IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NORTH CAROLINA
CHARLOTTE DIVISION

United States and the State of North Carolina *ex rel.* Kerrie Dyer Badger,

Plaintiffs,

v.

Bethany Medical Center, P.A., LJP Lab, LLC, and Lenin Peters, M.D.,

Defendants.

Case No: 5:20 cv 86-KDB

COMPLAINT FOR VIOLATIONS OF 31 U.S.C. § 3729, *et seq.* AND N.C. Gen. Stat. § 1-605, *et seq.*

JURY TRIAL DEMANDED

FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)

TABLE OF CONTENTS

Page

Plaintiff Kerrie Dyer Badger, by and through her attorneys, Wyatt & Blake LLP, on behalf of herself and the United States and the State of North Carolina (collectively "Plaintiffs") for her Complaint against Defendant Bethany Medical Center, P.A., LJP Lab, LLC, and Lenin Peters, M.D. alleges based upon personal knowledge, relevant documents and information and belief, as follows:

I. INTRODUCTION

1. Defendants Bethany Medical Center, P.A. ("Bethany"), LJP Lab, LLC, and Lenin Peters, MD ("Dr. Peters") are defrauding the United States and the State of North Carolina by systematically upcoding services, billing for services that are not medically necessary, billing for services that were never provided or were not provided as represented, and otherwise billing for services in violation of the laws and regulations governing reimbursement for government healthcare services.

2. Defendants are acting with actual knowledge of the material falsity of the claims submitted to government healthcare programs. Relator, an experienced healthcare revenue manager, immediately recognized widespread billing fraud when she started working at Bethany in March 2020 as Director of its Revenue Cycle Department. She informed Bethany management on multiple occasions that its billing practices were unlawful. Her warnings fell on deaf ears. In addition, other sources, including private insurance companies, have informed Bethany multiple times that they were rejecting claims under the same criteria that government healthcare payors use. Despite these repeated warnings, Bethany has refused to change its ways. Even if Bethany did not have actual knowledge that claims for payment it was submitting to the United States and North Carolina were false or fraudulent, Defendants have acted in deliberate ignorance or reckless

disregard of fundamental requirements for coverage and reimbursement by federal healthcare programs.

3. Bethany's management incentivizes the healthcare providers it employs to falsely and fraudulently code and bill for unnecessary services by financially rewarding providers who bill for more tests, and pressures providers who are not willing to order unnecessary tests. These practices have been ongoing for years and continue to the present. Because Bethany has created false records and statements to support the false claims for payment, the government has been unaware of the scope of Bethany's knowing violations.

4. Relator has standing to initiate a legal action on behalf of the United States in order to redress the wrongdoing alleged in this Complaint pursuant to the *qui tam* provisions of the FCA.

5. The FCA was originally enacted in 1863 and was substantially amended in 1986 by the False Claims Amendments Act. Congress enacted the 1986 amendments to enhance and modernize the Government's tools for recovering losses sustained by frauds against it after finding that federal program fraud was pervasive. The amendments were intended to create incentives for individuals with knowledge of Government frauds to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit resources to prosecuting fraud on the Government's behalf. Congress amended the Act again in 2009 and 2010 to address court interpretations of the Act that were inconsistent with Congress's intent in modernizing the statute.

6. The FCA imposes liability on anyone who, *inter alia*: (a) knowingly presents, or causes to be presented, false or fraudulent claims for payment or approval to the United States Government; (b) knowingly makes, uses, or causes to be made or used false records and statements to induce the Government to pay or approve false and fraudulent claims; (c) conspires to defraud

the Government by getting a false or fraudulent claim allowed; or (d) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government.

7. Any person who violates the FCA is liable for a civil penalty for each violation, plus three times the amount of the damages sustained by the United States.

8. The FCA allows any person having information about false or fraudulent claims to bring an action for the person and the United States, and to share in any recovery. The FCA requires that the complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time).

9. North Carolina has a false claims statute ("NCFCA") patterned on the FCA that similarly prohibits the submission or causing the submission of false claims for payment or making, using or causing to be made or used false records or statements material to false claims to the State of North Carolina. The NCFCA also prohibits knowingly making, using, or causing to be made or used a false record or statement material to an obligation to pay money to the State or knowingly and improperly avoiding or decreasing an obligation to pay money to the State.

10. *Qui tam* plaintiff and Relator Kerrie Dyer Badger brings the current action based on the FCA and NCFCA and seeks through this action to recover damages and civil penalties arising from the Defendants' knowing fraud on the United States and the State of North Carolina.

II. PARTIES

11. The Relator, Kerrie Dyer Badger, ("Relator") is the Director of the Revenue Cycle Department for Defendant Bethany Medical Center, where she has been employed since March 2020. In her position, Relator manages the Bethany employees who do Bethany's medical billing, including the entering of the data, the submission of the claims for payment, and the appeals of

denied claims. Relator has over thirty years of experience in healthcare billing and has extensive knowledge of coding and billing requirements. As the Director of the department that oversees Bethany's billing, Relator has personal first-hand knowledge of the billing process and claims submission by Bethany. When she started working for Bethany she was immediately concerned both with the level of unlawful practices she observed and the lack of concern when she raised these issues with Bethany management.

12. Defendant Bethany Medical Center, P.A. ("Bethany"), is a North Carolina professional corporation controlled by its Chief Executive Officer Lenin ("Lenny") Peters, MD ("Dr. Peters"). Bethany is a multi-specialty practice that provides a range of medical services, including primary care and pain management. Bethany has 10 locations in North Carolina, including in North Wilkesboro, North Carolina, and employs approximately 55 healthcare providers. The majority of Bethany patients are beneficiaries under federal healthcare programs including Medicare and Medicaid.

13. Defendant LJP Lab, LLC is a medical lab, with its principle office in High Point, North Carolina and its laboratory located in Kernersville, North Carolina. Dr. Peters is identified in the State's business records as the member/manager and his daughter Elise Peters Carey is listed as a manager. The Lab's website identifies Mary Beth Lovin, Ph.D as the Director of the Lab and Darrell Terry as the Lab Manager. Dr. Lovin is also identified as the "laboratory manager at Bethany Medical Center." The lab has a CLIA license.

14. Defendant Lenny Peters, MD, is the Chief Executive Officer of Bethany. He is also the CEO of Peters Development, LLC, which leases office space to Bethany, and is the manager of LJP Lab, LLC, to which Bethany providers refer most of their lab tests. All three entities share the same principle office address in High Point, North Carolina.

III. JURISDICTION AND VENUE

15. This Court has jurisdiction over the subject matter of this action pursuant to both 28 U.S.C. § 1331 and 31 U.S.C. § 3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730.

