APPENDIX

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APPENDIX A

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 22-3481

STEPHEN B. GRANT, ON BEHALF OF THE UNITED STATES OF AMERICA AND ON BEHALF OF THE STATE OF IOWA,

Plaintiff-Appellee

v.

STEVEN ZORN; IOWA SLEEP DISORDERS CENTER, P.C.; IOWA CPAP, L.L.C.,

Defendants-Appellants.

No. 22-3591

STEPHEN B. GRANT, ON BEHALF OF THE UNITED STATES OF AMERICA AND ON BEHALF OF THE STATE OF IOWA,

Plaintiff-Appellant

v.

STEVEN ZORN; IOWA SLEEP DISORDERS CENTER, P.C.; IOWA CPAP, L.L.C.,

Defendants-Appellees.

Appeal from United States District Court

for the Southern District of Iowa - Central

Submitted: December 13, 2023

Filed: July 5, 2024

BEFORE: SMITH,[1] CHIEF JUDGE, GRUENDER AND GRASZ, CIRCUIT JUDGES.

GRUENDER, CIRCUIT JUDGE.

The False Claims Act ("FCA") and the Iowa False Claims Act ("IFCA") authorize private citizens, known as *qui tam* relators, to recover from those who make false or fraudulent claims for payment to the United States and the State of Iowa respectively. Relator, Stephen Grant, a sleep medicine practitioner, brought this *qui tam* action under the FCA and the IFCA against Steven Zorn, Iowa Sleep Disorders Center ("Iowa Sleep"), and Iowa CPAP. After a bench trial, the district court found that the defendants had

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[1] Judge Smith completed his term as chief judge of the circuit on March 10, 2024. *See* 28 U.S.C. § 45 (a)(3)(A).

submitted 1,050 false claims to the United States and the State of Iowa. The district court subsequently imposed a total award of $7,598,991.50. For the reasons set forth below, we affirm in part, vacate in part, and remand for further proceedings consistent with this opinion.

I.

Zorn operated and held substantial ownership interests in Iowa Sleep, a medical practice specializing in sleep medicine, and Iowa CPAP, a medical equipment company. Due to financial difficulties at Iowa Sleep, Iowa CPAP provided loans to Iowa Sleep. Iowa Sleep referred patients to Iowa CPAP for free consultations.

Iowa Sleep accepted state and federal funds for its services through government reimbursement programs like Medicare, Medicaid, and Tricare. The amount that can be billed for services rendered through government healthcare programs depends on a variety of factors, including the time spent with the patient and the complexity of the visit. The government determines the appropriate amount to be reimbursed based on the "code" billed by the provider. In sleep medicine, claims for initial patient visits are coded from 99201 to 99205, and claims for established patient visits are coded from 99211 to 99215. The last number of a code represents the complexity of the visit. Codes ending in the number "5" (e.g., "99205") are considered the most complex and are reimbursed by the government at a higher rate than any other code.

The Centers for Medicare & Medicaid Services ("CMS") oversees claims submitted to the federal government for reimbursement. CMS contracts with third-party administrators like AdvanceMed to handle claims and review, investigate, and audit payments made on behalf of the federal government. CMS, through AdvanceMed, advises service providers on proper billing practices and may notify service providers of suspected discrepancies between submitted claims and actual services rendered.

In September 2016, AdvanceMed sent a letter to Zorn expressing concern that Zorn was overbilling the government for his services. The letter informed Zorn that, between June 2012 and June 2016, he had billed the majority of his established patient visits at codes 99214 and 99215 and all of his initial patient visits at code 99205. AdvanceMed stated that "[m]ore variety would be expected," and it "would like to educate [Zorn's] office" on proper billing practices.

In January 2018, following an audit of patient records from January 2017 to September 2017, AdvanceMed sent another letter to Zorn. This letter informed Zorn that AdvanceMed had "identified overpayments made to" him. The letter suggested that Zorn "[c]onsider and implement corrections to billing procedures that could prevent such errors in the future."

Grant practiced sleep medicine at Iowa Sleep and held 10% ownership interests in both Iowa Sleep and Iowa CPAP. Grant obtained copies of the AdvanceMed letters through Iowa Sleep's office manager. He

became concerned that "if there were any forensic ramifications from [Zorn's overbilling], it would fall squarely on [Grant], as well as the knowledge that Dr. Zorn was doing this and [Grant] was not doing anything about it."

In March 2018, Grant filed this *qui tam* action on behalf of the United States and the State of Iowa (collectively, "the government") against Zorn, Iowa Sleep, and Iowa CPAP, alleging the defendants had violated the FCA and the IFCA by knowingly overbilling the government for initial and established patient visits. *See* 31 U.S.C. § 3729(a)(1); Iowa Code § 685.2. He further alleged that the defendants had violated the FCA and the IFCA by knowingly soliciting and directing referrals from Iowa Sleep to Iowa CPAP in violation of the Anti-Kickback Statute and the Stark Law. *See* 42 U.S.C. §§ 1320a-7b(b)(2)(A), 1395nn(a)(1)(A). The government declined to intervene in the action. See 31 U.S.C. § 3730(b)(2); Iowa Code § 685.3(2)(b).

Zorn fired Grant from Iowa Sleep in September 2018. Grant subsequently amended his complaint to include a claim for retaliation under the FCA and the IFCA against Iowa Sleep. *See* 31 U.S.C. § 3730(h); Iowa Code § 685.3(6). He alleged that Zorn fired him for reporting potential FCA and IFCA violations to the government.

During discovery, Grant requested 1,167 medical files from the defendants. Believing Grant's request to be too burdensome, the defendants asked Richard Braak, a certified public accountant, to randomly

select thirty-one patient files from a list of Zorn's patient files. Braak randomly chose thirty-one files, all of which pertained to initial patient visits, and the defendants provided these thirty-one files to Grant.

Instead of asking the district court to compel the defendants to produce additional patient files, Grant retained Ted Lodden, a certified public accountant, to determine whether the thirty-one file sample size provided by the defendants was representative of Zorn's entire billing practice. Lodden did not independently calculate the statistical validity of the thirty-one file sample size. Nevertheless, he testified that extrapolation from the thirty-one files to the entirety of Zorn's billing practice was appropriate.

The defendants subsequently filed a motion to exclude Lodden's testimony under *Daubert* and Federal Rule of Evidence 702. They asserted that Lodden's testimony on extrapolation was entirely speculative since it was based on a sample size not proven to be statistically valid. The district court concluded that a statistically valid sample was not necessary for extrapolation in this case and declined to exclude Lodden's testimony.

Grant also retained Nizar Suleman, a sleep medicine physician, as an expert witness. In his expert report, Suleman compared Zorn's billing rates to publicly available data on average billing rates. Suleman concluded that Zorn had overbilled for his services. For their part, the defendants retained James Alexander, a physician and medical coding consultant, as their expert witness. In his expert

report, Alexander reviewed the sample of thirty-one patient files and determined that, depending on the amount of services received by patients, either twenty or twenty-four of those files were billed inaccurately.

The defendants filed a motion to exclude Suleman's testimony under Daubert and Federal Rule of Evidence 702. In opposition to the defendants' motion, Grant produced a "supplemental" report authored by Suleman. In this additional report, Suleman examined the same thirty-one patient files reviewed by Alexander and concluded that Zorn had overbilled in all thirty-one cases. In their reply brief in support of their motion to exclude Suleman's original testimony, the defendants also argued that Suleman could not testify as to the thirty-one files because his additional report was an untimely and improper rebuttal report. The district court excluded some of Suleman's original testimony. It also concluded that the defendants were not prejudiced by the information contained in Suleman's additional report and declined to exclude it.

The defendants moved for summary judgment, arguing that Grant's claims were barred by the public disclosure provisions of the FCA and IFCA, which prohibit qui tam claims based on information available in the public domain. *See* 31 U.S.C. § 3730(e)(4); Iowa Code § 685.3(5)(c). The defendants further argued that they should be awarded summary judgment on the Anti-Kickback Statute and Stark Law claim due to insufficient evidence of an illegal kickback or self-referral scheme. The district court rejected the defendants' public disclosure defense but

awarded summary judgment to the defendants on the Anti-Kickback Statute and Stark Law claim.

After a bench trial, the defendants renewed their request to dismiss the claims pursuant to the public disclosure provisions of the FCA and IFCA. The district court rejected this request and instead found the defendants liable on several claims. The district court held that Iowa Sleep had violated the anti-retaliation provisions of the FCA and IFCA by firing Grant. Accordingly, the district court awarded Grant $50,000 in backpay and $300,000 in special damages resulting from emotional distress. The district court, however, declined to award any punitive damages under the anti-retaliation provisions of the FCA and IFCA.

The district court also concluded that the defendants had overbilled on initial patient visits but not on established patient visits. It estimated that 90% of the initial patient claims submitted to the government were false, resulting in a total number of 230 false claims to Medicaid, 764 false claims to Medicare, and 56 false claims to Tricare. The district court held that the 764 false claims to Medicare resulted in actual damages to the government of $86,332. Because the FCA and IFCA provide for treble damages, the district court subsequently trebled the actual damages to $258,996. *See* 31 U.S.C. § 3729(a)(1)(G); Iowa Code § 685.2. The district court, however, did not assess any damages for the false Medicaid or Tricare claims due to a lack of evidence regarding their reimbursement rates.

The FCA and IFCA provide that a person who submits false or fraudulent claims to the government is liable for a civil penalty for each false or fraudulent claim. *See* 31 U.S.C. § 3729(a)(1)(G); Iowa Code § 685.2. To calculate the civil penalty, the district court assessed statutory per-claim penalties of $5,000 for those violations that occurred on or before November 2, 2015 and statutory per-claim penalties of $12,537 for those violations that occurred after November 2, 2015 for the Medicare, Medicaid, and Tricare claims.[2] This produced a total civil penalty of $7,699,525. Citing the Eighth Amendment's Excessive Fines Clause, the district court reduced the total civil penalty to $6,474,900. As a result, the combined award of treble damages and civil penalties was reduced from $7,958,521 to $6,733,896. The district court thus imposed an award of treble damages and civil penalties twenty-six times the amount of treble damages and seventy-eight times the amount of actual damages.

