mso-wa.com

Attachment N

The Home Doctor®
Phone: (253) 589-6573
FAX: (253) 984-1079
e-mail: homedoctor@mso-wa.com
Mailing Address: P.O. Box 98886
Tacoma, WA 98498-0886

Note: Brandler compliments Dr. Shetty, yet names her in the qui tam filing.

To: Ritu Shetty

From: Bruce Brandler

Subject: Audit of Charts

Date: May 3, 2004

Hello, and thanks for all your hard work with the Home Doctor.

This memo is being sent in order to follow-up on some notes that Dr. Smith made as he reviewed charts. As medical director, he did his review on all the providers, and we are required to do this as part of our compliance plan. It's also a good idea to do it as part of improving the quality of the documentation which reflects your work in the field.

Note: detailed attention in compliance program.

Overall, Tim has been impressed with your efforts, and his main comment was there has been a lack of any documented physical exam on Burke on 3/25/04;Fawcett on 2/10/04; and Breedlove on 3/30/2004. He also thought that you could benefit by adding some more information on your assessment portion of the chart.

If you have any questions on this review, you can certainly call Tim. But I think you just need to do a little more documentation to support what you are doing, so you won't be challenged by the saying, "if it ain't documented, then it ain't done."

Thanks again, and we get many positive comments about how well the patients like you as their doctor!

Regards,

Bruce

Attachment O

The Home Doctor℠
Phone: (253) 589-6573
FAX: (253) 984-1079
e-mail: homedoctor@msn-wa.com
Mailing Address: P.O. Box 98886
Tacoma, WA 98498-0886

To: Nina Spalek

From: Bruce Brandler

Subject: Audit of Charts

Date: May 3, 2004

Hello, and thanks for all your hard work with the Home Doctor.

This memo is being sent in order to follow-up on some notes that Dr. Smith made as he reviewed charts. As medical director, he did his review on all the providers, and we are required to do this as part of our compliance plan. It's also a good idea to do it as part of improving the quality of the documentation which reflects your work in the field.

Tim thinks that you must provide much more documentation to support the visit. This pertains to your subjective, objective and assessment/plan parts of the medical record.

On the other hand, Charles said that he has been working with you, and when I returned from vacation last week, he showed me some charts that were significantly improved from your earlier ones. And this is what we hope you will continue to do. Also, if you have any questions, please feel free to contact Dr. Smith, Charles, or myself.

I know that you want to do a good job, and you may have done things differently in your clinic, but our primary goal is to assist the providers in any way we can to ensure that they have good documented and valid records. This is good care and is required by law and medical standards.

Regards,

Bruce

Attachment P

The Home Doctor®

Phone: (253) 589-6573
FAX: (253) 984-1079
e-mail: homedoctor@msn-wa.com
Mailing Address: P.O. Box 98886
Tacoma, WA 98498-0886

To: Margaret Gaines

From: Bruce Brandler

Subject: Audit of Charts

Date: May 3, 2004

Hello, and thanks for all your hard work with the Home Doctor.

This memo is being sent in order to follow-up on some notes that Dr. Smith made as he reviewed charts. As medical director, he did his review on all the providers, and we are required to do this as part of our compliance plan. It's also a good idea to do it as part of improving the quality of the documentation, which reflects your work in the field.

Tim reviewed charts that were randomly pulled for each provider, but on yours, he couldn't find any, or very little, information on each patient in ATLAS. I realize that many of your patients are seen in the nursing home and the documentation is there, as you explained, but it would be a lot safer and more conducive to follow-up care if we could extract information as in the case of other providers.

You are an excellent physician---very well trained and educated beyond the typical amount for a primary care doctor, so I think you should get credit for what you know and what you do by reflecting that in the chart. If you don't adequately document, then some could say, "if it ain't documented then it ain't done."

Note: continued focus on detail.

If your documentation is at home, then so be it, but I am only trying to help you in case of an audit and you will therefore be required to provide records. Truly, I want to help and not hinder. Our primary goal is to assist the providers in any way we can to ensure that they have well documented records. Although we don't do coding but are rather a management and billing company, we nevertheless try to promote proper documentation that is both required by law and medical standards.

Please let me know your thoughts on this, and I will proceed with how you want us to process your records.

Thanks again for your wealth of experience and for being a part of the Home Doctor team. If you have any questions, you can contact me or Tim.

Regards.

Attachment Q

The Home Doctor®

Phone: (253) 589-6573
FAX: (253) 984-1079
e-mail: homedoctor@mcleod.com
Mailing Address: P.O. Box 98886
Tacoma, WA 98498-0886

To: Phiroce Ishaque

From: Bruce Brandler

Subject: Audit of Charts

Date: May 3, 2004

Hello, and thanks for all your hard work with the Home Doctor.

Note: Brandler writes "Good job!" on coding and documentation.

This memo is being sent in order to follow-up on some notes that Dr. Smith made as he reviewed charts. As medical director, he did his review on all the providers, and we are required to do this as part of our compliance plan. It's also a good idea to do it as part of improving the quality of the documentation, which reflects your work in the field.

Tim reviewed charts that were randomly pulled for each provider, and on yours, he was very complimentary. Good job!

If you ever have comments about documentation or other issues, please call me or Charles.

Thanks again.

Attachment R

The Home Doctor®
Phone: (253) 589-6573
FAX: (253) 984-1079
e-mail: homedoctor@nwo-wa.com
Mailing Address: P.O. Box 98886
Tacoma, WA 98498-0886

To: Georgia Mohler

From: Bruce Brandler

Subject: Audit of Charts

Date: May 3, 2004

Hello, and thanks for all your hard work with the Home Doctor.

