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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA &
STATE OF NEW YORK, ex rel.

KEITH JOHNSON, M.D.,
LAURA SCHMIDT, R.N.,

Plaintiffs,

DECLARATION

Civ. No. 07-cv-6149

BRINGING THIS ACTION ON
BEHALF OF THE UNITED STATES
OF AMERICA

c/o

Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York , 14202

-and-

Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

v.

THE UNIVERSITY OF ROCHESTER
MEDICAL CENTER &
STRONG MEMORIAL HOSPITAL,

Defendants.

CHRISTINA A. AGOLA, ESQ., pursuant to *28 U.S. C. Section 1746*, declares under the
penalty of perjury:

1. I am an attorney at law duly admitted to practice in the State of New York, and before this
Court. I am the attorney for the Plaintiffs- Relators KEITH JOHNSON, M.D., LAURA
SCHMIDT, R.N.. As such, I am fully familiar with the pleadings and proceedings
herein, and this Declaration is based on that knowledge.

2. I submit this Declaration in opposition to the Defendants UNIVERSITY OF ROCHESTER MEDICAL CENTER & STRONG MEMORIAL HOSPITAL's motion to dismiss.
3. In addition to this Declaration, Plaintiff has submitted the following documents:
 - a. Appendix Common to Both Response to Motion to Dismiss & Motion to Amend
 - b. Plaintiff's Memorandum of Law.
4. Relators filed the original complaint in this case under seal on March 16th, 2007 alleging violations of the False Claim Act . (Dkt. #1), and submitted a written disclosure statement to the United States Government as required by 31 U.S.C. § 3730(b)(2) on that same day.¹
5. The United States declined to intervene in Relators' action, see 31 U.S.C. §3730(b)(4)(B), and Relators served the complaint on the named defendants. (Dkt. # 10).

¹ Section 3730(b)(2) states:

A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence information.

- 6 On November 6, 2008, Defendants filed a Motion to Dismiss claiming (1) relators have failed to plead any purported False Claims Act violations with sufficient particularity; (2) relators have failed to state a claim for retaliation under the False Claims Act, and have failed to comply with “several procedural requisites”, specifically, that relators have (3) failed to plead subject matter jurisdiction; and (4) that relators have failed to provide the requisite disclosure statement. (Dkt. # 14; Dec. of Thomas D’Antonio, p. 2, ¶ 7).
7. In response, and in sum, Plaintiff-Relators have (1) complied with Fed. R. Civ. P. Rule 9 (b); (2) have stated a claim for retaliation under the FCA; (4) have sought to amend their complaint to properly plead subject matter jurisdiction; and (4) have indeed provided the requisite disclosure statement pursuant to 31 U.S.C. § 3730(b)(2) .
8. For the reasons set forth in detail in the accompanying Memorandum of Law, Defendants’ motion to dismiss should be denied in it’s entirety.

Dated: December 31st, 2008
Rochester, New York

/s/ Christina A. Agola, Esq.

Christina A. Agola, Esq.

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA &
STATE OF NEW YORK, ex rel.

KEITH JOHNSON, M.D.,
LAURA SCHMIDT, R.N.,

Plaintiffs,

Certificate of Service

Civ. No. 07-cv-6149

BRINGING THIS ACTION ON
BEHALF OF THE UNITED STATES
OF AMERICA

c/o

Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York , 14202

-and-

Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

v.

THE UNIVERSITY OF ROCHESTER
MEDICAL CENTER &
STRONG MEMORIAL HOSPITAL,

Defendants.

Please take note that on this 31st day of December 2008, the undersigned caused the following Response to Defendant's Motion to Dismiss, including Declaration of Christina A. Agola, Appendix and Memorandum of Law; and Cross Motion to Amend, including Declaration of Christina A. Agola to be served electronically via e.c.f. on Thomas D'Antoinio, counsel for defendants THE UNIVERSITY OF ROCHESTER MEDICAL CENTER & STRONG MEMORIAL HOSPITAL.

Dated: December 31, 2008
Rochester, New York

/s/ Christina A. Agola

Christina A. Agola, Esq.

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA &
STATE OF NEW YORK, ex rel.
KEITH JOHNSON, M.D.,
LAURA SCHMIDT, R.N.,

Plaintiffs,

MEMORANDUM OF LAW

07-cv-6149 (L)

BRINGING THIS ACTION ON
BEHALF OF THE UNITED STATES
OF AMERICA

c/o

Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York , 14202

-and-

Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

v.

THE UNIVERSITY OF ROCHESTER
MEDICAL CENTER &
STRONG MEMORIAL HOSPITAL,

Defendants.

I. INTRODUCTION

Relators KEITH JOHNSON, M.D. and LAURA SCHMIDT, R.N., (“Relators”) filed the original complaint in this case under seal on March 16th, 2007 alleging violations of the False Claim Act (Dkt. #1), and submitted a written disclosure statement to the United States Government as required by 31 U.S.C. § 3730(b)(2)¹ on that same day. (Dkt. # 1; Ex. A; Ex. B; Ex. C)²

¹ Section 3730(b)(2) states:

A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to Rule 4(d)(4) of the Federal Rules of Civil Procedure. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence information.

² All Exhibits referenced herein are annexed to the Appendix to the Declaration of Christina A. Agola, Esq., common to both the Plaintiff-Relators response to Defendants’ Motion

The United States declined to intervene in Relators' action, see 31 U.S.C. §3730(b)(4)(B), and Relators served the complaint on the named defendants on (Dkt. # 10).

On November 6, 2008, Defendants filed a Motion to Dismiss claiming (1) relators have failed to plead any purported False Claims Act violations with sufficient particularity; (2) relators have failed to state a claim for retaliation under the False Claims Act, and have failed to comply with "several procedural requisites", specifically, that relators have (3) failed to plead subject matter jurisdiction; and (4) that relators have failed to provide the requisite disclosure statement. (Dkt. # 14; Dec. of Thomas D'Antonio, p. 2, ¶ 7).

For the reasons that follow, defendants motion should be denied in its entirety.

II. BACKGROUND

The original complaint asserts that as a teaching hospital, billing by U of R faculty physicians for services *actually* performed by resident physicians in training is in violation of both federal and state law, since under the Medicare program, the United States already pays for a substantial portion of the residents' training and salaries through GME, and their services cannot be billed to the Medicare program on a "fee-for service basis." (Ex. A, ¶¶ 14-132).

Relators disclosed, based upon non-public information the Relators obtained first-hand while employed at SH, that there are potentially thousands of SH faculty physician bills which falsely represent that teaching physicians had *provided services actually rendered by residents in the OR and OBGYN units*. (Ex. A, ¶¶ 14-154). The central SH faculty physicians who are responsible for condoning this illegal practice are Dr. Stewart Lustik, Dr. James Robotham, Dr. Whistler, Dr.

to Dismiss and Plaintiff-Relators' Cross Motion to Amend their original complaint pursuant to Fed. R. Civ. P. 15 (a).

Bigeliesen; Dr. Issacson; Dr. Glance, Dr. Chibber, and Dr. Borovancani, *inter alia*. (Ex. A, ¶ 16).

Accordingly, the allegations in this *qui tam* action encompass many allegedly false claims over a substantial period of time; Relators clearly pled that they “cannot at this time identify all of the false claims for payment that were caused by Defendant’s conduct. That information is solely within the possession of the Defendants” (Dkt. # 1, ¶ 162) as detailed below.

A. RELATOR JOHNSON’S CLAIMS

Relator Johnson was in a class of residents who began their Residency in Anesthesiology in or about July of 2004 along with Dr. Jayaram Srivatsan, who provided an affidavit in support of Relators’ claims herein in the disclosure statement provided to the Government pursuant to 31 U.S.C. § 3730(b)(2). (Ex. A, ¶ 17; Ex. D; Ex. E).

Upon entry to the program, it was made known to Relator Johnson and Dr. Srivatsan by Dr. Robotham that “when [he] came to the U of R, we were in danger of being closed down; now the Anesthesia Department is the highest grossing department in the University.” The Anesthesiology Department is the largest grossing department of SH, despite the fact that there had been no concomitant increase in staff size to deal with a growing influx of patients. (Ex. A, ¶ 19).

Despite the constant emphasis on the money making ability of the Anesthesiology Department, and the high number of Medicare cases at SH, Relator Johnson received **no** training in compliance with the Center for Medicare and Medicaid Services (“CMS”) regulations, as described in detail in the Complaint, (Ex. A.), either at the commencement of his internship or at any relevant time up and until his termination on October 5, 2006. (Ex. A, ¶ 22).

Relator Johnson claims that he, along with other residents, were compelled to perform medical procedures without an attending physician, for which his attending physician would then bill to all insurance carriers, including Medicaid and Medicare, which violates both Medicaid and Medicare

teaching physician guidelines, particularly in the OB and Anesthesiology Department. (Ex. A, ¶¶ 23-153). Relator Johnson also claims that in a large number of cases, no postoperative reports were ever filed, in further violation of state and federal regulations which govern Medicaid and Medicare programs, as well as private insurance. (Ex. A, ¶¶ 42-46).

In sum, medical records would indicate that an attending physician was present, when in actuality, as a resident, Relator Johnson was doing epidurals and extubations without supervision, and then handing the chart to the attending to “sign off” the next morning, specifically identifying the room and name of patient, so that the attending physician would sign off the chart as though he or she was actually there. (Ex. A, ¶¶ 77-80).

In support of those claims, prior to September 5, 2005, it was a well known and accepted policy of Strong Hospital to permit Anesthesia Residents to perform procedures without any attending physicians. These procedures were then billed to Medicaid and Medicare in violation of both Medicaid and Medicare teaching physician guidelines. In or about September 24, 2003 Dr. Stewart Jay Lustik sent to all Anesthesiology residents the following letter:

Dear residents:

Our Department Policy requires that the attending is present for induction and emergence. ***If the attending specifically tells you that he/she does not need to be present, then it is OK for you to proceed if you feel comfortable.*** This will rarely happen with induction, but in certain situations with senior residents the attending may allow it. Under no circumstances are you to induce a patient without an attending present unless you receive specific instructions from your supervising attending to do so.

Remember, your attending is always available for questions and assistance. Please see me with any questions. (Ex. A, ¶ 44).

That the above stated memo was in direct contradiction to New York State Public Health Law in so much as it states that it is ***“OK” for an unlicensed physician to perform procedures***

without an attending physician. The above stated memorandum also contradicts well known billing procedures for Medicaid and Medicare, which prohibit the billing of services rendered without an attending physician which requires the attending physician to be within “line of sight” supervision. (Ex. A, ¶ 44).

From the date that this letter was drafted by Dr. Lustik in or about September 2003 until April of 2005, constant informal complaints were made by the Relator Johnson as well as Dr. Srivatsan to Dr. Lustik about : (1) medical procedures being performed without an attending anesthesiologist; and (2) that this practice and policy was in violation of Medicare/Medicaid billing practices. (Ex. A, ¶¶ 80-87).

No further actions was taken with regard to these illegal practices in fact, Relator Johnson was told by attending physician Dr. Sheldon Issacson that as a senior resident, he was not to call him in the middle of the night because this was a “sign of weakness” which compelled him to perform numerous unsupervised key procedures. (Ex. A, ¶ 65).

Between 7/1/2004 and 6/1/06, Relator Johnson performed several thousands of unsupervised procedures, including epidurals, mainly on the OB floor and several thousand extubations performed in the OR; a great number of these key procedures were performed in violation of the “concurrency rule” put into effect on January 1, 2004. (Ex. A, ¶¶ 52-80).

In or about April of 2005, the Relator Johnson and Dr. Srivatsan confronted Dr. Lustik after class and complained that as unlicensed physicians, they were performing medical procedures unsupervised in dereliction of state and federal law, and that this was in further violation of Medicaid/ Medicare billing procedures; before this they had begun to notate the medical records to preserve evidence that attending physicians were not present during key portions of

medical procedures. (Ex. A, ¶¶ 83- 84).

Relator Johnson did this because no remedial action was taken to curb the practice of permitting residents to perform medical procedures without an attending physician, Plaintiff took *affirmative steps* to preserve evidence of such violations. (Ex. A, ¶ 83-84).

In or about September 1, 2005 Strong Memorial Hospital agreed to pay nearly \$500,000.00 to Medicaid and Medicare for fraudulent claims made by a former department head, Dr. Uma Sundaram, former Chief of Strong's Digestive Disease Unit, who ***violated Medicaid and Medicare regulations by allowing physicians under going specialized training to do procedures without attending physician Sundaram's supervision.*** In agreements with the New York State Attorney General's Medicaid Fraud Unit (MFCU) and with the U.S. Attorney's Office, Strong agreed to resolve the audit allegations by repaying \$292,507 to Medicaid and \$200,00 to Medicare. (Ex. A, ¶¶ 95-96); the defendants were expected to comply thereafter with CMS regulations with regard to supervision of their residents. (Ex. A, ¶ 96).

However, as of September 5, 2005 and continuing through the completion of Relator Johnson's residency, no such compliance program was put into place; in fact, Strong Memorial Hospital continued to allow Anesthesiology Residents to perform key procedures without an attending physician physically present. (Ex. A, ¶¶ 97-99).

In response, on November 4, 2005, a memo was sent to ***anaesthesiology residents only warning them not to notate the charts of patients*** for which procedures had been performed without an attending physician in violation of Medicaid and Medicare billing practices:

1. All neuraxial labor analgesics (ex. Labor, epidurals and saddle blocks, placements or replacements) will be performed *in line of sight supervision from the responsible anesthesiology attending*. The department will credential residents for neuraxial labor analgesia under general supervision, based on the performance of individual residents in OB anesthesia. However, it is unlikely that this credential will be used by residents, except for the rare occasion when the supervising anesthesiology attending can not provide line of sight supervision due to an emergency with another patient.
2. The anesthesiology resident should *not* comment on this issue in the medical record.
3. “Line of Sight” supervision is defined at a minimum as attending presence in the patient’s room when the block needle enters its target space. (Ex. A, ¶ 100).

Despite these admonitions, the attending physicians still failed to supervise the residents, for which Relator Johnson continued to complain to Dr. Lustik. (Ex. A, ¶ 101).

Despite the issuance of this Confidential Memorandum on November 5, 2005, SH’s teaching physicians still continued to failed to supervise the Anesthesiology Residents, including Relator Johnson himself, for which Relator continued to complain to Dr. Lustik, whose response was “gee, I don’t know about that.” The Confidential Memorandum, however, expressly precluded Relator Johnson’s ability to notate the patient’s medical records to indicate the lack of teaching physician’s presence, control and direct line of sight supervision for the continuing performance of epidurals, extubations and post operative reports that persisted until Relator’s termination. Further in or about the winter of 2005 the Anesthesia Residents were advised by Dr. Robotham prior to grand rounds **not** to notate medical records indicating that attending physicians were not present during medical procedures performed by residents. (Ex. A, ¶¶ 102-104).

On one such incident occurred in or about June 6, 2006 when a pregnant patient with fetal distress went for an emergency c-section and the *teaching physician (Dr. Issacson) was unable to be found*. The Anesthesia Resident could not induce the patient and thus the c-section had to be done *under local anesthesia* due entirely to lack of supervision for which Relator Johnson had brought to the attention of SH many occasions previously. (Ex. A, ¶ 105).

On the night of September 1st, 2006, Relator Johnson did not go home until 8:45 p.m.; state law required him to stay out for 10 hours, so Relator did not return to work until 6:45 the next morning. When he arrived at work, Dr. Kahn the night OB resident informed Relator that there was an “urgent” c-section and that Relator should go to the OB floor immediately. (Ex. A, ¶ 108).

Relator Johnson went to see the “urgent” patient who was obese and pre-eclamptic. The patient revealed a prior history of a c-section, not done at SH, but performed with a spinal which was a bad experience for this patient. Relator Johnson, unable to intubate a patient without a teaching physician physically present in the room, immediately went to the OB office and tried to locate a teaching physician or attending physician, which was Dr. Borovancani, a doctor fired from her previous position in Buffalo, whose English, as a side bar, was her second language and was very difficult to understand. (Ex. A, ¶¶ 109-110).

Dr. Borovancani could not be found; her habitual tardiness was an ongoing problem in the department. (Ex. A, ¶ 111).

Relator Johnson called Dr. Dooley the Clinical Coordinator and explained that they had a patient who would potentially be a difficult airway case, and that *he was alone without a teaching physician or attending physician and that given the situation, if emergency bells went off, i.e. an emergency c-section, Relator Johnson would not be able to intubate or induce this patient without*

a teaching physician or attending physician. (Ex. A, ¶ 112).

Dr. Dooley sent the residency director, Dr. Lustik, to assist Relator Johnson this patient until Dr. Borocavani arrived at 7:25 a.m.. When Dr. Borocavani arrived, she was very angry that Dr. Lustik had been called to “fill in” for her, and she was greatly “embarrassed.” (Ex. A, ¶ 113-114)

Dr. Borocavani told Relator Johnson that his actions in contacting a teaching physician to cover for her made her “look bad” and that it was “unprofessional” for him to have called another teaching physician to take her place, despite the fact that CMS regulations require teaching physicians to be physically present for the purpose of intubation or inducement. (Ex. A, ¶ 115).

Relator Johnson attempted to steer the conversation back to the patient, informing Dr. Borocavani that the patient may be a difficult intubation, a difficult airway given her weight and pre-eclampsia, and that she had a difficult prior spinal, to which Dr. Borocavani angrily instructed Relator to obtain the old chart from Medical Records, despite the fact that Relator had already informed Dr. Borocavani that the spinal was not performed at SH but in another hospital in Newark, New York. (Ex. A, ¶ 116).

Relator called Medical Records to appease Dr. Borocavani and told her that there was no chart; Dr. Borocavani then stated “how can there be no chart if you told me she was a difficult intubation?” Dr. Borocavani then met with the patient and Relator to go through and perform a pre-anesthetic evaluation; had there not been any confusion, there would have been no pre-anesthetic evaluation, since it was clear that *Dr. Borocavani never performed a pre-anesthetic evaluation in this case in violation of CMS regulations.* (Ex. A, ¶¶ 117-118).

It was only in June of that same year that an OB patient was forced to undergo a c-section under *local anesthesia* due to the lack of the physical presence of a teaching physician or attending

physician. Relator Johnson would not permit this patient to suffer the same fate. The patient had an uneventful c-section and a healthy baby was delivered. (Ex. A, ¶ 119).

Immediately thereafter a previously planned c-section was begun under epidural. The teaching physician and the First Year Resident “bolused” the epidural and the teaching physician then left the floor. Relator Johnson was doing epidurals on the OB deck; upon finishing, he returned to the OR and found the patient’s epidural “worn down”. The First year resident did not have the experience to recognize the situation the patient was hysterical and Relator Johnson then immediately had no choice but to re-establish the epidural. Dr. Borocavani was called and she stated she was off the floor talking to Dr. Lustik, and stated that Relator Johnson should go ahead and re-establish the epidural which Relator Johnson had already done. (Ex. A, ¶ 120).

Later that day, Relator Johnson was summoned by Dr. Lustik, Dr. Glance and Dr. Borocavani to a meeting where he was chastised by all for allegedly “lying” about the earlier OB patient’s medical history when Relator indicated to Dr. Borocavani that the patient may be a difficult induction, further insinuating that Relator may have “put the patient at risk” despite the fact that Dr. Borocavani never performed a pre-anesthetic evaluation of this patient. (Ex. A, ¶ 121).

No mention was made about Relator’s complaint that there was no teaching physician present until 7:25 a.m., and that had this patient needed an emergency c-section, that Relator would be unable to induce or intubate this patient in the absence of a teaching physician or attending physician, thus jeopardizing mother and child. (Ex. A, ¶ 122).

After Relator Johnson categorically denied lying about anything to Dr. Borocavani, Relator was placed on “administrative leave” until he was advised that there would be a hearing. (Ex. A, ¶ 123).

Present at the meeting, which occurred on Friday September 5, 2007, was Dr. Lustik, Dr. Dooley, Dr. Sabnis, Dr. Chibber, Dr. Robotham and Dr. Glance. It was determined after the meeting that Relator Johnson had “lied” and that he did not “deal well with a stressful situation.”(Ex. A, ¶¶ 124-127).

Again, in or about September 5, 2006, SH permitted another resident with only three months of training to perform a c-section without a teaching physician or attending physician physically present in the OR. (Ex. A, ¶¶ 106-107).

Relator Johnson was ordered to undergo a *psychiatric evaluation* by defendants to determine if he had a “propensity for lying” or a “personality disorder.” Relator was not permitted by defendants to see the result of the psychiatric evaluation. (Ex. A, ¶¶ 124-128).

It was determined on October 5, 2006 that Relator be terminated; Relator Johnson was apprised of this fact by his Resident Advisor and warned by him that if he did not resign first he would be reported to the State of New York and his license would be revoked. (Ex. A, ¶ 129).

Relator Johnson’s resignation was accepted by Dr. Robotham. (Ex. A, ¶ 130).

In turn, Dr. Robotham compelled Relator Johnson to speak with Dr. Lustik and Dr. Glance, who stated that Relator Johnson had to sign the termination letter under duress. (Ex. A, ¶ 131).

After Relator Johnson signed the termination letter he was threatened by Dr. Robotham, the Chair of Anesthesia, that he would “never work in medicine again.” (Ex. A, ¶ 132).

B. RELATOR SCHMIDT’S CLAIMS

Relator Schmidt is a Registered Nurse who worked for 14 years at SH in the OR. Throughout her employment at SH, Relator Schmidt acquired direct personal knowledge and

personal knowledge and non-public information of the defendants's fraudulent practices; in particular, Relator Schmidt witnessed first hand the failure of teaching physicians to supervise resident physicians in violation of the CMS requirements, including Relator Johnson. (Ex. A ¶ 140).