16. Although the issue is no longer jurisdictional, there has been no statutorily relevant public disclosure of the "allegations or transactions" in this Complaint within the meaning of 31 U.S.C. § 3730(e)(4). Moreover, Relator would qualify under that section as an "original source" of the information in this Complaint even had such a public disclosure occurred as she has direct and independent information that would materially add to any publicly disclosed allegations or transactions of fraud and she voluntarily provided her information to the Government before filing this Complaint.

17. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732(a) because that section authorizes nationwide service of process and because Defendants have minimum contacts with the United States.

18. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) because one or more Defendants transact business in, and acts proscribed by 31 U.S.C. § 3729 were committed in, the Western District of North Carolina.

IV. BACKGROUND

A. Bethany Medical Center

19. Founded in 1987 by Dr. Peters, Bethany is a multi-specialty healthcare practice in North Carolina with ten locations in this state. Bethany employs approximately 55 physicians who provide primary healthcare services and pain management to patients, including Medicare and Medicaid beneficiaries.

20. Dr. Peters is the CEO of Bethany. His daughter, Elise Peters Carey, who is not a doctor, is the President of Bethany. Dr. Peters is also a prominent real estate investor operating through Peters Development, LLC, and Peters Holdings, LLC, which owns the buildings in which Bethany offices are located.

21. Dr. Peters sets the policies, including billing policies, implemented by Bethany healthcare providers. The providers are paid incentives for ordering testing, including but not limited to lab tests, x-rays, vascular studies and pulmonary function testing. In addition, Bethany management, including Dr. Peters, pressure and harass providers who do not want to bill in ways that are unlawful.

22. Most of the lab tests ordered by Bethany providers are referred to LJP Lab, LLC. LJP Lab was formed in 2017 and Dr. Peters and his daughter, Elise Carey Peters, are identified in business records as the member/managers of the lab.

23. The upcoding, miscoding and billing for services not provided are not occasional lapses, but a way of doing business designed to maximize revenue for Defendants in ways that knowingly violate the federal programs that fund those services.

B. Applicable Law

1. The False Claims Act

24. The False Claims Act ("FCA"), 31 U.S.C. § 3729, *et seq.*, as amended, prohibits any person from knowingly making, or causing to be made, a false or fraudulent claim for payment to the United States. 31 U.S.C. § 3729(a)(1)(A). The FCA also prohibits knowingly making, using, or causing to be made or used a false record or statement material to a false or fraudulent claim. 31 U.S.C. § 3729(a)(1)(B). The FCA also prohibits knowingly making or using false records or statements material to an obligation to pay money to the United States or knowingly

and improperly concealing or avoiding an obligation to pay money to the United States. 31 U.S.C. § 3729(a)(1)(G).

25. A false or fraudulent claim under the FCA may take many forms, "the most common of which is a claim for payment for goods and services not provided or provided in violation of contract terms, specification, statute or regulation." False Clams Amendment Act of 1986, S. Rep. No. 99-345, at 9 (1986), *reprinted in* 1986 U.S.C.C.A.N. 5266, 5274. The terms "false or fraudulent" have the same meaning as under the common law and extend to misrepresentations by omission.

26. The misrepresentation must be material, which the FCA defines as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property." 31 U.S.C. § 3729(b)(4).

27. The FCA defines knowingly to include actual knowledge, reckless disregard, and deliberate ignorance. 31 U.S.C. § 3729(b)(1)(A). No specific intent to defraud need be shown. 31 U.S.C. § 3729(b)(1)(B).

2. The Stark Statute

28. The Stark Statute, 42 U.S.C. § 1395nn, prohibits a physician from making a referral to an entity for designated health services if the physician or an immediate family member has a financial interest in the entity, unless an exception applies. An entity may not submit claims for payment for services furnished pursuant to a prohibited referral.

29. A financial interest under the Stark Statute includes an ownership or investment interest, including limited liability company memberships. 42 C.F.R. § 411.354(b)(1). Designated health services include clinical laboratory services. 42 C.F.R. § 411.351. The referrals of

physicians in a group practice may be imputed to a physician who directs and controls referrals. 42 C.F.R. § 411.353(a).

30. Claims submitted in violation of the Stark Statute are false claims within the meaning of the FCA.

3. The North Carolina False Claims Act

31. The NCFCA is patterned after the FCA. The NCFCA prohibits knowingly submitting or causing the submission of false claims for payment to the State of North Carolina, N.C. Gen. Stat. § 1-607(a)(1), and prohibits making, using, or causing to be made or used false records or statements material to such claims. N.C. Gen. Stat. § 1-607(a)(2). The NCFCA also prohibits knowingly using false records or statements to avoid an obligation to pay money to the State or knowingly or improperly concealing or avoiding an obligation to pay money to the State. N.C. Gen. Stat. § 1-607(a)(7).

4. Federal Healthcare Programs

32. Congress established the Medicare program, or Title XVIII of the Social Security Act, in 1965 with the goal of providing national health coverage for Americans aged 65 and older. *See* 42 U.S.C. § 1395, *et seq.* In addition to the elderly, a large portion of Medicare's patient population is disabled.

33. The United States Department of Health and Human Services ("HHS") and the Centers for Medicare and Medicaid Services ("CMS"), an agency within HHS, direct and administer the Medicare program.

34. Medicare has four parts: Part A, which provides hospital insurance; Part B, which provides medical insurance; Part C, which provides funding for Medicare Advantage plans; and

Part D, which provides prescription drug benefits. Medicare Part B provides coverage for doctor and other health care provider services, including diagnostic laboratory tests.

35. In general, Medicare pays only for medical and health services that are "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A). Diagnostic tests are covered if supported by the individual treatment needs of a patient. Tests not ordered by the physician who is treating the beneficiary are not reasonable and necessary. 42 C.F.R. § 410.32(a). "Laboratory [t]ests that are performed in the absence of signs, symptoms, complaints, personal history of disease, or injury are not covered except when there is a statutory provision that explicitly covers tests for screening as described." Medicare Claims Processing Manual, Chapter 16—Laboratory Services 120.1. The physician ordering the test must maintain documentation of medical necessity in the beneficiary's medical record. 42 C.F.R. § 410.32(d)(2)(i). The entity submitting the claim must maintain documentation received from the ordering physician. 42 C.F.R. § 410.32(d)(2)(ii).

36. Medicare establishes its national payment policy for covered items or services through national coverage determinations ("NCDs"), which are formal decisions by the Secretary of the Department of Health and Human Services ("HHS") regarding whether, and under what circumstances, Medicare covers a particular item or service. 42 U.S.C. § 1395ff(1); 42 C.F.R. § 405.1060(a).