This memo is being sent in order to follow-up on some notes that Dr. Smith made as he reviewed charts. As medical director, he did his review on all the providers, and we are required to do this as part of our compliance plan. It's also a good idea to do it as part of improving the quality of the documentation which reflects your work in the field.

Overall, Tim thinks that you might be undercoding and you could justify a little higher code if you put more documentation down---particularly with your assessment/plan. Also, take a look at your exams and make sure that you are comfortable with your documentation in those areas. For reference, Tim looked at the records of Brulotte on 2/23/04; Davis on 3/25/04; and Hunter on 2.20/04. These were randomly selected.

Note: Brandler noting the excellence in medication management.

Tim was impressed with your med lists in ATLAS, and from a personal point of view, I know that the facilities and patients are very happy with your care---keep up the good work!

If you have any questions on this review, you can certainly call Tim. But I think you just need to do a little more documentation to support what you are doing.

Regards,

Bruce

Attachment S

The Home Doctor®

Phone: (253) 589-6574
FAX: (253) 984-1079
e-Mail: homedoctor@msn-wa.com
Mailing Address: P.O. Box 98885
Tacoma, WA 98498-0885

Note: Tom Smith, MD is the brother of Tim Smith, MD-the medical director. Brandler points out (correctly) the conflict of interest had Dr. Tim conducted the review.

To: Tom Smith

From: Bruce Brandler

Subject: Audit of Charts

Date: May 3, 2004

Hello, and thanks for all your hard work with the Home Doctor.

This memo is being sent in order to follow-up on some notes that Charles made as he reviewed your charts. Since Tim, as our medical director, can't review your charts due to a perceived conflict of interest, Charles did the review.

He found that you have appropriate documentation for all the charts, and I didn't expect anything less! Great job.

Thanks again, and I will place this and the other memos in our compliance file.

Attachment T

Tom Smith

MSO
WASHINGTON, INC

An Integrated Healthcare Company

Bruce – Where are the excerpts from the audit Tom

To: All MSO Providers

From: Bruce Brandler

Subject: Documentation Information

Date: February 9, 2005

Note: Brandler continues his focus on documentation and coding into 2005.

As part of an ongoing effort to provide information on coding and documentation, I'm forwarding some excerpts from an audit that was recently performed by Medicare on a Home Doctor provider. This provider was selected as part of a random audit, and a random selection of patients were tested on Medicare's documentation standards.

The audit went very well, and our provider had over 91% of his patients with no error rates. Of the 3 patients in which there were some deficiencies, Medicare only reduced the visit by one level. All in all, this audit showed that our provider is conscientious and their records thus reflect accuracy and thoroughness.

Medicare's message reinforces what we have discussed at medical staff meetings, and with memos pertaining to adequate documentation to support a patient visit. They require complete legible records that justify the medical necessity for the visit, as well as the coding level. And any deficiencies in those areas can warrant that they either deny payment or reduce the level of the visit. Further, the Program Safeguard Contractor for Medicare can invoke more severe penalties if they identify uncorrected patterns of abuse.

Please note that they address issues such as the frequency of the visit and the number of tests ordered, and they give examples.

I hope this information is useful, and if you have any questions, please give me a call.

Adult Medicine Associates
The Home Doctor
Medical Billing
Documentation Management
Medical Legal Exams

4901 108th Street SW
Post Office Box 98886
Tacoma, WA 98498-0886
Tel: 253.984.7247
Fax: 253.588.8244
www.mso-wa.com

Attachment U

The Home Doctor®

Phone: (253) 589-6573
FAX: (253) 984-1079
e-mail: homedoctor@msc-wa.com
Mailing Address: P.O. Box 98886
Tacoma, WA 98498-0886

Note: Brandler continued his focus on compliance. This Memo was dated the month before his termination.

To: Dick Coe

From: Bruce Brandler

Subject: Coding

Date: September 6, 2005

Dick, we spoke about coding at the retreat, and also at our medical staff meetings, and I was hoping that it would create a conservative approach to the providers' coding.

In looking at the chart of Lucille Hunt, you coded it as a level 5. However, level 5's need the following: a comprehensive history, a comprehensive exam, and medical complexity of a high level. Most importantly, the patient should be unstable and in need of immediate medical attention---and that is what worries me about your level 5. Did she meet those criteria?

In regard to the history, you do list some, but it's not exhaustive. The Review of systems is very limited, and the narrative is very brief.

In regard to the exam, that was thorough based on the documentation.

The medical complexity shows that data was reviewed, but the risk (the urgency of the visit) did not seem to warrant a 5 level.

Of course, I am not a clinician, so I can't speak about those things from that perspective, however, from an administrative one, this seems like a level 3, or perhaps a 4 level.

If you want any more information, or want to discuss this further, please call me.

Thanks for your help.

Attachment V

Alaska •
Arizona •
Colorado •
Hawaii •
Iowa •
Nevada •
North Dakota •
Oregon •
South Dakota •
Washington •
Wyoming •

Medicare

Medicare Service Center • 4305 13th Avenue South • Fargo, North Dakota 58103-3373

December 22, 1999

Bruce Brandler
MSO Washington, Inc.
PO Box 98886
Tacoma, WA 98498

Dear Mr. Brandler:

This is in response to your November 29, Freedom of Information Act request for clarification on what is considered a "home" for billing place of service '12'.