Relator Schmidt has witnessed an increased patient case load since the year 2004, but with no concomitant increase in staff to assist in the treatment of these patients, a large percentage of which are Medicare and Medicaid patients. (Ex. A, ¶ 141).

There are 28 operating rooms at SH with 4 to 5 cases in each room being performed every day. (Ex. A, ¶ 142). From January 2004 through the date of her termination in June of 2006, Relator Schmidt witnessed Surgical Residents perform key portions of surgeries if not entire surgeries in the OR without the supervision of a teaching physician or attending physician. During this time period there was no compliance training or any other training provided by SH that dealt with the supervision of residents physicians. (Ex. A, ¶ 143).

From January 2004 through the date of her termination in June of 2006, Relator Schmidt witnessed Anesthesiology Residents, including Relator Johnson, perform on a daily basis the following key services or procedures outside the presence of an attending physician: spinal; epidurals; intubation; extubations; line placement; central line placement; arterial line placement; caudal blocks. (Ex. A, ¶ 144).

After the surgical procedure was completed outside the physical presence of a teaching physician, the teaching physician would often require Relator Schmidt to put down on the patient's medical record that the teaching physicians or attending physician was present when indeed, the teaching physician or attending physician was nowhere to be found, by either checking a box on the patient's medical record or by stating the following:

“Agree with above, “ following by legible countersignature or identity;

“Rounded, Reviewed, Agree,” followed by legible countersignature or

identity;
“Discussed with resident, Agree,” followed by legible
countersignature or identity;
“Seen and agree,” followed by legible countersignature or identity;
“Patient seen and evaluated,” followed by legible countersignature or identity;
and/or
A legible countersignature or identity alone. (Ex. A, ¶ 145).

That the issue of the failure of attending physician supervision of the resident physicians became so chronic due to the increased case load in 2004, that Relator Schmidt had to physically leave the OR and attempt to locate a teaching physician or attending physician. (Ex. A, ¶ 146).

Further, attending physicians often gave verbal reports over the phone, failed to complete postoperative reports, and instructed Relator Schmidt to indicate that they were present when indeed they were not. (Ex. A, ¶ 147).

Relator Schmidt complained frequently about the failure of supervision by the teaching physician that she became known as a “trouble maker” and her evaluations were marked to indicate that she was a “problem.” Relator Schmidt was constantly called into the office and admonished for complaining. (Ex. A, ¶ 148).

On one such incident, in the spring of 2005, Relator Schmidt was approached by Dr. Chibber and was asked to *alter* medical records to reflect that an attending physician was present during a key surgical procedure when indeed the attending never showed for the procedure. (Ex. A, ¶ 149).

When Relator Schmidt objected to altering medical records to reflect that an attending was present when he as indeed not present, Dr. Chibber’s response was “we wont’ be able to bill for the case if there was no attending” to which Relator Schmidt responded, “well, I guess it’s a freebie” because she refused to alter a medical record. (Ex. A, ¶ 150).

Thereafter, Relator Schmidt, afraid to speak up for fear of losing her job after being told

by her supervisor that if she did not stop complaining that she would lose her job, Relator Schmidt was compelled to continually reflect in the medical records that teaching physicians or attending physicians were present for key services or procedures when indeed, they were not physically present.

Several months later, Relator Schmidt would be terminated after serving SH for over 14 years as an OR nurse. (Ex. A, ¶ 151).

Relator Schmidt witnessed first hand as a *patient* the failure of attending physicians to be physically present for key services and procedures that were performed unsupervised by resident physicians. (Ex. A, ¶ 152).

In September of 2002, Relator Schmidt was admitted to SH for knee surgery for which Dr. Bigeliesen was the attending physician. (Ex. A, ¶ 153).

An epidural was administered by resident physician Dr. Marika Stone who performed the procedure without the supervision of a teaching physician. The epidural became disconnected; the resident came up and put it back together; later the teaching physician came into the room due to the Relator's complaints that she was in severe pain and that the epidural was not placed correctly, and abruptly pulled out the epidural and threw it on the floor. The Relator contacted the Residency Director to complain about the lack of supervision and the botched epidural; the next day, the resident came to apologize to Relator Schmidt, stating that they had not been relieved by the teaching physician all night. (Ex. A, ¶ 154).

III. DISCUSSION

A. Legal Standard

When considering a motion to dismiss a complaint for failure to state a claim under Federal Rules of Civil Procedure 12(b)(6),³ the Federal Rules require only that a plaintiff provide “a short and plain statement of the claim...[that will] give the defendant fair notice of what the [plaintiff’s] claim is and the grounds upon which it rests.” See Erickson v. Pardus, 127 S. Ct. 2197, 2200 (2007) (citing Fed. R. Civ. Pro. 8 (a)(2)). In Bell Atlantic v. Twombly, 127 S. Ct. 1955 (2007), the United States Supreme Court discussed the standard of pleading that a plaintiff must meet in order to survive a motion to dismiss under Rule 12(b)(6). The Court stated that the facts alleged in the complaint “must be enough to raise a right to relief above the speculative level,” Id. At 1965, or must be sufficient “to state a claim for relief that us plausible on its face.” Id. at 1974. The Court referred to this as “the plausibility standard,” Id. at 1968, but emphasized that it was not imposing a heightened fact pleading or specifics or a probability requirements at the pleading stage. Id. at 1973-74.

The court “must accept as true all of the factual allegations contained in the complaint.” See Kassem v. Wash. Hosp. Ctr., 513 F.3d 251, 253 D.C. Cir. 2008)(quoting Erickson, 127 S.Ct. At 2200). See also Twombly, 127 S.Ct. At 1963; Brown v. Dist. Columbia, 514 F.3d 1279, 1281 (D.C. Cir. 2008). “Detailed factual allegations” are not necessary to withstand a Rule 12(b)(6) motion to

³ Rule 12 (b)(6) provides that:

Every defense in law or fact, to a claim for relief in any pleading ...shall be asserted in the responsive pleading thereto if one is required, except that the following defenses may at the option of the pleader be made by motion:... (6) failure to state a claim upon which relief can be granted....

Fed. R. Civ. P. 12 (b)(6).

dismiss, but a plaintiff must furnish “more than labels and conclusions” or “a formulaic recitation of the elements of a cause of action.” Twombly, 127 S.Ct. At 1964-65. The complaint is construed liberally in the plaintiffs’ favor, “with the benefit of all reasonable inferences alleged,” In re Sealed Case, 494 F.3d 139, 145 (D.C. Cir. 2007), but the court need not accept inferences unsupported by facts in the complaint, nor must the court accept plaintiffs’ legal conclusions. Kowal v. MCI Commc’n Corp., 16 F. 3d 1271, 1276 (D.C. Cir. 1994).

The court is considering facts alleged in the complaint, any documents attached to or incorporated in the complaint, matters of which the court may take judicial notice, and matters of public record. See E.E.O.C. v. St. Francis Xavier Parochial Sch., 117 F.3d 621, 624 (D.C. Cir. 1997).

B. Defendant’s Motion

The defendant’s motion, as gleaned from the Declaration of Thomas S. D’Antonio, is premised on the following: (1) relators have failed to plead any purported False Claims Act violations with sufficient particularity; (2) relators have failed to state a claim for retaliation under the False Claims Act, and have failed to comply with “several procedural requisites” (Dec. of Thomas D’Antonio, p. 2, ¶ 7), specifically, that relators have (3) failed to plead subject matter jurisdiction; and (4) that relators have failed to provide the requisite disclosure statement.

Each argument will be analyzed below.

1. Rule 9 (b) Compliance

The False Claims Act, 31 U.S.C. §§ 3729-3733, imposes a civil penalty and treble damages on any individual who, *inter alia*, “knowingly presents, or causes to be presented, to an officer or employer of the United States Government...a false or fraudulent claim for payment or approval.”

See 31 U.S.C. §3729 (a). The FCA permits a private party, a “relator,” to initiate a qui tam action on behalf of the government. U.S.C. § 3730(b). The government may opt to take over the suit, but if it declines to do so, the relator may elect to proceed and collect a significant percentage of any recovery. Rel Williams v. Martin-Baker Aircraft Co., 389 F.3d 1251, 1254 (D.C. Cir. 2004)(citing §§ 3730 (b)(4)-(d).

The defendants argue that the complaint fails to allege FCA violations with particularity, as required by Federal Rule of Civil Procedure 9 (b). Rule 9 (b) provides that “[i]n all averments of fraud or mistake, the circumstances constituting fraud or mistake shall be stated with particularity. Malice, intent, knowledge, and other condition of mind of a person may be averred generally.”

A clear and unequivocal requirement that a relator allege specific false claims emerges from the conjunction of Rule 9(b) and the statutory text of the FCA: Rule 9(b) requires that for all “averments of fraud,” “the circumstances constituting fraud” must be pled with “particularity,” in contrast to the mens rea of fraud, which may be pled “generally.” Section 3729 (a)(1) imposes liability not for defrauding the government generally; it instead only prohibits a “narrow species of fraudulent activity”: presen[ting], or caus[ing] to be presented,...a false or fraudulent claim for payment or approval.” United States ex rel Bledsoe v. Cnty. Health Systems (“Bledsoe I”), 342 F.3d 634, 637-640 (6th Cir. 2003). The “circumstances constituting fraud” for the purpose of the FCA therefore must include an averment that a false or fraudulent claim for payment or approval has been submitted to the government- “the sine qua non of a False Claims Act violation.” United States ex rel. Karvelas v. Melrose-Wakefield Hosp., 360 F.3d 220, 235 (1st Cir. 2004) (“[Relator’s] failure to identify with particularity any actual false claims that the defendant submitted to the government is, ultimately, fatal to his complaint.” In order to survive Rule 9 (b) scrutiny, the complaint must “allege the time, place, and content of the alleged misrepresentation on which he relied; the fraudulent

scheme; the fraudulent intent of the defendants; and the injury resulting from the fraud” and enables the defendants to ‘prepare an informed pleading responsive to the specific allegations of fraud.’”

Bledsoe, 342 F.3d at 643.

Here the Relators have two hurdles that limit their ability to plead each and every instance of fraud with particularity pursuant to Rule 9(b) : (1) the allegations in a relator’s complaint are complex and far-reaching, and span several years; and, most importantly, (2) the confidential medical records which would prove that attending physicians were **not** present during key portions of procedures are in the exclusive control and dominion of the defendant, even though Relators still provide specific examples in the complaint.

The law recognizes these hurdles, and provides in part that where the allegations in a relator’s complaint are “complex and far-reaching, pleading every instance of fraud would be extremely ungainly, if not impossible.” United States ex rel Franklin v. Parke Davis, Div. Of Warner-Lambert Co., 147 F. Supp. 2d 39, 49 (D. Mass. 2001); see also In re Cardiac Devices Qui Tam Litg., 221 F.R.D. 318, 333 (D. Conn. 2004)(“[W]here the alleged fraudulent scheme involved numerous transactions that occurred over a long period of time, courts have found it impractical to require the plaintiff to plead the specifics with respect to each and every instance of fraudulent conduct.”); cf United States ex rel Johnson v. Shell Oil Co., 183 F.R.D. 204, 206-07 (E.D. Tex. 1998)(collecting cases supporting the proposition that “where the fraud allegedly was complex and occurred over a period of time, the requirements of Rule 9(b) are less stringently applied”).

Further, in circumstances where a relator demonstrates that he cannot allege the specifics of actual false claims that in all likelihood exist, and the reason that the relator cannot produce such allegations is not attributable to the conduct of the relator, courts relax the stringency of Rule 9(b). For example, in Hill v. Morehouse Medical Associates, Inc., No. 02-14429, 2003 WL 22019936

(11th Cir. Aug 15, 2003)(unpublished)(per curium), the relator worked in the billing department of the hospital, she described the alleged fraud in great detail, and she allegedly possessed first-hand knowledge that false claims had been submitted to the government. Id. At *4. More importantly, the relator identified specific confidential documents that contained the evidence of false claims, and alleged that those documents were in the exclusive control of the defendant. Id.; accord United States ex rel Thompson v. Columbia /CHA Healthcare Corp., 125 F.3d 899, 903 (5th Cir. 1997)

(“[a]lthough courts have permitted allegations of fraud based upon “information and belief,” the complaint ‘must set forth a factual basis for such belief,’ and the allowance of this exception must not be mistaken for license to base claims of fraud on speculation and conclusory allegations.”

Because this case presents such circumstances, i.e. Relators pled a complex and far reaching fraudulent scheme with particularity, and provides examples of specific false claims submitted to the government pursuant to that scheme, and more importantly, the Relators alleged that the documents, i.e. medical records and billing records to Medicare and Medicaid are in the exclusive control of the defendant,⁴ the case should be permitted to proceed to discovery.

2. Qui Tam Action under § 3730 (h)

Title 31 U.S.C. § 3729 creates liability for any person who presents false claims to the federal government for payment. Section 3720 allows a private person to bring a civil action on behalf of the Government for violations of § 3729 (i.e. , a “qui tam action”). Section 3730 (h)—sometimes called the “whistle blower” provision of the False Claims Act— “prevents the harassment, retaliation, or threatening of employees who assist in or bring qui tam actions.” Zahodnik v. IBM Corp., 135

⁴ The complaint states at ¶ 162:

Relators cannot at this time identify all of the false claims for payment that were caused by Defendant’s conduct. That information is solely within the possession of the Defendants. (Dkt. # 1, ¶ 162).

F.3d 911, 914 (4th Cir. 1997). It provides:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

31 U.S.C. § 3730 (h). Three elements exist under § 3730 (h) that constitute a prima facie case:

“[A]n employee must prove that (1) that he engaged in protected activity; (2) that his employer knew of these acts; and (3) his employer [retaliated against] him as a result of these acts.” Zahodnik, 135 F.3d at 914. The defendants claim that neither Relators engaged in protected activity.

A. PROTECTED ACTIVITY

Protected activity is established when the employee’s actions satisfy two conditions. First, the employee’s conduct must have been in furtherance of an FCA action. See United States ex rel Hopper v. Anton, 91 F.3d 1261, 1269 (9th Cir. 1996)(quoting 31 U.S.C §3730(h) Second the conduct must be aimed at matters which are calculated, or reasonably could lead, to a viable FCA actions. Id. The second condition has been clarified as follows:

An employee engages in protected activity where (1) the employee in good faith believes, and (2) a reasonable employee in the same or similar circumstances might believe, that the employer is possibly committing fraud against the government. Moore v. Cal. Inst. Tech. Jet Propulsion Lab, 275 F.3d 838, 845 (9th Cir. 2002). The protected activity element of a retaliation claim does not require the plaintiff to have filed an FCA lawsuit or to have developed a winning claim at the time of the alleged retaliation. United States ex rel. Karvelas v. Melrose-Wakefield Hosp., 360 F.3d 220, 236 (1st Cir. 2004). Indeed § 3730 (h) protects internal whistle blowers who make a complaint about fraud against the government. See Robertson v. Bell Helicopter Textron. Inc., 32 F.3d 948, 951 (5th

Cir. 1994).

I. Relator Johnson

According to Relator Johnson, he complained continuously to his supervisors that . To support that claim, he began notating the medical records to substantiate the existence of fraud. This is not an activity that is within a resident's job duties, i.e. noting in the record when an attending physician is present for billing purposes, nor to check medical records for compliance with federal regulatory requirements such as CMS.

In this light, Relator Johnson has established all three elements of a prima facie case under § 3730(h). First, he was engaged in activity protected by the False Claims Act. Second, the complaint satisfies the requirement that U of R must have known that Dr. Johnson was engaged in such conduct, since it specifically alleges that they did. Whether U of R had knowledge of Dr. Johnson's protected activity is an issue of fact that cannot be resolved on a motion to dismiss. See e.g. Wilkims v. State of Ohio, 885 F. Supp. 1055, 1061 (S.D. Oh. 1995). Third, Dr. Johnson has sufficiently plead that U of R retaliated against him because of his protected activity when they terminated him.⁵

ii. Relator Schmidt

Relator Schmidt complained frequently about the failure of supervision by the teaching physicians that she became known as a "trouble maker" and her evaluations were marked to indicate that she was a "problem." Relator Schmidt was constantly called into the office and admonished for complaining. (Ex. A, ¶ 148).

On one such incident, in the spring of 2005, Relator Schmidt was approached by Dr. Chibber and was asked to *alter* medical records to reflect that an attending physician was present

⁵ The retaliation continued as Dr. Lustik then submitted a defamatory and negative report to the Board of Medical Practice of the State of Delaware as set forth in Relator Johnson's Proposed Amended Complaint.

during a key surgical procedure when indeed the attending never showed for the procedure. (Ex. A, ¶ 149).

When Relator Schmidt objected to altering medical records to reflect that an attending was present when he as indeed not present, Dr. Chibber's response was "we wont' be able to bill for the case if there was no attending" to which Relator Schmidt responded, "well, I guess it's a freebie" because she refused to alter a medical record. (Ex. A, ¶ 150).

Thereafter, Relator Schmidt, afraid to speak up for fear of losing her job after being told by her supervisor that if she did not stop complaining that she would lose her job, Relator Schmidt was compelled to continually reflect in the medical records that teaching physicians or attending physicians were present for key services or procedures when indeed, they were not physically present.

Several months later, Relator Schmidt would be terminated after serving SH for over 14 years as an OR nurse. (Ex. A, ¶ 151).

3. Relators Have Satisfied the "Requisite Jurisdictional Prerequisites"

Relators concede that § 3732 (a) of the FCA does not govern subject matter jurisdiction, but rather only personal jurisdiction and venue. In good faith, Relators have amended their complaint to correctly state that this Court has subject matter jurisdiction over their FCA claims under 28 U.S.C § 1331, which vests in federal district courts subject matter jurisdiction to hear suits brought under federal law, and under 28 U.S.C. § 1343, which authorizes federal district courts to hear cases in which the United States is a plaintiff. See e.g. *United States v. Morton*, 467 U.S. 822, 828 (1984)(Subject matter jurisdiction defines the court's authority to hear a given type of case.

4. Relators Have Provided the Requisite Disclosure Statement

Section 3730(b)(2) states:

A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the Government pursuant to **Rule 4(d)(4) of the Federal Rules of Civil Procedure**. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The Government may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence information.⁶ (emphasis added).

Pursuant to Rule 4(d)(4), on March 16th, 2007, relators, via fed ex, sent to then Attorney General of the United States Alberto Gonzalez, the Honorable Terrence P. Flynn, United States Attorney, and Robert Trusiak, Esq., a copy of the qui tam complaint filed under seal on March 16th, 2007, along with the Notice of Motion and Proposed Order seeking to file that claim under seal, along with the Relators' Appendix of Exhibits and the Relators' Disclosure Statement.⁷ (Ex.).

On March 19th, 2007, relators supplemented their Disclosure Statement with the Affidavit of Dr. Jayram Srivatsan and sent the same via fed ex to the parties named above. (Ex.).

Accordingly, relators have complied with Section 3730(b)(2).

⁶ There is no requirement in the Federal Rules of Civil Procedure that a relator must "allege in their pleading" that they have served the Government with a Disclosure Statement pursuant to Section 3730(b)(2), as defendant erroneously argues on page 22 of their Memorandum of Law.

⁷ Defendant can request a copy of the Disclosure Statement in discovery.

Dated: December 31st, 2008
Rochester, New York

/s/ Christina A. Agola, Esq.

Christina A. Agola, Esq.

Christina A. Agola
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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA &
STATE OF NEW YORK, ex rel.

KEITH JOHNSON, M.D.,
LAURA SCHMIDT, R.N.,

Plaintiffs,

Certificate of Service

Civ. No. 07-cv-6149

BRINGING THIS ACTION ON
BEHALF OF THE UNITED STATES
OF AMERICA

c/o

Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York , 14202

-and-

Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

v.

THE UNIVERSITY OF ROCHESTER
MEDICAL CENTER &
STRONG MEMORIAL HOSPITAL,

Defendants.

Please take note that on this 31st day of December 2008, the undersigned caused the following Response to Defendant's Motion to Dismiss, including Declaration of Christina A. Agola, Appendix and Memorandum of Law; and Cross Motion to Amend, including Declaration of Christina A. Agola to be served electronically via e.c.f. on Thomas D'Antoinio, counsel for defendants THE UNIVERSITY OF ROCHESTER MEDICAL CENTER & STRONG MEMORIAL HOSPITAL.

Dated: December 31, 2008
Rochester, New York

/s/ Christina A. Agola

Christina A. Agola, Esq.

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UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA &
STATE OF NEW YORK, *ex rel.*

KEITH JOHNSON, M.D.,
LAURA SCHMIDT, R.N.,

Plaintiffs,

APPENDIX

Civ. No.: 07-cv-6149

BRINGING THIS ACTION ON
BEHALF OF THE UNITED STATES
OF AMERICA

c/o

Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York, 14202

-and-

Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

v.

THE UNIVERSITY OF ROCHESTER
MEDICAL CENTER &
STRONG MEMORIAL HOSPITAL,

Defendants.

Plaintiff, by and through his attorney Christina A. Agola, Esq. in further opposition to defendant's motion to dismiss, and in support of his motion to amend submit the following appendix of exhibits common to the response to defendant's motion to dismiss and Plaintiff's motion to amend:

- EXHIBIT A:** Complaint Filed March 16, 2007
- EXHIBIT B:** March 16, 2007 Letter to the U.S. Attorneys Office Enclosing the Complaint, Appendix of Exhibits and Disclosure Statement
- EXHIBIT C:** Fed Ex Receipts for Delivery of Complaint, Appendix of Exhibits and Disclosure Statement to the U.S. Attorneys Office
- EXHIBIT D:** March 19, 2007 Letter to the U.S. Attorneys Office enclosing the Affidavit of Dr. Jayram Srivatsan
- EXHIBIT E:** Fed Ex Receipts for Delivery March 19, 2007 letter and Affidavit to the U.S. Attorneys Office
- EXHIBIT F:** April 27, 2007 Letter to Dr. Stewart Lustik
- EXHIBIT G:** December 2, 2008 Order by the Board of Medical Practice of the State of Delaware
- EXHIBIT H:** November 15, 2006 Letter from Dr. Lustik to Delaware Board
- EXHIBIT I:** Proposed Amended Complaint

Dated: December 31st, 2008
Rochester, New York

/s/ Christina A. Agola, Esq.