Grant requested and was awarded attorneys' fees of $432,448.50, costs of $75,786.27, and interest on backpay of $6,860.73. He also requested that, as relator, the district court award him 30% of the treble damages and civil penalty. *See* 31 U.S.C. § 3730(d)(2) (providing that relators in non-intervened *qui tam*

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[2] We take no position on whether civil penalties under the FCA and IFCA can be assessed without an underlying finding of actual damages on the Medicaid and Tricare claims. The defendants did not brief the issue. *See Allison v. Dep't of Corr.*, 94 F.3rd 494, 497 n.1 (8th Cir. 1996)

actions are entitled to "not less than 25 percent and not more than 30 percent of the proceeds of the action"); Iowa Code § 685.3(4)(b). The district court held that Grant was entitled to 30% of the treble damages and civil penalty and thereby awarded him an additional $2,020,168.80. Pursuant to an agreement between the United States and the State of Iowa, the remaining balance of $4,713,727.20 would be remitted solely to the United States.

In total, the defendants were held liable for backpay plus interest of $56,860.73, special damages of $300,000, treble damages of $258,996, an adjusted civil penalty of $6,474,900, attorneys' fees of $432,448.50, and costs of $75,786.27. Combining these amounts produced a total award of $7,598,991.50.

II.

On appeal, the defendants assert Grant's claims are barred by the public disclosure provisions of the FCA and IFCA, the district court should have excluded Suleman's testimony regarding the thirty-one patient files, and the district court should have excluded Lodden's testimony on extrapolation. Grant cross-appeals, asserting the district court should have found defendants liable for overbilling on established patient visits, the district court erred in granting summary judgment on the Stark Law and Anti-Kickback Statute claim, and the district court should have awarded Grant punitive damages under the anti-retaliation provisions of the FCA and IFCA. Both

parties take issue with the district court's determination of damages and civil penalties.

A.

1.

We begin by addressing the defendants' challenge to the district court's denial of their public disclosure defense. The defendants assert Grant's *qui tam* action is barred because the AdvanceMed letters publicly disclosed the defendants' fraudulent billing practices prior to Grant bringing suit. We review *de novo* the district court's determination regarding the applicability of the public disclosure bar. *U.S. ex rel. Paulos v. Stryker Corp.*, 762 F.3d 688, 692 (8th Cir. 2014).

The public disclosure provisions of the FCA and IFCA bar a *qui tam* action whenever a *qui tam* relator brings suit based on information available in the public domain, unless the relator is an "original source of the information." 31 U.S.C. § 3730(e)(4); Iowa Code § 685.3(5)(c). A relator brings suit based on information available in the public domain when "substantially the same allegations or transactions as alleged in the action or claim were publicly disclosed . . . in a congressional, Government Accountability Office, or other Federal report, hearing, audit, or investigation." 31 U.S.C. § 3730(e)(4)(A). The public disclosure bar aims to "strike a balance between encouraging private persons to root out fraud and stifling parasitic lawsuits." *Graham Cnty. Soil & Water Conservation Dist. v. U.S. ex rel. Wilson*, 559 U.S. 280, 295 (2010).

We conclude the public disclosure bar is inapplicable because Grant's complaint did not allege "substantially the same allegations" contained in the AdvanceMed letters.[3] To establish liability, Grant was required to prove that the defendants "knowingly present[ed], or cause[d] to be presented, a false or fraudulent claim for payment or approval" to the government. 31 U.S.C. § 3729(a)(1)(A); Iowa Code § 685.2. In line with this objective, Grant's complaint alleged that the defendants *knowingly* submitted false claims to the government. The AdvanceMed letters, however, revealed only the possibility of inaccurate billing. They did not disclose that the fraudulent actions had occurred. *See U.S. ex rel. Rabushka v. Crane Co.*, 40 F.3d 1509, 1513 (8th Cir. 1994) (finding the public disclosure bar to be inapplicable when the publicly available information "fail[ed] to suggest to the uninitiated reader . . . that [the defendant's] pension liability was *intentionally* understated" (emphasis added)).

Even though the AdvanceMed letters failed to accuse expressly the defendants of committing fraud, the defendants contend that the public disclosure bar should still be given effect as the letters contained the "essential elements comprising [the] fraudulent transaction[s] . . . so as to raise a reasonable inference of fraud." *Id*. at 1514. To the contrary, an uninitiated reader of the AdvanceMed letters would infer that the

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[3] We do not address whether the AdvanceMed letters constitute a public "Federal report, hearing, audit, or investigation."

defendants had acted without the requisite scienter. The September 2016 letter instructed the defendants to use the information in the letter "to determine whether corrections to [their] billing and claim submission procedures [would be] required to prevent future errors." It offered to "educate" Zorn's office on proper billing practices. The January 2018 letter included information on proper billing procedures and asked the defendants to "[c]onsider and implement corrections to billing procedures that could prevent such errors in the future." Given the letters repeated references to the defendants' "errors" and the accompanying offers for remedial education, an uninitiated reader would not reasonably infer from the letters that the defendants had committed fraud. The district court thus properly rejected the defendants' public disclosure defense, and we need not decide whether Grant qualifies as an "original source."

2.

Next, the defendants contend the district court improperly admitted Suleman's testimony, first articulated in his additional report, that the defendants had overbilled on all thirty-one patient files. The defendants assert the additional report was an untimely and improper rebuttal report, the introduction of which prejudiced them at trial. Because the defendants filed a motion to exclude Suleman's testimony, which the district court denied, we review the district court's evidentiary ruling for an abuse of discretion. *See United States v. Flenoid*, 415 F.3d 974, 976 (8th Cir. 2005). A district court abuses

its discretion when it bases its decision "on an erroneous view of the law or a clearly erroneous assessment of the evidence." *Lancaster v. BNSF Ry. Co.*, 75 F.4th 967, 969 (8th Cir. 2023).

Federal Rule of Civil Procedure 26(e) requires a party to supplement a previous disclosure if they learn "that in some material respect the disclosure . . . [was] incomplete or incorrect." This duty to supplement a prior disclosure extends to information included in expert reports and given during expert depositions. Fed. R. Civ. P. 26(e)(2). Parties must submit these supplemental expert disclosures "by the time the party's pretrial disclosures under Rule 26(a)(3) are due." *Id*. If a party fails to timely disclose or supplement a report, then "the party is not allowed to use that information . . . to supply evidence on a motion, at a hearing, or at trial, unless the failure [to produce the report] was substantially justified or harmless." Fed. R. Civ. P. 37(c)(1).

Grant was required to supplement expert reports by July 1, 2020 and submit rebuttal expert reports by December 23, 2020. He did not submit Suleman's additional report until January 6, 2021. Despite this untimely submission, Grant could rely on the information first articulated in Suleman's additional report at trial if the failure to produce it was "substantially justified or harmless." *Id*. Here, the district court extended the expert deposition deadline to allow the defendants to depose Suleman about the additional report. In addition, Suleman's additional report was based entirely on data provided by the defendants themselves. We therefore discern no abuse

of discretion in the district court's determination that the defendants were not prejudiced by the information first articulated in the additional report.

3.

The defendants also take issue with Lodden's testimony that extrapolation from the sample of thirty-one patient files provided by the defendants to the entirety of Zorn's billing practice was appropriate. They assert that, under Federal Rule of Evidence 702 and *Daubert*, which prohibit reliance on unreliable scientific evidence, Lodden should have been precluded from testifying on statistical sampling and extrapolation, as he did not independently calculate the statistical validity of the thirty-one file sample size. *See* Fed. R. Evid. 702; *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 589 (1993) ("[T]he trial judge must ensure that any and all scientific testimony or evidence admitted is . . . reliable."). Because the defendants filed a motion to exclude Lodden's testimony, which the district court denied, we review the district court's admission of Lodden's testimony for an abuse of discretion. *See Flenoid*, 415 F.3d at 976.

Although a statistical analysis regarding the validity of a thirty-one sample size would have been preferable, we cannot say the district court abused its discretion in allowing Lodden's testimony. The concerns underlying *Daubert* exclusion of dubious scientific testimony are less stringent in a case such as this one, which involved a bench trial where the judge served as both factfinder and gatekeeper of

evidence. *See In re Zurn Pex Plumbing Prod. Liab. Litig.*, 644 F.3d 604, 613 (8th Cir. 2011) ("The district court's gatekeeping function under Daubert ensures that expert evidence submitted *to the jury* is sufficiently relevant and reliable, but there is less need for the gatekeeper to keep the gate when the gatekeeper is keeping the gate only for himself." (citations and internal quotation marks omitted)). Lodden explained that, based on the AdvanceMed letters, the reports by Suleman and Alexander, and Braak's use of random selection, he believed the thirty-one files provided by the defendants were chosen from a "homogeneous population." Because the thirty-one files were randomly chosen from a homogeneous population and thirty-one "is a common sample size when [dealing with] a population of a thousand," Lodden testified that extrapolation was appropriate. Despite any statistical deficiencies in Lodden's testimony, we cannot say it was entirely "speculative, unsupported by sufficient facts, or contrary to the facts of the case." *Lancaster*, 75 F.4th at 970-71 (noting that expert testimony is unreliable when the expert's opinion is "speculative"). We discern no abuse of discretion.

B.

1.

Turning now to the cross-appeal, Grant contends the district court also should have found the defendants liable for overbilling on established patient visits. He claims there existed sufficient evidence showing the defendants fraudulently overbilled the government on

those codes as well. Following a bench trial, we review the district court's legal conclusions de novo and its factual findings for clear error. *Kaplan v. Mayo Clinic*, 847 F.3d 988, 991 (8th Cir. 2017).