A home is defined as any place a beneficiary resides or will reside in for more than six months. A private residence is considered to be a home.

Boarding homes such as those for the mentally retarded and assisted living facilities that are residences where one or more persons live in a private unit on a permanent basis would be considered a home (private residence).

In all of these instances, place of service '12' would be appropriate. The information you received from the call center was correct.

Sincerely,

John Noel

John Noel
Research Specialist
Medicare Service Center

Attachment W

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GORDON, THOMAS, HONEYWELL, MALANCA, PETERSON & DAHEIM LLP

TACOMA OFFICE
1201 PACIFIC AVENUE, SUITE 2200
POST OFFICE BOX 1157
TACOMA, WASHINGTON 98401-1157
(253) 620-6500
FACSIMILE (253) 620-6565

SEATTLE OFFICE
ONE UNION SQUARE
600 UNIVERSITY, SUITE 2100
SEATTLE, WASHINGTON 98101-4185
(206) 676-7500
FACSIMILE (206) 676-7575

REPLY TO TACOMA OFFICE

WARREN E. MARTIN
ATTORNEY AT LAW
DIRECT (253) 620-6479
(206) 676-6479
E-MAIL wmartin@gth-law.com

December 13, 2005

Charles Plunkett
MSO Washington, Inc.
4901 108th St. SW
P.O. Box 98886
Tacoma, WA 98498-0886

RE: Bruce Brandler

Dear Mr. Plunkett:

This firm represents Bruce Brandler with respect to potential claims arising out of his Employment Agreement with MSO: Washington, Inc.

I have reviewed the Employment Agreement and the various compensation agreements. As you know, the most recent compensation program (Exhibit D) provided Mr. Brandler a bonus based on the remaining profit for all MSO operations and for any profits from Atlas Software and Healthcarefinders. Mr. Brandler wants to ensure that he has been properly compensated according to the terms of the Employment Agreement.

To assess that issue, Mr. Brandler must have access to all financial records of MSO (including the Home Doctor, the Specialty Centre and Adult Medicine Associates) as well as all financial records for Atlas Software, Healthcarefinders and all companies related to the above entities (including the LLC). Accordingly, this letter will formally demand copies of or access to all financial records for all of the above mentioned entities from August 27, 1999 through the present.

I also note that Section 13 of the Employment Agreement contains an arbitration provision. The Agreement further provides that the arbitration shall be conducted in accordance with the Civil Rules for the Superior Court of the State of Washington. The Civil Rules independently provide Mr. Brandler with a right to access these financial records through discovery. Although we would prefer to resolve issues regarding access to financial records and any resulting compensation owed informally, we are prepared to commence a legal process should that be necessary to obtain access to the requested financial records.

Please respond to this letter within 14 days and advise whether you will provide access to the requested financial records. If I have not heard from you or your attorney by then, I will conclude that you are denying Mr. Brandler access to these financial records and will proceed with legal process accordingly.

Very truly yours,

Warren E. Martin

WEM:jmh
(17151-00003)

cc: Bruce Brandler

Attachment X

FILED LODGED RECEIVED

AUG 03 2006

CLERK U.S. DISTRICT COURT WESTERN DISTRICT OF WASHINGTON AT TACOMA BY DEPUTY

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

UNITED STATES OF AMERICA, ex rel. BRUCE BRANDLER, Plaintiff, v. MSO WASHINGTON, INC., a Washington corporation; CHARLES PLUNKETT, RICHARD RYNES, M.D.; GLEN KEITZER, M.D.; ANDREW ABOLINS, M.D.; KENITH AARO, M.D.; SAM KARANAM, M.D.; CORAL HILBY, M.D.; EXPEDITA CASTRO, M.D.; TIMOTHY SMITH, M.D.; DOUGLASS HARROUN, M.D.; LYNN OSTENSON, M.D., THOM MCDONNELL, M.D.; THOMAS SMITH, M.D.; MARGARET GAINES, M.D.; DICK COE, M.D.; RITU SHETTY, M.D.; JOHN LORD, DPM; JOHN FORD, DPM; COLLEEN WOJCIECHOWSKI; GIGI HARDTKE; RICHARD ATER; PHIROCE ISHAQUE; GEORGIA MOHLER; LINDA LEPAPE; Defendants.	NO. C06 5437 RBL COMPLAINT FILED EX PARTE AND UNDER SEAL JURY TRIAL DEMANDED

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GORDON, THOMAS, HONEYWELL, MALANCA, PETERSON & DAHEIM LLP
1201 PACIFIC AVENUE, SUITE 2100
POST OFFICE BOX 1157
TACOMA, WASHINGTON 98401-1157
(253) 620-6500 - FACSIMILE (253) 620-6565

COMPLAINT
(False Claims Act)

PRELIMINARY STATEMENT

This lawsuit is based on a scheme by defendants to defraud the United States Government through its health insurance programs, including the Medicare and the Medicaid programs. Defendants provide medical care delivered to the home and other non-medical office settings for elderly, disabled and mentally incapacitated patients in the greater Puget Sound area. Defendants have billed those programs for medically unnecessary and improperly/undocumented services, and have billed those programs unreasonable and improper charges for those services. Defendants' scheme was designed to defraud the United States, the Medicare and Medicaid programs and the American taxpayers of millions of dollars through fraud, waste, abuse and mismanagement while preying upon patients who were least likely to discover and resist defendants' fraudulent activities.