Christina A. Agola, Esq.

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EXHIBIT A

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA &
STATE OF NEW YORK, ex rel.

KEITH JOHNSON, M.D.,
LAURA SCHMIDT, R.N.,

Plaintiffs,

BRINGING THIS ACTION ON
BEHALF OF THE UNITED STATES
OF AMERICA

c/o

Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York , 14202

-and-

Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

v.

THE UNIVERSITY OF ROCHESTER
MEDICAL CENTER &
STRONG MEMORIAL HOSPITAL,

Defendants.

MAR 1 3 2007
BY: *M. Boyle*

FILED UNDER SEAL

COMPLAINT
QUI TAM ACTION
Civ. No.

07CV 0149 (LF)

JURY TRIAL DEMANDED

FILED UNDER SEAL

INTRODUCTION

1. This is an action by qui tam Relator Dr. Keith Johnson (“Relator Johnson”) and Laura Schmidt, R.N., (“Relator Schmidt”) in the name of the United States and the State of New York, to recover penalties and damages arising from the University of Rochester’s (“U of R”) and Strong Hospital’s (“SH”) willful and deliberate overcharging of the New York Medicaid and federal programs for anesthesiology services performed in the Obstetric and Gynecological Department (“OBGYN”) and Operating rooms (“OR”) of Strong Hospital. Defendants have done this by fraudulently submitting tens of thousands of claims for reimbursement for professional services by residents in training that were *never provided, supervised or controlled by the faculty Teaching Physician* (“TP”) in violation of the Center for Medicare and Medicaid Services (CMS) regulations which mandate the presence of a TP during the “key portion” of any service or procedure performed in the teaching hospital and clinical setting, and which further requires that the presence of the TP be reflected in the patient’s medical record. This action against the U of R and SH is being brought under the Federal False Claims Act, 31 U.S.C. § 3729, et seq; this case also concerns the anti-retaliation provision of the False Claims Act (“FCA”), 31 U.S.C. §§ 3730 (h) for the termination of Relator Johnson after he identified fraudulent billing

practices, and the New York State Whistleblower Act.

2. Relators Johnson and Schmidt disclose that there are tens of thousands of SH faculty physician bills which falsely represent that TPs themselves had personally provided the service done by the residents outside of their physical presence. This complaint is based upon non-public information the Relators obtained while employed at the SH, their personal observations of the acts and conduct of the defendants, and by non-public information Relators and their attorney obtained during the investigation of this matter.

JURISDICTION AND VENUE

- 3 These claims arise under 31 U.S.C. §3729 & §3730, *et seq.*, known as the “False Claims Act.”

- 4 This Court has jurisdiction pursuant to 31 U.S.C. §3732(a) and 31 U.S.C. §3732(b) because this case is brought under 31 U.S.C. §3730.

- 5 Venue is proper in this Court under 31 U.S.C. 3732(a) because SH and the U of R transacts business in the Western District of New York, and committed a number of the acts proscribed by 31 U.S.C. §3729 in the Western District of New York.

6. This Court has supplemental jurisdiction over the state law claims contained in this action pursuant to 28 U.S.C. §1367(a), as such claims form part of the same case or controversy as the federal claims.

PARTIES

- 7 Relator Schmidt is a Registered Nurse who worked for 14 years at SH in the OR. Throughout her employment at SH, Relator Schmidt acquired direct personal knowledge and personal knowledge and non-public information of the defendants's fraudulent practices.

8. Relator graduated from Syracuse Upstate Medical Facility with a Medical Doctorate on or about May of 2002; he completed his internship between the years of 2002-2003 with the University of Rochester. Relator Johnson commenced his residency in anesthesiology in 2004 with SH until he was terminated from his last year of residency in November of 2006. Throughout his employment at SH, Relator acquired direct personal knowledge and personal knowledge and non-public information of the defendants's fraudulent practices.

9. The defendant U of R Medical Center includes the School of Medicine and Dentistry, School of Nursing, Eastman Dental Center, Strong Memorial hospital, Golisano Children's Children's Hospital at Strong, and Medical Faculty Group.
10. The defendant SH is a business corporation organized and existing under the laws of the State of New York, with its principal office located at 601 Elmwood Avenue, Rochester, New York 14642, Rochester, New York. SH is a major tertiary (Level III) referral center and a teaching hospital in an approved direct Graduate Medical Education payment methodology, or "GME." SH has a very high percentage of Medicare/Medicaid patients. Medicaid is a federal and state funded program established to pay for medical care for the indigent. For reimbursement purposes, SH is specially designated as a teaching hospital and is reimbursed on a per diem basis for key services and procedures it provides under the supervision of an attending physician.
11. TPs supervise, train and advise Residents in the practice of medicine in a teaching setting in which Medicare payment for the services of residents is made by the GME residency program in medicine.

12. The ratio of TPs to Residents is 3 Residents per 1 TP at night; and 2 Residents per 1 TP during the daytime. It was common knowledge that the ratio was 3 to 1 on the night shift to avoid government inspection; it was assumed by management that the government would only audit during the daytime.
13. SH annually admits more than 50,0000 patients from the Rochester, New York area, the State of New York and the world. Over 65 % of the patients at SH have Medicare/ Medicaid Coverage, and as such, SH is governed by regulations promulgated by the Centers for Medicare and Medicaid Services (CMS).
14. As a teaching hospital, billing by faculty physicians for services actually performed by resident physicians in training is in violation of both federal and state law, since under the Medicare program, the United States already pays for a substantial portion of the residents' training and salaries through GME, and their services cannot be billed to the Medicare program on a fee-for service basis.
15. However, in direct contravention to this well settled practice, Relators disclose, based upon non-public information the Relators obtained while employed at the SH, and their personal observations of the acts and conduct of the defendants, that there

are potentially tens of thousands of SH faculty physician bills (or more) which falsely represent that TPs had *personally provided the service done by the residents in the OR and OBGYN units.*

16. The central SH faculty physicians who are responsible for condoning this illegal practice are Dr. Stewart Lustik, Dr. James Robotham, Dr. Whistler, Dr. Bigeliesen; Dr. Issacson; Dr. Glance, Dr. Chibber, and Dr. Borovancani, *inter alia*, as described below.

1. RELATOR JOHNSON'S RESIDENCY AT STRONG HOSPITAL

17. In 2002, Relator Johnson was in a class of 10 categorical residents who began their Residency in Anesthesiology in or about July of 2004.

18. Relator Schmidt at this time was an OR nurse who observed Relator Johnson on frequent occasion act as a Resident in the OR unit, and bears witness to Relator Johnson's claims herein.

19. Upon entry to the program, it was made known to Relator and all other Residents by Dr. Robotham that "when [he] came to the U of R, we were in danger of being closed down; now the Anesthesia Department is the highest grossing department in the University."

20. It is well known that the Anesthesiology Department is the largest grossing department of SH.
21. It was also well known that since Dr. Robotham took over as Chair of Anesthesia in late 2002 that SH had a huge influx of cases, approximately 30 to 40%, with no concomitant increase in staff size to deal with these patients.
22. Despite the constant emphasis on the “money making ability” of the Anesthesiology Department, and the high number of Medicare and Medicaid cases at SH, Relator Johnson received no training in compliance with the Center for Medicare and Medicaid Services (“CMS”) regulations, as described in detail below, either at the commencement of his internship, or at any relevant time up and until his termination on October 5, 2006.

1. CMS Regulations

23. The CMS issued regulations as late as January 13, 2006 (Transmittal 811) clarifying and specifying the TP “presence requirement” in the teaching hospital and clinical setting for the purpose of billing, and incorporating Transmittal 1780, dated November 22, 2002.

24. The CMS policy is clear with regard to those cases where the teaching anesthesiologist is involved in 2 concurrent anesthesia cases with residents on or after January 1, 2004, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he or she is present with the resident.
25. Under CMS regulations, SH employees and SH agents shall not submit a claim for reimbursement for professional services from any Federal Health Care Program or Health Care benefit Program unless the TP personally provided, or supervised and controlled the provision of the key portions of the service.
26. The TP's "physical presence" during the key portion of any service or procedure shall be reflected in the patient's medical record as per CMS regulations.
27. "Physical presence," as defined by CMS, means simply that the TP is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face to face service.

2. Payment for Physician Services in Teaching Settings

28. Pursuant to 42 C.F.R. § 415.170, services furnished in teaching settings are paid under the physician fee schedule if the services are:

- **Personally furnished by a physician who is not a resident;**
- **Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service; or**
- **Certain E/M services furnished by a resident under the conditions contained in §100.01C.**

29. In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the FI.

3. Evaluation and Management (“E/M”) Services

30. For the purpose of payment, E/M services billed by teaching physicians require that they personally document at least the following:

- That they performed the service or were physically present during the key or critical portions of the services when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

31. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.

32. The following are examples of unacceptable documentation by the TP in patient's medical records:

"Agree with above, " following by legible countersignature or identity;

"Rounded, Reviewed, Agree," followed by legible countersignature or identity;

"Discussed with resident, Agree," followed by legible countersignature or identity;

"Seen and agree," followed by legible countersignature or identity;

*"Patient seen and evaluated," followed by legible countersignature or identity; and
A legible countersignature or identity alone.*

33. The above stated documentation of the record is unacceptable to CMS because it makes it impossible to determine whether the teaching physician was present, evaluated the patient, and or had any involvement with the plan of care.

4. Exception for E/M Services Furnished in Certain Primary Care Centers

34. TPs providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. TPs may submit claims for services furnished by residents in the absence of the TP under the primary code exception G0344 (initial preventative physical examination; face-to-face visit services limited to new beneficiaries during the first 6 months of Medicare enrollment).

35. If a service other than those listed in G0344 needs to be provided, then the general teaching physician policy set forth in §100.1 applies. Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program and Centers must maintain information on site as per 42 U.S.C. 413.79(a)(6).

36. TPs submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The TP must:

- Have no responsibilities at the time he/she is supervising the Residents;
- Assume management responsibility for patients seen by the Residents;
- Ensure that the services furnished are appropriate;
- Review the patient's medical history, physical examination, diagnosis, and record of tests and therapies with each Resident during, or in the outpatient setting, immediately after each visit;
- Personally document in the medical record the extent of his or her own participation in the review and direction of the services furnished to each patient.

5. *Anesthesia*

37. Medicare pays an unreduced fee schedule payment if a teaching anesthesiologist is involved in a single procedure with one resident.

38. The TP in this instance must document in the medical records that he/she was *present* during all critical (or key) portions of the procedure.

39. The TP's physical presence during *only* the preoperative or postoperative visits with the beneficiary is not sufficient to receive medicare payment.

40. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetists, Medicare pays for the anesthesiologist's services as *medical direction*.

41. In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents or after January 1, 2004, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he/she is present with the resident and should use the "AA" modifier to report such cases and must document his/her involvement in cases with residents sufficient to warrant Medicare payment.

6. *Post Operative Reports*

42. CMS guidelines indicate that all patients who have received an anesthetic must have a note in the record that indicates evaluation written by the attending physician that indicates that evaluation was provided postoperatively by the attending physician. The note must be recorded with a date and time, should be documented on the back of the intra operative report and must occur within 48 hours of the anesthetic. This note must also contain documentation that addresses the four following concerns:

- Cardiopulmonary Status
- Level of Consciousness
- Follow-up care or observations
- Presence or absence of postoperative complications

7. *SH's Written Policies As of September 24, 2003*

43. Despite these well settled CMS regulations, it was, however, a well settled *written* policy of SH at the commencement of Relator Johnson's Residency to permit Anesthesiologist Residents to perform key portions of medical services and procedures that TPs0 rarely if ever personally provided, supervised, or controlled, including epidurals in the OBGYN unit and extubations or emergence procedures in the OR unit.

44. In or about September 24, 2003, Dr. Stewart Jay Lustik sent to all Anesthesiology Residents the following letter for which Relator Johnson became aware of in 2006:

Dear residents:

Our Department Policy requires that the attending is present for induction and emergence. *If the attending specifically tells you that he/she does not need to be present, then it is OK for you to proceed if you feel comfortable.* This will rarely happen with induction, but in certain situations with senior residents the attending may allow it. Under no circumstances are you to induce a patient without an attending present unless you receive specific instructions from your supervising attending to do so.

Remember, your attending is always available for questions and assistance. Please see me with any questions.

45.

That the above stated memo was in direct contradiction to the above stated CMS regulations, yet it was accepted policy and practice at SH for Anesthesiology Residents to routinely perform key procedures in the OR and OBGYN unit including epidurals and extubations/emergence without line of sight supervision, without the presence of a TP and for which Residents were compelled to perform without supervision and to provide the medical chart to the TP to sign after the procedures were completed.

46.

Relator Johnson also witnessed that TPs failed to complete numerous postoperative reports in further violation of the CMS regulations.

8. Anesthesiology Resident's Caseload Per Year

47.

On average, there are 7500 cases that are handled by a U of R Anesthesiology Residents over the course of their three year residency, or 2500 per year per each of the 40 Anesthesiology Residents who were divided into classes of 10.

48. Over a 24 hour period there are 8 epidurals performed daily without direct line of sight supervision and in the absence of the TP's physical presence by Anesthesiology Residents, or 2500 per year at the rate of \$700.00 per procedure.
49. Over a 24 hour period there are 3 to 4 extubations/emergence procedures performed by the Anesthesiology Residents daily or 30-50 per day without direct line of sight supervision and in the absence of the TP's physical presence in violation of the above stated CMS regulations.
50. Over a 24 hour period , there are an extremely high number of postoperative reports, too many to count, that were **never** placed in the patient's record as per the above stated CMS regulations by the TP or attending physician.
51. After January 1, 2004, over a 24 hour period there have been countless occasions

9. Key Procedures Performed by Johnson Without Supervision

I. Year 7/2003 through 6/2004

52. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed several hundred pre-anesthetic evaluations which should be performed by the TP or attending physician in violation of the seven requirements that must be met by the TP to qualify as "supervision" under the CMS regulations.
53. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed approximately 40 epidurals without the supervision of a TP.
54. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed 2 to 3 extubations/emergence procedures without the supervision of a TP per day, or approximately 500 extubations/emergence procedures per year.

55.

For the year 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that TPs rarely if ever completed postoperative reports as required by CMS regulations.

ii. Year 7/2004 through 6/2005

56.

For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed several hundred pre-anesthetic evaluations which should be performed by the TP or attending physician in violation of the seven requirements that must be met by the TP to qualify as "supervision."

57.

For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed approximately a hundred of epidurals without the supervision of a TP and outside of their physical presence.

58.

For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed 2 to 3 extubations/emergence procedures per day without the supervision of a TP, or approximately 500 unsupervised extubations/emergence procedures.

59.

For the year 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that less than 5% of post operative reports were performed by the TPs.

iii. Year 7/2005 through 10/2006

60.

For the year of 7/2005 through October 5, 2006, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed several hundred anesthetic evaluations which should be performed by the TP or attending physician in violation of the seven requirements that must be met by the TP to qualify as "supervision."

61. For the year of 7/2005 through October 5, 2006, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed hundreds of epidurals without the supervision of a TP and outside of their physical presence.

62. For the year of 7/2005 through October 5, 2006, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed 2 to 3 extubations/emergence procedures daily or 30-50 for the entire Anesthesiology Residents without the supervision of a TP, or approximately 500 extubations/emergence procedures per year without the physical presence of a TP.

63. For the year 7/2005 through October 5, 2006, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that less than 5% of post operative reports were completed by the TP.

64. That from 2004 through October of 2006, Relator had great difficulty locating TPs in the middle of the night to assist in key procedures.

65. In fact, Relator was told repeatedly by attending physician Dr. Sheldon Issacson, (**subsequently terminated from SH after October 2006**), that as a senior resident, Relator was not to call him in the middle of the night because this was a “sign of weakness” in total arrogant disregard of the CMS regulations.

66. Some TPs even lie asleep on stretchers in the hallway; Dr. Bigeliesen was nicknamed “Big who lies in sin” for this very reason.

10. Violation of The CMS Concurrency Rule after January 1, 2004

67. The CMS regulations provide that those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents or after January 1, 2004, the teaching anesthesiologist (TP) may bill the usual base units and anesthesia time for the amount of time he/she is present with the resident and should use the “AA” modifier to report such cases and must document his/her involvement in cases with residents sufficient to warrant Medicare payment.

68. If the TP was **not** present in the scenario where he oversaw 2 concurrent anesthesia cases with the resident for key services and procedures such as epidurals and extubation/emergence, then that TP could only bill for this as “*medical direction.*”

69. The TP’s physical presence during *only* the preoperative or postoperative visits with the beneficiary is not sufficient to receive medicare payment; the TP must be present for key services and procedures such as epidurals, and extubations/emergence.

70. That on all shifts the ratio of residents to TP was 3 residents to 1 TP on any given shift.

71. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents or after January 1, 2004, Relator Johnson estimates that he performed 40 epidurals without the supervision of a TP in violation of the CMS Concurrency Rule.

72.

For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents or after January 1, 2004, Relator estimates that he performed 2 to 3 extubation/emergence procedures without the supervision of a TP per day, or approximately 500 extubation/emergence procedures per year in violation of the CMS Concurrency Rule.

73.

For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, Relator estimates that he performed hundreds of epidurals without the supervision of a TP in violation of the CMS Concurrency Rule.

74.

For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, Relator estimates that he performed 2 to 3 extubation/emergence procedures without the supervision of a TP, or approximately 500 unsupervised epidurals in violation of the CMS Concurrency Rule.

75.

For the year of 7/2005 through 10/2006, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, Relator estimates that he performed hundreds of epidurals without the supervision of a TP in violation of the CMS Concurrency Rule.

76.

For the year of 7/2005 through 10/2006, under circumstances for which none of the exceptions to the CMS regulations apply, and for those cases where the TP is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, Relator estimates that he performed 2 to 3 extubation/emergence procedures daily without the supervision of a TP, or approximately 500 extubation/emergence procedures per year in violation of the CMS Concurrency Rule.

11. Manner in Which Key Procedures Performed Without Supervision Were Credited to Faculty Physicians For the Purpose of Billing Medicare and Medicaid

77.

That from July of 2003 through October of 2006 Relator was compelled to perform pre-anesthetic evaluations for all patients he handled over the course of his residency for which he placed in writing and hand delivered to his TP or attending physician who would simply sign off by indicating the following:

*“Agree with above, “ following by legible countersignature or identity;
“Rounded, Reviewed, Agree,” followed by legible countersignature or identity;
“Discussed with resident, Agree,” followed by legible countersignature or identity;
“Seen and agree,” followed by legible countersignature or identity;
“Patient seen and evaluated,” followed by legible countersignature or identity; and/or
A legible countersignature or identity alone.*

78.

That from July of 2003 through October of 2006, Relator was compelled to hand over the chart at the end of the night for the purpose of the TP to sign, falsely indicating on the patient’s medical records that the TP or attending physician was present for key procedures for all of the times and dates given above, who would simply sign off by indicating the following:

*“Agree with above, “ following by legible countersignature or identity;
“Rounded, Reviewed, Agree,” followed by legible countersignature or identity;
“Discussed with resident, Agree,” followed by legible countersignature or identity;
“Seen and agree,” followed by legible countersignature or identity;
“Patient seen and evaluated,” followed by legible countersignature or identity; and/or
A legible countersignature or identity alone.*

79.

Specifically, from 2003 through the date of the Relator’s termination in November of 2006, Relator was instructed to maintain a list of all epidurals performed without TP supervision, control or line of sight supervision so that the medical file could be signed by the TP the following morning to reflect that the TP was present when indeed, the TP was not present, who would simply sign off by indicating the following:

*“Agree with above, “ following by legible countersignature or identity;
“Rounded, Reviewed, Agree,” followed by legible countersignature or identity;
“Discussed with resident, Agree,” followed by legible countersignature or identity;
“Seen and agree,” followed by legible countersignature or identity;
“Patient seen and evaluated,” followed by legible countersignature or identity; and/or
A legible countersignature or identity alone.*

12. Relator Johnson’s Complaints About Defendants Illegal Practice

80. From the date of the commencement of Relator Johnson’s residency in July of 2004, until the date of Relator’s termination in October of 2006, constant informal complaints were made by Relator Johnson to Dr. Lustik about (1) medical procedures being performed without a TP, and (2) that this practice and policy was in violation of Medicaid and Medicare billing practices.

81. Relator Schmidt witnessed Relator Johnson make these complaints in the OR, at the desk and in the hallway to TPs directly, including Dr. Lustik

82. No action was taken by Dr. Lustik; in fact, his reaction was always that of complete ignorance that any such problem was occurring.

83. Because no remedial action was taken to curb the practice of permitting residents to perform medical procedures without an attending physician, Plaintiff took *affirmative steps* to preserve evidence of such violations, e.g. *he began to notate or write in the patient records that TPs were not present for key procedures for fear that if Relator Johnson was to harm a patient during a procedure for which a TP was not present then the TP would merely indicate that he did not authorize the procedure/*

84. Finally, in or about April of 2005, Anesthesiology Resident Dr. Jay Ram and Relator Johnson confronted Dr. Lustik and complained that they were performing medical procedures unsupervised in dereliction of the above stated CMS regulations, and that this was in further violation of Medicaid and Medicare billing procedures.