Here, Grant failed to present any evidence showing the defendants submitted false or fraudulent documentation to the government for established patient visits. Grant cannot rely on the sample of thirty-one patient files as evidence of liability for established patient visits because all thirty-one files pertained to *initial* patient visits. As the district court noted, "[a]lthough the Court has found that extrapolation from the 31 chart sample is appropriate for charts coded 99205, extrapolation is not warranted for entirely different codes, where no patient charts were ever examined by any expert witness." Although Grant asserts there is no reason to distinguish between initial and established patient visits, Suleman testified that, unlike initial patient visits, most established patient visits are routinely billed at the highest coding levels. In light of this testimony, one cannot necessarily infer the defendants fraudulently overbilled the government on established patient visits just because they did so on initial patient visits. Therefore, the district court did not err in declining to find liability on established patient visits.

2.

Grant asserts the district court erred in granting summary judgment to the defendants on the Anti-Kickback Statute and Stark Law claim because he

presented sufficient evidence of an illegal kickback and self-referral scheme. We review *de novo* the district court's grant of summary judgment. *Minn. Ass'n of Nurse Anesthetists v. Allina Health Sys. Corp.*, 276 F.3d 1032, 1051 (8th Cir. 2002). Summary judgment is proper if, "taking the evidence in the light most favorable to the non-moving party, there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law." *Id*.

The Anti-Kickback Statute prohibits medical providers from knowingly or willfully paying another "to induce such person to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a Federal health care program." 42 U.S.C. § 1320a-7b(b)(2)(A). The Stark Law prohibits physicians from making a referral to an entity for "the furnishing of designated health services" if the referring physician has a nonexempt "financial relationship" with that entity. 42 U.S.C. § 1395nn(a)(1)(A).

Neither the Anti-Kickback Statute nor the Stark Law provide for a private right of action. They are criminal statutes. Therefore, Grant sued the defendants for violations of these statutes under the FCA and the IFCA, claiming the defendants' violations of these statutes resulted in the submission of fraudulent claims to the government. Although Grant presented evidence that a kickback or self-referral scheme existed between Iowa Sleep and Iowa CPAP, he failed to present evidence that any purported violations of the Anti-Kickback Statute or

the Stark Law resulted in the submission of false or fraudulent claims to the government. The mere existence of a kickback or self-referral scheme does not establish liability under the FCA or the IFCA. The "*sine qua non*" of an FCA or IFCA violation is "the act of submitting a fraudulent claim to the government." *U.S. ex rel. Benaissa v. Trinity Health*, 963 F.3d 733, 739-40 (8th Cir. 2014) (rejecting the plaintiff's argument "that, if [the defendant] compensated physicians for illegal referrals in violation of the federal Stark and Anti-Kickback statutes, every claim submitted for services provided by those physicians would be a false or fraudulent claim under the FCA"); *see U.S. ex rel. Thayer v. Planned Parenthood of the Heartland*, 765 F.3d 914, 916 n.1 (8th Cir. 2014). Summary judgment was therefore proper.

3.

Grant asserts the district court should have awarded him punitive damages under the anti-retaliation provisions of the FCA and IFCA. We review the district court's denial of punitive damages for an abuse of discretion. *McAdoo v. Martin*, 899 F.3d 521, 525 (8th Cir. 2018).

According to Grant, punitive damages are available under the FCA because the FCA provides relief "shall include reinstatement[,] . . . 2 times the amount of back pay, interest on the back pay, and compensation for any special damages." 31 U.S.C. § 3730(h)(2). Grant contends the word "include" denotes a non-exhaustive list of recoverable damages that includes punitive damages. In declining to award Grant

punitive damages under the FCA, the district court stated that the double backpay award "signals an intent by Congress to impose punitive relief." The district court held that an award of punitive damages would render the double backpay award superfluous. In light of this double backpay provision, we cannot say the district court abused its discretion in declining to award punitive damages. Grant fails to cite any cases specifically holding that punitive damages are available under the FCA's anti-retaliation provision.

Grant contends punitive damages are available under the IFCA because Iowa law provides "[i]n a trial of a claim involving the request for punitive or exemplary damages, the court . . . shall make findings, indicating . . . [w]hether . . . the conduct of the defendant . . . constituted willful and wanton disregard for the rights or safety of another." Iowa Code § 668A.1(1)(a). Even if we were to assume that Iowa Code § 668A.1(1)(a) is applicable to the instant case, the statute only requires the district court "make findings" as to the defendant's conduct. It does not mandate the district court actually impose punitive damages. Therefore, the district court did not act inconsistently with Iowa Code § 668A.1(1)(a) in declining to award Grant punitive damages under the IFCA. We discern no abuse of discretion.

C.

The defendants and Grant both challenge the district court's determination of damages and civil penalties. Following a bench trial, we review the district court's legal conclusions *de novo* and its

factual findings for clear error. *Kaplan*, 847 F.3d at 991.

1.

The defendants assert the district court should not have estimated the number of false claims because damages must be "proved with mathematical precision . . . through an expert statistician utilizing reliable sampling methodology." However, in cases involving the FCA and the IFCA, "the Government is entitled to rough remedial justice, that is, it may demand compensation according to somewhat imprecise formulas." *U.S. ex rel. Zissler v. Regents of the Univ. of Minn.*, 154 F.3d 870, 873 (8th Cir. 1998); *see Thayer*, 765 F.3d at 916 n.1. We thus reject the defendants' contention that damages be proved with mathematical precision.

2.

Grant contends the district court should have applied a civil penalty of $5,500 for each false claim that occurred on or before November 2, 2015 to account for inflation. Under the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, civil monetary penalties must be adjusted for inflation. Pub. L. No. 114-74, § 701 (codified at 28 U.S.C. § 2461 note). For "all violations occurring on or before November 2, 2015," the minimum penalty for FCA violations was raised "from $5,000 to $5,500." 28 C.F.R. § 85.3(a)(9). Here, the district court imposed a minimum penalty of $5,000 for those violations occurring on or before November 2, 2015. The district

court should have determined a minimum penalty of $5,500 for each false claim.

3.

Both parties assert the district court misapplied the Eighth Amendment's Excessive Fines Clause. Grant asserts the district court should not have remitted the original award of treble damages and civil penalties from $7,958,521 to $6,733,896. The defendants claim the treble damages and civil penalties award of $6,733,896 still violates the Excessive Fines Clause.

The Eighth Amendment prohibits the imposition of "excessive fines." U.S. Const. amend. VIII. The Excessive Fines Clause "limits the government's power to extract payments, whether in cash or in kind, as punishment for some offense." *United States v. Bajakajian*, 524 U.S. 321, 329 (1998) (internal quotation marks omitted). The FCA's combination of treble damages with per-claim penalties constitutes a punitive sanction that falls within the reach of the Excessive Fines Clause. *United States v. Aleff*, 772 F.3d 508, 512 (8th Cir. 2014).

As a threshold matter, we must determine whether the Excessive Fines Clause applies in *qui tam* actions where the government has chosen not to intervene. The Supreme Court has declined to answer this question. *See Browning-Ferris Indus., Inc. v. Kelco Disposal, Inc.*, 492 U.S. 257, 275 n.21 (1989). We also have not conclusively answered this question. In a *qui tam* action in which the government declined to intervene at the district court, we stated that FCA penalties fall within the reach of the Excessive Fines

Clause; however, we ultimately decided the case on a different issue. *See Hays v. Hoffman*, 325 F.3d 982, 992 (8th Cir. 2003).

One of our sister circuits, however, has answered this question in the affirmative. In *Yates v. Pinellas Hematology & Oncology, P.A.*, 21 F.4th 1288, 1308 (11th Cir. 2021), the Eleventh Circuit noted that the Excessive Fines Clause "applies only to payments imposed by the United States (or the States) and payable to it (or them)." The Eleventh Circuit held that the monetary awards in non-intervened *qui tam* actions are "payable" to the government because the government shares in the proceeds of the action. *Id*. The monetary awards in non-intervened *qui tam* actions are also "imposed" by the government because the government maintains "sufficient control" over the action. *Id*. at 1310. For example, the government retains the right to request to intervene at any time, can obtain a stay of discovery, and can settle the action notwithstanding the objections of the relator. *Id*. at 1311. Even though the government is not a formal party to a non-intervened *qui tam* action, "it remains a real party in interest." *Id*. at 1309-10. Because the monetary awards in non-intervened actions are imposed by the government and payable to it, the Eleventh Circuit held that the damages and statutory penalties awarded in non-intervened *qui tam* actions are subject to the Excessive Fines Clause. *Id*. at 1314. We see no reason to depart from *Yates* in this regard and likewise hold that the Excessive Fines Clause applies in non-intervened *qui tam* actions.

Having determined that the Excessive Fines Clause applies in non-intervened *qui tam* actions, we next address whether the punitive sanction imposed by the district court is "excessive." A punitive sanction under the FCA is "excessive" when it is "grossly disproportional to the gravity of a defendant's offense." *Bajakajian*, 524 U.S. at 334. Proportionality is determined by a variety of factors, including the reprehensibility of the defendant's conduct, the relationship between the penalty and the harm to the victim, the sanctions in other cases for comparable misconduct, legislative intent, and the defendant's ability to pay. *Aleff*, 772 F.3d at 512. The plaintiffs assert, and the defendants accept, that cases analyzing punitive damages under the Due Process Clause are instructive in analyzing punitive sanctions under the Excessive Fines Clause. Indeed, in *Aleff*, we applied due process principles from *BMW of North America, Inc. v. Gore*, 517 U.S. 559 (1996), to evaluate the constitutionality of a punitive sanction under the Excessive Fines Clause. *See* 772 F.3d at 512-13; *see also U.S. ex rel. Drakeford v. Tuomey*, 792 F.3d 364, 387-90 (4th Cir. 2015) (concluding that a punitive sanction was constitutional under both the Due Process Clause and the Excessive Fines Clause after conducting a due process analysis); *United States v. Rogan*, 517 F.3d 449, 454 (7th Cir. 2008) (noting, in the context of an Excessive Fines Clause challenge, that the punitive sanction imposed by the district court was "less than four times actual damages, [which is] well within the single-digit level that *State Farm Mut. Auto Ins. Co. v. Campbell*, 538 U.S. 408

(2003), thinks not 'grossly excessive' for punitive damages" and that "[i]t's hard to see why the [Supreme] Court's approach to punitive damages under the Fifth Amendment would differ dramatically from analysis under the Excessive Fines Clause").