Since at least 2000, defendants' pervasive pattern of fraud has included: (1) overly frequent visits to patients; (2) a failure adequately to document the necessity of the frequent visits and the services rendered during those visits; (3) mislabeling diagnoses or treatments to increase the purported value of Medicare and Medicaid claims ("upcoding"); (4) a failure to document and justify why medical services were rendered in a non-office setting, resulting in dramatically increased Medicare and Medicaid claims; and (5) an electronic medical record system known as ATLAS, which was designed and/or utilized by defendants to implement and facilitate the fraudulent practices set forth above.

Plaintiff (the Relator), by the undersigned counsel and acting on behalf of and in the name of the United States of America, brings this civil action under the *qui tam* provisions of the federal False Claims Act, 31 U.S.C. §§ 3729-3733, and alleges:

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[illegible]

JURISDICTION AND VENUE

1. This Complaint is a civil action by plaintiff acting on behalf of and in the name of the United States, against all defendants under the federal False Claims Act, 31 U.S.C. §§ 3729-3733. This Court has jurisdiction pursuant to 28 U.S.C. §§ 1331 and 1345, and 31 U.S.C. § 3732(a).

2. Each defendant transacts business in this judicial district. In addition, virtually all of the acts proscribed by 31 U.S.C. §3729 occurred in this judicial district. This Court has personal jurisdiction over the defendants, and venue is appropriate in this district pursuant to 31 U.S.C. §3732(a).

3. None of the allegations set forth in this Complaint is based on a public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a congressional, administrative, or General Accounting Office report, hearing, audit, or investigation, or from the news media.

4. Plaintiff has direct and independent knowledge, within the meaning of 31 U.S.C. § 3730(e)(4)(B), of the information on which the allegations set forth in this Complaint are based, and he has voluntarily provided the information to the Government prior to any public disclosure of these allegations and prior to the filing of this Complaint.

PARTIES

Plaintiff

5. Plaintiff is a citizen of the United States and a resident of this judicial district and is suing in the name of and on behalf of the United States. Plaintiff was employed by defendant MSO Washington ("MSO") from approximately June, 1999 through October, 2005. MSO (which stands for "Management Services Organization") provides physician practice management services, contracts with Evercare and Secure Horizons for Medicare managed

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care services, and provides physician and other ancillary services to patients living in adult family homes, assisted living facilities, independent living facilities, individual homes, mental health facilities and group homes. This latter service operates as "The Home Doctor." Plaintiff served as Compliance Officer for MSO/Home Doctor, and was also responsible for marketing the Home Doctor program. In performing these duties, plaintiff detected a systematic pattern of billing on the part of defendants which, upon further investigation, led him to conclude that defendants were (1) billing for services which were not medically necessary; (2) seeing patients too often; (3) improperly documenting visits; (4) improperly coding; and (5) engaging in other fraudulent practices. Thus, plaintiff's specific knowledge of defendants' fraudulent activities comes from his personal observation of the events described herein.

Defendants

6. Defendant MSO is a privately owned Subchapter S corporation incorporated in 1993 in Washington State. Physicians and other providers of medical services, such as nurse practitioners, enter into contracts with MSO. A copy of portions of a representative contract between a physician and MSO is attached as Exhibit 1.

7. Defendant Charles Plunkett is the sole shareholder of defendant MSO. In or about 2000, Mr. Plunkett played a key role in designing ATLAS to include features and components which fostered and enabled defendants' fraudulent course of conduct. Mr. Plunkett and MSO encouraged and actively participated in that fraudulent course of conduct, and knowingly made, used or caused to be made or used false records or statements to get false or fraudulent Medicare and Medicaid claims paid or approved by the Government.

8. Defendant Dr. Richard Rynes was the MSO Medical Director in 2001, and was a MSO/Home Doctor medical provider from 1999 through 2002.

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9. Defendant Dr. Glen Keitzer was an MSO/Home Doctor medical provider from 1999 through 2001.

10. Defendant Dr. Andrew Abolins was an MSO/Home Doctor medical provider from at least 2000 through at least October, 2005.

11. Defendant Dr. Kenith Aaro was an MSO/Home Doctor medical provider in 2000.

12. Defendant Dr. Sam Karanam was an MSO/Home Doctor medical provider from 2001 through 2002.

13. Defendant Dr. Coral Hilby was an MSO/Home Doctor medical provider in 2000.

14. Defendant Dr. Expedita Castro was an MSO/Home Doctor medical provider from 2000 through 2005.

15. Defendant Dr. Timothy Smith has been an MSO/Home Doctor medical provider from 2000 through the present.

16. Defendant Dr. Douglass Harroun was an MSO/Home Doctor medical provider from 2000 through 2003.

17. Defendant Dr. Lynn Ostenson was an MSO/Home Doctor medical provider from 2001 through 2003.

18. Defendant Dr. Thom McDonnell was an MSO/Home Doctor medical provider in 2002.

19. Defendant Dr. Thomas Smith has been a MSO/Home Doctor medical provider from 2001 through the present.

20. Defendant Dr. Margaret Gaines was a MSO/Home Doctor medical provider from 2003 through the present.

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[redacted]