37. Medicare Administrative Contractors ("MACs") act as agents for the government in reviewing and paying claims submitted by health care providers. 42 U.S.C. § 1395kk-1; 42 C.F.R. §§ 421.3, 421.100. MACs process and pay Medicare claims within a specific jurisdiction on behalf of the Centers for Medicare and Medicaid Services ("CMS") and have authority to issue

local coverage determinations ("LCDs") for that jurisdiction. 42 U.S.C. § 1395ff(f)(2)(B); § 1395m-1(g). The MAC for North Carolina is Palmetto GBA, LLC.

38. Medicare enters into agreements with physicians to establish the physician's eligibility to participate in the Medicare program. By becoming a participating provider, an enrolled provider agrees to abide by the rules, regulations, policies, and procedures governing reimbursement. Specifically, on the Medicare enrollment form, CMS Form 8551, the "Certification Statement" that the medical provider signs states "You MUST sign and date the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below." Those requirements include:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to me .... The Medicare laws, regulations and program instructions are available through the fee-for-service contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions ... and on the supplier's compliance with all applicable conditions of participation in Medicare.
>
> ****
>
> I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare, and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.

39. Medicaid was created in 1965 under title xix of the Social Security Act, 42 U.S.C. § 1396, *et seq.* It is a public assistance program that provides for payment of medical expenses for certain low-income and disabled patients. Funding for Medicaid is shared between the federal government and the states.

40. Federal Medicaid regulations require that each state designate a single state agency to be responsible for the state's Medicaid program. North Carolina Medicaid, N.C. Gen.

Stat. § 108A-54, *et seq.*, is administered by the North Carolina Department of Health and Human Services.

41. The state's Medicaid agency must create and implement a "plan for medical assistance" that is consistent with the Medicaid statute and regulations. After CMS approves the plan submitted by the state, the state is entitled each quarter to be reimbursed for a percentage of its expenditures made in providing specific types of "medical assistance." 42 U.S.C. § 1396b(a)(1). This reimbursement is called federal financial participation ("FFP").

42. Providers who participate in the Medicaid program, including physicians, must sign enrollment agreements with the State that certify compliance with state and federal Medicaid requirements. The agreements require that the Medicaid providers agree to comply with all state and federal laws and Medicaid rules and regulations in connection with providing services and care to patients and billing the state Medicaid program for services or supplies furnished. *See* North Carolina DHHS Provider Administrative Participation Agreement ("all claims are subject to the North Carolina False Claims Act" and the "federal False Claims Act" and "all claims shall be true, accurate, and complete").

43. Medicaid providers, including physicians, must affirmatively certify, as a condition of payment of the claims submitted for reimbursement by Medicaid, compliance with applicable federal and state laws and regulations.

44. Each State Medicaid plan includes its own requirements for reimbursement. In North Carolina, "medical services shall be medically necessary." State regulations provide that medical necessity "shall be determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants." 10A NCAC 25A.0201. Specific

services have additional requirements set forth in clinical coverage policies. *See* www.medicaid.ncdhhs.gov/providers/clinical-coverage-policies.

45. The federal government administers other healthcare programs that include, but are not limited to, TRICARE, 10 U.S.C. § 1071, *et seq.*, a healthcare program for individuals and dependents affiliated with the armed forces administered by the United States Department of Defense, and CHAMPVA, 38 U.S.C. § 1781, *et seq.*, a healthcare program for the families of veterans with 100-percent service-connected disabilities administered by the United States Department of Veterans Affairs.

46. TRICARE does not pay for services that are not authorized by law or that are fraudulently billed. 32 C.F.R. § 199.7(i)(3) CHAMPVA only pays for covered services that are medically reasonable and necessary. 38 C.F.R. § 17.30(a)(1).

47. In order to receive payment from the Government for medical services covered by government healthcare programs, a provider must submit a claim for payment that describes the services provided. The claim must contain Healthcare Common Procedure Coding System ("HCPCS") Codes which are standardized medical codes that identify the medical, surgical and diagnostic procedures and services provided. Level 1 is comprised of Current Procedural Terminology ("CPT") Codes, a uniform coding system that identifies medical services and procedures furnished by physicians and other healthcare providers. Level II is for non-physician services not represented in CPT. Each code corresponds to a certain level of reimbursement, depending on what other codes are billed. A diagnosis code (ICD code) reflects the patient diagnosis.

48. When a physician submits a claim for payment it must identify the HCPCS code, the diagnosis code, the date of the service, the name of the patient, and the provider's unique

identifier. The claim is submitted on CMS Form 1500, or by electronic process. The CMS Form 1500 requires a certification that the services "were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision."

49. In addition, for a claim to be eligible for reimbursement, the provider must document the medical necessity and quality of the services provided. 42 U.S.C. § 1320c-5(a)(3).

V. ALLEGATIONS

50. Defendants have been engaged in a longstanding practice of knowingly submitting or causing the submission of false or fraudulent claims for payment to federal and state healthcare programs, and making and using false statements and records material to those false or fraudulent claims. As demonstrated below, this has included the submission of claims for unnecessary medical services, services not provided, and services that were not provided as represented, or otherwise in violation of law. In many of the examples discussed below, more than one of these violations is involved.

A. Defendants Have Submitted and Caused to be Submitted False Claims for Payment or Approval, Made, Used, and Caused to Be Made and Used False Records Material to Those Claims, and Avoided Obligations to Pay Money to the United States and North Carolina.

51. Defendant Bethany regularly knowingly bills government healthcare payors for a range of services that were not provided, not medically necessary, not provided as represented, or were otherwise not in compliance with applicable rules and regulations governing coverage and reimbursement.

52. The patient files maintained by Bethany contain records and information that contradict the diagnosis and service codes billed to government healthcare payors.

53. The following are non-exclusive examples that illustrate Bethany's systematic disregard of the billing requirements for reimbursement by government healthcare payors.

1. Billing for Medically Unnecessary Services

54. At Bethany it is standard practice for providers to order and bill for a battery of tests in connection with a routine physical exam even though the tests are not medically reasonable and necessary for the treatment of the patient's individual condition. The electronic records template that Bethany uses is pre-set to order these tests, and information is added to the claim to support getting the tests paid, often after the payment is first rejected because the claim is not supported. Typically ordered medically unnecessary screening tests include, but are not limited to, spirometry, electrocardiograms ("EKGs"), and chest x-rays.

55. Although Medicare pays for an annual wellness visit, that does not mean Medicare covers any tests that may be ordered in connection with such a visit. The visit is for the purpose of developing a personalized health plan to keep the patient healthy and any tests ordered should be based on personal health and risk factors. As illustrated by the examples below, Bethany regularly and systematically orders tests that are not based on the evaluation of an individual patient's conditions.