We conclude the punitive sanction imposed by the district court violates the Excessive Fines Clause, and we discern two errors in the district court's analysis. First, the district court should not have used the entire treble damages amount of $258,996 as the representative amount of "the gravity of [the defendants'] offense." Bajakajian, 524 U.S. at 334. The "gravity of [the defendants'] offense" refers to the amount of compensatory damages and does not include a punitive portion. *See State Farm*, 538 U.S. at 425 ("[A]n award of more than four times the amount of compensatory damages might be close to the line of constitutional impropriety." (emphasis added)). Although the Supreme Court has recognized that treble damages have a compensatory aspect "beyond the amount of the fraud," it has also noted that treble damages serve "punitive objectives." *Cook County v. U.S. ex rel. Chandler*, 538 U.S. 119, 130 (2003). Therefore, the difference between the amount of treble damages ($258,996) and the amount of actual damages ($86,332) is a hybrid of compensatory and punitive damages. *See Drakeford*, 792 F.3d at 389 ("[T]he additional sum . . . resulting from the trebling of actual damages is a hybrid of compensatory and

punitive damages."). [4] The district court improperly inflated the amount of compensatory damages by using the entire amount of treble damages as its baseline. It should have instead removed the punitive portion from its analysis.

The Supreme Court has not provided guidance as to the exact division between compensatory and punitive damages in a treble damages award. However, it has noted that the government's injury includes not merely the amount of the fraud itself, but also "the costs, delays, and inconveniences occasioned by fraudulent claims." *Cook County*, 538 U.S. at 130. According to the Supreme Court, "[t]he most obvious indication that the treble damages ceiling has a remedial place . . . is its *qui tam* feature with its possibility of diverting as much as 30 percent of the Government's recovery to a private relator who began the action." *Id*. at 131; *see Drakeford*, 792 F.3d at 389 (holding to be compensatory at least the portion of the trebled award allocated to the relator). We decline to decide the exact amount of compensatory damages and instead leave to the district court the task of determining that amount in the first instance. *See Tovar v. Essentia Health*, 857 F.3d 771, 779 (8th Cir. 2017) ("[W]hen it would be beneficial for the district

[4] We are aware the amounts of treble and actual damages may be higher than $258,996 and $86,332 respectively considering the district court did not assess any damages for the false Medicaid or Tricare claims. However, Grant failed to present any evidence regarding the reimbursement rates for such claims. Therefore, $258,996 and $86,332 are the relevant amounts for our purposes here.

court to consider an alternative argument in the first instance, we may remand the matter to the district court.").

The second error we discern is the imposition of a punitive sanction twenty-six times the amount of treble damages and seventy-eight times the amount of actual damages awarded. The Supreme Court has stated that "an award of more than four times the amount of compensatory damages might be close to the line of constitutional impropriety." *State Farm*, 538 U.S. at 425. In addition, "[t]he most important indicium of the reasonableness of a punitive damages award is the degree of reprehensibility of the defendant's conduct," and the Supreme Court has held that purely economic harm, as here, is less reprehensible than "tortious conduct [that] evince[s] an indifference to . . . the health or safety of others." *Id*. at 419. Although we have previously upheld double-digit multipliers in *Adeli v. Silverstar Automotive, Inc.*, 960 F.3d 452 (8th Cir. 2020), and *Grabinski v. Blue Springs Ford Sales, Inc.*, 203 F.3d 1024 (8th Cir. 2000), we cannot say the defendants' conduct here was as reprehensible as the defendants' conduct in those cases. In *Adeli* and *Grabinski*, the defendants engaged in tortious conduct that evinced an indifference to the health or safety of others. The defendants here caused a relatively small amount ($86,332) of only economic loss and did not endanger the health or safety of others. Even though Grant asserts the defendants engaged in tortious conduct by destroying medical records, contriving false diagnoses, and declining to consider treatment

alternatives, Grant does not cite any record support for these allegations. While these injuries "were theoretically possible," we "cannot let the imagination run wild" in terms of speculated harm. *Adeli*, 960 F.3d at 462-63. We thus conclude this case is unlike *Adeli* and *Grabinski* and that the imposition of a double-digit multiplier is unwarranted under these facts. *See State Farm*, 538 U.S. at 425 (stating that "few awards exceeding a single digit ratio between punitive and compensatory damages, to a significant degree," are constitutional); *see also Solem v. Helm*, 463 U.S. 277, 294 (1983) (acknowledging that decisions involving line-drawing are "troubling" but that "courts are constantly called upon to draw . . . lines in a variety of contexts").

Our conclusion is supported by circuit precedent. In a comparable case involving the FCA, where the defendants similarly caused only economic loss, we upheld a punitive sanction 4.3 times the amount of actual damages and 1.4 times the amount of treble damages. *See Aleff*, 772 F.3d at 513. In justifying this punitive sanction, we reasoned that the defendants' scheme to defraud the government spanned two states and more than six years. *Id*. at 512-13. The defendants received $303,890 to which they were not entitled. *Id*. at 513. Due to the defendants' wrongful conduct, the government "had to bear the cost of investigating the fraud and suffered damage to the integrity of one of its programs." *Id*. Based on these comparable facts, we conclude the district court should have limited the punitive sanction to a single-digit multiplier of compensatory damages.

The concurrence emphasizes we owe Congress's judgment "substantial deference" and asserts that "fair notice" is a key factor in determining whether a punitive sanction constitutes an excessive fine. We recognize the punitive sanction of $6,733,896 is within the FCA's and the IFCA's statutory limits and that we must accord "substantial deference" to legislative judgments concerning appropriate sanctions for the conduct at issue. *Grabinski*, 203 F.3d at 1026. However, we must be mindful not to give "undue deference" to legislative judgments about excessiveness. *Yates*, 21 F.4th at 1323 (Newsom, J., concurring); *see Bajakajian*, 524 U.S. at 336 (noting that "judgments about the appropriate punishment for an offense belong in the first instance to the legislature" but that a statutorily prescribed forfeiture was nonetheless unconstitutional under the Excessive Fines Clause). Otherwise, Congress would in effect be "suppl[ying] an answer to the questions of what a fine should be *and* whether it's excessive." *Yates*, 21 F.4th at 1318 (Newsom, J., concurring); *see id*. (stating that the Eleventh Circuit's "strong presumption of constitutionality" had created a dynamic that was "strange for much the same reason that it would be odd . . . to presume that a police officer's use of force wasn't excessive simply because he said so").[5]

[5] Unlike the Eleventh Circuit, we are not bound by our precedents to maintain a "hyper-deferential posture toward Congress's judgments about excessiveness." *Id*. at 1318; *see,*

Rather, in determining the constitutionality of a punitive sanction, the reprehensibility of the defendant's conduct is the "most important indicium." *State Farm*, 538 U.S. at 419. We do not mean to suggest the defendants' conduct here was not reprehensible. The defendants received money to which they were not entitled and damaged government programs. Nevertheless, the defendants caused a modest amount of economic loss. A "more modest punishment for this reprehensible conduct could have satisfied the [government's] legitimate objectives." *Id*. at 419-20.

III.

For the foregoing reasons, we vacate the punitive sanction and remand with directions to apply a baseline civil penalty of $5,500 for those violations that occurred on or before November 2, 2015, determine the amount of treble damages that is compensatory and the amount that is punitive, ensure the punitive sanction falls within an appropriate single-digit multiplier of the amount of compensatory damages, and enter judgment accordingly. The judgment of the district court is otherwise affirmed.

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e.g., *United States v. Lippert*, 148 F.3d 974, 977 (8th Cir. 1998); *Aleff*, 772 F.3d at 512-13.

SMITH, Chief Judge, concurring in part and concurring in the judgement.

I join the court's opinion, except for Section II(C)(3) and Part III. I agree that the district court misapplied the Eighth Amendment's Excessive Fines Clause, and I agree with vacatur of the civil penalties award and with remand, but I would do so for different reasons. In the majority's view, the Excessive Fines Clause requires a downward adjustment of the False Claims Act's (FCA) civil penalties to a single-digit ratio. In my view, no adjustment is required. At least on this record, the FCA's civil penalties are not excessive. I would direct the district court to increase the civil penalties award to the minimum amount that the FCA prescribes.

The current version of the FCA declares that persons who knowingly defraud federal programs should pay treble damages and a per-claim civil penalty of $5,000 to $10,000 (adjusted for inflation). 31 U.S.C. § 3729(a)(1). Here, the trier of fact found that Steven Zorn and his businesses (collectively, "Zorn") knowingly defrauded three federal programs—Medicare, Medicaid, and Tricare—1,050 times. Thus, in addition to treble damages, the FCA requires Zorn to pay civil penalties between $5.25 million and $10.50 million (plus inflation adjustments).

Circuit precedent describes the FCA's civil penalties as "punitive in nature" and reviewable under the Excessive Fines Clause. *United States v. Aleff*, 772

F.3d 508, 512 (8th Cir. 2014). A court should reduce these penalties if they are "grossly disproportional to the gravity of a defendant's offense." *Id*. (internal quotation marks omitted). "Proportionality is determined by a variety of factors, including the reprehensibility of the defendant's conduct; the relationship between the penalty and the harm to the victim; and the sanctions in other cases for comparable misconduct." *Id*. Civil penalties "within the FCA's statutory limits," or "less than [the] statutory maximum," are generally not excessive. *See id*. at 513.