21. Defendant Dr. Dick Coe has been a MSO/Home Doctor medical provider from 2004 through the present.

22. Defendant Dr. Ritu Shetty has been a MSO/Home Doctor medical provider from 2003 through the present.

23. Defendant Dr. John Lord has been a MSO/Home Doctor medical provider from 2003 through the present.

24. Defendant Dr. John Ford has been a MSO/Home Doctor medical provider from 2003 through the present.

25. Defendant Colleen Wojciechowski was a Nurse Practitioner with MSO/Home Doctor from 2000 through 2002.

26. Defendant Gigi Hardtke was a Nurse Practitioner with MSO/Home Doctor in 2003.

27. Defendant Richard Ater was a Nurse Practitioner with MSO/Home Doctor in 2003.

28. Defendant Phiroce Ishaque has been a Nurse Practitioner with MSO/Home Doctor from 2003 through the present.

29. Defendant Georgia Mohler has been a Nurse Practitioner with MSO/Home Doctor from 2004 through the present.

30. Defendant Linda LePape has been a Nurse Practitioner with MSO/Home Doctor from 2005 through the present.

FEDERALLY-FUNDED HEALTH INSURANCE PROGRAMS

Medicare

31. 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

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[illegible]

program. The United States Department of Health and Human Services ("DHHS"), acting by and through the Center for Medicare and Medicaid Services ("CMS"), is an agency of the United States responsible for, among other things, administering the Medicare program under which the providers of services may be reimbursed with federal funds.

32. DHHS, through CMS, provides health insurance to eligible aged and disabled Americans (Medicare beneficiaries) pursuant to the provisions of the Medicare Program, Title XVIII of the Social Security Act, 42 U.S.C., Sections 1395, *et. seq*. The Medicare Program provides health care services and benefits to certain eligible groups such as persons over ages sixty-five, disabled persons and qualifying homebound persons in need of medical and nursing care. The Medicare Program is administered under two distinct parts. Medicare Part A, "Hospital Insurance for the Aged and Disabled", covers health care services furnished by hospitals, home health agencies, hospices, and skilled nursing facilities. Medicare Part B, "Supplementary Medical Insurance for the Aged and Disabled", covers laboratory services, x-rays, physicians' services and other non-institutional services, such as medical supplies and durable medical equipment (DME), as well as some other services not reimbursed under Medicare Part A.

33. Defendants would primarily apply to CMS for reimbursement of Home Doctor services under Medicare Part B.

34. Approximately 75 per cent of the billings at issue in this action were reimbursed by Medicare.

Medicaid

35. Medicaid is a cooperative federal-state program that provides financial assistance to states to subsidize certain costs of medical treatment for certain low-income

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individuals. Washington State has adopted a Medicaid State Plan and is a participating Medicaid state.

36. Approximately 25 per cent of the billings at issue in this action were reimbursed by Medicaid.

Medicare and Medicaid Coverage and Payments

37. Medicare and Medicaid coverage and payments are based both on the reasonableness of the charges for, and the medical necessity of, the services rendered. For example, Title XVIII of the Social Security Act, 42 U.S.C. § 1395y provides, in pertinent part, that "no payment may be made under Part A or Part B for any expenses incurred for items or services—which . . . . are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

BACKGROUND OF DEFENDANTS' ACTIVITIES

Plaintiff's Efforts to Enforce Compliance Policies and Lawful Conduct

38. Throughout the course of his employment with MSO, plaintiff consistently took steps to attempt to insure that defendants' medical record documentation was complete, accurate and appropriate. For example, plaintiff was primarily responsible for compiling, circulating and educating relevant Providers, including the individual defendants, with an MSO Compliance Program (Exhibit 2) and with an MSO Washington Training Guide—Manual To Assist Providers In Their Coding And Documentation (Exhibit 3).

39. Exhibit 4 is an extensive collection of memoranda, minutes of MSO/Home Doctor medical staff meetings and other documentation which have been highlighted and which demonstrate the detailed and consistent efforts undertaken by plaintiff in an attempt to insure appropriate and well-documented Medicare and Medicaid billing practices by defendants. For example:

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TACOMA, WASHINGTON [illegible]
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- At least in 2001 and 2002, plaintiff prepared, circulated and posted Clinical Documentation Standards. These Standards included, among other things, the following admonitions and policies:

> The following is a listing of unacceptable practices, and a violation of any one of them will create severe disciplinary action -- including termination of employment or termination of an independent contractor agreement:
>
> - Billing for items or services not actually rendered
> - Billing for medically unnecessary services
> - Duplicate billing
> - Knowingly billing for inadequate or sub-standard care
> - Insufficient documentation
> - Falsifying plans of care
> - Forged physician signatures
> - Creating referrals without the physician approval or initiation
> - Forging any document
> - Theft
>
> The chart must be sufficiently detailed to include documentation which supports the level of the code. To achieve this goal, coding will include the history, examination, medical decision-making, and the amount and/or complexity of data reviewed. Practitioners were given these coding protocols in a past medical staff meeting, and one such tool was entitled, "Choosing the Appropriate Outpatient E/M Code." These are available in the office.

- The Minutes of a January 24, 2002 Medical Staff Meeting state as follows:

> Under compliance report, [Mr. Brandler] handed-out information on how the company will support the physician providers in any way possible, but the physicians deliver the care and they must meet Medicare Medical Necessity Criteria as outlined in the material he handed out. He also reminded them that the frequency

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of their visits is also a function of the patient's problems and it is a clinical decision that the doctor must make. He said that whether the patient is seen every month or every 6 months, as an example, it is up to the doctor to determine as per their clinical judgment. ATLAS was set-up to default to 5 weeks, but the doctors can vary that as they see fit. All of this information was sent to the doctors last year and was addressed at various medical staff meetings.