85. No remedial action was taken by Dr. Lustik.

86. As a side bar, in May of 2005, Plaintiff also complained to Dr. Lustik that he was exceeding his mandatory hours as a resident under the Bell Commission.

13. Actions Taken Against Relator Johnson As a Result of His Complaints

87. In May 2005 Relator Johnson signed an Agreement of Appointment (“Agreement”) that designated his status as a PGY4 senior year resident which had to be signed by June 30, 2005.

88. This would have been Relator’s *last year of residency*, after which he would be able to take the ABA National Boards and proceed in the private practice of Anesthesia as a physician.

89. Two months after Relator Johnson complained to Dr. Lustik regarding his good faith belief that defendants were in violation of Medicaid and Medicare billing practices, defendant, with full knowledge that Plaintiff had made such a complaint, retaliated against Relator Johnson by revoking the duly executed Agreement designating his status as PGY4 senior year resident which he had already duly signed in or about the end of May of 2005.

90. On or about June 25 2005, Plaintiff was approached by Dr. Lustik who informed Plaintiff *he had 3 days to consider whether he would quit or resign his residency on the eve of its completion, or whether he would repeat the second year of his residency.*

91.

At that meeting, Plaintiff was given a letter dated June 23, 2005 which stated that Plaintiff had “deficiencies” in his clinical skill set, despite the fact that in July of 2005, Plaintiff took the ABA Training Examination and scored within the *75 percentile which is the top quarter of all anesthesiologists in the nation.*

92.

In a letter dated June 27th, 2005, to the ABA, defendant claimed that Plaintiff was insufficient in three of thirty three categories. Plaintiff was not given the opportunity to re-do any of the three enumerated criteria, despite the fact that he successfully completed 30 criteria, but was rather forced to repeat the *entire* year.

93.

Relator had no choice but to chose to repeat his second year of residency and was given an Agreement that “SUPERCEDES and NULLIFIES the previous agreement of appointment FOR PGY4 LEVEL.

94.

Relator signed the Agreement under duress and *repeated* his second year of residency.

95. A few months later, in or about September 1, 2005 SH agreed to pay nearly \$500,000.00 to Medicaid and Medicare for fraudulent claims made by a former department head, Dr. Uma Sundaram, former chief of Strong's Digestive Disease Unit, who violated Medicaid and Medicare regulations by allowing physicians undergoing specialized training to do procedures without attending physician Sundaram's supervision in violation of the CMS regulations.

96. After the investigation of SH's Digestive Disease Unit concluded in September of 2005, all SH units, not just the Digestive Disease Unit, were expected to comply with the CMS regulations.

97. Despite this expectation of compliance with the CMS regulations, Relator still received no further training in CMS compliance.

98. In fact, SH *continued* to allow its Anesthesiology Residents, including Relator, to perform the key portions of anesthesia services and procedures including epidurals, extubation, outside the presence, control, and line of sight supervision of the TP.

99.

Indeed, following the September 2005 resolution of the fraudulent claims brought against it for allowing physicians under going specialized training to do procedures without attending physician Sundaram's supervision in violation of the CMS regulations, SH distributed a Confidential Memorandum directing residents including Relator to not comment on the TP's presence during the key portion of any service or procedure in the patient's medical record.

100.

Issued on November 4, 2005, less than two months following the above referenced fine paid to Medicaid, the Medicaid Compliance Officer issued a "Confidential Memo" that was sent to all Anaesthesiology Residents stating:

1. All neuraxial labor analgesics (ex. Labor, epidurals and saddle blocks, placements or replacements) will be performed *in line of sight supervision from the responsible anesthesiology attending*. The department will credential residents for neurxial labor analgesia under general supervision, based on the performance of individual residents in OB anesthesia. However, it is unlikely that this credential will be used by residents, except for the rare occasion when the supervising anesthesiology attending can not provide line of sight supervision due to an emergency with another patient.
2. *The anesthesiology resident should not comment on this issue in the medical record.*

101. Despite the issuance of this Confidential Memorandum on November 5, 2005, SH's TPs still continued to failed to supervise the Anesthesiology Residents, including Relator, for which Relator continued to complain to Dr. Lustik.

102. Dr. Lustik's response was "gee, I don't know about that."

103. The Confidential Memorandum, however, expressly precluded Relator Johnson's ability to notate the patient's medical records to indicate the lack of TP's presence, control and direct line of sight supervision for the continuing performance of epidurals, extubation and post operative reports that persisted until Relator's termination.

104. Further in or about the winter of 2005 the Anesthesia Residents were advised by Dr. Robotham prior to Grand Rounds **not** to notate medical records indicating that attending physicians were not present during medical procedures performed by residents.

105. On one such incident occurred in or about June 6, 2006 when a pregnant patient with fetal distress went for an emergency c-section and the *TP (Dr. Issacson) was unable to be found.*

106. The Anesthesia Resident could not induce the patient and thus the c-section had to be done *under local anesthesia* due entirely to lack of supervision for which Relator Johnson had brought to the attention of SH many occasions previously.

107. Again, in or about September 5, 2006, SH permitted a resident with only three months of training to perform a c-section without a TP or attending physician physically present in the OR.

108. On the night of September 1st, 2006, Relator Johnson did not go home until 8:45 p.m.; state law required him to stay out for 10 hours, so Relator did not return to work until 6:45 the next morning. When he arrived at work, Dr. Kahn the night OB resident informed Relator that there was an “urgent” c-section and that Relator should go to the OB floor immediately.

109. Relator Johnson went to see the “urgent” patient who was obese and pre-eclamptic. The patient revealed a prior history of a c-section, not done at SH, but performed with a spinal which was a bad experience for this patient.

110. Relator Johnson, unable to intubate a patient without a TP physically present in the room, immediately went to the OB office and tried to locate a TP or attending physician, which was Dr. Borovancani, a doctor fired from her previous position in Buffalo, whose English, as a side bar, was her second language and was very difficult to understand.

111. Dr. Borovancani could not be found; her habitual tardiness was an ongoing problem in the department.

112. Relator Johnson called Dr. Dooley the Clinical Coordinator and explained that they had a patient who would potentially be a difficult airway case, and that he was alone without a TP or attending physician and that given the situation, if emergency bells went off, i.e. an emergency c-section, Relator Johnson would not be able to intubate or induce this patient without a TP or attending physician.

113. Dr. Dooley sent the residency director, Dr. Lustik, to assist Relator Johnson this patient until Dr. Borocavani arrived at 7:25 a.m..

114.

When Dr. Borocavani arrived, she was very angry that Dr. Lustik had been called to “fill in” for her, and she was greatly “embarrassed.”

115.

Dr. Borocavani told Relator Johnson that his actions in contacting a TP to cover for her made her “look bad” and that it was “unprofessional” for him to have called another TP to take her place, despite the fact that CMS regulations require TPs to be physically present for the purpose of intubation or inducement.

116.

Relator Johnson attempted to steer the conversation back to the patient, informing Dr. Borocavani that the patient may be a difficult intubation, a difficult airway given her weight and pre-eclampsia, and that she had a difficult prior spinal, to which Dr. Borocavani angrily instructed Relator to obtain the old chart from Medical Records, despite the fact that Realtor had already informed Dr. Borocavani that the spinal was not performed at SH but in another hospital in Newark, New York.

117.

Relator called Medical Records to appease Dr. Borocavani and told her that there was no chart; Dr. Borocavani then stated “how can there be no chart if you told me she was a difficult intubation?”

118.

Dr. Borocavani then met with the patient and Relator to go through and perform a pre-anesthetic evaluation; had there not been any confusion, there would have been no pre-anesthetic evaluation, since it was clear that *Dr. Borocavini never performed a pre-anesthetic evaluation in this case in violation of CMS regulations.*

119.

It was only in June of that same year that an OB patient was forced to undergo a c-section under *local anesthesia* due to the lack of the physical presence of a TP or attending physician. Relator Johnson would not permit this patient to suffer the same fate. The patient had an uneventful c-section and a healthy baby was delivered.

120.

Immediately thereafter a previously planned c-section was begun under epidural. The TP and the First Year Resident bolused the epidural and the TP then left the floor. Relator Johnson was doing epidurals on the OB deck; upon finishing, he returned to the OR and found the patient's epidural "worn down". The First year resident did not have the experience to recognize the situation the patient was hysterical and Relator Johnson then immediately had no choice but to re-establish the epidural. The TP Dr. Borocavini

was called and she stated she was off the floor talking to Dr. Lustik and stated that Relator Johnson should go ahead and re-establish the epidural which Relator Johnson had already done.

121.

Later that day, Relator Johnson was summoned by Dr. Lustik, Dr. Glance and Dr. Borocavani to a meeting where he was chastised by all for allegedly "lying" about the earlier OB patient's medical history when Relator indicated to Dr. Borocavani that the patient may be a difficult induction, further insinuating that Relator may have "put the patient at risk" despite the fact that Dr. Borocavani never performed a pre-anesthetic evaluation of this patient.

122.

No mention was made about Relator's complaint that there was no TP present until 7:25 a.m. and that had this patient needed an emergency c-section, that Relator would be unable to induce or intubate this patient in the absence of a TP or attending physician, thus jeopardizing the mother and child.

123.

After Relator Johnson categorically denied lying about anything to Dr. Borocavani, Relator was placed on administrative leave until Tuesday in which he was advised that there would be a hearing.

124. Present at the meeting, which actually occurred on Friday September 5, 2007, was Dr. Lustik, Dr. Dooley, Dr. Sabnis, Dr. Chibber, Dr. Robotham and Dr. Glance.

125. The meeting was taped recorded.

126. It was determined after the meeting that Relator Johnson had "lied" and that he did not "deal well with a stressful situation."

127. Relator Johnson was ordered to undergo a psychiatric evaluation by defendants to determine if he had a "propensity for lying" or a "personality disorder."

128. Relator was not permitted by defendants to see the result of the psychiatric evaluation.

129. It was determined on October 5, 2006 that Relator be terminated; Relator Johnson was apprised of this fact by his Resident Advisor and warned by him that if he did not resign first he would be reported to the State of New York and his license would be revoked.

130. Relator Johnson's resignation was accepted by Dr. Robotham.

131. In turn, Dr. Robotham compelled Relator Johnson to speak with Dr. Lustik and Dr. Glance, who stated that Relator Johnson had to sign the termination letter under duress.

132. After Relator Johnson signed the termination letter he was threatened by Dr. Robotham, the Chair of Anesthesia, that he would "never work in medicine again."

14. *Defendant's Reasons For Relator Johnson's Termination are Pretextual*

133. The reasons for Plaintiff's termination are pre-textual and are in retaliation for his constant complaints about the failure of TP supervision of the Anesthesiology Residents.

134. Relator Johnson was not fired because of his performance as an Anesthesiology Resident but because defendant desperately wanted to characterize him as a "liar," even going so far as contacting Relator's former employers and educators to determine whether Relator had a history of lying, which was universally denied by all.

135. That the actions of the defendant were in retaliation for Plaintiff's actions in furtherance of a civil action for false claims as per 31 U.S.C. § 3730(h).

136. Further, there were other Residents whose performance was indeed jeopardizing the safety of others for which Defendant was on direct notice but did not terminate. For example, defendant was aware of a Resident that abused drugs, and another Resident that was disposing of narcotics and not reporting them as waste, both state violations that were made known to Dr. Lustik but for which the residents were not terminated.

137. That the failure of defendant to allow Relator Johnson to finish his last year of residency, coupled with the fact that defendant compelled him to repeat his second year of residency, all after he engaged in protected activity by complaining of the failure of TP supervision over resident physicians were intended to indeed ruin the Relator's career as an Anesthesiologist.

138. However, Relator Johnson, to his credit, was able on March 15, 2007 to secure a position as a third year resident at New York Methodist Hospital which commences on July 1, 2007.

139.

When Relator Johnson explained to the physicians at New York Methodist Hospital the circumstances of his termination and compelled resignation, the universal response was that no resident physician of his standing should have been fired for allegedly “lying” about a patient chart where in fact the attending physician herself had not performed any pre-anesthetic evaluation on the patient, in further violation of the above stated CMS regulations.

RELATOR SCHMIDT’S CLAIMS

140.

Relator Schmidt is a Registered Nurse who worked for 14 years at SH in the OR. Throughout her employment at SH, Relator Schmidt acquired direct personal knowledge and personal knowledge and non-public information of the defendants’s fraudulent practices; in particular, Relator Schmidt witnessed first hand the failure of TPs to supervise resident physicians in violation of the CMS requirements.

141.

Relator Schmidt has witnessed an increased patient case load since the year 2004, but with no concomitant increase in staff to assist in the treatment of these patients, a large percentage of which are Medicare and Medicaid patients.

142.

There are 28 operating rooms at SH with 4 to 5 cases in each room being performed every day.

143.

From January 2004 through the date of her termination in June of 2006, Relator Schmidt witnessed Surgical Residents perform key portions of surgeries if not entire surgeries in the OR without the supervision of a TP or attending physician. During this time period there was no compliance training or any other training provided by SH that dealt with the supervision of residents physicians.

144.

From January 2004 through the date of her termination in June of 2006, Relator Schmidt witnessed Anesthesiology Residents, including Relator Johnson, perform on a daily basis the following key services or procedures outside the presence of an attending physician:

- spinal;**
- epidurals;**
- intubation;**
- extubation;**
- line placement;**
- central line placement;**
- arterial line placement;**
- caudal blocks.**

145.

After the surgical procedure was completed outside the physical presence of a TP, the TP would often require Relator Schmidt to put down on the patient's medical record that the TP or attending physician was present when indeed, the TP or attending physician was nowhere to be found, by either checking a box on the patient's medical record or by stating the following:

“Agree with above, “ following by legible countersignature or identity;

“Rounded, Reviewed, Agree,” followed by legible countersignature or identity;

“Discussed with resident, Agree,” followed by legible countersignature or identity;

“Seen and agree,” followed by legible countersignature or identity;

“Patient seen and evaluated,” followed by legible countersignature or identity; and/or

A legible countersignature or identity alone.

146.

That the issue of the failure of attending physician supervision of the resident physicians became so chronic due to the increased case load in 2004 that Relator Schmidt had to physically leave the OR and attempt to locate a TP or attending physician.

147.

Further, attending physicians often gave verbal reports over the phone, failed to complete postoperative reports, and instructed Relator Schmidt to indicate that they were present when indeed they were not.

148.

Relator Schmidt complained frequently about the failure of supervision by the TPs that she became known as a “trouble maker” and her evaluations were marked to indicate that she was a “problem.” Relator Schmidt was constantly called into the office and admonished for complaining.

149.

On one such incident, in the spring of 2005, Relator Schmidt was approached by Dr. Chibber and was asked to *alter* medical records to reflect that an attending physician was present during a key surgical procedure when indeed the attending never showed for the procedure.

150.

When Relator Schmidt objected to altering medical records to reflect that an attending was present when he was indeed not present, Dr. Chibber's response was "we won't be able to bill for the case if there was no attending" to which Relator Schmidt responded, "well, I guess it's a freebie" because she refused to alter a medical record.

151.

Thereafter, Relator Schmidt, afraid to speak up for fear of losing her job after being told by her supervisor that if she did not stop complaining that she would lose her job, Relator Schmidt was compelled to continually reflect in the medical records that TPs or attending physicians were present for key services or procedures when indeed, they were not physically present. Several months later, Relator Schmidt would be terminated after serving SH for over 14 years as an OR nurse.

152.

Relator Schmidt witnessed first hand as a *patient* the failure of attending physicians to be physically present for key services and procedures that were performed unsupervised by resident physicians.

153.

In September of 2002, Relator Schmidt was admitted to SH for knee surgery for which Dr. Bigeleisen was the attending physician.

154.

An epidural was administered by resident physician Dr. Marika Stone who performed the procedure without the supervision of a TP. The epidural became disconnected; the resident came up and put it back together; later the TP came into the room due to the Relator's complaints that she was in sever pain and that the epidural was not placed correctly, and abruptly pulled out the epidural and threw it on the floor. The Relator contacted the Residency Director to complain about the lack of supervision and the botched epidural; the next day, the resident came to apologize to Relator Schmidt, stating that they had not been relieved by the TPs all night.

**COUNT ONE:
FAILURE TO SUPERVISE RESIDENTS IN VIOLATION OF CMS REGULATIONS**

155. Relators repeat and reallege the above stated paragraphs as if fully set forth herein.

156. This is a civil *qui tam* action brought by Relators on behalf of the United States to recover treble damages and civil penalties under 31 U.S.C. §3729(a) of the False Claims Act.

157. 31 U.S.C. § 3729 (a) provides, in pertinent part liability for any person who:

(1) Knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval.

158. U of R and SH violated 31 U.S.C. §3729 (a) in that at least from July 2004 through the present, it repeatedly, willfully and intentionally presented false claims for payment to the New York State Medicaid program and the federal Medicare programs by and through the actions described herein, that occurred in the OR and the OBGYN units of SH, and potentially elsewhere in SH. It is well settled that SH employees and SH agents shall not knowingly present a claim to any Federal Health Care Program or Health Care

Benefit Program for an item or service the person knows or Should Know, was not provided or was fraudulent. No item or service shall be submitted that is based on a code that the person knows or Should Know will result in greater payment than the code the person knows or Should Know is applicable to the item or service actually provided.

159.

It is also well settled that SH shall not knowingly and wilfully:

1. Falsify, conceal, or cover up by any trick, scheme or device a material fact; or
2. make any materially false, fictitious, or fraudulent statements or representations, or make or use any materially false writing or document, knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of, or payment for, health care benefits, items or services.

And/or,

SH employees and agents shall not:

1. knowingly present or cause to be presented a false or fraudulent claim for payments to a governmental agency, or Health Care Benefit Program;
2. knowingly use or cause to be presented a false record or statement to obtain payment on a false or fraudulent claim from a governmental agency or Health Care benefit Program by attempting to have a fraudulent claim paid;
3. conspire to defraud a governmental agency or Health Care Benefit Program by attempting to have a false or fraudulent claim paid;
4. participate in any other act prohibited by the False Claims Act.

160. The United States Government, by and through the New York State Medicaid program and Medicare program, and unaware of their falsity, paid the claims submitted in connection therewith.

161. Each claim for reimbursement that the U of T and/or SH made for providing key services and procedures without the presence of an attending physician or TP and for which resident physicians performed without supervision represents an unlawful claim and/or fraudulent claim for payment.

162. Relators cannot at this time identify all of the false claims for payment that were caused by Defendant's conduct. That information is solely within the possession of the Defendants.

163. Had the United States Government known that U of R and/or SH submitted claims to it for the provision of key services and procedures performed without the supervision of an attending physician or TP, it would not have paid those claims.

164. As a result of U of R and/or SH's violations fo 31 U.S.C. §3729(a), the United States has been damaged in an amount in excess of millions of dollars, exclusive of interest.

165.

Relators are private persons with direct, personal knowledge of the allegations of this Complaint, who have brought this action pursuant to §3730(h) on behalf of themselves and the United States.

COUNT II AS TO RELATOR JOHNSON

166.

The above stated paragraphs are hereinafter realleged and incorporated by reference.

167.

31 U.S.C. Section 3730 (h) states in pertinent part:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of the lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

168.

To make a prima facie case for a retaliatory discharge under 3730(h) in most jurisdictions, the Relator must show the following: (1) that he took acts in furtherance of a qui tam suit, i.e. she engaged in protected activity; (2) that his employer knew of the acts; and (3) that his employer discharged her as a result of these acts.

169.

Relator Johnson engaged in protected activity from the date he commenced his residency in 2004 until he was terminated in October of 2006, by repeatedly advising his superiors that he believed that SH was inadequately supervising its' resident physicians and permitting residents to perform key services and procedures in the absence of an attending physician or TP in violation of the CMS regulations (even after SH was fined for Medicaid fraud in September of 2005). In furtherance of his FCA claims, he notated certain medical records to indicate when TPs or attending physicians were not present.

170.

Thereafter, in June of 2005, several days after Relator Johnson signed his contract for his second year of residency, he was compelled to repeat his second year of residency and subject o undue criticism.

171.

Dr. Robotham, the Chair of Anesthesiology was amply aware of Relator Johnson's complaints; however, the only remedy taken in November of 2005, 2 months after SH was fined for Medicaid Fraud, was to advise residents not to notate the medical records to indicate whether an attending physician or TP was present or not, effectively ceasing Relator's ability to notate the records when attending physicians were not present.

172.

Thereafter, when Relator attempted once again to advise his Residency Director on September 1, 2006 that his attending was not present for an imminent c-section, he was placed on administrative leave, labeled a "liar" and compelling him to resign one month later on October 3, 2006 from the SH residency program under the threat of revoking his license to practice medicine, compelling his to locate a program in the United States that would allow him to complete his third year of residency.

173.

The timing of his constructive discharge as well as the increased criticism of his work and being labeled a "liar" for complaining of the failure of SH TPs and attending physicians to supervise resident physicians during key services and procedures and the fact that TPs signed off on medical records fraudulently indicating they were present when they were not was motivated solely by illegal animus prohibited by 31 U.S.C. Section 3730(h).

174.

As a result of having to repeat his second year of residency and his constructive discharge under the threat of losing his license, Relator Johnson has sustained a loss of wages, emotional distress and severe professional and personal embarrassment.

COUNT III AS TO RELATOR SCHMIDT

175.

The above stated paragraphs are hereinafter realleged and incorporated by reference.

176.

31 U.S.C. Section 3730 (h) states in pertinent part:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of the lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

177.

To make a prima facie case for a retaliatory discharge under 3730(h) in most jurisdictions, the Relator must show the following: (1) that she took acts in furtherance of a qui tam suit, i.e. she engaged in protected activity; (2) that her employer knew of the acts; and (3) that her employer discharged her as a result of these acts.

178.