56. For example, on March 26, 2020, Medicare patient A presented for a "recheck of Medicare annual wellness exam." The basis for the "recheck" was anxiety and depression. A spirometry test (CPT 94375) and EKG (CPT 93000) were ordered along with a battery of other tests without documentation of symptoms supporting them. Diagnoses were added to the claim because screening tests would not be paid. The exam and assessment was performed by a nurse practitioner and also falsely billed as if provided by a physician.

57. In another egregious example, Medicaid patient B was provided multiple tests for which there was no clinical reason or support in the medical record. Many of the same tests were provided multiple times even when the initial tests were negative. For example, the patient was given THC thyroid tests (CPT 84443) on June 19, 2019, then again a day later on June 20, 2019, then several more times over the course of the following year. A THC test is to determine whether the thyroid is working properly. There would no clinical reason to perform the same test multiple times for a year when the tests were consistently negative. Nor was this one test an isolated event for this patient. The patient was also repeatedly given urine drug screening tests ("UDTs"), EKGs, spirometry tests, and smoking cessation counseling sessions even though the patient record at one point indicated no history of tobacco use, and later indicated that the patient had quit 11 years ago.

58. These examples and the examples below are illustrative of Bethany's systemic practice of billing for medically unnecessary tests. While certain tests are the most commonly abused, the medically unnecessary testing extends to many other types of testing. If a procedure is denied, Bethany simply changes the claim to bill for a lower code or adds a diagnosis even though the medical record does not support it. This approach is directed by the CEO, Defendant Dr. Peters.

a. Medically Unnecessary Spirometry Tests

59. Medicare covers medically necessary pulmonary function tests, including spirometry. Spirometry is performed by having a patient breathe into a mouthpiece that is connected to an instrument called a spirometer. The spirometer records the amount of air and the rate that it is breathed in and out over a specified amount of time. It is most useful for assessing obstructive lung diseases such as asthma and chronic obstructive pulmonary disease ("COPD"). Diagnostic indications for its use include detecting the presence or absence of lung dysfunction

suggested by history or clinically significant physical signs and symptoms, or to detect lung dysfunction suggested by other diagnostic tests. Monitoring indications include assessing the change in lung function, or to assess the risk for surgical procedures known to affect lung function. However, Medicare does not cover routine screening tests for asymptomatic patients. Routine or repetitive tests are not clinically reasonable.

60. Bethany regularly orders spirometry tests for patients who do not present diagnostic or monitoring indications for this test. Bethany bills for these screening spirometry tests under CPT Code 94375.

61. For example, on March 16, 2020, Medicare patient C presented for a "Welcome to Medicare" visit. The medical record indicated that shortness of breath, including upon exertion, was not present, no cardiovascular concerns were present, and the patient had "good energy." Spirometry (CPT 94375) and chest x-rays (CPT 71046) were ordered and billed with diagnoses of fatigue and shortness of breath on exertion added to the claim to justify payment even though this conflicted with the patient medical record.

62. As another example, on November 21, 2019, a claim was submitted for Medicare patient D for a spirometry test (CPT 94375), EKG (CPT 93000), and chest x-ray (CPT 71046) with a diagnosis of shortness of breath. No patient complaint or findings supported the diagnosis or the testing. Spirometry was billed although there was no documentation in the patient chart supporting that it occurred.

63. These examples are not exhaustive but are representative of a pattern of billing for unnecessary spirometry tests, often along with medically unnecessary EKGs and chest x-rays, as further discussed below.

64. When Relator first arrived at Bethany, she questioned members of her billing department about these types of inconsistencies between billing and the underlying patient records. They explained that they add "shortness of breath" to the billing to get the spirometry test paid. They explained that they had been instructed by Patrick Watterson, Bethany Vice President of Operations, that the billing description has to match the test that is ordered for the bill to be paid. While the description should match the test ordered, Watterson's instructions skip the essential first requirement of medical necessity – that a patient diagnosis must support the medical service ordered.

b. Medically Unnecessary Electrocardiograms

65. An electrocardiogram ("EKG") measures a heart's electrical activity and is used to determine whether a patient has a heart condition. Medicare covers EKGs as diagnostic tests based on a patient's symptoms or other clinical reason, but does not cover use of EKGs as screening tests or as part of a routine exam, unless it is part of the one-time "Welcome to Medicare" preventive visit. NCD 20.15.

66. Medicaid covers an EKG for the evaluation of signs and symptoms related to, and disorders of, cardiac rhythm, anatomy, blood flow and myocardial function or as an adjunct in the assessment of certain drug toxicities and metabolic disorders. N.C. Medicaid Clinical Coverage Policy 1R-4, Electrocardiography, § 3.2.1(a).

67. Bethany regularly bills for EKGs as part of routine physical exams, without symptoms or clinical reasons supporting them, and not as a permitted part of the one-time "Welcome to Medicare" visit. Bethany bills these screening EKGs under CPT 93000.

68. For example, Medicare patient E presented at Bethany's Winston Salem location for an annual wellness visit on February 26, 2020. The diagnosis "shortness of breath," is indicated

for billing, but the patient record shows that shortness of breath was not present and no documentation supports this definitive diagnosis. Nevertheless, an EKG (CPT 93000) and chest x-ray (CPT 71046) were ordered and billed. This is a typical pattern at Bethany.

69. On June 18, 2019, Medicaid patient F was seen for an annual exam and an EKG (CPT 93000) and chest x-ray (CPT 71046) were ordered. The diagnosis listed was shortness of breath, but nothing in the medical record supports that diagnosis or testing. In addition, the exam was billed at the highest level, and although the treatment was provided by a nurse practitioner, it was billed as if provided by a physician.

70. On June 22, 2019, for Medicare patient G, a spirometry test (CPT 94375), EKG (CPT 93000) and chest x-ray (CPT 71046) were ordered for a diagnosis of shortness of breath. No patient complaint or findings supported the diagnosis or testing. In addition, Bethany billed for two visits that day when there was documentation of only one visit.

71. These examples are not exhaustive but are illustrative of Bethany's extensive improper billing of medically unnecessary EKGs, often ordered along with screening spirometry and chest x-rays.

c. Medically Unnecessary Chest X-rays

72. Another medically unnecessary test that Bethany frequently orders and bills for is a screening chest x-ray (CPT 70146). A chest x-ray is an imaging test that uses x-rays to look at the structure and organs in the chest. The test helps monitor and diagnose conditions such as pneumonia, heart failure, and lung cancer, and to check complications from certain surgeries or procedures. Routine screening use of chest x-rays is not medically necessary.