- The July 31, 2003 Medical Staff Meeting Minutes provide as follows:

> The first item on the agenda was compliance. We handed out both the MSO Compliance Plan, as well as the Code of Conduct. We reminded them that they received this and signed the physician acknowledgment, however, we wanted to use the time to refresh them on compliance issues and our expectations.
>
> Mr. Brandler highlighted various issues such as billing, coding, and documentation, and he asked if there were any questions. Our attorney was present to handle any questions or concerns.
>
> Mr. Brandler then spoke about the need for the providers to document their visit, and to address issues such as medical necessity. He also handed out various memos that have been distributed in the past to point out clinical documentation expectations. These memos address medical necessity, frequency of visits, proper coding, and other related topics. He mentioned that he sent out a memo to the billing and Home Doctor staff to have them be aware of these issues and to have the providers submit proper documentation.

- On May 1, 2004, plaintiff circulated the following memorandum, with attachments:

> I thought it would be helpful to remind all the providers about Medicare's Medical Necessity Criteria to justify patient visits.
>
> To be considered reasonable and necessary, I have attached a few pages from our Medicare Manual, and as you can see, the key is documentation. The situation is

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> the same with your coding, you have to have sufficient support for whatever code you bill.

- A July 6, 2004 Memorandum from plaintiff to all Home Doctor providers states as follows:

> As a reminder, as you code and document, there should neither be downcoding or upcoding, but rather appropriate coding. That is, medical necessity must be met, and then code your evaluation and management (E/M) visit according to your supporting documentation.

40. Despite plaintiff's best efforts, medical record documentation for Medicare and Medicaid reimbursement by defendants was woefully and intentionally deficient. As demonstrated above, plaintiff made defendants acutely aware of those deficiencies.

Defendants' Fraudulent Scheme

41. ATLAS, the electronic record system created by defendants MSO and Plunkett, was the engine which powered defendants' fraudulent scheme. ATLAS is a software program which was used by the individual defendant medical providers as they saw patients and documented their encounters. Each MSO medical provider used ATLAS on a laptop computer.

42. ATLAS was designed with a variety of electronic fields, including fields for subjective notes; historical information; lab, x-ray and other consult buttons; a pharmacy component; and a button to click for the exam of body systems. Defendants MSO and Plunkett expressly designed ATLAS so that each medical provider could input an entire patient encounter in ATLAS. MSO and Mr. Plunkett sought to make it easier for the provider to make entries, and to eliminate bulky paperwork, and that was the rationale given for the electronic records.

43. However, the medical provider could and did also "cookie-cutter" records by clicking buttons that created "canned entries." The individual defendants and other medical

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providers use a standardized system of numerical codes for patients' services, required by Medicare, Medicaid and other Government programs. These codes are based on criteria established by the American Medical Association in the Physicians' Current Procedural Terminology ("CPT"). CPT codes describe medical procedures performed by physicians and other health providers, and also include a component for the location (or place of service ("POS")) where the medical services are rendered (home, physicians' office, hospital, etc.). ATLAS includes billing buttons which make POS and CPT options available for a medical provider to click.

44. In regard to a patient examination, for example, clicking one button would create "Normal" for a particular body system, and other buttons brought-up medical problems, diagnoses, and medications from prior visits. Thus, it was very easy to create a medical record by replicating previous patient encounter entries. Even if a provider spent a few minutes with a patient, the clinical and financial record could easily be made by clicking a few buttons. Moreover, MSO greatly encouraged provides to use these buttons, called "macros."

45. ATLAS was expressly programmed to implement and facilitate defendants' scheme to defraud the Government. Beginning in approximately 2000, ATLAS was programmed to schedule medical appointments with each Home Doctor patient every five weeks. Although the individual defendants retained the flexibility to schedule these medical appointments more or less frequently as called for by each individual patients' unique circumstances, in fact the individual defendants almost never countermanded this automatic, five week interval scheduling of appointments by ATLAS.

Brandler insisted that the scheduler be programmed to avoid or eliminate patients being seen in less than one month.

46. Moreover, throughout the course of his employment with MSO, plaintiff became aware that the individual defendants virtually never provided sufficient

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documentation for the justification or necessity of any of the medical services at non-office settings, much less medical services rendered on a routine, every five week basis.

47. Plaintiff does not currently have access to defendants' billing records. A detailed review and audit of these records, however, will reveal that in connection with billings submitted to the Government, defendants: (a) churned MSO/Home Doctor patients by engaging in unnecessarily frequent medical visits; (b) provided unnecessary medical services; and (c) failed to adequately document the necessity for, and nature of, medical services rendered to MSO/Home Doctor patients, in non-office settings.

Brandler fails to note that the group passed every audit with any problem.

48. As noted in Paragraph 43, medical providers (including defendants) who bill Medicare or Medicaid and other Government programs use a standardized system of numerical CPT codes for patient services. "Upcoding" is a practice where a medical provider mislabels diagnoses or treatments on claim forms to increase the value of the claim. During the course of his employment with MSO, plaintiff consistently warned defendants to avoid upcoding and other improper billing practices, including insufficient documentation to support medical bills. Although plaintiff does not currently have access to defendants' billing records, a detailed review and audit of those records will reveal that in connection with billings submitted to the Government, defendants frequently (a) upcoded medical services rendered to MSO/Home Doctor patients, and (b) failed to adequately document the necessity for, and nature of, those medical services.

49. Another significant component of MSO/Home doctor billings submitted by defendants to the Government is the place of service ("POS").