In Eighth Amendment cases, we must remain mindful "that judgments about the appropriate punishment for an offense belong in the first instance to the legislature." *United States v. Bajakajian*, 524 U.S. 321, 336 (1998). When Congress specifies a penalty, we owe its judgment "substantial deference." *Grabinski v. Blue Springs Ford Sales, Inc.*, 203 F.3d 1024, 1026 (8th Cir. 2000) (quoting *BMW of N. Am., Inc. v. Gore*, 517 U.S. 559, 583 (1996)). "The Supreme Court long ago declared that damages awarded pursuant to a statute violate [the Constitution] only if they are 'so severe and oppressive as to be wholly disproportioned to the offense and obviously unreasonable.'" *Capitol Recs., Inc. v. Thomas-Rasset*, 692 F.3d 899, 907 (8th Cir. 2012) (quoting *St. Louis, Iron Mountain & S. Ry. Co. v. Williams*, 251 U.S. 63, 67 (1919)). We will set aside an award as "grossly excessive" only if it "'shock[s] the conscience' of the court or 'demonstrate[s] passion or prejudice on the part of the trier of fact.'" *May v. Nationstar Mortg.,*

LLC, 852 F.3d 806, 815 (8th Cir. 2017) (quoting *Ondrisek v. Hoffman*, 698 F.3d 1020, 1028 (8th Cir. 2012)). The court will properly "reduce[] a verdict only in rare situations where there is 'plain injustice or a monstrous or shocking result.'" *Ondrisek*, 698 F.3d at 1027 (quoting *Vanskike v. Union Pac. R.R. Co.*, 725 F.2d 1146, 1150 (8th Cir. 1984)).

The standard for assessing shock value is a dim and dotted line in Eighth Amendment jurisprudence. Supreme Court precedent points in two directions.[6] *Compare United States v. Tsarnaev*, 595 U.S. 302, 319–20 (2022) (evaluating an Eighth Amendment claim with reference to the government's "traditional authority"); *Timbs v. Indiana*, 586 U.S. 146, 151–53 (2019) (tracing the ban on excessive fines to medieval England and concluding that "the protection against excessive fines has been a constant shield throughout Anglo-American history"), *with Kennedy v. Louisiana*, 554 U.S. 407, 419 (2008) ("The [Eighth] Amendment draws its meaning from the evolving standards of decency that mark the progress of a maturing society." (cleaned up)); *Atkins v. Virginia*, 536 U.S. 304, 312 (2002) ("Proportionality review under those evolving standards should be informed by objective factors to

[6] In practice, laws made by Congress rarely violate the Eighth Amendment. A penalty imposed by an act of Congress has shocked the Supreme Court's conscience only twice. *See Bajakajian*, 524 U.S. at 337 (invalidating as excessive the forfeiture of $357,144 cash after an international traveler did not report the sum to customs inspectors); *Trop v. Dulles*, 356 U.S. 86, 101 (1958) (plurality opinion) (invalidating as cruel and unusual the denaturalization of a military deserter).

the maximum possible extent. We have pinpointed that the clearest and most reliable objective evidence of contemporary values is the legislation enacted by the country's legislatures." (cleaned up)). Regardless of which approach is better law, Zorn's civil penalties do not clearly offend historical or evolving standards.[7]

On the contrary, the majority opinion finds that civil penalties of $5.25 million to $10.50 million are excessive in relation to $86,332 in actual damages, or $258,996 in treble damages, that Zorn caused. The majority opinion largely relies on three cases (or their

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[7] The FCA and its robust civil penalties find support in English and American history and in modern federal and state legislation. *See* Note, *The History and Development of Qui Tam*, 1972 Wash. U. L.Q. 81, 83–101 (discussing the history of qui tam actions); Harold J. Krent, *Executive Control over Criminal Law Enforcement: Some Lessons from History*, 38 Am. U. L. Rev. 275, 296–97 & n.104 (1989) (collecting pertinent acts of Congress from the 1790s); Kenneth Mann, P*unitive Civil Sanctions: The Middleground Between Criminal and Civil Law*, 101 Yale L.J. 1795, 1844 (1992) ("Legislative adoption of punitive civil sanctions—multiple damages, forfeitures, and penalties—grew rapidly during the middle of the century and has continued to expand in recent years."); Isaac D. Buck, *Side Effects: State Anti-Fraud Statutes, Off-Label Marketing, and the Solvable Challenge of Causation*, 36 Cardozo L. Rev. 2129, 2138 (2015) (observing that "as many as thirty states had false claims acts" in mid-2014). Zorn has not shown that his penalties are excessive compared to historical or contemporary penalties for similar misconduct. *See Aleff*, 772 F.3d at 512 (identifying "the sanctions in other cases for comparable misconduct" as an important factor in our proportionality analysis).

progeny). *See Gore*, 517 U.S. 559; *State Farm Mut. Auto. Ins. Co. v. Campbell*, 538 U.S. 408 (2003); *Yates v. Pinellas Hematology & Oncology, P.A.*, 21 F.4th 1288 (11th Cir. 2021). I read these cases differently.

In *Gore*, a car owner sued an automobile distributor, arguing that the company violated Alabama law by maintaining a nationwide policy of making minor repairs to damaged vehicles but then selling those vehicles as new. 517 U.S. at 563–64. An Alabama jury awarded $4,000 in actual damages and $4 million in punitive damages, *id*. at 565, basing the punitive damages on "similar sales in other jurisdictions," *id*. at 567. The Alabama Supreme Court reduced the punitive damages to $2 million. *Id*. The United States Supreme Court granted certiorari and held that $2 million was excessive and arbitrary under the Fourteenth Amendment's Due Process Clause. *Id*. at 568, 585–86. By penalizing the distributor, BMW, for not disclosing minor repairs, Alabama sought to impose its own views about consumer protection on the rest of the country. *Id*. at 568–73, 585. The Court said: "[W]hile we do not doubt that Congress has ample authority to enact such a policy for the entire Nation, it is clear that no single State could do so, or even impose its own policy choice on neighboring States." *Id*. at 571 (footnote omitted). The $2 million award was arbitrary because Alabama never gave BMW fair notice that it would consider out-of-state conduct. *Id*. at 572–74 & nn.20–21. "Elementary notions of fairness enshrined in our constitutional jurisprudence dictate that a person receive fair notice not only of the conduct that will subject him to

punishment, but also of the severity of the penalty that a State may impose." *Id*. at 574. "[T]hat BMW did not receive adequate notice of the magnitude of the sanction that Alabama might impose for adhering to the nondisclosure policy . . . [led the Court] to the conclusion that the $2 million award against BMW [was] grossly excessive . . . ." *Id*. at 574–75.

In *State Farm*, a husband and wife sued their automobile insurer, State Farm, in Utah state court following a serious car accident and insurance dispute. 538 U.S. at 412–14. The couple argued not only that State Farm personally wronged them but also that State Farm had "a national scheme to meet corporate fiscal goals by capping payouts on claims company wide." *Id*. at 415 (internal quotation marks omitted). At trial, they presented evidence about "State Farm's business practices for over 20 years in numerous States." *Id*. "The jury awarded the [couple] $2.6 million in compensatory damages and $145 million in punitive damages, which the trial court reduced to $1 million and $25 million respectively." *Id*. "The Utah Supreme Court . . . reinstated the $145 million punitive damages award." *Id*. The United States Supreme Court granted certiorari and held that the award was "grossly excessive or arbitrary" under the Fourteenth Amendment's Due Process Clause. *Id*. at 416, 429. Quoting *Gore*, the Court reiterated that punitive damages may not be imposed without "fair notice." *Id*. at 417 (quoting *Gore*, 517 U.S. at 574). "[P]unitive damages," the Court said, "pose an acute danger of arbitrary deprivation of property" because "[j]ury instructions typically leave

the jury with wide discretion in choosing amounts." Id. (quoting *Honda Motor Co. v. Oberg*, 512 U.S. 415, 432 (1994)). "[A]s a general rule," a state does not have a legitimate interest "in imposing punitive damages to punish a defendant for unlawful acts committed outside of the State's jurisdiction." *Id*. at 421. To the extent a state court may seek to hold a defendant accountable for out-of-state conduct, it "would need to apply the laws of the[] relevant jurisdiction[s]," not its own state's laws. *Id*. at 421–22.

Gore and *State Farm* are readily distinguishable from this case. Those cases concerned the Due Process Clause; this case concerns the Excessive Fines Clause. Those cases were about the extraterritorial application of state law; this case is about the domestic application of federal law. Those cases involved punitive damages awarded by juries; this case involves civil penalties determined by Congress. And most notably, this case does not raise fair notice concerns.

"Elementary notions of fairness enshrined in our constitutional jurisprudence dictate that a person receive fair notice not only of the conduct that will subject him to punishment, but also of the severity of the penalty that [the government] may impose." *Gore*, 517 U.S. at 574. Zorn chose to participate in Medicare, Medicaid, and Tricare and voluntarily submitted to the laws and regulations that govern these programs. If he wanted to know the severity of penalties imposed on persons who knowingly submit false claims, he merely needed to consult the statute. *See* 31 U.S.C. § 3729(a)(1). He had fair notice about the potential

consequences of his actions. This fair notice diminishes any concern about the civil penalties award being excessive. *See Capitol*, 692 F.3d at 907 ("The Supreme Court never has held that the punitive damages guideposts are applicable in the context of statutory damages. . . . Th[e] concern about fair notice does not apply to statutory damages, because those damages are identified and constrained by the authorizing statute.").

In *Yates*, the Eleventh Circuit confronted the same question presented here. A medical practice tried to defraud Medicare by submitting numerous false claims. 21 F.4th at 1295. A federal jury found 214 violations, resulting in $755.54 in actual damages. *Id*. at 1296. Applying the FCA, the district court trebled those damages to $2,266.62 and imposed inflation-adjusted civil penalties of $1,177,000, the statutory minimum. *Id*. at 1297. On the excessive fines issue, the Eleventh Circuit affirmed. *Id*. at 1314. It acknowledged that a 1,558:1 ratio "may raise an eyebrow." *Id*. However, any excessiveness concerns "are negated when one realizes that this total is the result of [the defendant's] repeated (214) instances of fraud against the United States." *Id*. "Congress, as a representative body, can distill the monetary value society places on harmful conduct . . . ." *Id*. (quoting *United States v. Chaplin's, Inc.*, 646 F.3d 846, 852 (11th Cir. 2011)). "Fraud harms the United States in ways untethered to the value of any ultimate payment." *Id*. at 1316. "Fraudulent claims make the administration of Medicare more difficult, and widespread fraud would undermine public confidence

in the system." *Id*. (quoting *United States v. Mackby*, 339 F.3d 1013, 1019 (9th Cir. 2003)). When fraud becomes common, it "shakes the public's faith in the government's competence and may encourage others similarly situated to act in a like fashion." *Id*. (quoting *United States ex rel. Bunk v. Gosselin World Wide Moving, N.V.*, 741 F.3d 390, 409 (4th Cir. 2013)). "'[S]ubstantial penalties,'" the Eleventh Circuit concluded, "'serve as a powerful mechanism to dissuade' repeated violations of the FCA." *Id*. (quoting *United States ex rel. Drakeford v. Tuomey*, 792 F.3d 364, 389 (4th Cir. 2015)).