73. At Bethany, chest x-rays are ordered and billed as part of routine physical exams, with no underlying support in the medical record. The billers in Relator's department add a

diagnosis of "pain" to chest x-ray claims to get the test paid. Bethany bills these screening chest x-rays under CPT 71406.

74. As an example, on March 16, 2020, Medicare patient C, *supra* ¶ 61, presented for a Welcome to Medicare visit. A chest x-ray (along with other screening tests) was billed without any documentation in the record that the patient's individual need supported the chest x-ray or other tests.

75. As another example, on August 12, 2019, a claim was submitted for a spirometry test (CPT 94375), an EKG (CPT 93000), and a chest x-ray (CPT 71046) with a diagnosis of shortness of breath for Medicaid patient H. No patient complaint or findings supported the diagnosis or the testing. A chest x-ray was billed, but there is no documentation in the chart that it was performed. In addition, the services were rendered by a nurse practitioner and billed as if rendered by a physician.

76. On June 20, 2019, a claim was submitted for Medicaid patient B, supra ¶ 57, for a spirometry test (CPT 94375), EKG (CPT 93000), and chest x-ray (CPT 71046) with diagnosis of shortness of breath. No patient complaint or findings supported the diagnosis or the testing. In addition, the highest level of care was billed without supporting documentation.

77. These examples are not exhaustive but are illustrative of Bethany's extensive billing for chest x-rays that are medically unnecessary.

d. Medically Unnecessary Urine Drug Tests

78. Bethany systematically submitted claims for medically unnecessary Urine Drug Tests ("UDTs"). UDTs are necessary and appropriate under certain circumstances for monitoring the treatment of pain patients and determining whether patients are compliant with their prescriptions.

79. It is common practice to first order a "qualitative" or "presumptive" test of urine to detect the presence or absence of a wide spectrum of drugs or drug metabolites. Qualitative testing (CPT Codes 80305-80307) does not measure the concentration of any particular drug. For patients deemed as high risk for the potential to abuse drugs, or if the provider suspects that a patient may have drugs in his system, on-site or point of care testing to obtain immediate results of qualitative testing is common medical practice. On site qualitative testing is reimbursed at a lower rate than off site testing.

80. Depending on the results of qualitative testing, it may be medically appropriate to perform a "quantitative" drug test to determine the concentration of a specific drug or drugs in the patient's system. (CPT Codes G0480-G0483). The purpose of quantitative testing is to confirm any unexpected positive results from the qualitative testing and to determine how much of a specific substance is in the patient's system. If the screening test is negative, there is no need for the quantitative test. Unlike a qualitative test, which can test for a broad spectrum of substances at once, quantitative testing requires a separate test for each specific drug the concentration of which is sought. The testing equipment is more sophisticated and the tests cost more and are reimbursed at a higher rate than qualitative testing.

81. Quantitative testing should only be performed once qualitative testing has indicated that testing for specific substances is needed and must be made on the basis of patient-specific elements identified during the clinical assessment and documented in the patient's medical record.

82. Medicare does not cover routine testing of patients for specific drugs when not indicated by the patient's record. *See* LCD: Controlled Substance Monitoring and Drugs of Abuse (L35724); Local Coverage Article: Billing and Coding: Lab: Controlled Substance Monitoring and Drugs of Abuse Testing (A54799).

83. Lab procedures are covered by Medicaid when medically necessary in the care and treatment of the beneficiary. The performing provider or laboratory must have the required CLIA certifications. N.C. Medicaid Clinical Coverage Policy 1S-3, Laboratory Services § 3.2.

84. Medicaid will reimburse for medically necessary drug testing in the treatment of chronic pain patients based upon beneficiary specific elements identified during clinical assessment and documented in the health record. These elements consist at a minimum of a complete history, physical exam, previous lab findings, current treatment plan, prescribed medications and potential for misuse, diversion and risk assessment plan. The health record must also document the appropriate testing frequency and how the results are to be used to guide care for both presumptive and definitive drug testing. NC Medicaid Clinical Coverage Policy No. 1S-8, Drug Testing for Opioid Treatment and Controlled Substance Monitoring, § 3.2.1.3(a).

85. Bethany regularly bills for medically unnecessary UDT, often billing for quantitative testing that was ordered before screening testing was completed, and without individual patient determinations of the need for the testing.

86. By way of example of billing for unnecessary UDT, on December 3, 2019, Medicare patient I presented at Bethany's High Point location with lower back pain. The patient was given a therapeutic injection and a definitive UDT was also ordered (G0481). Three days later, on December 6, the patient again presented with low back pain and both a screening test and a definitive UDT (G0481) were ordered. The boiler plate explanation in the chart for ordering a definitive test before the screening was completed was that it was done in the interest of the patient to ensure that the patient is not abusing other drugs and to "protect the patient" given the area drug abuse patterns. Nothing in the medical record supports that there were any concerns about the particular patient.

87. As another example, on October 25, 2019, Medicare patient J presented for chronic back pain. Bethany billed for a screening UDT and a definitive UDT (G0481) for 8-14 drug classes. Medicare denied the latter as not medically necessary and Bethany resubmitted it as a definitive UDT (G0480) for 1-7 drug class. The patient record did not support the need to check for additional classes of drugs.

88. On October 3, 2019, Medicare patient K presented for pain and both a screening and definitive UDT were ordered, without confirmation that the definitive test was needed. The definitive UDT (G0481) was denied. Bethany resubmitted the claim at the lesser definitive code G0480, which was paid.

89. As another example, on October 16, 2019, Medicare patient L presented for pain and both a screening and definitive UDT (G0481) was ordered, without support that a definitive test was needed. The claim for G0481 was denied and resubmitted as G0480, which was paid.

90. These examples are part of a widespread pattern of ordering and billing for unsupported UDT definitive tests for all pain patients. In 2019 alone, Bethany received $2.2 million in payments from government healthcare programs for presumptive drug tests and $4 million for quantitative drug tests.

e. Other Medically Unnecessary Services

91. Bethany bills for a number of other medically unnecessary services, including but not limited to thyroid tests, vitamin deficiency tests, and smoking cessation counseling.

92. By way of example, Bethany bills for medically unnecessary smoking cessation counseling. Medicare covers up to 8 visits for smoking and tobacco use cessation counseling in a 12 month period when the person uses tobacco (CPT Codes 99406 and 99407). To be eligible for

payment for these sessions, the patient must be a current smoker, be alert, and the counseling must be provided by a qualified physician or other Medicare recognized healthcare provider.

93. As one of the standard battery of tests ordered in connection with physicals, Bethany regularly billed for smoking cessation counseling for patients with no history of tobacco use or who had quit tobacco use for many years and have no current use and are not eligible for (and do not need) this service. Many of the smoking cessation counseling sessions were not supported by the patient's medical record, or were billed but never occurred.