50. Medicare pays for services provided by providers such as defendants to program beneficiaries. Although providers routinely perform many of these services in a facility setting, including an outpatient hospital department or a freestanding ambulatory

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surgical center, certain of the same services may also be performed in non-facility settings, such as a physician's office, a home, or a nursing care facility. To account for the increased practice expense incurred by providers in non-facility settings, Medicare reimburses a higher amount for services performed in this setting. Physicians are required to identify the place of service on the health insurance claim from submitted to Medicare carriers for payment. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform the service.

51. In order for providers like defendants to receive a higher non-facility practice expense payment, the service must meet the requirements of 42 CFR 414.22(b)(5)(i)(B) as follows:

> . . . The higher non-facility practice expense [payments] apply to services performed in a physician's office, a patient's home . . . a nursing facility, or a facility or institution other than a hospital or skilled nursing facility . . . .

52. POS codes are two-digit codes placed on health care professional forms to indicate the setting in which a service was provided. A list of POS Codes is attached as Exhibit 5.

53. Throughout the course of his employment with MSO, plaintiff cautioned defendants and others that appropriate POS Codes must be used and that the reasons for the selection of particular POS codes must be fully and appropriately documented.

54. Throughout the course of plaintiff's employment with MSO, defendants consistently billed MSO/Home Doctor medical services at POS Code 12 ("Home"). Despite plaintiffs' efforts, defendants almost never documented why (1) it was medically necessary to visit patients in a non-office settling, and (2) MSO/Home Doctor medical services were billed under POS Code 12 ("Home") rather than under POS Codes 13 (Assisted Living Facility"),

Place of service (POS) 13 did not exist during Brandler's employment.

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14 ("Group Home"), 32 ("Nursing Facility") or 33 ("Custodial Care Facility"). Payments for POS Code 12 services are significantly higher than payments for POS Codes 13, 14, 32 and 33.

55. In or about 2000, ATLAS was modified to include a box which the medical provider defendants could and did simply check to indicate that rendering of medical services at a patient's alleged "home" (POS Code 12) was medically necessary. For example, if an adult family home was on the screen and the provider clicked the billing button, the CPT codes for that location were those for a POS 12 (private residence). This was programmed by Mr. Plunkett, the owner of MSO, since he insisted that adult family homes are a Place of Service 12.

Brandler was the one who insisted on this modification of the electronic medical record.

56. Although plaintiff does not currently have access to defendants' billing records, a detailed review and audit of these records will reveal that thousands of billings to the Government under POS Code 12, as well as under POS Codes 13, 14, 32 and 33, were improper and were not properly documented.

CAUSES OF ACTION

COUNT I
(Federal False Claims Act – 31 U.S.C. § 3729(a)(1))

57. Plaintiff realleges and incorporates by reference paragraphs 1 through 56 as though fully set forth herein.

58. Defendants have knowingly submitted false or fraudulent claims for payment, or caused false or fraudulent claims for payment to be submitted, to officials of the United States Government, in violation of 31 U.S.C. § 3729(a)(1).

59. Because of the defendants' conduct set forth in this Court, the United States has suffered actual damages.

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COUNT II
(Federal False Claims Act – 31 U.S.C. § 3729(a)(2))

60. Plaintiff realleges and incorporates by reference paragraphs 1 through 59 as though fully set forth herein.

61. Defendants have knowingly made or used, or caused to be made or used, false records or statements to get false or fraudulent claims paid or approved by officials of the United States Government, in violation of 31 U.S.C. § 3729(a)(2).

62. Because of the defendants' conduct set forth in this Court, the United States has suffered actual damages.

PRAYER FOR RELIEF

WHEREFORE, plaintiff prays for the following relief:

1. On Counts I and II, judgment for the United States against the defendants in an amount equal to three times the damages the United States Government has sustained because of the defendants' actions, plus a civil penalty of $11,000 for each violation of 31 U.S.C. § 3729.

2. On Counts I and II, an award to the Relator of the maximum allowed under 31 U.S.C. § 3730(d).

3. Attorneys' fees, expenses, and costs of suit herein incurred; and

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

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GORDON, THOMAS, HONEYWELL, MALANCA,
PETERSON & DAHEIM LLP
[illegible]
POST OFFICE BOX 1157
TACOMA, WASHINGTON [illegible]
[illegible] - FACSIMILE [illegible]

DEMAND FOR JURY TRIAL

Plaintiff demands that this matter be tried before a jury.

Dated this 31 day of August, 2006.

GORDON, THOMAS, HONEYWELL, MALANCA, PETERSON & DAHEIM LLP

By _____
Warren E. Martin, WSBA No. 17235
wmartin@gth-law.com
Kenneth G. Kieffer, WSBA No. 10850
kkieffer@gth-law.com
Attorneys for Plaintiff

LAW OFFICES
GORDON, THOMAS, HONEYWELL, MALANCA, PETERSON & DAHEIM LLP
[redacted]

Attachment Y

☆ Mine—Thanks

MSO WASHINGTON, INC

CORPORATE HIPAA/COMPLIANCE TRAINING ADULT MEDICINE ASSOCIATES AND HOME DOCTOR PROFESSIONAL STAFF

SKAGIT COUNTY RESORT
July 29, 2005

Bruce Brandler
Compliance and HIPAA Officer

The Keys to Compliance are:

- **Prevention**
- **Detection**
- **Self-Reporting**

Plus, train, train, train…

MSO Washington, Inc.
Corporate Compliance Training
Professional Staff Retreat
July 29, 2005

Agenda

1. **What is compliance?**

   Compliance is intended to prevent and detect violations of the law. It has been stated that an effective compliance program must be reasonably designed, implemented, and enforced so that the prevention and detection of criminal conduct can occur. The hallmark of an effective program is that the organization exercised due diligence in seeking to prevent and detect criminal conduct by its employees and other agents.