Yates does not support Zorn's excessive fines defense. *Yates* affirmed a ratio of civil penalties to actual damages of 1,558:1 based on 214 violations totaling $755.54 ($3.53 per violation). The majority opinion directs the district court to reduce Zorn's civil penalties to a single-digit ratio based on 1,050 violations totaling $86,332 ($82.22 per violation). Zorn's fraud surpasses the fraud committed in *Yates*. I would follow the Eleventh Circuit's example and enforce the FCA's minimum civil penalties against Zorn. *See* 31 U.S.C. § 3729(a)(1).

Congress has wide discretion to decide "the most effective way to insure the integrity of federal funds." *United States v. Sabri*, 326 F.3d 937, 944 (8th Cir. 2003), aff'd, 541 U.S. 600 (2004). When Congress amended the FCA, it decided that a per-claim civil penalty of $5,000 to $10,000 (adjusted for inflation) was necessary to compensate the government, incentivize qui tam relators, and deter knowing submissions of false claims. *See Cook Cnty. v. United*

States ex rel. Chandler, 538 U.S. 119, 133 (2003) (describing how Congress's "1986 amendments . . . increased the Government's measure of recovery[] and enhanced the incentives for relators to bring suit"); *Hudson v. United States*, 522 U.S. 93, 102 (1997) ("[A]ll civil penalties have some deterrent effect."); *United States v. Ursery*, 518 U.S. 267, 283–84 (1996) ("Civil penalties are designed as a rough form of 'liquidated damages' for the harms suffered by the Government as a result of a defendant's conduct." (quoting *Rex Trailer Co. v. United States*, 350 U.S. 148, 153–54 (1956))).

"It makes no sense to consider the disparity between 'actual harm' and an award of [civil penalties] when [civil penalties] are designed precisely for instances where actual harm is difficult or impossible to calculate." *Capitol*, 692 F.3d at 907–08. The constitutionality of Zorn's civil penalties should not depend on "a simple mathematical formula . . . that compares actual and potential damages to the [FCA's] punitive award." *Gore*, 517 U.S. at 582 (emphasis omitted). The FCA gave Zorn "fair notice" about the potential consequences of defrauding Medicare, Medicaid, and Tricare. *See id*. at 574. Still, he knowingly submitted 1,050 false claims. Requiring Zorn to pay the amount that Congress has prescribed is not a "plain injustice or a monstrous or shocking result." *Ondrisek*, 698 F.3d at 1027 (quoting *Vanskike*, 725 F.2d at 1150). "[T]he severity of the penalty" was predictable from Zorn's standpoint, *see Gore*, 517 U.S. at 574, and "is not grossly disproportional" to "the

reprehensibility of [his] conduct," *Aleff*, 772 F.3d at 512.

I concur in part and concur in the judgment, but I respectfully decline to join the majority opinion's directions to the district court on remand.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF IOWA
CENTRAL DIVISION

Civil No. 4:18-cv-00095-SMR-SBJ

STEPHEN B. GRANT, ON BEHALF OF THE UNITED STATES OF AMERICA AND ON BEHALF OF THE STATE OF IOWA,

Plaintiff/Relator,

v.

STEVEN K. ZORN, IOWA SLEEP DISORDERS CENTER, P.C., AND IOWA CPAP, L.L.C.,

Defendants.

Filed: September 23, 2022

TRIAL ORDER

Plaintiff/Relator Dr. Stephen B. Grant ("Plaintiff," or "Dr. Grant") [1] filed this *qui tam* lawsuit as a whistleblower on behalf of the United States of America and the State of Iowa. He alleges his former employer, a sleep medicine clinic, violated state and federal law by overbilling government payors for medical services. The case proceeded to trial after the state and federal government declined to intervene. A five-day bench trial was held from January 10, 2022 to January 14, 2022. This Order presents the Court's findings of fact and conclusions of law.

I. BACKGROUND AND FINDINGS OF FACT[2]

Rule 52 of the Federal Rules of Civil Procedure provides, "[i]n an action tried on the facts without a

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[1] In this case, Dr. Grant brings both *qui tam* claims and a wrongful termination claim. For the *qui tam* claims, his role in the case is as a "relator" because the United States and the State of Iowa are the real parties in interest. *See United States ex rel. Joshi v. St. Luke's Hosp., Inc.,* 441 F.3d 552, 560 (8th Cir. 2006). Dr. Grant brings wrongful termination claims on his own behalf which makes him a typical "plaintiff." For simplicity, the Court will refer to him as "Plaintiff" in this Order, even when discussing the *qui tam* claims.

[2] As used in this Order, citations beginning with "Pl. Ex.," refer to Plaintiff's exhibits; citations beginning with "Def. Ex.," refer to Defendants' exhibits; and citations beginning with "Tr." refer to the trial transcript. The parties' exhibits are cited with the exhibit identifier and page number. Thus, "Def. Ex. 1 at 1," refers to page one of Defendants' exhibit one. Transcript citations are formatted such that the number preceding the colon is the page number, and the number

jury . . ., the court must find the facts specially and state its conclusions of law separately. The findings and conclusions . . . may appear in an opinion or a memorandum of decision filed by the court." Fed. R. Civ. P. 52(a)(1). Consistent with Rule 52, the Court's findings of fact are set out in Section I. The procedural history of this case is recited in Section II. The Court's conclusions of law are set out in its legal analysis of Plaintiff's claims in Section III.

In a bench trial under Federal Rule of Civil Procedure 52, the court's findings of fact are presumed to be based on admissible evidence only. *Williams* v. *Illinois,* 567 U.S. 50, 69 (2012); *Harris v. Rivera,* 454 U.S. 339, 346 (1981) ("In bench trials, judges routinely hear inadmissible evidence that they are presumed to ignore when making decisions."). It is a "'well-established presumption' that 'the judge [has] adhered to basic rules of procedure,' when the judge is acting as a factfinder." *Williams,* 567 U.S. at 69–70 (quoting *Harris,* 454 U.S. 346–47) (alterations in original and emphasis omitted). Therefore, any objections that relate to evidence which the Court cites below are overruled.

A. Dr. Steven K. Zorn

Defendant Dr. Steven K. Zorn graduated from medical school at the University of Wisconsin-Madison in 1972. Pl. Ex. 1 at 1. He originally began practicing pulmonary medicine before transitioning into sleep medicine around 1990. Tr. 3:6–3:7, 3:23–25,

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following the colon is the line number. Thus, "Tr. 756:14" refers to line 14 of page 756 of the trial transcript.

671:1–671:2. Dr. Zorn began exclusively practicing sleep medicine in 2006. Tr. 4:1–4:3, 5:5–5:10.

At trial, Dr. Zorn explained that a sleep physician specializes in sleep disorders including insomnia, hypersomnia, and parasomnia. Tr. 670:21–670:25. He explained that sleep medicine is a referral-based practice and the patients he sees at Iowa Sleep are sent to him because they experience sleep difficulties. Tr. 53:16–54:1. Dr. Zorn holds board certifications in sleep medicine from the American Academy of Sleep Medicine ("AASM") and the American Board of Internal Medicine ("ABIM"). Pl. Ex. 1 at 2. In addition to his sleep medicine certifications, he holds a Registered Polysomnographic Technologist ("RPSGT") certification, which ensures basic competency in polysomnographic technology used to identify sleep abnormalities. Pl. Ex. 1 at 2; Tr. 4:16–4:20.

B. Dr. Stephen B. Grant

Plaintiff Dr. Stephen B. Grant is also a board-certified sleep physician, having graduated from the University of Colorado Health Sciences Center in 2002. Pl. Ex. 3 at 1; Tr. 377:13–377:17. He also serves as a lieutenant colonel in the United States Air Force. Tr. 373:13–373:20. Dr. Grant is a flight surgeon with the Air Force and he is married with five children. Pl. Ex. 3 at 1; Tr. 372:16–372:20. He was hired by Iowa Sleep Disorders Center ("Iowa Sleep") in August 2009 and worked there until his termination on September 28, 2018. Pl. Ex. 53; Tr. 82:4–82:8.

C. Iowa Sleep

1. In General

Dr. Zorn opened Iowa Sleep in 2006 and was originally the sole owner of the medical practice. Tr. 5:9–5:12, 682:11–682:15. Iowa Sleep operates one location in West Des Moines and one in Ankeny. Tr. 5:13–5:14, 5:20–6:1, 6:7–6:8. The West Des Moines clinic is the original location and the Ankeny location opened in 2008. Tr. 6:5–6:6, 6:11–6:12. Dr. Zorn and Dr. Grant would alternate between the West Des Moines and Ankeny locations; thus, they were rarely in the same location at the same time. Tr. 11:6–11:8, 387:21–387:23. Since 2006, Iowa Sleep has employed two physicians other than Dr. Zorn—Dr. Grant and Dr. Kahleel Ahmed. Tr. 6:13–6:15, 163:5–163:6. Dr. Ahmed worked at Iowa Sleep until approximately 2010. Tr. 6:23–6:24.

At Iowa Sleep, new patients will typically see a top-level provider for their initial visit but if they are progressing well, they will be seen by a mid-level provider, such as a physician's assistant. Tr. 684:15–685:1. New patients at Iowa Sleep were randomly assigned to either Dr. Zorn or Dr. Grant. Tr. 63:7–63:11. Return visits for established patients were also randomly assigned. Tr. 704:11–704:14.