94. As a representative example of billing for these services that were not medically necessary or did not occur, Medicare patient M never smoked and never received counseling, but these sessions were ordered and billed in connection with the patient's wellness visit.

2. Billing for Procedures Not Provided as Represented

a. Upcoding with Modifier 25

95. Procedure code modifiers are two digit codes that are added to a basic five-digit CPT code under limited circumstances to provide additional information related to the patient encounter. Physicians are required to maintain documentation in the patient's file showing that the addition of the modifier was justified.

96. Modifier 25 indicates that a "significant, separately identifiable" evaluation and management service was provided by the same physician on the same day as another service was provided. Medicare Claims Processing Manual, Ch. 12, § 30.6.6(B), Rev. 4431, 11-01-19.

97. Bethany regularly added modifier 25 to office visits when no separately identifiable service was provided.

98. For example, Medicare patient E presented for an annual wellness exam on February 2, 2020 characterized as a "SUBSEQUENT" exam. On the same day, the provider billed

for an established patient exam, (CPT 99214), with a modifier of 25. The bill indicates a diagnosis of shortness of breath and a spirometry test, but a spirometry test is not a separately identifiable procedure from the wellness exam itself. As noted, *supra* ¶ 68, there was no supporting documentation for the spirometry test either.

99. As another example, on February 20, 2020, Medicare patient N presented for complications from a fall. A check-up was performed, along with smoking cessation counseling and lab tests were ordered. The office visit was billed with modifier 25 to indicate a separate procedure, but no documentation supports that any separately identifiable procedure was performed.

100. As another example, on March 16, 2020, Medicare patient C presented at Bethany for a Welcome to Medicare visit. As noted *supra* ¶ 61, some tests, including EKG, spirometry, and chest x-rays were performed, but no significant separately identifiable procedures were documented that would support modifier 25. The claim added modifier 25 to the code for the exam (CPT 99214).

101. These are representative examples of Bethany's standard practice of use of modifier 25 to increase the charges for patient encounters with no significant, separately identifiable procedure.

102. Other modifiers are also misused. For example, on March 3, 2020, Medicare patient O presented for a capsule endoscopy. The office visit had modifier 25 added to it. In addition, a separate charge for the procedure itself had modifier 59 added to it, which signifies a distinct or independent service. No documentation supported either modifier.

b. Services Not Provided by the Billing Physician

103. A claim for payment must identify the provider who rendered the service. Bethany routinely submitted claims to government healthcare programs falsely claiming that a doctor was the "Rendering Provider" when that person did not work for Bethany at the time, was not in the office or available to immediately supervise, or the actual provider lacked the credentials to bill for the service.

104. For example, a number of patients were billed as having been seen by Dr. Anthony Wheeler after he was laid off in March 2020 and not working for Bethany at the time he allegedly provided these services:

° On April 22, 2020, Medicare patient P was allegedly seen by Dr. Wheeler.
° On April 27, 2020, Medicare patient Q was allegedly seen by Dr. Wheeler.
° Medicare patient R was also allegedly seen by Dr. Wheeler on April 27, 2020.

105. Similarly, a number of patients were billed as having been seen by Dr. John Mitchell after he was laid off in March 2020 and not working for Bethany at the time he allegedly provided these services:

° Medicare patient S was allegedly seen by Dr. John Mitchell on May 12, 2020.
° Medicaid patient T was allegedly seen by Dr. Mitchell on April 8, 2020.
° Medicare patient U was allegedly seen by Dr. Mitchell on April 11, 2020.

106. Bethany also bills for services as if a physician provided them when in fact a mid-level provided them and the doctor ostensibly billing was not in the office or in a position to immediately supervise. Although a supervising provider does not have to be physically present in the treatment room, they must be present in the office suite and immediately available to render assistance if necessary. Medicare Benefit Policy Manual, 100-02, Chapter 15, § 60.1; MLN Matters, No. SE0441; Palmetto GBA "Incident To" and Split/Shared Services FAQ.

107. This type of miscoding inflates the amount the government pays because services provided by a physician are reimbursed at a higher rate than services provided by a nurse practitioner or other nonphysician healthcare provider.

108. The Bethany billing system has a set of "actual providers" that are used as dummy providers to substitute in for the providers who rendered the service but are ineligible to bill due to license, scope of license, or credentialing issues. These include Dr. Anthony Wheeler, Dr. Marc Fedder, Dr. Robert Foster, Dr. Stanley Kinkaid, Dr. Fernando Sanchez-Brugal, and Dr. Yun Sun. For example, Dr. Sanchez is hard-coded into the electronic record keeping system for services provided by nurse practitioner Carmen Mayo.

109. On many occasions the chart for a patient indicated the patient had been seen by Dr. Walter Wofford, but the chart was signed by physician assistant Patrick Watterson and billed under the NPI for Dr. Stanley Kinkaid:

- January 3, 2020, Medicare patient V;
- January 2, 2020, Medicare patient W;
- December 31, 2019, Medicare patient X; and
- December 24, 2019, Medicare patient Y.

110. Similarly, on many occasions the chart for a patient whom the chart indicated had been seen by Dr. Haku Kahoano was billed under the NPI for Dr. Fernando Sanchez-Brugal:

- March 9, 2020, Medicaid patient Z;
- March 9, 2020, Medicaid patient AA;
- March 9, 2020, Medicaid patient BB;
- March 9, 2020, Medicare patient CC; and
- April 14, 2020, Medicare patient DD.

111. These examples are not exhaustive but are illustrative of the regular practice at Bethany of substituting providers on the claim form who did not render the services for which Bethany billed.

112. At the Bethany North Wilkesboro location, Bethany frequently bills for treatment under a provider who did not treat the patient:

° On January 25, 2020, Medicaid patient EE was treated by a nurse practitioner and the claims were billed as if provided by a physician;
° On May 5, 2020, Medicaid patient FF was treated by a nurse practitioner and the claims were billed as if provided by a physician who was no longer working at Bethany at the time;
° On May 1, 2020, Medicare patient GG was treated by a nurse practitioner and the claims were billed as if provided by a physician who does not work at that location; and
° On April 29, 2020, at 11:30 Medicare patient HH and Medicaid patient II were allegedly treated at appointments at the same time by the same physician but in different locations an hour apart (North Wilkesboro and Winston Salem). The physician does not work at the North Wilkesboro location.

113. The claims for services include an attestation that the services were provided by the billing physician or by someone under his or her immediate supervision, which in many cases was untrue.

c. Unbundling Services to Increase Payment

114. Bethany often splits services into different claims in order to increase the charges. For example, if a venipuncture is done at the office visit, it will be billed as if done at the time of the lab services in order to bill two separate claims.