Relator Schmidt engaged in protected activity as late as the date of her termination in June of 2006 by repeatedly advising her superiors that she believed that SH was inadequately supervising its' resident physicians and permitting residents to perform key services and procedures in the absence of an attending physician or TP in violation of the CMS regulations (even after SH was fined for Medicaid fraud in September of 2005). In furtherance of her FCA claims, she refused in the spring of 2005 to alter medical records to fraudulently assert that an attending physician or TP was present for a procedure when indeed he was not.

179.

Thereafter, Relator Schmidt was subject to negative reviews and her job was threatened and she was subject to undue criticism.

180.

Dr. Robotham, the Chair of Anesthesiology was amply aware of Relator Schmidt's complaints; however, the only remedy taken in November of 2005, 2 months after SH was fined for Medicaid Fraud, was to advise residents not to notate the medical records to indicate whether an attending physician or TP was present or not, effectively ceasing the ability of residents to notate the records when attending physicians were not present.

181.

Relator was eventually terminated in June of 2006, just months prior to Relator Johnson's constructive discharge.

182.

The timing of her termination as well as the increased criticism of her work and being labeled a "problem" for complaining of the failure of SH TPs and attending physicians to supervise resident physicians during key services and procedures and the fact that TPs signed off on medical records fraudulently indicating they were present when they were not was motivated solely by illegal animus prohibited by 31 U.S.C. Section 3730(h).

183.

As a result of being terminated from her long term position, Relator Schmidt has sustained a loss of wages, emotional distress and severe professional and personal embarrassment.

PRAYER FOR RELIEF

WHEREFORE, Relators prays for judgement against Defendants as follows:

1. That defendants cease and desist violating 31 U.S.C. §3729;
2. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States Government has sustained because of Defendant's actions, plus a civil penalty of not less than \$5,000 and not more than \$10,000 for each violation of 31 U.S.C. §3729;
3. That Relators be awarded the maximum amount allowed pursuant to §3730 of the False Clams Act;

4. That this Court enter judgment against Defendants pursuant to 31 U.S.C. §3730(h) in an amount equal to two times plaintiff's accrued back pay, as of the date of entry of judgement, together with interest thereon, plus full damages for plaintiff's mental anguish; suffering and humiliation; that such judgment award Relator full damages for future lost wages and benefits;
5. That Relators be awarded all costs and expenses of this action, including attorneys' fees;
6. That Relators recover such other relief as the Court deems just and proper.

Respectfully Submitted:

LAW OFFICE OF CHRISTINA A. AGOLA

By: /s/ Christina A. Agola, Esq.

Christina A. Agola
730 First Federal Plaza
28 East Main Street
Rochester, New York 14614
(O)585.262.3320
(C)585.262.3325
caaesq@rochester.rr.com
ATTORNEYS FOR RELATORS

Dated: March 13, 2007
Rochester, New York

EXHIBIT B

CHRISTINA A. AGOLA

Attorneys and Counselors at Law, PLLC

March 16, 2007

Via Fed Ex

Honorable Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

Honorable Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York , 14202

Re: *Relator Keith Johnson, M.D. & Relator Laura Schmidt, R.N., v. University of Rochester Medical Center and Strong Memorial Hospital*

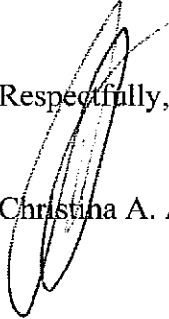
Civ. No.: *07-cv-6149*

Dear Sirs:

Enclosed herein please find a copy of the *qui tam* Complaint in the above captioned matter filed under seal on this 16th day of March, 2007, in the District Court for the Western District of New York, pursuant to a Notice of Motion and Proposed Order filed contemporaneously with the Complaint to maintain the document as sealed for a period of sixty (60) days, as well as Relators' Appendix of Exhibits which are described in detail in Relators' Disclosure Statement.

Please contact me directly with any further questions.

Respectfully,


Christina A. Agola

cc: Robert Trusiak, Esq.
Assistant United States Attorney, Buffalo New York
Via Facsimile at 716.551.3052

EXHIBIT C

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FedEx First Overnight
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4b Express Freight Service *Packages over 150 lbs.*

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 FedEx 2Day Freight Second business day. Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
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5 Packaging
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EXHIBIT D

CHRISTINA A. AGOLA

Attorney and Counselor at Law

Writers Direct Dial: (585) 262-2641
Email: caaesq@rochester.rr.com

March 19, 2007

Via Fed Ex

Honorable Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

Honorable Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York , 14202

Re: *Relator Keith Johnson, M.D. & Relator Laura Schmidt, R.N., v. University of Rochester Medical Center and Strong Memorial Hospital*

Civ. No.: *07-cv-6149*

Dear Sirs:

Enclosed herein please find duly executed Affidavit of Dr. Jayram Srivatsan which was contained within the Relators' Appendix of Exhibits initially but unsigned as of March 16, 2007.

Please contact me directly with any further questions.

Respectfully,

Christina A. Agola

cc: Robert Trusiak, Esq.
Assistant United States Attorney, Buffalo New York
Via Facsimile at 716.551.3052

EXHIBIT E

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 FedEx 3Day Freight Third business day** Saturday Delivery NOT available.
* Call for Confirmation. ** To most locations.

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 FedEx Envelope* FedEx Pak* Includes FedEx Small Pak, FedEx Large Pak, and FedEx Sturdy Pak. FedEx Box FedEx Tube Other
* Declared value limit \$500.

6 Special Handling Include FedEx address in Section 3.
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Earliest next business morning delivery to select locations.* Saturday Delivery NOT available.
 FedEx 2Day
Second business day.* Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
 FedEx Express Saver
Third business day.* Saturday Delivery NOT available.
* To most locations.

4b Express Freight Service
 FedEx 1Day Freight*
Next business day.** Friday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
 FedEx 2Day Freight
Second business day.** Thursday shipments will be delivered on Monday unless SATURDAY Delivery is selected.
 FedEx 3Day Freight
Third business day.** Saturday Delivery NOT available.
* Call for Confirmation. ** To most locations.

5 Packaging
 FedEx Envelope* **FedEx Pak*** **FedEx Box** **FedEx Tube** **Other**
* Declared value limit \$500.

6 Special Handling
 SATURDAY Delivery
NOT Available for FedEx Standard Overnight, FedEx First Overnight, FedEx Express Saver, or FedEx 3D Day Freight.
 HOLD Weekday at FedEx Location
NOT Available for FedEx First Overnight.
 HOLD Saturday at FedEx Location
Available ONLY for FedEx Priority Overnight and FedEx 2Day to select locations.
 Does this shipment contain dangerous goods?
Use box must be checked.
 No Yes Yes Dry Ice Cargo Aircraft Only
As per attached Shipper's Declaration. Shipper's Declaration not required. Dry Ice, 3, UN 1845, x kg. Dangerous goods (including dry ice) cannot be shipped in FedEx packaging.

7 Payment Bill to: Sender Recipient Third Party Credit Card Cash/Check
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520

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CHRISTINA A. AGOLA

Attorney and Counselor at Law

Via Facsimile & Certified Mail
585. 244.7271

Writers Direct Dial: (585) 262-2641
Email: caaesq@rochester.rr.com

April 27, 2007

Dr. Stewart Lustik
Department of Anesthesiology
University of Rochester
601 Elmwood Avenue, Box 604
Rochester, New York 14642

Re: Dr. Keith Johnson

Dear Dr. Lustik:

As you are aware, Dr. Johnson has secured a new residency slot at New York Methodist Hospital after you terminated Dr. Johnson for, allegedly, "misrepresenting" a client's history, thereby precluding Dr. Johnson the ability to complete his residency program, and foreclosing and forestalling his ability to become an anesthesiologist.

Please be aware that we are in possession of all of Dr. Johnson's evaluations, letters of commendation, et cetera.

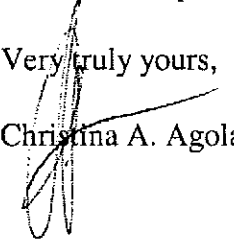
It is our understanding that you have personally contacted Dr. Johnson's new employer, for reasons unknown, and that Dr. Johnson will be signing a release for his evaluations to be sent to New York Methodist on this date.

You are hereby advised that any documentation sent to New York Methodist Hospital must be sent to this office contemporaneously.

You are further advised that any information surreptitiously added to Dr. Johnson's evaluations, either previously unseen or unread, will form the basis for certain litigation against you personally and the University of Rochester as well.

Whatever your personal bias or contempt is towards Dr. Johnson, I admonish you not to derail Dr. Johnson's attempt at prospective employment, particularly given the fact that Dr. Johnson has scored within the 75% percentile of the anesthesiology in-service exam; why you continue to target Dr. Johnson is a mystery, but rest assured, we intend to protect him vigorously.

Very truly yours,


Christina A. Agola

CAA/cia

EXHIBIT G

**BEFORE THE BOARD OF MEDICAL PRACTICE
OF THE STATE OF DELAWARE**

**IN THE MATTER OF)
THE APPLICATION OF) ORDER
KEITH EWING JOHNSON, M.D.)**

NATURE OF THE PROCEEDINGS

On September 9, 2008 the Delaware Board of Medical Practice (the "Board") reviewed Dr. Johnson's application for licensure to practice medicine in the State of Delaware and proposed to deny his application based upon his apparent failure to meet the statutory qualifications.

Specifically, the verification of post graduate medical education form submitted by Dr. Johnson's residency program director from the Department of Anesthesiology at the University of Rochester indicated that Dr. Johnson was placed on probation for 3 months during his residency for difficulties managing stressful situations in the course of managing clinical patient care, a pattern and frequency of "near misses" and poor communication skills. The information indicated that Dr. Johnson was not promoted and was instead offered the opportunity to repeat the second year of his residency due to his responses to critical incidents and deficiencies in his clinical skill set.

In addition, the Clinical Competency Committee recommended that Dr. Johnson take a voluntary leave of absence pending the results of a fitness for duty evaluation stemming from a preponderance of evidence that Dr. Johnson committed a serious ethical breach by fabricating important details regarding a patient's past medical history. As a result of the fitness for duty evaluation Dr. Johnson's resident appointment was terminated due to maladaptive responses to

stressful situations and multiple documented episodes in which anesthesiology faculty questioned his honesty. He was given a determination of not competent in patient care, interpersonal and communication skills and professionalism competency areas.

The Board's proposal to deny is based upon 24 Del. C. § 1720 (b) (4) in that Dr. Johnson was unable to submit a sworn statement that he has not been disciplined by a licensed hospital or by the medical staff of the hospital, including the resignation of privileges under pressure of investigation or other disciplinary action where the discipline was based upon a finding of the hospital or medical staff of unprofessional conduct, professional incompetence or professional malpractice.

The Board has the authority to waive the disqualifications under 24 Del. C. §1720(b)(4) pursuant to 24 Del. C. § 1720 (e). However, the standard to be applied by the Board in granting any waiver of a license disqualification requires an affirmative vote of at least 12 members of the Board if those Board members find by clear and convincing evidence:

1. That the applicant's education, training, qualifications, and conduct have been sufficient to overcome the deficiency or deficiencies, and,
2. That the applicant is capable of practicing medicine and surgery in a competent and professional manner, and,
3. That the granting of the waiver will not endanger the public health, safety or welfare.¹

Dr. Johnson made a timely request for a hearing to present evidence to the Board that it should grant him a certificate to practice medicine in Delaware. Pursuant to his request a public hearing was held before the undersigned members of the Board of Medical Practice on October 7,

¹ The fourth criterion relates to criminal convictions and is not applicable to Dr. Johnson.

2008. Dr. Johnson appeared pro se.

SUMMARY OF THE EVIDENCE

The Board considered the application packet and supporting documentation submitted by Dr. Johnson (Board Exhibit 1.) Dr. Johnson submitted a packet of documents that included a list of references, a resident training report, copies of two Recommendation of Chief of Staff forms, a clinical competency report from The American Board of Anesthesiology, and a final evaluation from the University of Rochester. The packet was admitted as Applicant's Exhibit 1, Tabs 1 through 5. Dr. Johnson also presented a copy of a Complaint in a Qui Tam Action filed in the United States District Court for the Western District of New York filed by the United States, the State of New York, Keith Johnson, M.D., and Laura Schmidt, RN, against the University of Rochester Medical Center & Strong Memorial Hospital. The Complaint was admitted as Applicant's Exhibit 2. Finally, nine letters of reference submitted in sealed envelopes were admitted as Applicant's Exhibit 3.

Keith Ewing Johnson, M. D., was sworn and testified that he voluntarily waived his right to the twenty-day notice requirement for the hearing in order to have his case expedited. Dr. Johnson responded to the concerns raised in the negative report to the Delaware Board from Dr. Stewart Lustik, former residency director of the University of Rochester ("U of R") Anesthesia Program. Dr. Johnson stated that he is a relator in a "Qui Tam" action against the U of R Anesthesia Program. The action was brought as a result of concerns that he and others had expressed throughout his U of R residency relating to the lack of supervision of residents that was generally occurring in the program.

The investigation was a sealed investigation by the US Department of Justice, the US Attorney's Office, and the FBI. Dr. Johnson testified that he has been cooperating with the investigation for the

past 2 years. He stated that he maintained the confidentiality of the sealed complaint despite being in a situation where his reputation and career were severely impacted as a result of unjustified retaliation by Dr. Lustik and other members of U of R Anesthesiology Department's senior management. He was notified in September that the seal was released enabling him to reference it and discuss its content relative to his application for licensure in the State of Delaware. Dr. Johnson added that Mr. Robert Trusiak, US Attorney, is willing to discuss this issue with the Board, if necessary, and agreed to be available by telephone for the hearing..

Dr. Johnson testified that residents in the U of R Anesthesia program were performing anesthesia, primarily in the labor and delivery ward and in the operating rooms, with little to no supervision. He stated that for patient safety it is a violation of both state and federal health law for a training program to allow residents to operate and perform procedures unsupervised. In addition, the practice raises ethical questions regarding the billing of procedures performed by residents who have little to no supervision. Dr. Johnson stated that a group of those individuals who cooperated in the investigation have had severe actions against their careers – including residents and nurses who voiced their concerns in the interest of patient safety. He stated, as an example, that a nurse with over 20 years of experience was fired as the result of voicing her concerns.

Dr. Johnson stated that the negative report by Dr. Lustik dated November 15th was a continuation of the pattern of retaliation against those who questioned the issues regarding supervision and ethics. The clinical competency director Dr. Laurent Glance and residency director Stewart Lustik told Dr. Johnson when he left the program that he would “never work in medicine again” because of his complaints regarding the supervision. Dr. Lustik further threatened him by

stating that "he would personally make sure [Dr. Johnson] would never work again".

Dr. Johnson testified that he contacted Ms. Christina Agola, Esquire, an employment and federal civil rights attorney, who immediately contacted federal authorities in order to conduct an investigation. His complaint and complaints from other medical professionals at the university led to a federal probe into issues within the U of R anesthesiology training program. Dr. James Robotham is no longer the program director. In addition, Dr. Stewart Lustik was replaced in his capacity as the residency director. Dr. Johnson stated that a number of recent changes were made in the program workflow, including the required presence of attendings for cases and call, the required preoperative and postoperative assessment of patients by attendings, and the required presence of attendings during cases so that residents are not operating unsupervised, thereby, providing a safer environment for U of R's patients.

Dr. Johnson stated that the allegation that he committed is a serious ethical breach by fabricating important details regarding a patient's past medical history was just one example of false information stemming from the lack of supervision. Dr. Johnson described the incident leading to the allegation in which an obese patient presented for an urgent C/S secondary to severe pre-eclampsia. The patient was a 350 pound female who had a history of a difficult spinal anesthesia recently in an outside hospital. Upon interviewing and examining the patient, Dr. Johnson stated that he paged his attending, as attending coverage is required in urgent C/S when the patient is likely to be intubated. His attending did not respond. She was repeatedly paged over a 30 minute period, at which point, Dr. Johnson contacted the department coordinator and asked for an attending. The anesthesia coordinator sent another attending, and the case was to begin, when the scheduled attending finally

arrived for the day, 35 minutes late. The scheduled attending told Dr. Johnson she was "disappointed in [him] for calling for help" and the case was begun. Later in the day Dr. Johnson found out that the attending told the program director (upon complaints from the OB service of her tardiness), that he had fabricated the patient's history and told her that there was a history of a difficult intubation in their hospital. Dr. Johnson testified that he stated then, and continues to maintain, that no such history was given.

In regard to Dr. Lustik's challenges to his competency and integrity, Dr. Johnson stated that his competency is evidenced by completion of medical school, completion of an accredited residency program, and passing the licensing boards (the USMLE Step III) resulting in licensure in New York. In addition, he successfully passed the written anesthesia boards in August 2008 on his first attempt. In his residency, he performed over 2100 cases, well above the 1600 necessary to graduate and exceeded his case count in all categories necessary for entering the board examination system by the ABA (*See Applicant's Exhibit 1, Tab 2*). Dr. Johnson added that there was never an issue of malpractice raised or filed in any of the cases. Dr. Johnson noted that his evaluation from his residency at Methodist Hospital in Brooklyn, NY shows his performance to be above average in all categories, which was communicated to the Medical Board as part of the "Recommendation from Chief of Staff or Chief of Service" form for the State of Delaware by both the chair and the vice-chair of the program (*See Applicant's Exhibit 1, Tab 3*).

Dr. Johnson testified that during his residency, the U of R Anesthesia Department asked him to obtain his NY State Medical license so that he could moonlight for them. The U of R anesthesia Department actually paid for his license, a further commentary on his competence, as the U of R's

policy was to deny licensing to any resident who was deemed academically or clinically unsatisfactory. Dr. Johnson stated that he held his New York State Medical License before and after this event, and it remains in good standing today.

Dr. Johnson testified that the competent evidence disputes the allegations against his integrity and the specific allegation that "Dr. Johnson committed a serious ethical breach by fabricating important details regarding a patient's history". He stated that the allegation by the clinical competency coordinator and the residency director that he had a "maladaptive response to stressful situations" was disproven by both the fitness for duty evaluation and by Dr. Jeffrey Levenkron, an independent psychologist who examined Dr. Johnson at the request of the U of R. Instead, Dr. Levenkron gave his opinion that "The details of this incident appeared to be a misunderstanding..." and expressed confidence that Dr. Johnson did not have a chronic or underlying stress-related psychiatric disorder that would require any special consideration or treatment during his residency. Dr. Levenkron stated that he offered his assessment having previously served as the Director of the Stress and Anxiety Clinic in the Department of Psychiatry at the University of Rochester Medical Center for 15 years. He "was not sure who in the U (of) R Anesthesia Residency offered a contrary opinion, but would question its accuracy". Dr. Levenkron agreed to be a reference for Dr. Johnson and a witness at the hearing by telephone, if needed.

Dr. Johnson also challenged Dr. Lustik's allegation that Dr. Johnson exhibited "difficulties managing stressful situations... pattern and frequency of 'near misses' and poor communications skill", resulting in probation beginning October, 2004 for three months. Dr. Johnson noted that the "probation" as Dr. Lustik described it, was never reported to the American Board of Anesthesiology

as required by the ACGME. In fact, the ABA Clinical Competency Committee report for his performance throughout the period in question makes no mention of the alleged difficulties. (See Applicant's Exhibit 1, Tab 4). Instead, the reports during this period (and during the previous 12 months leading up to the probation claim), show that Dr. Johnson's performance in all areas is listed as satisfactory. Dr. Johnson stated that in reality, the alleged "probation" was threatened but never formalized and resulted from his expressing concerns about lack of supervision of residents and the direct impact on patient safety that it posed.

Dr. Johnson next highlighted the contradiction between his Final Evaluation from U of R (See Applicant's Exhibit 1, Tab 5) and the memo from Dr. Lustik, dated November 15, 2006. In the final examination dated October 4, 2006, Dr. Lustik stated in question 6 that there were no "health problems, either physical or mental, including substance abuse, which might affect his/her (i.e. the resident's) performance in patient care." However, 40 days later on November 15, 2006, he authored the memo stating that there was a "maladaptive stress response" as a psychological diagnosis despite his previous response on the final examination that there was no stress-related psychiatric issue present. In addition, Dr. Lustik stated in response to question 2 that there were no "Pending professional misconduct proceedings or pending malpractice actions, judgments, or settlements?" Yet, in the November 15th memo, Dr. Lustik stated that a serious ethical breach was committed by fabricating a patient's past medical history. Dr. Johnson noted that, again, this directly contradicts what was originally submitted. Dr. Johnson asked the Board to take notice of the fact that although he was able to review and sign the final examination of October 4th which he did under duress; the later memo was never presented to him for his acknowledgement by the department.

Dr. Johnson added that the witnesses listed on Applicant's Exhibit 1, Tab 1, were standing by to testify by telephone to set the record straight if needed. In addition, Dr. Jonathan Weinberg, Methodist Hospital Department Chief of Obstetric Anesthesia, traveled to Delaware to testify on Dr. Johnson's behalf to speak to any questions regarding competency or integrity. Finally, Dr. Johnson added that he presented numerous letters of recommendation, both from the University of Rochester and from Methodist Hospital, which were presented sealed to maintain confidentiality (Applicant's Exhibit 3).

Dr. Johnson summarized by stating that Dr. Lustik's allegations regarding integrity and competency have been shown to be without merit. He added that there are numerous factual errors and erroneous impressions left by Dr. Lustik's document as previously described. He noted that his evaluations from the Methodist program and even from the U of R demonstrate no issues regarding either his competency or professionalism. Dr. Johnson stated that he is competent as evidenced by graduation from an accredited anesthesia program, successful completion of written boards in August, and holding his license in good standing in New York State. In addition, the recent recommendations by the chair and vice chair of Methodist Anesthesia to the Delaware Board demonstrate his competence and integrity with above average ratings in all areas queried. He asked for the opportunity to continue the reason he began medical school, to make a difference one case at a time, as a licensed anesthesiologist in the state of Delaware. He thanked the Board for their consideration of the matter.