Upon his hiring, Dr. Grant received a ten percent equity interest in both Iowa Sleep and Iowa CPAP. Tr. 5:18–5:19, 819:9–819:22. Dr. Grant is the only other physician who has held an ownership stake in Iowa Sleep. Tr. 5:18–5:19. Dr. Grant had a contractual option to buy a larger stake in both companies but he

never exercised it. Tr. 829:5–829:9. Since Dr. Grant's termination, Dr. Zorn has again been the sole owner of Iowa Sleep. Tr. 5:13–5:14.

2. Sleep Studies

A sleep study is a diagnostic tool used by sleep physicians. It is a cardiovascular and respiratory test designed to diagnose sleep disorders, primarily obstructive sleep apnea ("OSA").[3] Tr. 40:14–40:16, 41:1–41:3. A sleep study records the body's activity during sleep, including a patient's breathing, pulse rate, and oxygen levels. It is designed to evaluate certain parameters of a person's sleep to ascertain whether they are experiencing arrhythmias, apneic events, or sleep arousals, among other issues. Tr. 829:12–829:19. Sleep studies have historically been conducted at a clinic under the supervision of medical professionals. Recently, technology has advanced to allow a patient to undergo a more limited sleep study without spending the night at a clinic, known as an "at-home" sleep study. Tr. 40:20–40:22. At-home sleep studies have limited diagnostic capabilities because they only measure a patient's oxygen levels, heart rate, and whether they stop breathing. Tr. 829:20–829:23. Thus, an at-home sleep study can only diagnose OSA. Tr. 829:23–829:25.

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[3] OSA is a condition where the airway collapses from the tip of the uvula to near the vocal cords. Tr. 688:2–688:3. Dr. Zorn asserted there is a strong correlation between strokes and OSA and the evidence is strengthening that strokes are often caused by untreated OSA. Tr. 685:13–685:18.

One key component of a sleep study is the scoring of apneas and hypopneas, which is done by counting "events" and dividing it by the number of hours slept. Tr. 42:9–42:25, 119:4–119:7. The "score" attributed for obstructive events is an Apnea Hypopnea Index or AHI score. Tr. 43:12–43:15. Mild OSA is diagnosed by an AHI of 5 to 15. Tr. 558:2–558:5. Moderate OSA requires an AHI of 15 to 30. Tr. 558:6–558:11. Severe OSA requires an AHI greater than 30. Tr. 558:12–558:13. Importantly, the AHI score determines whether an insurer will pay for a CPAP machine.[4] Tr. 119:16–119:18.

Sleep studies performed at Iowa Sleep are scored by certified sleep technicians.[5] Tr. 41:4–41:6, 41:14–41:16, 118:21–118:24. The results of a sleep study, reflected on a "sleep record," are transmitted to a physician to verify its accuracy. Tr. 119:7–119:11. The AASM recommends that sleep studies be reviewed by a board-certified sleep physician. Tr. 132:23–133:2.

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[4] A continuous positive air pressure machine ("CPAP") provides a constant level of air pressure to a sleeping individual's upper respiratory tract, allowing oxygen to reach their lungs thereby preventing collapse of the airway. Tr. 690:21–691:4. A CPAP machine can be ordered regardless of a patient's AHI score, but it will only be paid for by insurance if the patient has an AHI score that determines that a CPAP is medically necessary, generally beginning at an AHI score of 5. Tr. 119:19–120:2.

[5] Testimony at trial indicated that some labs use sleep scoring by machines but all the labs at Iowa Sleep manually scored the studies. Tr. 500:1–500:5.

3. Financial Difficulties

Iowa Sleep has experienced financial difficulties for several years but both locations continue to operate. Tr. 10:4–10:13. The financial difficulties stem primarily from a transition from in-lab sleep studies to at-home sleep studies, a trend that began in central Iowa around 2011. Tr. 94:21–94:23. At-home sleep studies have a significantly lower reimbursement rate, making it a more attractive option for health insurance companies. This in turn leads them to authorize fewer in-lab studies when an at-home version is an option. Tr. 94:6–94:18, 838:14–838:18. Iowa Sleep's operations manager Brandon Butters echoed Dr. Zorn's testimony that, beginning in 2011, at-home sleep studies began widespread use in clinical sleep medicine. Tr. 105:24–106:7.

Both Dr. Zorn and Dr. Grant were paid a salary of $240,000 per year by Iowa Sleep. Tr. 12:1–12:10, 97:1–97:2. In response to the financial strain, Dr. Zorn testified that he started working Saturdays beginning in 2013; loaned money from Iowa CPAP to Iowa Sleep; and took a salary reduction from 2012 through 2019. Tr. 95:4–95:24. Dr. Zorn testified that he personally loaned $55,000 to Iowa Sleep, which is still outstanding. Tr. 841:19–841:24. He testified that Iowa Sleep's bank frequently contacted the company to transfer funds to allow it to meet payroll. Tr. 843:7–843:11. Iowa Sleep rents its West Des Moines building from Dr. Zorn, but he has not collected rent since 2012. Tr. 13:5–13:8, 841:25–842:4. Dr. Zorn testified that he considers the rents still owed. Tr. 15:19–15:20.

D. Iowa CPAP

In 2011, Dr. Zorn opened Iowa CPAP, a durable medical equipment ("DME") company which supplies equipment for patients diagnosed with OSA. Tr. 6:25–7:1, 690:12–690:14. The original Iowa CPAP is in West Des Moines in a building directly adjacent to Iowa Sleep. Pl. Ex. 40. A second Iowa CPAP location was opened in Ankeny in 2008. Tr. 9:3–9:5. The Iowa CPAP in Ankeny is approximately three miles from the Iowa Sleep location in Ankeny. Tr. 9:21. Dr. Zorn receives a management fee from Iowa CPAP and 90 percent of the profits from the company, which has been profitable since 2011. Tr. 12:19–12:25, 14:21–14:22.

The Iowa CPAP building in West Des Moines was purchased by Zorn Investments II in approximately 2012; the company purchased the Iowa Sleep location in Ankeny in 2009. BZ Tr. 42:2–42:7, 43:13–43:14.[6] The building for the Iowa Sleep location in West Des Moines is owned by Dr. Zorn personally, which he purchased around 1980. Tr. 7:25–8:3, 8:17–8:19, BZ Tr. 42:14–42:21. It is a triple net lease, meaning that Iowa Sleep is responsible for property taxes, building maintenance, and insurance. Tr. 930:3–930:9, BZ Tr.

[6] Dr. Zorn's wife, Barb Zorn, served as the administrator of Iowa Sleep and Iowa CPAP. BZ Tr. 5:12–5:18. She was deposed in pre-trial discovery but, sadly, she died prior to trial. The parties agreed to submit her testimony via deposition. Her testimony will be identified with the prefix "BZ Tr."

45:6–45:22. Iowa CPAP rents its Ankeny location from another company. BZ Tr. 44:1–44:4.

Iowa CPAP does not accept government-payors because the Stark Law prohibits referrals from Iowa Sleep in light of Dr. Zorn's ownership stake. Tr. 139:5–139:9; *see also* 42 U.S.C. § 1395nn(a)(1). However, Iowa CPAP permits patients with government insurance to pay for equipment out of pocket. Tr. 695:16–695:18.

E. Relationship between Iowa Sleep and Iowa CPAP

As previously noted, because of Iowa Sleep's financial problems, Iowa CPAP has provided several loans to the company. Tr. 16:3–16:5. Some loans remain outstanding. Tr. 16:17–16:18. Beyond this financial relationship, the Court heard testimony about the companies' extensive affiliation.

1. CPAP Coordinator

In 2012, Butters informed Iowa Sleep employees via memorandum that the company was establishing a position titled "Iowa Sleep Disorders Center CPAP Coordinator." Pl. Ex. 43 at 1. Despite its title, the CPAP Coordinator was paid by Iowa CPAP and maintained an office at Iowa CPAP. Tr. 17:18–17:19, 18:20–18:22. Barb Zorn described the CPAP coordinator as a shared employee between the two companies. BZ Tr. 6:10–6:15. The CPAP coordinator has access to the electronic medical records system ("EMR") at Iowa Sleep and, according to Dr. Zorn, the coordinator's job is to collate the information for the patient to ease the insurance approval process. Tr. 16:25–17:17, 692:5–692:7.

Dr. Zorn describes the CPAP coordinator as a "free service" for Iowa Sleep patients, including those on Medicare. Tr. 18:22–18:24, 695:4–695:7. He maintains the CPAP coordinator service is provided regardless of the DME supplier the patient chooses. Tr. 18:23–19:4, 20:16–20:19, 695:4–695:18. However, he acknowledged that the health care records of a patient prescribed CPAP therapy would typically be provided to the CPAP coordinator and no hard copy of a prescription was provided to the patient. Tr. 20:20–20:25, 21:20–21:25. This is supported by Plaintiff's Exhibit 42, which is a notice from Iowa Sleep informing a patient that "[w]e will give our Iowa CPAP Coordinator your order and demographic information" and the patient will be contacted within two business days. Pl. Ex. 42; Tr. 23:9–23:20. Dr. Zorn rejected the suggestion that patients are "escorted" over to Iowa CPAP after they are prescribed CPAP therapy, claiming that Iowa CPAP loses money by providing a CPAP coordinator to patients with a government payor. Tr. 713:11–713:18.

2. Referrals to Iowa CPAP

Butters testified that during his time at Iowa CPAP, all CPAP referrals were sent over to Iowa CPAP. Tr. 127:18–127:19. Plaintiff's Exhibit 21 are notes from an Iowa Sleep leadership team meeting from May 24, 2016. The notes suggest that all new orders were to be sent to Iowa CPAP. Pl. Ex. 21. Evidence was introduced at trial that outside DMEs were not permitted to advertise at Iowa Sleep, which Dr. Zorn acknowledged was accurate. He implied that it was not his decision and an email sent by Butters to Iowa

Sleep employees about this prohibition was not sent at his direction. Pl. Ex. 44; Tr. 24:9–24:18.