115. For example, Medicare patient N, *supra* ¶99, was seen in one location and the blood draw was sent to the lab. The claim was split into multiple claims – one for an office visit, one for the blood draw and smoking cessation counseling, and one for lab work.

d. Services Not Provided at Represented Location

116. Bethany bills for services under a different location than the location where the services are provided in order to ensure the claims are paid. When a Medicaid patient has used the allotted visits for a fiscal year, Medicaid will only pay claims for additional visits authorized to be provided at a specific location and NPI. When patients are treated at a Bethany office that is

not authorized, the claim is submitted as if the services were performed at the authorized location rather than the actual location.

117. For example, the claim form for services to Medicaid patient JJ on February 11, 2020 states that he was seen at Bethany's Greensboro location, but the location of the rendering provider is not Greensboro.

118. Similarly, the claim form for services to Medicare patient KK on February 4, 2020 indicates that he was seen at Bethany's Skeet Club Road office in High Point, but the location of the rendering provider is not the Skeet Club Road office.

3. Billing for Services Not Provided at All

119. Bethany also bills for services not provided at all, often billing for multiple tests provided in connection with an annual exam when the tests were not actually performed. As described above, the documentation that a spirometry test or other screening test was actually performed may not exist. Because insured patients are often not paying the bill, they do not necessarily notice the extra charges. However, some patients who have been charged a co-pay for services not provided have noticed and called Relator's department to complain. When that happens, but only when that happens, Bethany removes the charge for services not provided.

120. For example, Bethany billed for smoking cessation counseling on January 7, 2020 and March 3, 2020, for Medicare patient M, *supra* ¶94 whose chart indicates that the patient was a former smoker and did not indicate any current tobacco use. The patient called to complain that the bill reflected charges for tobacco counseling that had never occurred, and further that she had never been a smoker. Both visits were also billed at CPT 99214 and the patient chart did not support that level of service which requires a detailed examination and medical decision making of moderate complexity.

121. As another example, patient LL presented on March 4, 2020 for a wellness exam at which a battery of Bethany standard screening tests were billed. This patient was privately insured and when billed for the balance of procedures the patient did not receive, the patient called to complain and the charges were removed. Although this was not a government patient, the example is illustrative of bills submitted for tests that were not actually provided, which pervades Bethany's billing across all categories of patients.

122. As another example, patient MM, a Medicare patient, was provided UDT (G0480) on March 24, 2020. The claim is billed under Bethany, which could not have done the lab work, and the medical record for the patient at Bethany has no documentation supporting that a lab test was done. The same pattern was followed for patient NN, a Medicare patient, on March 12, 2020. These are not isolated events, but rather examples of a persistent practice.

4. Billing for Services Provided in Violation of the Stark Statute

123. The Stark Statute, 42 U.S.C. §1395nn, prohibits a physician from referring to an entity in which the physician or an immediate family member has a financial interest, including an ownership interest unless an exception applies.

124. Defendant Dr. Peters and his daughter have financial interests in Defendant LJP Lab as managers/members of the LLC.

125. Most lab tests ordered by Bethany physicians are sent to LJP Lab, LLC. Although the lab's principle office is listed as the same location as Bethany's office in High Point, North Carolina, it is not an in-office lab. The lab itself is located in Kernersville, where Bethany also maintains a lab in the same building.

126. The lab tests that Bethany providers refer to LJP Lab are frequently billed as performed at the Kernersville location, but under Bethany's provider number even though LJP

Lab is not an in-office lab. Tammy Barnett, who does the billing for LJP Lab, explained to Relator that they bill under Bethany's NPI because LJP Lab is not credentialed to provide lab services to some insurers.

127. Because Dr. Peters directs and controls the referrals of Bethany providers, Bethany referrals to the lab in which he has a financial interest violate the Stark Statute. 42 U.S.C. § 1395nn; 42 C.F.R § 411.353.

128. Claims for payment for services furnished based on referrals prohibited by Stark are false claims under the FCA.

B. Defendants Act Knowingly

129. Defendants act with actual knowledge and at a minimum reckless disregard of their obligations to comply with billing requirements.

130. Relator repeatedly raised concerns with Bethany management about the unlawful billing, starting shortly after she started work there in March 2020. Given her extensive background in revenue cycle, she was taken aback at the extensive unlawful billing she witnessed. On multiple occasions she questioned her colleagues about the billing practices. Her colleagues explained that Bethany had always billed this way and her staff acknowledged that they were aware it was unlawful.

131. Relator first raised these issues with management, including her then supervisor VP of Operations Patrick Watterson, who is also a physician's assistant. Relator met with Watterson in person during her first week at Bethany, the week of March 2, 2020. Relator had noticed that the charge entry staff who worked in her department were changing the doctors' medical diagnoses in order to get the claims paid. For example, they were adding "shortness of breath" to every bill

for spirometry, regardless of the underlying record. Her staff had told her that they changed the diagnoses because otherwise the claim would not be paid.

132. Watterson told Relator that Bethany has always done billing that way. He said that as long as the diagnosis that is added goes with the test that is being billed, it is fine.

133. Towards the end of March, Relator spoke directly to the President of the company, Elise Peters Carey and told her of her concerns. Carey deferred to Watterson, whom she described as the person who knew about billing requirements.

134. As of May 2020, Relator no longer reports to Watterson and reports directly to Carey. On June 15, 2020, Carey directed Relator to write a letter to inform Blue Cross, in response to an audit, that Bethany has a coding education program and will review provider coding accuracy, even though Bethany does not have such an education program or engage in such review.

135. In March of 2020, Bethany hired a new COO, Dean Ruth. Ruth questioned Relator about "incident to billing" charges, involving providers signing off on charts and not being in the building. Relator sent him the information she had and copied Carey. Ruth emailed back and told Carey she did not need to worry about this issue as he was looking into it. Ruth subsequently informed Relator that he had spoken to Watterson and Watterson said there was no problem. Relator emailed the requirements to Ruth on June 2, 2020.

136. In Relator's department, multiple longtime Bethany staff – Georgette Loughman, Amy Thomas, Kathy Howard, Amy Shelton, and Vivana Phiphapthana – are aware of the false and fraudulent billing. During her first weeks on the job, Relator sat with each member of her team to learn what they do. Each one of them told Relator that they were aware that what they were doing was illegal. When Relator questioned Amy Thomas, the team leader for charge entry, about the

illegal billing practice, Thomas said she was told by Watterson or the previous revenue manager to do this.

