Memorandum

To: File

From: Craig Ratner, Esq.

Date: 2/15/2018

Re: US v. [redacted]

On XX/XX/XXXX, a Consolidated Complaint in Intervention was filed in the US District Court in the Eastern District of VA against [redacted] and affiliates – US intervened after the district court consolidated three whistleblower actions against [redacted] – alleging that [redacted] knowingly and routinely submitted false claims to Medicare and Tricare for rehabilitation therapy services that were not medically reasonable and necessary. More specifically, the complaint alleges that, from at least XX/XX/XXXX through XX/XX/XXXX, [redacted] engaged in a nationwide scheme to bill federal healthcare programs at the Ultra High level without regard to its patients' actual conditions or needs.

Two Key Quotes from the Complaint:

1. "This plan to maximize revenue by billing at the Ultra High level originated in [redacted]'s corporate offices and was imposed on the administrators who ran [redacted] and on the therapists who treated the patients."

2. "In XX/XXXX, according to its own data, [redacted] billed Medicare at the Ultra High level for 38.8 percent of all days that it billed for rehabilitation therapy. In February 2010 the Company billed 81.3 percent of its rehabilitation days at the Ultra High level, or more than twice the October 2006 percentage.

Although this case is ongoing, I reviewed some of the unsealed documents on PACER and thought you would interested in viewing the second attachment. This is a XX/XX/XXXX opinion from the US Court of Appeals for the 4th Circuit affirming the district court's dismissal of one of the three whistleblower's (Whistleblower #1) qui tam actions under the FCA for lack of subject matter jurisdiction but vacating and remanding the portion of the district court's judgment concerning Whistleblower #1's retaliation and state fraud claims.

I think it is important to point out that the Circuit Court found that "[n]either Whistleblower #1's factual additions nor the fact that his experience took place in Pennsylvania…saves him from the first-to-file bar." Whistleblower #1 did not avoid § 3730(b)(5)'s first-to-file bar simply by alleging additional facts relating to how [redacted] overbilled the Government.

In light of this recent Circuit Court opinion, although your client's potential retaliation claim against [redacted] is still strong, we may need to find alternative evidence of fraud against [redacted] to avoid being barred by the first-to-file rule under the FCA. In looking at [redacted] memo to file and [redacted] interview transcript, the following items may serve as our alterative evidence of fraud:

1. The "Smoking Gun" – Show that Nurse #1 performed Medicare-Required SNF PPS Assessments while attending the [redacted] 2016 Fall Symposium—[redacted] at the [redacted] in [redacted] (The name of the association and dates and location of the conference are slightly different from your memo.) This may require a FOIA request from CMS, but if we can show that Nurse #1 was completing and filing these required assessments while attending a conference that is 100 miles away from the SNF where she works, any claims submitted as a result of these improper assessments are false claims.
2. According to the Circuit Court opinion, the qui tam claims are based on the alleged concerted effort by [redacted] to maximize revenue by billing at the Ultra High level for rehabilitation therapy. Therefore, we need to show that Nurse #1, Nurse #2, and nurse's aides inputted other false information – besides the level of nursing care and number of therapy minutes – into Medicare-Required SNF PPS Assessments or other forms. your memo references services – i.e., showering and weighing patients – that were never provided. Billing for services not provided is clearly different than billing for a higher level of care. Again, this may require a FOIA request from CMS, but we need to find documentation of services that Nurse #1, Nurse #2, and nurse's aides submitted to the fiscal intermediary (MAC) for Pennsylvania – Novitas Solutions – that we can show were ultimately not provided to patients at [redacted]. Again, these are false claims.