2. **The goal of compliance**

   MSO's goal is the prevention of non-compliant conduct. We are focused on prevention, detection, and self-reporting of violations of law. We are concentrating on effective internal controls that promote adherence to applicable federal and state law, and the program requirements of federal, state, and private health plans.

   We are advancing the prevention of fraud, abuse, and waste in healthcare, and furthering our mission to provide quality healthcare to all our patients.

3. **Why have a compliance program?**

   The Office of Inspector General of the Department of Health and Human Services (OIG), in 1997, declared a zero tolerance for fraud and asked healthcare providers to adopt and maintain compliance programs. There is an increased level of scrutiny of healthcare compliance, and the go ernment has employed many investigators and agents to detect fraud and abuse and thereby lower the cost of healthcare.

   Compliance can identify and prevent illegal and unethical conduct. It increases awareness of compliance with reimbursement requirements. It deters private plaintiffs from suing for false healthcare claims. It documents preventive action by officers and directors of the company in discharging their organizational fiduciary duties. It reduces the level of sanctions, penalties, and exclusions if violations occur, and it follows the directive of the OIG.

4. **Elements of our compliance program:**
   - Written standards of conduct
   - Designation of a compliance officer
   - Education and training
   - Audits and other evaluation techniques
   - Internal reporting process (hotline)
   - Disciplinary mechanisms
   - Investigation and remediation

COMPLIANCE TALKING PAPER

- **There are various laws pertaining to compliance---go to sheet**

1. Go over the items on the **printed hand-out agenda**. This explains the whys and goals.

2. Next, read **The Compliance Program** adopted Febuary, 2001.

3. Read **The Code of Conduct**, the **#1 element of our plan**---at the beginning of our plan and the ORHS material under a separate tab of the notebook.

4. Go over the **#2 element of our plan,** the Compliance Officer. This must be at a high level, autonomy, confidentiality, and no retaliation. There is also a hotline, see page **43 of the book.**

5. Cover the **#3 element,** the Education and Training. This is the most important element of our plan, since it can prevent violations and non-compliant behavior.

   The focus is on coding and documentation. The doctor's code. Inadequate documentation is the leading cause of improper Medicare payments. Second is lack of medical necessity.

   Training is to all employees, doctors, and vendors. **SHOW CODING MANUAL**

6. Address the **#4 element,** Audits and Evaluation. See page 53 of the book.

7. Go over Internal reporting and the Hotline. These are the **#5 elements** of the plan. There is an open door on this issue.

8. Go over discipline, this is the **#6 element** of the plan. This can involve oral warning to termination.

9. Go over Investigation and Remediation. These are **#7 elements** of the plan. I must investigate questionable conduct and take action. This is where reporting comes into play.

10. Lastly, **cover coding** and the need for the doctors to do it. Address the sheets to code.

VARIOUS LAWS PERTAINING TO COMPLIANCE

(See the compliance book)

1. The **Federal Anti-Kickback Statute.** Page 112 of the book.
2. **Stark Laws.** Page 113-114
3. There are **criminal provisions** of the Social Security Act. Read top of page 93
4. Next, read the **civil provisions** of the Social Security Act. Read pages, 93, 101 and 106. These refer to **HIPAA.**
5. The **False Claims Act.** Read pages 103 and 104.
6. **Common Billing Frauds**, see page 107 of the book.
7. Read the **Conclusion** on page 108 of the book.

Attachment Z

Subject: Re: Re: Re: Re: WHOA
To: bruce
Sent: 7/8/2004, 4:48:03 AM

Live & Learn on with it.
drtim

Original Message:
From: bruce
To: drtim2
Sent: 7/2/2004, 10:38:20 AM

Tim,
Tim,

Note: In Brandler's own words - . . . ."nothing to hide" . . . and "by the book"

It doesn't matter what Medicare knows, since we have nothing to hide, and as you know, I am a conservative person who likes to do things "by the book"

I need to repeat that those were not consults, they don't mean anything until approved by the PCP, and that is why I sought their approval before Dr. Chua goes out. Lisa and Shelly both knew that, and I am very versed on the fact that we don't generate referrals. I was just trying to make it easy on the PCP to decide which patients to send to Dr. Chua.

We have not had the luxury of a mobile rheumatologist, and therefore I was seeing who the PCP wanted to be seen.

Thanks for your comments.

Bruce

Original Message:
From: drtim2
To: bruce
Sent: 6/30/2004, 9:11:01 PM

Yes, we spoke and we will continue to speak about this. You'll find an additional E-mail. This apparent 'glitch" has stirred up provider karma.
Margaret feels it is usary ? sp ? the F work, that is f r a u d.
Got Charles all upset. However, we have seen a variant of this before with Safe Steps., pain referrals. Medicare can sniff such things out. They know alot more than we assume.
I wish you guys would remember to just include me in the loop before you act, so that i can give the provider take on such maneuvers.
What I would have done is pulled up names of specific diagnosis, and then circulated these for possible referrals for cchua.
I guess we learn.
drtim

Original Message:
From: bruce