137. In addition to Relator, private insurers repeatedly informed Bethany that it was billing for noncovered services. Humana and Blue Cross rejected the claims that were not covered for the same reasons government payors would not cover them. Humana and Blue Cross had denied many Bethany submitted claims of the type noted above for lack of medical necessity, often instructing Bethany on the requirements that were not being met. Dr. Peters has received these communications and has knowledge that Bethany is billing for medically unnecessary services, and he and the other Defendants have at a minimum acted with reckless disregard for the billing requirements for federal and state healthcare programs.

138. Bethany has an obligation to return any overpayments it identifies, but even when specifically informed that a claim for a medically unnecessary service is not supported, rather than return any identified overpayment as required under 42 U.S.C. § 1320a-7k(d)(2), Bethany has added false diagnoses or submitted a lesser, but similarly unsupported code.

C. Defendants' Misrepresentations are Material

139. A misrepresented code for procedures and services on a claim for payment submitted to the federal government is material to the government's payment decision because it directly relates to how much the government pays. The code used directly determines the amount of the government reimbursement for the service.

140. The government has identified upcoding and coding for services not provided as examples of fraud. *See, e.g.*, Medicare Program Integrity Manual, Section 4.2.1, Rev. 827, 09-21-18.

141. If the government is aware of actual misrepresented coding, it will deny the claim.

142. The government has frequently enforced coding requirements when it has been actually aware of intentional miscoding and upcoding.

143. Violations of the Stark Statute are material to claims for payment, as the statute prohibits payment of claims submitted in violation of the statute, which is a criminal statute, and the government has an extensive history of enforcing the Stark Statute generally, and in particular with respect to referrals for clinical labs in which the referring physician has a financial interest.

VI. CAUSES OF ACTION

Count I
Federal False Claims Act
31 U.S.C. § 3729(a)(1)(A)-(B), (G)

144. Relator realleges and incorporates by reference the allegations contained in paragraphs 1 through 143 above as though fully set forth herein.

145. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §§ 3729 – 3733.

146. By virtue of the acts described above, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment to the United States, in violation of 31 U.S.C. § 3729(a)(1)(A).

147. By virtue of the acts described above, Defendants knowingly made or used, or caused to be made or used, false records or statements material to false or fraudulent claims, in violation of 31 U.S.C. § 3729(a)(1)(B).

148. By virtue of the acts described above, Defendants knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the government, in violation of 31 U.S.C. § 3729(a)(1)(G).

149. The United States, unaware of the falsity of the records, statements, and claims that Defendants made or caused to be made, paid and continues to pay claims that would not be paid but for Defendants' illegal conduct.

150. The United States, unaware that Defendants were knowingly concealing and/or knowingly seeking to avoid or decrease their obligation to pay or transmit money or property to the government, did not collect from Defendants monies that it would have collected but for Defendants' unlawful conduct.

151. Defendants have damaged, and continue to damage, the United States in a substantial amount to be determined at trial.

152. Additionally, the United States is entitled to the maximum penalty under 31 U.S.C. § 3729, as adjusted by the Federal Civil Penalties Inflation Adjustment Act of 1990, for each and every violation alleged herein.

Count II
North Carolina False Claims Act
N.C.Gen. Stat. § 1-607(a)(1), (2), (7)

153. Relator realleges and incorporates by reference the allegations contained in paragraphs 1 through 143 above as though fully set forth herein.

154. This is a claim for treble damages and penalties under the North Carolina False Claims Act, N.C. Gen. Stat. §1-605, *et seq*.

155. By virtue of the acts described above, Defendants knowingly presented, or caused to be presented, false or fraudulent claims for payment or approval to the State of North Carolina, in violation of N.C. Gen. Stat. § 1-607(a)(1).

156. By virtue of the acts described above, Defendants knowingly made or used, or caused to be made or used, false records or statements material to false or fraudulent claims in violation of N.C. Gen. Stat. § 1-607(a)(2).

157. By virtue of the acts described above, Defendants knowingly made, used, or caused to be made or used, false records or statements material to an obligation to pay or transmit money or property to the state or knowingly concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to the state in connection with the North Carolina False Claims Act, in violation of N.C. Gen. Stat. § 1-607(a)(7).

158. The State of North Carolina, unaware of the falsity of the records, statements, and claims that Defendant made or caused to be made, paid and continues to pay claims that would not be paid but for Defendants' illegal conduct.

159. The State of North Carolina, unaware that Defendants were knowingly concealing and/or knowingly seeking to avoid or decrease their obligation to pay or transmit money or property to the state in connection with the North Carolina False Claims Act, did not collect from the Defendants monies that it would have collected but for Defendants' illegal conduct.

160. Defendants have damaged, and continue to damage, the State of North Carolina in a substantial amount to be determined at trial.

161. Additionally, pursuant to N.C. Gen. Stat. § 1-607(a), the State of North Carolina is entitled to the maximum penalty under the North Carolina False Claims Act, as adjusted, for each and every violation alleged herein.

PRAYER

WHEREFORE, Relator prays for judgment against Defendants as follows:

1. That Defendants cease and desist from violating 31 U.S.C. §§ 3729 – 3733 and N.C. Gen. Stat. § 1-605, *et seq*.

2. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States and North Carolina have sustained because of Defendants' actions, plus the maximum civil penalty permitted for each violation of the Federal False Claims Act and the North Carolina False Claims Act;

3. That Relator be awarded the maximum amount allowed pursuant to § 3730(d) of the Federal False Claims Act and N.C. Gen. Stat. § 1-610.

4. That Relator be awarded all fees, costs, and expenses incurred in connection with this action, including attorneys' fees, costs, and expenses; and

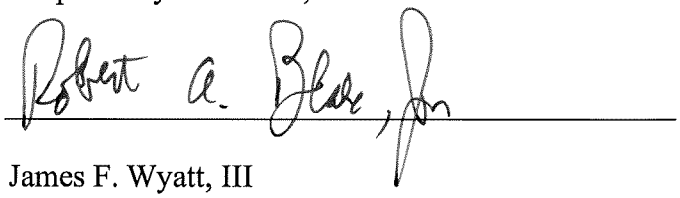
5. That Relator recover such other relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

Pursuant to Rule 38 of the Federal Rules of Civil Procedure, Relator hereby demands a trial by jury.

Dated: July 2, 2020

Respectfully submitted,



James F. Wyatt, III
NC Bar #13766
jwyatt@wyattlaw.net
Robert A. Blake, Jr.
NC Bar # 20858
rblake@wyattlaw.net
Wyatt & Blake, LLP
435 E. Morehead St.
Charolotte, NC 28202
Tel: (704) 331-0767
Counsel for Qui Tam Plaintiff Kerrie Dyer Badger