On examination by the Board members, Dr. Johnson stated that at U of R there was 1 attending for 5 to 6 rooms at night. At Methodist Hospital there is a 1 to 1 ratio. Dr. Johnson stated

that there were 38 residents at the U of R program. Two of the other residents brought up the issue of supervision. One was placed on the probation. U of R tried to place the other resident on probation but his sister was a lawyer. Dr. Johnson stated that he left U of R and went to Methodist because of the ethics of the program at U of R.

Dr. Johnson stated that Dr. Lustik was aware of the situation with the tremor in Dr. Johnson's hand. He stated that the condition went undiagnosed for 2 years. One of the treatments they gave him actually made the situation worse by increasing his heart rate. Because he is a long distance runner he could barely stand up. Since his diagnosis and surgery he has had no problems.

With regard to the issue of his communication skills, Dr. Johnson added that he has also matured and grown as a person since his time at U of R and has learned how to approach and talk to people. He thinks a lot about what he says and how it will be perceived by the other person involved. He does not believe he has problems with his communication skills.

Jonathon Weinberg, M.D., was sworn and testified that he is the Director of Obstetrics and Anesthesiology at Methodist Hospital. He stated that they perform 6000 deliveries a year providing plenty of opportunity to be stressed. He is also Dr. Johnson's faculty advisor and has gotten to know him well during labor and delivery rotations. They first met in June of 2007. As the faculty advisor, he is the point man for other professionals to express concern. He stated that Dr. Johnson's integrity is demonstrated by the fact that he never talked about the Federal case against U of R despite its obvious import. The first Dr. Weinberg heard of the case was in connection with Dr. Johnson's hearing on his Delaware application. He stated that Dr. Johnson's professional skills and knowledge base are excellent. He has observed no ethical breaches or questions of professionalism. Dr. Johnson

has no issues with communication skills and no problems handling stressful situations. He has personally seen him work with gravely ill patients and has no reservations about his patient care. He has never observed the substantive tremors noted in the report. He stated that Dr. Johnson was treated for hypothyroidism that caused a fine tremor. Dr. Weinberg did not see it as a problem; it had a medical cause that was treated.

As Dr. Johnson's faculty advisor, Dr. Weinberg was asked to be on the lookout for problems with stress and professionalism. He did not note any problems and spoke to others who also did not observe any clinical issues. He could only attest to his own observations and could not state whether the U of R assessments were influenced by the lawsuit.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter is before Board due the negative verification of post graduate medical education form submitted by Dr. Johnson's residency program director from the Department of Anesthesiology at the University of Rochester which indicated that Dr. Johnson was placed on probation for 3 months during his residency and had difficulty managing stress and had issues with professionalism, patient safety and integrity.

As a result, the Board proposed to deny Dr. Johnson's application under the provisions of 24 Del. C. § 1720 (b) (4) in that he could not submit a sworn statement that he has not been disciplined by a licensed hospital or by the medical staff of the hospital, including the resignation of privileges under pressure of investigation or other disciplinary action where the discipline was based upon a finding of the hospital or medical staff of unprofessional conduct, professional incompetence or professional malpractice.

The Board finds from the evidence presented that Dr. Johnson has more than satisfactorily demonstrated his competence and ability to interact safely with patients. The Board commends Dr. Johnson on his thorough presentation and the seriousness with which he has taken the hearing. Appearing at a licensure hearing is in and of itself a stressful situation. The Board had the opportunity to view Dr. Johnson's ability to handle the stress and observes that he presented the case well and calmly. The Board is persuaded by Dr. Johnson's evidence that he does not suffer from any psychiatric disorders. In addition, the evidence established that the previously undiagnosed hypothyroidism that caused his slight hand tremor has now been adequately treated and does not pose an issue to patient safety.

Dr. Johnson has presented with numerous credible references attesting to his character, integrity, compassion for patients and the quality of his professional skills. He is described as having good judgment and a solid knowledge of clinical anesthesia in addition to being a team player. His references note that he is competent, quick thinking and decisive when taking action. Many of those references, although not called to testify, agreed to be on standby to support Dr. Johnson's application.

The Board found the testimony of Dr. Weinberg to be extremely persuasive on the issues before the Board. Dr. Weinberg has worked closely and personally with Dr. Johnson at Methodist Hospital and was asked to monitor his performance as a result of the negative report from U of R. He found Dr. Johnson able to handle stressful situations and observed no ethical breaches or questions regarding his professionalism. He found Dr. Johnson's professional skills and knowledge base to be excellent. In fact, he thought enough of Dr. Johnson to travel to Delaware for the hearing to vouch

for Dr. Johnson's integrity and clinical skills. Dr. Weinberg supported Dr. Johnson wholeheartedly and without reservation.

While the Board cannot make a conclusive finding as to what actually happened at the U of R, the Board does find that Dr. Johnson has pointed to enough contradictions to call the negative reference into question and diminish the weight it should be given in this hearing. The Qui Tam Action supported by the United States and the State of New York also bolsters Dr. Johnson's credibility with regard to many of the issues.

Lastly, Dr. Johnson is currently licensed in good standing in New York. No action was instituted by the New York Board of Medical Practice against Dr. Johnson as a result of the allegations made by the U of R.

The Board finds that the Applicant's training, qualifications and conduct have been sufficient to overcome the deficiency created by the one negative experience in his training record. Further, the Board finds from the evidence presented that Dr. Johnson is capable of practicing medicine in a competent and professional manner. The Board finds that the granting of the waiver will not endanger the public's health, safety or welfare.

DECISION AND ORDER

The Board concludes that the Applicant has met his burden of proof in this case and should therefore be granted a waiver and licensed to practice medicine in the State of Delaware.

For the reasons stated above, the deficiency posed by Dr. Johnson's inability to meet the requirements of 24 *Del. C.* §1720(b)(4) is waived by the affirmative vote of the undersigned fourteen

(14) members the Board of Medical Practice. The application of Dr. Keith Ewing Johnson for a Certificate to Practice Medicine in the State of Delaware is unanimously approved.

IT IS SO ORDERED this 2nd day of December, 2008.

[Signature]
Galicano Inguito, M.D., President

[Signature]
Anthony M. Policastro, M.D., Vice-President

[Signature]
Raymond L. Moore, Sr., Secretary

[Signature]
John Banks, Public Member

[Signature]
Gregory Adams, M.D.

[Signature]
George Brown, Public Member

[Signature]
Stephen Cooper, M.D.

Dustin Davis, D.O.

[Signature]
Sharon Jones, Public Member

Nasreen Khan, D.O.

[Signature]
Vincent Lobo, D.O.

[Signature]
Karl McIntosh, M.D.

[Signature]
Oluseyi Senu-Oke, M.D.

[Signature]
Lindsey Slater, M.D.

Date Mailed: 12/04/08

EXHIBIT H

November 15, 2006

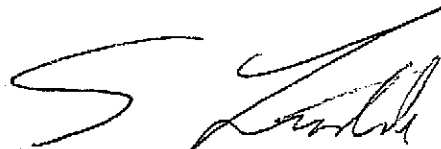
Re: Keith Johnson, MD

Because of difficulties with managing stressful situation that arise in the course of managing clinical patient care, pattern and frequency of "near-misses" and poor communication skills, the Anesthesiology Clinical Competency Committee put Dr. Johnson on probation from October 12, 2004 for 3 months. On February 7, 2005, the committee met again and recommended that he be restored to normal resident status.

The committee met again on June 22, 2005 and decided that (1) Dr. Johnson would not be promoted to the CA3 year and (2) that he would be offered the opportunity to repeat the CA2 year. This additional year of training was hoped to enable Dr. Johnson to develop the skills of a consultant in anesthesiology. The American Board of Anesthesiology on October 6, 2005 approved of this step due to Dr. Johnson's responses to critical incidents and deficiencies in his clinical skill set.

On September 5, 2006, the committee recommended that Dr. Johnson request a voluntary leave of absence pending the results of a fitness for duty evaluation. This step was taken due to preponderance of evidence that Dr. Johnson committed a serious ethical breach by fabricating important details regarding a patient's past medical history. As a result of the fitness for duty evaluation results, the committee recommended on September 28, 2006 that Dr. Johnson's resident appointment be terminated due to maladaptive responses to stressful situations and multiple documented episodes in which anesthesiology faculty questioned Dr. Johnson's honesty. Dr. Johnson was given a determination of not competent in patient care, interpersonal and communication skills, and professionalism competency areas.

Prior to final disposition, Dr. Johnson resigned on October 3, 2006.



11/16/06

Stewart J. Lustik, MD

EXHIBIT I

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF NEW YORK

THE UNITED STATES OF AMERICA &
STATE OF NEW YORK, ex rel.

KEITH JOHNSON, M.D.,
LAURA SCHMIDT, R.N.,

Plaintiffs,

BRINGING THIS ACTION ON
BEHALF OF THE UNITED STATES
OF AMERICA

c/o

Terrence P. Flynn
United States Attorney
138 Delaware Avenue
Buffalo, New York , 14202

-and-

Alberto Gonzales
Attorney General of the United States
Department of Justice
10th & Constitution Avenue, N.W.
Washington D.C. 20530

v.

THE UNIVERSITY OF ROCHESTER
MEDICAL CENTER &
STRONG MEMORIAL HOSPITAL, &
DR. STEWART LUSTIK,

Defendants.

PROPOSED AMENDED COMPLAINT
QUI TAM ACTION
Civ. No.

JURY TRIAL DEMANDED

INTRODUCTION

1. This is an action by qui tam Relator Dr. Keith Johnson (“Relator Johnson”) and Laura Schmidt, R.N., (“Relator Schmidt”) in the name of the United States and the State of New York, to recover penalties and damages arising from the University of Rochester’s (“U of R”) and Strong Hospital’s (“SH”) willful and deliberate overcharging of the New York Medicaid and federal programs for anesthesiology services performed in the Obstetric and Gynecological Department (“OBGYN”) and Operating rooms

(“OR”) of Strong Hospital. Defendants have done this by fraudulently submitting tens of thousands of claims for reimbursement for professional services by residents in training that were *never provided, supervised or controlled by the faculty Teaching Physician (“TP”)* in violation of the Center for Medicare and Medicaid Services (CMS) regulations which mandate the presence of a TP during the “key portion” of any service or procedure performed in the teaching hospital and clinical setting, and which further requires that the presence of the TP be reflected in the patient’s medical record. This action against the U of R and SH is being brought under the Federal False Claims Act, 31 U.S.C. § 3729, et seq; this case also concerns the anti-retaliation provision of the False Claims Act (“FCA”), 31 U.S.C. §§ 3730 (h) for the termination of Relator Johnson after he identified fraudulent billing practices, and the New York State Whistleblower Act.

2. Relators Johnson and Schmidt disclose that there are tens of thousands of SH faculty physician bills which falsely represent that TPs themselves had personally provided the service done by the residents outside of their physical presence. This complaint is based upon non-public information the Relators obtained while employed at the SH, their personal observations of the acts and conduct of the defendants, and by non-public information Relators and their attorney obtained during the investigation of this matter.

JURISDICTION AND VENUE

3. These claims arise under 31 U.S.C. §3729 & §3730, *et seq.*, known as the “False Claims Act.”

4. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 and 28 U.S.C. § 1343.

5. Venue is proper in this Court under 31 U.S.C. 3732(a) because SH and the U of R transacts business in the Western District of New York, and committed a number of the acts proscribed by 31 U.S.C. §3729 in the Western District of New York.

6. This Court has supplemental jurisdiction over the state law claims contained in this action pursuant to 28 U.S.C. §1367(a), as such claims form part of the same case or controversy as the federal claims.

PARTIES

7. Relator Schmidt is a Registered Nurse who worked for 14 years at SH in the OR. Throughout her employment at SH, Relator Schmidt acquired direct personal knowledge and personal knowledge and non-public information of the defendants’s fraudulent practices.

8. Relator graduated from Syracuse Upstate Medical Facility with a Medical Doctorate on or about May of 2002; he completed his internship between the years of 2002-2003 with the University of Rochester. Relator Johnson commenced his residency in anesthesiology in 2004 with SH until he was terminated from his last year of residency in November of 2006. Throughout his employment at SH, Relator acquired direct personal knowledge and personal knowledge and non-public information of the defendants's fraudulent practices.

9. The defendant U of R Medical Center includes the School of Medicine and Dentistry, School of Nursing, Eastman Dental Center, Strong Memorial hospital, Golisano Children's Children's Hospital at Strong, and Medical Faculty Group.

10. The defendant SH is a business corporation organized and existing under the laws of the State of New York, with its principal office located at 601 Elmwood Avenue, Rochester, New York 14642, Rochester, New York. SH is a major tertiary (Level III) referral center and a teaching hospital in an approved direct Graduate Medical Education payment methodology, or "GME." SH has a very high percentage of Medicare/Medicaid patients. Medicaid is a federal and state funded program established to pay for medical

care for the indigent. For reimbursement purposes, SH is specially designated as a teaching hospital and is reimbursed on a per diem basis for key services and procedures it provides under the supervision of an attending physician.

11. TPs supervise, train and advise Residents in the practice of medicine in a teaching setting in which Medicare payment for the services of residents is made by the GME residency program in medicine.
12. The ratio of TPs to Residents is 3 Residents per 1 TP at night; and 2 Residents per 1 TP during the daytime. It was common knowledge that the ratio was 3 to 1 on the night shift to avoid government inspection; it was assumed by management that the government would only audit during the daytime.
13. SH annually admits more than 50,0000 patients from the Rochester, New York area, the State of New York and the world. Over 65 % of the patients at SH have Medicare/ Medicaid Coverage, and as such, SH is governed by regulations promulgated by the Centers for Medicare and Medicaid Services (CMS).

14. As a teaching hospital, billing by faculty physicians for services actually performed by resident physicians in training is in violation of both federal and state law, since under the Medicare program, the United States already pays for a substantial portion of the residents' training and salaries through GME, and their services cannot be billed to the Medicare program on a fee-for service basis.
15. However, in direct contravention to this well settled practice, Relators disclose, based upon non-public information the Relators obtained while employed at the SH, and their personal observations of the acts and conduct of the defendants, that there are potentially tens of thousands of SH faculty physician bills (or more) which falsely represent that TPs had *personally provided the service done by the residents in the OR and OBGYN units.*
16. The central SH faculty physicians who are responsible for condoning this illegal practice are Dr. Stewart Lustik, Dr. James Robotham, Dr. Whistler, Dr. Bigeliesen; Dr. Issacson; Dr. Glance, Dr. Chibber, and Dr. Borovancani, *inter alia*, as described below.

1. RELATOR JOHNSON'S RESIDENCY AT STRONG HOSPITAL

17. In 2002, Relator Johnson was in a class of 10 categorical residents who began their Residency in Anesthesiology in or about July of 2004.
18. Relator Schmidt at this time was an OR nurse who observed Relator Johnson on frequent occasion act as a Resident in the OR unit, and bears witness to Relator Johnson's claims herein.
19. Upon entry to the program, it was made known to Relator and all other Residents by Dr. Robotham that "when [he] came to the U of R, we were in danger of being closed down; now the Anesthesia Department is the highest grossing department in the University."
20. It is well known that the Anesthesiology Department is the largest grossing department of SH.
21. It was also well known that since Dr. Robotham took over as Chair of Anesthesia in late 2002 that SH had a huge influx of cases, approximately 30 to 40%, with no concomitant increase in staff size to deal with these patients.

22. Despite the constant emphasis on the “money making ability” of the Anesthesiology Department, and the high number of Medicare and Medicaid cases at SH, Relator Johnson received no training in compliance with the Center for Medicare and Medicaid Services (“CMS”) regulations, as described in detail below, either at the commencement of his internship, or at any relevant time up and until his termination on October 5, 2006.

1. CMS Regulations

23. The CMS issued regulations as late as January 13, 2006 (Transmittal 811) clarifying and specifying the TP “presence requirement” in the teaching hospital and clinical setting for the purpose of billing, and incorporating Transmittal 1780, dated November 22, 2002.

24. The CMS policy is clear with regard to those cases where the teaching anesthesiologist is involved in 2 concurrent anesthesia cases with residents on or after January 1, 2004, the teaching anesthesiologist may bill the usual base units and anesthesia time for the amount of time he or she is present with the resident.

25. Under CMS regulations, SH employees and SH agents shall not submit a claim for reimbursement for professional services from

any Federal Health Care Program or Health Care benefit Program unless the TP personally provided, or supervised and controlled the provision of the key portions of the service.

26. The TP's "physical presence" during the key portion of any service or procedure shall be reflected in the patient's medical record as per CMS regulations.

27. "Physical presence," as defined by CMS, means simply that the TP is located in the same room (or partitioned or curtained area, if the room is subdivided to accommodate multiple patients) as the patient and/or performs a face to face service.

2. Payment for Physician Services in Teaching Settings

28. Pursuant to 42 C.F.R. § 415.170, services furnished in teaching settings are paid under the physician fee schedule if the services are:

- **Personally furnished by a physician who is not a resident;**
- **Furnished by a resident where a teaching physician was physically present during the critical or key portions of the service; or**
- **Certain E/M services furnished by a resident under the conditions contained in §100.01C.**

29. In all situations, the services of the resident are payable through either the direct GME payment or reasonable cost payments made by the FI.

3. *Evaluation and Management (“E/M”) Services*

30. For the purpose of payment, E/M services billed by teaching physicians require that they personally document at least the following:
- That they performed the service or were physically present during the key or critical portions of the services when performed by the resident; and
 - The participation of the teaching physician in the management of the patient.
31. Documentation by the resident of the presence and participation of the teaching physician is not sufficient to establish the presence and participation of the teaching physician.
32. The following are examples of unacceptable documentation by the TP in patient’s medical records:
- “Agree with above, “ following by legible countersignature or identity;*
- “Rounded, Reviewed, Agree,” followed by legible countersignature or identity;*
- “Discussed with resident, Agree,” followed by legible countersignature or identity;*
- “Seen and agree,” followed by legible countersignature or identity;*
- “Patient seen and evaluated,” followed by legible countersignature or identity; and*
- A legible countersignature or identity alone.*
33. The above stated documentation of the record is unacceptable to CMS because it makes it impossible to determine whether the teaching physician was present, evaluated the patient, and or had

any involvement with the plan of care.

4. Exception for E/M Services Furnished in Certain Primary Care Centers

34. TPs providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. TPs may submit claims for services furnished by residents in the absence of the TP under the primary code exception G0344 (initial preventative physical examination; face-to-face visit services limited to new beneficiaries during the first 6 months of Medicare enrollment).
35. If a service other than those listed in G0344 needs to be provided, then the general teaching physician policy set forth in §100.1 applies. Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program and Centers must maintain information on site as per 42 U.S.C. 413.79(a)(6).
36. TPs submitting claims under this exception may not supervise more than four residents at any given time and must direct the care from such proximity as to constitute immediate availability. The TP must:

- Have no responsibilities at the time he/she is supervising the Residents;
- Assume management responsibility for patients seen by the Residents;
- Ensure that the services furnished are appropriate;
- Review the patient's medical history, physical examination, diagnosis, and record of tests and therapies with each Resident during, or in the outpatient setting, immediately after each visit;
- Personally document in the medical record the extent of his or her own participation in the review and direction of the services furnished to each patient.

5. *Anesthesia*

37. Medicare pays an unreduced fee schedule payment if a teaching anesthesiologist is involved in a single procedure with one resident.
38. The TP in this instance must document in the medical records that he/she was *present* during all critical (or key) portions of the procedure.
39. The TP's physical presence during *only* the preoperative or postoperative visits with the beneficiary is not sufficient to receive medicare payment.
40. If an anesthesiologist is involved in concurrent procedures with more than one resident or with a resident and a non-physician anesthetists, Medicare pays for the anesthesiologist's services as *medical direction*.
41. In those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents or after January 1, 2004, the teaching anesthesiologist may bill the usual base units and anesthesia

time for the amount of time he/she is present with the resident and should use the “AA” modifier to report such cases and must document his/her involvement in cases with residents sufficient to warrant Medicare payment.

6. Post Operative Reports

42. CMS guidelines indicate that all patients who have received an anesthetic must have a note in the record that indicates evaluation written by the attending physician that indicates that evaluation was provided postoperatively by the attending physician. The note must be recorded with a date and time, should be documented on the back of the intra operative report and must occur within 48 hours of the anesthetic. This note must also contain documentation that addresses the four following concerns:
- Cardiopulmonary Status
 - Level of Consciousness
 - Follow-up care or observations
 - Presence or absence of postoperative complications

7. SH's Written Policies As of September 24, 2003

43. Despite these well settled CMS regulations, it was, however, a well settled *written* policy of SH at the commencement of Relator Johnson's Residency to permit Anesthesiologist Residents to

perform key portions of medical services and procedures that TPs **rarely if ever personally provided, supervised, or controlled,** including epidurals in the OBGYN unit and extubations or emergence procedures in the OR unit.

44. In or about September 24, 2003, Dr. Stewart Jay Lustik sent to all Anesthesiology Residents the following letter for which Relator Johnson became aware of in 2006:

Dear residents:

Our Department Policy requires that the attending is present for induction and emergence. ***If the attending specifically tells you that he/she does not need to be present, then it is OK for you to proceed if you feel comfortable.*** This will rarely happen with induction, but in certain situations with senior residents the attending may allow it. Under no circumstances are you to induce a patient without an attending present unless you receive specific instructions from your supervising attending to do so.

Remember, your attending is always available for questions and assistance. Please see me with any questions.

45. That the above stated memo was in direct contradiction to the above stated CMS regulations, yet it was accepted policy and practice at SH for Anesthesiology Residents to routinely perform key procedures in the OR and OBGYN unit including epidurals and extubations/emergence without line of sight supervision, without the presence of a TP and for which Residents were compelled to perform without supervision and to provide the medical chart to the TP to sign after the procedures were completed.

46. Relator Johnson also witnessed that TPs failed to complete numerous postoperative reports in further violation of the CMS regulations.

8. *Anesthesiology Resident's Caseload Per Year*

47. On average, there are 7500 cases that are handled by a U of R Anesthesiology Residents over the course of their three year residency, or 2500 per year per each of the 40 Anesthesiology Residents who were divided into classes of 10.
48. Over a 24 hour period there are 8 epidurals performed daily without direct line of sight supervision and in the absence of the TP's physical presence by Anesthesiology Residents, or 2500 per year at the rate of \$700.00 per procedure.
49. Over a 24 hour period there are 3 to 4 extubations/emergence procedures performed by the Anesthesiology Residents daily or 30-50 per day without direct line of sight supervision and in the absence of the TP's physical presence in violation of the above stated CMS regulations.

50. Over a 24 hour period , there are an extremely high number of postoperative reports, too many to count, that were **never** placed in the patient's record as per the above stated CMS regulations by the TP or attending physician.

51. After January 1, 2004, over a 24 hour period there have been countless occasions

9. Key Procedures Performed by Johnson Without Supervision

I. Year 7/2003 through 6/2004

52. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed several hundred pre-anesthetic evaluations which should be performed by the TP or attending physician in violation of the seven requirements that must be met by the TP to qualify as "supervision" under the CMS regulations.

53. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed approximately 40 epidurals without the supervision of a TP.

54. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed 2 to 3 extubations/emergence procedures without the supervision of a TP per day, or approximately 500 extubations/emergence procedures per year.

55. For the year 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that TPs rarely if ever completed postoperative reports as required by CMS regulations.

ii. Year 7/2004 through 6/2005

56. For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed several hundred pre-anesthetic evaluations which should be performed by the TP or attending physician in violation of the seven requirements that must be met by the TP to qualify as “supervision.”

57. For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply,

Relator estimates that he performed approximately a hundred of epidurals without the supervision of a TP and outside of their physical presence.

58. For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed 2 to 3 extubations/emergence procedures per day without the supervision of a TP, or approximately 500 unsupervised extubations/emergence procedures.

59. For the year 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that less than 5% of post operative reports were performed by the TPs.

iii. Year 7/2005 through 10/2006

60. For the year of 7/2005 through October 5, 2006, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed several hundred anesthetic evaluations which should be performed by the TP or attending physician in violation of the seven requirements

that must be met by the TP to qualify as “supervision.”

61. For the year of 7/2005 through October 5, 2006, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed hundreds of epidurals without the supervision of a TP and outside of their physical presence.
62. For the year of 7/2005 through October 5, 2006, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that he performed 2 to 3 extubations/emergence procedures daily or 30-50 for the entire Anesthesiology Residents without the supervision of a TP, or approximately 500 extubations/emergence procedures per year without the physical presence of a TP.
63. For the year 7/2005 through October 5, 2006, under circumstances for which none of the exceptions to the CMS regulations apply, Relator estimates that less than 5% of post operative reports were completed by the TP.

64. That from 2004 through October of 2006, Relator had great difficulty locating TPs in the middle of the night to assist in key procedures.
65. In fact, Relator was told repeatedly by attending physician Dr. Sheldon Issacson, (**subsequently terminated from SH after October 2006**), that as a senior resident, Relator was not to call him in the middle of the night because this was a “sign of weakness” in total arrogant disregard of the CMS regulations.
66. Some TPs even lie asleep on stretchers in the hallway; Dr. Bigeliesen was nicknamed “Big who lies in sin” for this very reason.

10. Violation of The CMS Concurrency Rule after January 1, 2004

67. The CMS regulations provide that those cases where the teaching anesthesiologist is involved in two concurrent anesthesia cases with residents or after January 1, 2004, the teaching anesthesiologist (TP) may bill the usual base units and anesthesia time for the amount of time he/she is present with the resident and should use the “AA” modifier to report such cases and must

document his/her involvement in cases with residents sufficient to warrant Medicare payment.

68. If the TP was **not** present in the scenario where he oversaw 2 concurrent anesthesia cases with the resident for key services and procedures such as epidurals and extubation/emergence, then that TP could only bill for this as “*medical direction.*”
69. The TP’s physical presence during *only* the preoperative or postoperative visits with the beneficiary is not sufficient to receive medicare payment; the TP must be present for key services and procedures such as epidurals, and extubations/emergence.
70. That on all shifts the ratio of residents to TP was 3 residents to 1 TP on any given shift.
71. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents or after January 1, 2004, Relator Johnson estimates that he performed 40 epidurals without the supervision

of a TP in violation of the CMS Concurrency Rule.

72. For the year of 7/2003 through 6/2004, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents or after January 1, 2004, Relator estimates that he performed 2 to 3 extubation/emergence procedures without the supervision of a TP per day, or approximately 500 extubation/emergence procedures per year in violation of the CMS Concurrency Rule.

73. For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, Relator estimates that he performed hundreds of epidurals without the supervision of a TP in violation of the CMS Concurrency Rule.

74. For the year of 7/2004 through 6/2005, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, Relator estimates that he performed 2 to 3 extubation/emergence procedures without the supervision of a TP, or approximately 500 unsupervised epidurals in violation of the CMS Concurrency Rule.
75. For the year of 7/2005 through 10/2006, under circumstances for which none of the exceptions to the CMS regulations apply, and in those cases where the TP is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, Relator estimates that he performed hundreds of epidurals without the supervision of a TP in violation of the CMS Concurrency Rule.
76. For the year of 7/2005 through 10/2006, under circumstances for which none of the exceptions to the CMS regulations apply, and for those cases where the TP is involved in two concurrent anesthesia cases with residents on or after January 1, 2004, Relator estimates that he performed 2 to 3 extubation/emergence procedures daily without the supervision of a TP, or approximately 500 extubation/emergence procedures per year in violation of the

CMS Concurrency Rule.

11. Manner in Which Key Procedures Performed Without Supervision Were Credited to Faculty Physicians For the Purpose of Billing Medicare and Medicaid

77. That from July of 2003 through October of 2006 Relator was compelled to perform pre-anesthetic evaluations for all patients he handled over the course of his residency for which he placed in writing and hand delivered to his TP or attending physician who would simply sign off by indicating the following:

*“Agree with above, “ following by legible countersignature or identity;
“Rounded, Reviewed, Agree,” followed by legible countersignature or identity;
“Discussed with resident, Agree,” followed by legible countersignature or identity;
“Seen and agree,” followed by legible countersignature or identity;
“Patient seen and evaluated,” followed by legible countersignature or identity; and/or
A legible countersignature or identity alone.*

78. That from July of 2003 through October of 2006, Relator was compelled to hand over the chart at the end of the night for the purpose of the TP to sign, falsely indicating on the patient’s medical records that the TP or attending physician was present for key procedures for all of the times and dates given above, who would simply sign off by indicating the following:

*“Agree with above, “ following by legible countersignature or identity;
“Rounded, Reviewed, Agree,” followed by legible countersignature or identity;
“Discussed with resident, Agree,” followed by legible countersignature or identity;
“Seen and agree,” followed by legible countersignature or identity;*

“Patient seen and evaluated,” followed by legible countersignature or identity; and/or

A legible countersignature or identity alone.

79.

Specifically, from 2003 through the date of the Relator’s

termination in November of 2006, Relator was instructed to

maintain a list of all epidurals performed without TP supervision,

control or line of sight supervision so that the medical file could be

signed by the TP the following morning to reflect that the TP was

present when indeed, the TP was not present, who would simply

sign off by indicating the following:

“Agree with above, “ followed by legible countersignature or identity;

“Rounded, Reviewed, Agree,” followed by legible countersignature or identity;

“Discussed with resident, Agree,” followed by legible countersignature or identity;

“Seen and agree,” followed by legible countersignature or identity;

“Patient seen and evaluated,” followed by legible countersignature or identity; and/or

A legible countersignature or identity alone.

12. Relator Johnson’s Complaints About Defendants Illegal Practice

80.

From the date of the commencement of Relator Johnson’s

residency in July of 2004, until the date of Relator’s termination in

October of 2006, constant informal complaints were made by

Relator Johnson to Dr. Lustik about (1) medical procedures being

performed without a TP, and (2) that this practice and policy was

in violation of Medicaid and Medicare billing practices.

81. Relator Schmidt witnessed Relator Johnson make these complaints in the OR, at the desk and in the hallway to TPs directly, including Dr. Lustik
82. No action was taken by Dr. Lustik; in fact, his reaction was always that of complete ignorance that any such problem was occurring.
83. Because no remedial action was taken to curb the practice of permitting residents to perform medical procedures without an attending physician, Plaintiff took *affirmative steps* to preserve evidence of such violations, e.g. *he began to notate or write in the patient records that TPs were not present for key procedures for fear that if Relator Johnson was to harm a patient during a procedure for which a TP was not present then the TP would merely indicate that he did not authorize the procedure/*
84. Finally, in or about April of 2005, Anesthesiology Resident Dr. Jay Ram and Relator Johnson confronted Dr. Lustik and complained that they were performing medical procedures unsupervised in dereliction of the above stated CMS regulations, and that this was in further violation of Medicaid and Medicare billing procedures.

85. No remedial action was taken by Dr. Lustik.

86. As a side bar, in May of 2005, Plaintiff also complained to Dr. Lustik that he was exceeding his mandatory hours as a resident under the Bell Commission.

13. Actions Taken Against Relator Johnson As a Result of His Complaints

87. In May 2005 Relator Johnson signed an Agreement of Appointment (“Agreement”) that designated his status as a PGY4 senior year resident which had to be signed by June 30, 2005.

88. This would have been Relator’s *last year of residency*, after which he would be able to take the ABA National Boards and proceed in the private practice of Anesthesia as a physician.

89. Two months after Relator Johnson complained to Dr. Lustik regarding his good faith belief that defendants were in violation of Medicaid and Medicare billing practices, defendant, with full knowledge that Plaintiff had made such a complaint, retaliated against Relator Johnson by revoking the duly executed Agreement designating his status as PGY4 senior year resident which he had already duly signed in or about the end of May of 2005.

90. On or about June 25 2005, Plaintiff was approached by Dr. Lustik who informed Plaintiff *he had 3 days to consider whether he would quit or resign his residency on the eve of its completion, or whether he would repeat the second year of his residency.*
91. At that meeting, Plaintiff was given a letter dated June 23, 2005 which stated that Plaintiff had “deficiencies” in his clinical skill set, despite the fact that in July of 2005, Plaintiff took the ABA Training Examination and scored within the *75 percentile which is the top quarter of all anesthesiologists in the nation.*
92. In a letter dated June 27th, 2005, to the ABA, defendant claimed that Plaintiff was insufficient in three of thirty three categories. Plaintiff was not given the opportunity to re-do any of the three enumerated criteria, despite the fact that he successfully completed 30 criteria, but was rather forced to repeat the *entire* year.
93. Relator had no choice but to chose to repeat his second year of residency and was given an Agreement that “SUPERCEDES and NULLIFIES the previous agreement of appointment FOR PGY4 LEVEL.

94. Relator signed the Agreement under duress and *repeated* his second year of residency.
95. A few months later, in or about September 1, 2005 SH agreed to pay nearly \$500,000.00 to Medicaid and Medicare for fraudulent claims made by a former department head, Dr. Uma Sundaram, former chief of Strong's Digestive Disease Unit, who violated Medicaid and Medicare regulations by allowing physicians undergoing specialized training to do procedures without attending physician Sundaram's supervision in violation of the CMS regulations.
96. After the investigation of SH's Digestive Disease Unit concluded in September of 2005, all SH units, not just the Digestive Disease Unit, were expected to comply with the CMS regulations.
97. Despite this expectation of compliance with the CMS regulations, Relator still received no further training in CMS compliance.

98. In fact, SH *continued* to allow its Anesthesiology Residents, including Relator, to perform the key portions of anesthesia services and procedures including epidurals, extubation, outside the presence, control, and line of sight supervision of the TP.

99. Indeed, following the September 2005 resolution of the fraudulent claims brought against it for allowing physicians under going specialized training to do procedures without attending physician Sundaram's supervision in violation of the CMS regulations, SH distributed a Confidential Memorandum directing residents including Relator to **not** comment on the TP's presence during the key portion of any service or procedure in the patient's medical record.

100. Issued on November 4, 2005, less than two months following the above referenced fine paid to Medicaid, the Medicaid Compliance Officer issued a "Confidential Memo" that was sent to all Anaesthesiology Residents stating:

1. All neuraxial labor analgesics (ex. Labor, epidurals and saddle blocks, placements or replacements) will be performed ***in line of sight supervision from the responsible anesthesiology attending.*** The department will credential residents for neurxial labor analgesia under general supervision, based on the performance of

individual residents in OB anesthesia. However, it is unlikely that this credential will be used by residents, except for the rare occasion when the supervising anesthesiology attending can not provide line of sight supervision due to an emergency with another patient.

2. ***The anesthesiology resident should not comment on this issue in the medical record.***

101. Despite the issuance of this Confidential Memorandum on November 5, 2005, SH's TPs still continued to failed to supervise the Anesthesiology Residents, including Relator, for which Relator continued to complain to Dr. Lustik.

102. Dr. Lustik's response was "gee, I don't know about that."

103. The Confidential Memorandum, however, expressly precluded Relator Johnson's ability to notate the patient's medical records to indicate the lack of TP's presence, control and direct line of sight supervision for the continuing performance of epidurals, extubation and post operative reports that persisted until Relator's termination.

104. Further in or about the winter of 2005 the Anesthesia Residents were advised by Dr. Robotham prior to Grand Rounds **not** to notate medical records indicating that attending physicians were not present during medical procedures performed by residents.
105. On one such incident occurred in or about June 6, 2006 when a pregnant patient with fetal distress went for an emergency c-section and the *TP (Dr. Issacson) was unable to be found.*
106. The Anesthesia Resident could not induce the patient and thus the c-section had to be done *under local anesthesia* due entirely to lack of supervision for which Relator Johnson had brought to the attention of SH many occasions previously.
107. Again, in or about September 5, 2006, SH permitted a resident with only three months of training to perform a c-section without a TP or attending physician physically present in the OR.
108. On the night of September 1st, 2006, Relator Johnson did not go home until 8:45 p.m.; state law required him to stay out for 10 hours, so Relator did not return to work until 6:45 the next morning. When he arrived at work, Dr. Kahn the night OB

resident informed Relator that there was an “urgent” c-section and that Relator should go to the OB floor immediately.

109. Relator Johnson went to see the “urgent” patient who was obese and pre-eclamptic. The patient revealed a prior history of a c-section, not done at SH, but performed with a spinal which was a bad experience for this patient.

110. Relator Johnson, unable to intubate a patient without a TP physically present in the room, immediately went to the OB office and tried to locate a TP or attending physician, which was Dr. Borovancani, a doctor fired from her previous position in Buffalo, whose English, as a side bar, was her second language and was very difficult to understand.

111. Dr. Borovancani could not be found; her habitual tardiness was an ongoing problem in the department.

112. Relator Johnson called Dr. Dooley the Clinical Coordinator and explained that they had a patient who would potentially be a difficult airway case, and that he was alone without a TP or

attending physician and that given the situation, if emergency bells went off, i.e. an emergency c-section, Relator Johnson would not be able to intubate or induce this patient without a TP or attending physician.

113. Dr. Dooley sent the residency director, Dr. Lustik, to assist Relator Johnson this patient until Dr. Borocavani arrived at 7:25 a.m..

114. When Dr. Borocavani arrived, she was very angry that Dr. Lustik had been called to “fill in” for her, and she was greatly “embarrassed.”

115. Dr. Borocavani told Relator Johnson that his actions in contacting a TP to cover for her made her “look bad” and that it was “unprofessional” for him to have called another TP to take her place, despite the fact that CMS regulations require TPs to be physically present for the purpose of intubation or inducement.

116. Relator Johnson attempted to steer the conversation back to the patient, informing Dr. Borocavani that the patient may be a difficult intubation, a difficult airway given her weight and pre-eclampsia,

and that she had a difficult prior spinal, to which Dr. Borocavani angrily instructed Relator to obtain the old chart from Medical Records, despite the fact that Realtor had already informed Dr. Borocavini that the spinal was not performed at SH but in another hospital in Newark, New York.

117. Relator called Medical Records to appease Dr. Borocavini and told her that there was no chart; Dr. Borocavani then stated “how can there be no chart if you told me she was a difficult intubation?”

118. Dr. Borocavani then met with the patient and Relator to go through and perform a pre-anesthetic evaluation; had there not been any confusion, there would have been no pre-anesthetic evaluation, since it was clear that *Dr. Borocavini never performed a pre-anesthetic evaluation in this case in violation of CMS regulations.*

119. It was only in June of that same year that an OB patient was forced to undergo a c-section under *local anesthesia* due to the lack of the physical presence of a TP or attending physician. Relator Johnson would not permit this patient to suffer the same fate. The patient had an uneventful c-section and a healthy baby was

delivered.

120. Immediately thereafter a previously planned c-section was begun under epidural. The TP and the First Year Resident bolused the epidural and the TP then left the floor. Relator Johnson was doing epidurals on the OB deck; upon finishing, he returned to the OR and found the patient's epidural "worn down". The First year resident did not have the experience to recognize the situation the patient was hysterical and Relator Johnson then immediately had no choice but to re-establish the epidural. The TP Dr. Borocavini was called and she stated she was off the floor talking to Dr. Lustik and stated that Relator Johnson should go ahead and re-establish the epidural which Relator Johnson had already done.

121. Later that day, Relator Johnson was summoned by Dr. Lustik, Dr. Glance and Dr. Borocavani to a meeting where he was chastised by all for allegedly "lying" about the earlier OB patient's medical history when Relator indicated to Dr. Borocavani that the patient may be a difficult induction, further insinuating that Relator may have "put the patient at risk" despite the fact that Dr. Borocavani never performed a pre-anesthetic evaluation of this patient.

122. No mention was made about Relator's complaint that there was no TP present until 7:25 a.m. and that had this patient needed an emergency c-section, that Relator would be unable to induce or intubate this patient in the absence of a TP or attending physician, thus jeopardizing the mother and child.
123. After Relator Johnson categorically denied lying about anything to Dr. Borocavani, Relator was placed on administrative leave until Tuesday in which he was advised that there would be a hearing.
124. Present at the meeting, which actually occurred on Friday September 5, 2007, was Dr. Lustik, Dr. Dooley, Dr. Sabnis, Dr. Chibber, Dr. Robotham and Dr. Glance.
125. The meeting was taped recorded.
126. It was determined after the meeting that Relator Johnson had "lied" and that he did not "deal well with a stressful situation."
127. Relator Johnson was ordered to undergo a psychiatric evaluation by defendants to determine if he had a "propensity for lying" or a "personality disorder."

128. Relator was not permitted by defendants to see the result of the psychiatric evaluation.
129. It was determined on October 5, 2006 that Relator be terminated; Relator Johnson was apprised of this fact by his Resident Advisor and warned by him that if he did not resign first he would be reported to the State of New York and his license would be revoked.
130. Relator Johnson's resignation was accepted by Dr. Robotham.
131. In turn, Dr. Robotham compelled Relator Johnson to speak with Dr. Lustik and Dr. Glance, who stated that Relator Johnson had to sign the termination letter under duress.
132. After Relator Johnson signed the termination letter he was threatened by Dr. Robotham, the Chair of Anesthesia, that he would "never work in medicine again."

14. Defendant's Reasons For Relator Johnson's Termination are Pretextual

133. The reasons for Plaintiff's termination are pre-textual and are in retaliation for his constant complaints about the failure of TP supervision of the Anesthesiology Residents.
134. Relator Johnson was not fired because of his performance as an Anesthesiology Resident but because defendant desperately wanted to characterize him as a "liar," even going so far as contacting Relator's former employers and educators to determine whether Relator had a history of lying, which was universally denied by all.
135. That the actions of the defendant were in retaliation for Plaintiff's actions in furtherance of a civil action for false claims as per 31 U.S.C. § 3730(h).
136. Further, there were other Residents whose performance was indeed jeopardizing the safety of others for which Defendant was on direct notice but did not terminate. For example, defendant was aware of a Resident that abused drugs, and another Resident that was disposing of narcotics and not reporting them as waste, both state violations that were made known to Dr. Lustik but for which the residents were not terminated.

137. That the failure of defendant to allow Relator Johnson to finish his last year of residency, coupled with the fact that defendant compelled him to repeat his second year of residency, all after he engaged in protected activity by complaining of the failure of TP supervision over resident physicians were intended to indeed ruin the Relator's career as an Anesthesiologist.
138. However, Relator Johnson, to his credit, was able on March 15, 2007 to secure a position as a third year resident at New York Methodist Hospital ("Methodist") which commenced on July 1, 2007, despite disparaging remarks made by Dr. Lustik to staff regarding Relator Johnson which were addressed by counsel directly to Dr. Lustik, asking him to "cease and desist" from making further disparaging comments and/or sending unsolicited documents to Methodist.
139. When Relator Johnson explained to the physicians at New York Methodist Hospital the circumstances of his termination and compelled resignation, the universal response was that no resident physician of his standing should have been fired for allegedly "lying" about a patient chart where in fact the attending physician herself had not performed any pre-anesthetic evaluation on the patient, in further violation of the above stated CMS regulations.

CONTINUED RETALIATION AND DEFAMATION OF RELATOR JOHNSON

140. Relator Johnson successfully completed his residency position at Methodist and subsequently accepted a position in Delaware as an anesthesiologist.

141. Relator Johnson began the process of licensure in the State of Delaware.

142. Dr. Lustik, despite being previously warned to cease and desist targeting Relator Johnson nonetheless saw fit to publish, on or about the summer of 2008, **unsolicited**, a negative reference to the State of Delaware Board of Medical Practice, dated November 15th, 2006, claiming erroneously that Relator Johnson suffered from a psychiatric disorder, and that he was unfit to practice medicine :

On September 5, 2006, the committee recommended that Dr. Johnson request a voluntary leave of absence pending the results of a fitness for duty evaluation. This step was taken due to a preponderance of evidence that Dr. Johnson committed a serious ethical breach by fabricating important details regarding a patient's past medical history. As a result of the fitness for duty evaluation results, the committee recommended on September 28, 2006 that Dr. Johnson's resident appointment be terminated due to maladaptive responses to stressful situations and multiple documented episodes in which the anesthesiology faculty questioned Dr. Johnson's honesty. Dr. Johnson was given a determination of not competent in patient care, interpersonal and communication skills and professionalism competency areas.

143. The Board of Medical Practice held a hearing on September 9th, 2008 to determine whether to license Relator Johnson.

144. It was determined by unanimous vote that :

“While the Board cannot make a conclusive finding as to what actually happened at the U of R., the Board does find that Dr. Johnson has pointed to enough contradictions to call the negative reference into question and diminish the weight it should be given at this hearing. The Qui Tam action supported by the United States and the State of New York also bolsters Dr. Johnson’s credibility with regard to many of these issues.

RELATOR SCHMIDT’S CLAIMS

145. Relator Schmidt is a Registered Nurse who worked for 14 years at SH in the OR. Throughout her employment at SH, Relator Schmidt acquired direct personal knowledge and personal knowledge and non-public information of the defendants’ fraudulent practices; in particular, Relator Schmidt witnessed first hand the failure of TPs to supervise resident physicians in violation of the CMS requirements.

146. Relator Schmidt has witnessed an increased patient case load since the year 2004, but with no concomitant increase in staff to assist in the treatment of these patients, a large percentage of which are Medicare and Medicaid patients.

147. There are 28 operating rooms at SH with 4 to 5 cases in each room being performed every day.
148. From January 2004 through the date of her termination in June of 2006, Relator Schmidt witnessed Surgical Residents perform key portions of surgeries if not entire surgeries in the OR without the supervision of a TP or attending physician. During this time period there was no compliance training or any other training provided by SH that dealt with the supervision of residents physicians.
149. From January 2004 through the date of her termination in June of 2006, Relator Schmidt witnessed Anesthesiology Residents, including Relator Johnson, perform on a daily basis the following key services or procedures outside the presence of an attending physician:
- spinal;**
 - epidurals;**
 - intubation;**
 - extubation;**
 - line placement;**
 - central line placement;**
 - arterial line placement;**
 - caudal blocks.**
150. After the surgical procedure was completed outside the physical presence of a TP, the TP would often require Relator Schmidt to put down on the patient's medical record that the TP or attending

physician was present when indeed, the TP or attending physician was nowhere to be found, by either checking a box on the patient's medical record or by stating the following:

*“Agree with above, “ following by legible countersignature or identity;
“Rounded, Reviewed, Agree,” followed by legible countersignature or identity;
“Discussed with resident, Agree,” followed by legible countersignature or identity;
“Seen and agree,” followed by legible countersignature or identity;
“Patient seen and evaluated,” followed by legible countersignature or identity; and/or
A legible countersignature or identity alone.*

151. That the issue of the failure of attending physician supervision of the resident physicians became so chronic due to the increased case load in 2004 that Relator Schmidt had to physically leave the OR and attempt to locate a TP or attending physician.
152. Further, attending physicians often gave verbal reports over the phone, failed to complete postoperative reports, and instructed Relator Schmidt to indicate that they were present when indeed they were not.
153. Relator Schmidt complained frequently about the failure of supervision by the TPs that she became known as a “trouble maker” and her evaluations were marked to indicate that she was a “problem.” Relator Schmidt was constantly called into the office

and admonished for complaining.

154. On one such incident, in the spring of 2005, Relator Schmidt was approached by Dr. Chibber and was asked to *alter* medical records to reflect that an attending physician was present during a key surgical procedure when indeed the attending never showed for the procedure.

155. When Relator Schmidt objected to altering medical records to reflect that an attending was present when he was indeed not present, Dr. Chibber's response was "we wont' be able to bill for the case if there was no attending" to which Relator Schmidt responded, "well, I guess it's a freebie" because she refused to alter a medical record.

156. Thereafter, Relator Schmidt, afraid to speak up for fear of losing her job after being told by her supervisor that if she did not stop complaining that she would lose her job, Relator Schmidt was compelled to continually reflect in the medical records that TPs or attending physicians were present for key services or procedures when indeed, they were not physically present. Several months

later, Relator Schmidt would be terminated after serving SH for over 14 years as an OR nurse.

157. Relator Schmidt witnessed first hand as a *patient* the failure of attending physicians to be physically present for key services and procedures that were performed unsupervised by resident physicians.

158. In September of 2002, Relator Schmidt was admitted to SH for knee surgery for which Dr. Bigeleisen was the attending physician.

159. An epidural was administered by resident physician Dr. Marika Stone who performed the procedure without the supervision of a TP. The epidural became disconnected; the resident came up and put it back together; later the TP came into the room due to the Relator's complaints that she was in sever pain and that the epidural was not placed correctly, and abruptly pulled out the epidural and threw it on the floor. The Relator contacted the Residency Director to complain about the lack of supervision and the botched epidural; the next day, the resident came to apologize to Relator Schmidt, stating that they had not been relieved by the TPs all night.

**COUNT ONE:
FAILURE TO SUPERVISE RESIDENTS IN VIOLATION OF CMS REGULATIONS**

160. Relators repeat and reallege the above stated paragraphs as if fully set forth herein.

161. This is a civil *qui tam* action brought by Relators on behalf of the United States to recover treble damages and civil penalties under 31 U.S.C. §3729(a) of the False Claims Act.

162. 31 U.S.C. § 3729 (a) provides, in pertinent part liability for any person who:

(1) Knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval.

163. U of R and SH violated 31 U.S.C. §3729 (a) in that at least from July 2004 through the present, it repeatedly, willfully and intentionally presented false claims for payment to the New York State Medicaid program and the federal Medicare programs by and through the actions described herein, that occurred in the OR and the OBGYN units of SH, and potentially elsewhere in SH. It is well settled that SH employees and SH agents shall not knowingly

present a claim to any Federal Health Care Program or Health Care Benefit Program for an item or service the person knows or Should Know, was not provided or was fraudulent. No item or service shall be submitted that is based on a code that the person knows or Should Know will result in greater payment than the code the person knows or Should Know is applicable to the item or service actually provided.

164.

It is also well settled that SH shall not knowingly and wilfully:

1. Falsify, conceal, or cover up by any trick, scheme or device a material fact; or
2. make any materially false, fictitious, or fraudulent statements or representations, or make or use any materially false writing or document, knowing the same to contain any materially false, fictitious, or fraudulent statement or entry, in connection with the delivery of, or payment for, health care benefits, items or services.

And/or,

SH employees and agents shall not:

1. knowingly present or cause to be presented a false or fraudulent claim for payments to a governmental agency, or Health Care Benefit Program;
2. knowingly use or cause to be presented a false record or statement to obtain payment on a false or fraudulent claim from a governmental agency or Health Care benefit Program by attempting to have a fraudulent claim paid;
3. conspire to defraud a governmental agency or Health

Care Benefit Program by attempting to have a false or fraudulent claim paid;

4. participate in any other act prohibited by the False Claims Act.

165. The United States Government, by and through the New York State Medicaid program and Medicare program, and unaware of their falsity, paid the claims submitted in connection therewith.

166. Each claim for reimbursement that the U of T and/or SH made for providing key services and procedures without the presence of an attending physician or TP and for which resident physicians performed without supervision represents an unlawful claim and/or fraudulent claim for payment.

167. Relators cannot at this time identify all of the false claims for payment that were caused by Defendant's conduct. That information is solely within the possession of the Defendants.

168. Had the United States Government known that U of R and/or SH submitted claims to it for the provision of key services and

procedures performed without the supervision of an attending physician or TP, it would not have paid those claims.

169. As a result of U of R and/or SH's violations fo 31 U.S.C. §3729(a), the United States has been damaged in an amount in excess of millions of dollars, exclusive of interest.

170. Relators are private persons with direct, personal knowledge of the allegations of this Complaint, who have brought this action pursuant to §3730(h) on behalf of themselves and the Unites States.

COUNT II AS TO RELATOR JOHNSON

171. The above stated paragraphs are hereinafter realleged and incorporated by reference.

172. 31 U.S.C. Section 3730 (h) states in pertinent part:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other

manner discriminated against in the terms and conditions of employment by his or her employer because of the lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under this section, shall be entitled to all relief necessary to make the employee whole.

173. To make a prima facie case for a retaliatory discharge under 3730(h) in most jurisdictions, the Relator must show the following:
- (1) that he took acts in furtherance of a qui tam suit, i.e. she engaged in protected activity; (2) that his employer knew of the acts; and (3) that his employer discharged her as a result of these acts.
174. Relator Johnson engaged in protected activity from the date he commenced his residency in 2004 until he was terminated in October of 2006, by repeatedly advising his superiors that he believed that SH was inadequately supervising its' resident physicians and permitting residents to perform key services and procedures in the absence of an attending physician or TP in violation of the CMS regulations (even after SH was fined for Medicaid fraud in September of 2005). In furtherance of his FCA claims, he notated certain medical records to indicate when TPs or attending physicians were not present.

175. Thereafter, in June of 2005, several days after Relator Johnson signed his contract for his second year of residency, he was compelled to repeat his second year of residency and subject to undue criticism.
176. Dr. Robotham, the Chair of Anesthesiology was amply aware of Relator Johnson's complaints; however, the only remedy taken in November of 2005, 2 months after SH was fined for Medicaid Fraud, was to advise residents not to notate the medical records to indicate whether an attending physician or TP was present or not, effectively ceasing Relator's ability to notate the records when attending physicians were not present.
177. Thereafter, when Relator attempted once again to advise his Residency Director on September 1, 2006 that his attending was not present for an imminent c-section, he was placed on administrative leave, labeled a "liar" and compelling him to resign one month later on October 3, 2006 from the SH residency program under the threat of revoking his license to practice medicine, compelling his to locate a program in the United States that would allow him to complete his third year of residency.
178. The timing of his constructive discharge as well as the increased

criticism of his work and being labeled a “liar” for complaining of the failure of SH TPs and attending physicians to supervise resident physicians during key services and procedures and the fact that TPs signed off on medical records fraudulently indicating they were present when they were not was motivated solely by illegal animus prohibited by 31 U.S.C. Section 3730(h).

179. As a result of having to repeat his second year of residency and his constructive discharge under the threat of losing his license, Relator Johnson has sustained a loss of wages, emotional distress and severe professional and personal embarrassment.

COUNT III AS TO RELATOR SCHMIDT

180. The above stated paragraphs are hereinafter realleged and incorporated by reference.

181. 31 U.S.C. Section 3730 (h) states in pertinent part:

Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of the lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed, or to be filed under this section, shall be entitled to all relief necessary to make the employee

whole.

182. To make a prima facie case for a retaliatory discharge under 3730(h) in most jurisdictions, the Relator must show the following: (1) that she took acts in furtherance of a qui tam suit, i.e. she engaged in protected activity; (2) that her employer knew of the acts; and (3) that her employer discharged her as a result of these acts.

183. Relator Schmidt engaged in protected activity as late as the date of her termination in June of 2006 by repeatedly advising her superiors that she believed that SH was inadequately supervising its' resident physicians and permitting residents to perform key services and procedures in the absence of an attending physician or TP in violation of the CMS regulations (even after SH was fined for Medicaid fraud in September of 2005). In furtherance of her FCA claims, she refused in the spring of 2005 to alter medical records to fraudulently assert that an attending physician or TP was present for a procedure when indeed he was not.

184. Thereafter, Relator Schmidt was subject to negative reviews and her job was threatened and she was subject to undue criticism.

185. Dr. Robotham, the Chair of Anesthesiology was amply aware of Relator Schmidt's complaints; however, the only remedy taken in November of 2005, 2 months after SH was fined for Medicaid Fraud, was to advise residents not to notate the medical records to indicate whether an attending physician or TP was present or not, effectively ceasing the ability of residents to notate the records when attending physicians were not present.
186. Relator was eventually terminated in June of 2006, just months prior to Relator Johnson's constructive discharge.
187. The timing of her termination as well as the increased criticism of her work and being labeled a "problem" for complaining of the failure of SH TPs and attending physicians to supervise resident physicians during key services and procedures and the fact that TPs signed off on medical records fraudulently indicating they were present when they were not was motivated solely by illegal animus prohibited by 31 U.S.C. Section 3730(h).
188. As a result of being terminated from her long term position, Relator Schmidt has sustained a loss of wages, emotional distress and severe professional and personal embarrassment.

THIRD CAUSE OF ACTION
Libel Per Se As And Against Dr. Lustik, the U of R, and SH

189. Plaintiff repeats and re-alleges by reference each and every allegation contained in the above stated paragraphs and incorporates the same as though fully set forth herein.

190. Dr. Lustik, despite being previously warned to cease and desist targeting Relator Johnson nonetheless saw fit to publish, on or about the summer of 2008 unsolicited, a negative reference to the State of Delaware Board of Medical Practice, dated November 15th, 2006, claiming erroneously that Relator Johnson suffered from a psychiatric disorder, and that he was unfit to practice medicine :

On September 5, 2006, the committee recommended that Dr. Johnson request a voluntary leave of absence pending the results of a fitness for duty evaluation. This step was taken due to a preponderance of evidence that Dr. Johnson committed a serious ethical breach by fabricating important details regarding a patient's past medical history. As a result of the fitness for duty evaluation results, the committee recommended on September 28, 2006 that Dr. Johnson's resident appointment be terminated due to maladaptive responses to stressful situations and multiple documented episodes in which the anesthesiology faculty questioned Dr. Johnson's honesty. Dr. Johnson was given a determination of not competent in patient care, interpersonal and communication skills and professionalism competency areas.

191. The statements published by defendants regarding Plaintiff were false, misleading and libelous *per se* in that they imputed the professional standing and reputation of the Plaintiff injuring him in his trade,

business and profession. Plaintiff was publicly disgraced and humiliated, both individually and with his business interests, he has been made the subject of public comment and notoriety, has been injured in his good name, reputation, business and credit, individually and in connection with his business interests, both in the community where he resides and the area in which he conducts his business affairs and throughout the entire area the false, malicious, defamatory, slanderous and libelous statements were published and circulated; and he has been the subject of ridicule, obloquy, scorn and shame, and has sustained mental, emotional and physical anguish and suffering as a result of his failure to be hired in his trade, business and profession, due in part to the falsehood published by the defendant.

192. Plaintiff was informed, and believes that the conduct of the defendants was done with fraud, oppression and malice and was done by, authorized and ratified by the highest level of defendant.

193. Through the outrageous conduct described above, defendants acted with the intent to cause, or with reckless disregard for the probability of causing Plaintiff to suffer pecuniary and emotional harm.

194. As a direct and proximate result of defendants' actions, Plaintiff has suffered and will continue to suffer pain and suffering, extreme and severe mental anguish, and emotional distress; he has suffered and will continue to suffer loss of earnings and other actual damages.

195. Defendants' conduct was malicious and oppressive and was done with a conscious disregard to plaintiff's rights.
196. The acts of the defendants were performed knowingly and maliciously, and exceeded whatever privilege that would attain to such publication, including absolute and conditional privileges.
197. The publication of the letter was done with malice as described above, and made willfully, wantonly and recklessly by the defendants who knew them to be untrue.
198. As a result of the foregoing actions, Plaintiff has been damaged in the amount to be determined by a jury.

THIRD CAUSE OF ACTION

Prima Facie Tort in the Alternative to Libel Per se As And Against Dr. Lustik, U of R; and SH

199. Plaintiff repeats and re-alleges by reference each and every allegation contained in the above stated paragraphs and incorporates the same as though fully set forth herein.
200. Dr. Lustik, acting as an agent for U of R and SH, despite being previously warned to cease and desist targeting Relator Johnson nonetheless saw fit to publish, in or about the summer of 2008, **unsolicited**, a negative reference to the State of Delaware Board of Medical Practice, dated November 15th, 2006, claiming

erroneously that Relator Johnson suffered from a psychiatric disorder, and that he was unfit to practice medicine:

On September 5, 2006, the committee recommended that Dr. Johnson request a voluntary leave of absence pending the results of a fitness for duty evaluation. This step was taken due to a preponderance of evidence that Dr. Johnson committed a serious ethical breach by fabricating important details regarding a patient's past medical history. As a result of the fitness for duty evaluation results, the committee recommended on September 28, 2006 that Dr. Johnson's resident appointment be terminated due to maladaptive responses to stressful situations and multiple documented episodes in which the anesthesiology faculty questioned Dr. Johnson's honesty. Dr. Johnson was given a determination of not competent in patient care, interpersonal and communication skills and professionalism competency areas.

201.

The statements published by defendants regarding Plaintiff were false, misleading and injurious to Plaintiff's reputation and published to a wide audience with malice with the intent to injure him, as they imputed the professional standing and reputation of the Plaintiff injuring him in his trade, business and profession, and directly claim that Plaintiff was "menacing" which is a felony and a serious crime. Plaintiff was publicly disgraced and humiliated, both individually and with his business interests, he has been made the subject of public comment and notoriety, has been injured in his good name, reputation, business and credit, individually and in connection with his business interests, both in the community where he resides and the area in which he conducts his business affairs and throughout the entire area the false, malicious, defamatory, slanderous and libelous statements were published and circulated with malice and intent to injure Plaintiff; and he has been the

subject of ridicule, obloquy, scorn and shame, and has sustained mental, emotional and physical anguish and suffering as a result of his failure to be hired in his trade, business and profession, due in part to the falsehood published by the defendant.

202. Plaintiff was informed, and believes that the conduct of the defendants was done with fraud, oppression and malice and was done by, authorized and ratified by the highest level of defendant.

203. Through the outrageous conduct described above, defendants acted with the intent to cause, or with reckless disregard for the probability of causing Plaintiff to suffer pecuniary and emotional harm.

204. As a direct and proximate result of defendants' actions, Plaintiff has suffered and will continue to suffer pain and suffering, extreme and severe mental anguish, and emotional distress; he has suffered and will continue to suffer loss of earnings and other actual damages.

205. Defendants' conduct was malicious and oppressive and was done with a conscious disregard to plaintiff's rights.

206. The acts of the defendants were performed knowingly and maliciously, and exceeded whatever privilege that would attain to such publication, including absolute and conditional privileges.

207. The publication of the negative reference was done with malice as described above, and made willfully, wantonly and recklessly by the

defendants who knew them to be untrue, and with a detached malevolence.

208.

As a result of the foregoing actions, Plaintiff has been damaged in the amount to be determined by a jury.

PRAYER FOR RELIEF

WHEREFORE, Relators prays for judgement against Defendants as follows:

1. That defendants cease and desist violating 31 U.S.C. §3729;
2. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States Government has sustained because of Defendant's actions, plus a civil penalty of not less than \$5,000 and not more than \$10,000 for each violation of 31 U.S.C. §3729;
3. That Relators be awarded the maximum amount allowed pursuant to §3730 of the False Clams Act;
4. That this Court enter judgment against Defendants pursuant to 31 U.S.C. §3730(h) in an amount equal to two times plaintiff's

accrued back pay, as of the date of entry of judgement, together with interest thereon, plus full damages for plaintiff's mental anguish; suffering and humiliation; that such judgment award Relator full damages for future lost wages and benefits;

5. That Relators be awarded all costs and expenses of this action, including attorneys' fees;

6. That Relators recover such other relief as the Court deems just and proper.

December 31, 2008
Rochester, New York

Respectfully Submitted:

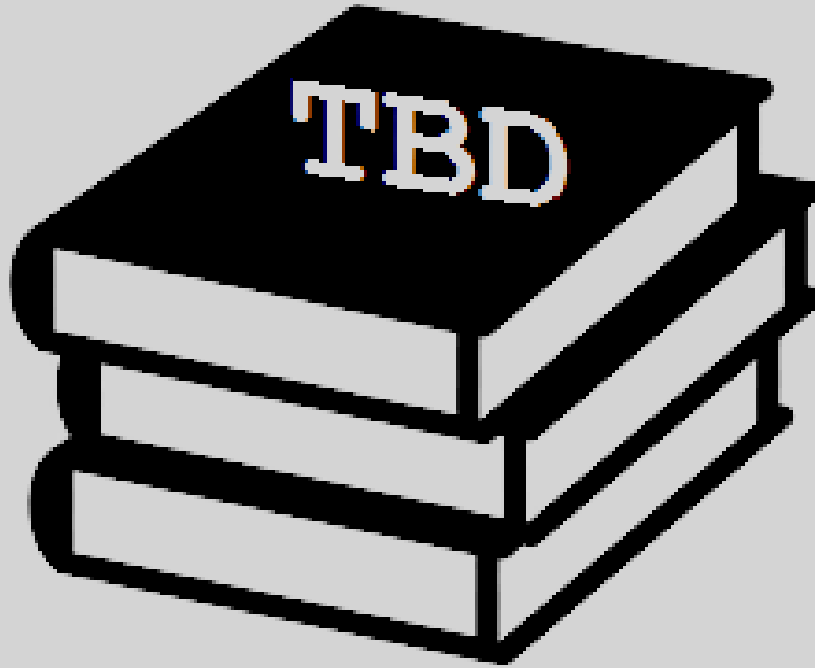
By: /s/ Christina A. Agola, Esq.

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