F. Allegations of Up-Coding

Voluminous evidence was presented at trial regarding medical billing, which included the legal and contractual requirements for medical providers to bill at certain levels. Both Dr. Zorn and Dr. Grant testified on the requirements. The Court also heard testimony expounding on the requirements by Plaintiff's expert witness Dr. Nizar Suleman and Defendants' expert witness Dr. James Alexander. Dr. Suleman is a board-certified, critical care physician who specializes in pulmonary and sleep disorders. Pl. Ex. 4. He has maintained a clinical practice since July 2005. Tr. 260:11–260:17. Dr. Alexander is a physician and health care compliance consultant who previously worked as a medical director for a large Medicare program and a commercial health insurance program. Tr. 580:3–580:9, 580:25–581:5. Dr. Alexander gives presentations to physicians about proper medical coding. Tr. 581:10–581:18. Defendants' Exhibit A, a reference guide ("Guidelines") circulated by Medicare to assist medical providers with coding, also developed the Court's knowledge in this area. *See* Def. Ex. A.

1. Medical Billing Generally

Health care providers receive compensation for their services by billing according to specific numerical codes. The codes were devised by the American Medical Association ("AMA") and are used across medical specialties. The Centers for Medicare & Medicaid Services ("CMS") has adopted the AMA

coding guidelines for the purpose of billing Medicare and Medicaid.[7] The amount of reimbursement to a provider is determined by the evaluation and management code ("E/M code") submitted by the medical provider, which is based on the level of service.

Providers must submit documentation to support their claims and codes. Two Guidelines govern the submission of documents in support of billing codes and are identified by year of promulgation: 1995 Guidelines and 1997 Guidelines. Providers were permitted to use either of these Guidelines for the time period relevant to this case.[8] Def. Ex. A at 4. Testimony at trial indicated that the 1995 Guidelines are easier to use and require less documentation. Tr. 284:21–284:22.

a. Component Billing

The CMS Guidelines direct that component billing should guide the selection of a billing code unless the visit is predominated by coordination of care and/or counseling ("CC/C"). Def. Ex. A at 10 (providing that "[v]isits that consist predominately of counseling and/or coordination of care are an exception to this

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[7] This Order will regularly refer to the government health insurance programs of Medicare and Medicaid. They have important distinguishing characteristics which the Court will define as needed. For simplicity, when discussing the two programs in a manner where the differences are irrelevant, the Court will simply use "Medicare."

[8] The AMA has since promulgated new E/M codes effective January 1, 2021.

rule."). For time-based billing, "time is the key or controlling factor to qualify for a particular level of E/M services." *Id.* The three key components for selecting the appropriate component billing level are patient history, examination, and medical decisionmaking ("MDM"). *Id.*

i. Patient history

The types of history a medical provider may discuss during a visit is: (a) the patient's chief complaint; (b) a brief history of present illness; (c) a review of symptoms; and (d) any pertinent past, family, and/or social history. A patient's history is categorized in ascending level of complexity as (1) problem focused; (2) expanded-problem focused; (3) detailed; or (4) comprehensive. *Id.* The level of complexity is determined by the degree of detail needed for each type of history. *Id.* Not all types of medical history (aside from the chief complaint) are necessary for this component.

ii. Physical examination

Next, a medical provider must conduct a physical examination of the patient. This examination may be a multi-system examination, involving the examination of one or more organ systems or body areas, or a single organ system examination. *Id.* at 14. Dr. Zorn conducted multisystem examinations, which are categorized in the same ascending order of complexity as patient history: problem focused, expanded-problem focused, detailed, or comprehensive. *Id.* at 16. A detailed examination includes at least six organ systems or body areas and

a comprehensive examination consists of eight or nine organ systems or body areas.

iii. Medical decisionmaking ("MDM")

MDM calls for a medical provider to establish a diagnosis and/or select a management option as guided by a patient's level of risk. *Id.* at 18. Level of risk is determined by the number of possible diagnoses, the amount and complexity of data to be reviewed, and the risk of significant complications. *Id.;* Tr. 268:14–268:25. MDM will be further expanded on below.

b. Time-based billing

Time-based billing, rather than component-based billing, is permissible when more than half the time with the patient is spent counseling or coordinating care. Def. Ex. A at 23; Tr. 315:6–315:14, 315:21–315:23. A medical provider who bills based on time must document the length of the patient visit and record the counseling and/or care coordination activities, a flat statement that a specific amount of time was spent on CC/C is not enough. Def. Ex. A at 23; Tr. 664:8–664:22.

It is undisputed that every service performed and billed for by a provider must be medically necessary. Tr. 286:25–287:2, 627:23–628:2. A provider may not "pre-bill" a visit under time-based billing by determining *ex ante* that an appointment is scheduled for 60 minutes so a top-level billing code is warranted. Tr. 289:6–289:10. Dr. Suleman testified that pre-billing "should never happen." Tr. 289:21. Dr. Suleman said billing must be based on medical

necessity as determined by patient presentation, amount of work-up, data review, and plan of care rather than billing based strictly on scheduled appointment duration. Tr. 289:12–289:16. On cross-examination, Dr. Zorn agreed that a doctor may not predicate time-based billing solely on the time allotted for the appointment. Tr. 853:6–853:17.

2. Medical Coding Used in Sleep Medicine

Three types of billing codes are used in sleep medicine: initial visit codes, return visit codes, and sleep study codes. Tr. 262:2–262:6. An initial visit for a new patient is coded 99201 through 99205 with the code depending on the medical needs of the patient and their medical complexity. Tr. 262:8–262:12. Initial visits require specific levels of the three components to satisfy a particular level of code. Def. Ex. A at 10; Tr. 262:19–262:21. Initial visit codes may only be billed to Medicare once every three years. Def. Ex. A at 9; Tr. 263:18–263:23.

Return visit codes are 99211 through 99215 and are determined predominantly by the complexity of the medical decisionmaking for the patient. Tr. 262:14–262:18. Established patient codes only require that two out of the three components—medical history, physical examination, and medical decisionmaking—be satisfied for a higher level of code. Tr. 262:21–262:24. A patient must receive treatment from a physician of the same specialty within the same group practice within the previous three years to be eligible for an established patient code. Def. Ex. A at 9.

a. Requirements for 99205 billing code

A 99205 billing code requires three things. First, it requires an extensive medical history with multiple components in the history, including a review of ten organs. Dr. Suleman explained the patient's medical, family, and social history must also be extensive and the patient must have multiple complex problems with high risk. Def. Ex. A at 10–15; Tr. 267:20–268:4, 518:4–518:9, 595:5–595:8.

Next, the physical examination must be comprehensive for a 99205 billing code. Dr. Suleman said physical examination of eight[9] or more organ systems or a comprehensive evaluation of a single organ system would qualify as a comprehensive examination. Def. Ex. A at 15–17; Tr. 268:9–268:13, 595:12–595:19. However, a comprehensive examination must be based on the patient's medical necessity and the presenting problem(s).

The last component to bill a code 99205 is the MDM. To appropriately bill for the highest level of MDM, decision making must be of the highest complexity for

[9] The 1997 Guidelines require findings about nine organ systems or body areas. Def. Ex. A at 16.

two of the three categories.[10] Def. Ex. A at 18; Tr. 300:8–300:13. As an example for medical management, a patient with a minor condition that is stable or improving is assessed a lower score, but a patient with a new problem needing follow-up care receives a higher score. Tr. 268:17–268:20. Dr. Suleman explained that the number of diagnoses and treatment options in sleep medicine is limited because so few sleep patients need complex care because they are medically stable. Tr. 301:7–301:13.

The amount and complexity of data to be reviewed depends on the existence of external medical diagnostics, such as an EKG, X-ray, or other lab tests. Tr. 268:22–268:25. According to Dr. Suleman, he typically only needs to review a limited universe of documents for a new patient including the referring physician's progress notes, a sleep questionnaire, and if the patient has had cardiac or lung function testing.

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[10] Below is a reproduction of the CMS Reference Guidelines outlining the categorization for MDM. A patient with two of the three "High Complexity" decisions is deemed as requiring a high level of MDM. Def. Ex. A at 18.

Type of Decisionmaking	Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Significant Complications, Morbidity, and/or Mortality
Straightforward	Minimal	Minimal or None	Minimal
Low Complexity	Limited	Limited	Low
Moderate Complexity	Multiple	Moderate	Moderate
High Complexity	Extensive	Extensive	High

Tr. 303:19–304:7. He testified the information is very focused and not particularly voluminous. Tr. 304:7–304:12.

Level of patient risk is the third component of MDM. Tr. 269:5–269:6. According to Dr. Suleman, level of risk can be determined by the presenting problem, diagnostic procedure *(i.e.,* basic lab test versus coronary angiogram), or management option (such as bed rest versus major elective surgery). Tr. 269:8–269:11, 269:15–269:20, 269:23–269:25. A high complexity patient has four or more diagnoses or treatment options, more than four data sets to be reviewed, and a high level of risk. Tr. 270:4–270:7.

In general, as well as in MDM billing, a doctor is not permitted to bill for a condition unrelated to the presenting problem because it would result in overlapping care and duplication of medical services. This would essentially create medical necessity rather than treating it.[11] Tr. 305:13–305:24. This principle is reflected in the CMS Guidelines which states, "[t]he services must also be within the scope of practice for the relevant type of provider in the State in which they are furnished." Def. Ex. A at 8.

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[11] Dr. Suleman expanded on this issue where he described it as "ethically wrong" to bill for a co–morbidity that is unrelated to the problem for which the patient is presenting. For example, a sleep doctor should not bill for coronary artery disease which is being treated by another physician. However, if the patient tells his sleep doctor that wearing his CPAP mask leads to pressure in his chest and radiation down his arm, it would be a different scenario. Tr. 305:19–306:5.

In sum, a code 99205 requires significant documentation of a comprehensive medical history, comprehensive examination, and a high level of MDM. Tr. 270:8–270:11. The Guidelines are clear that sheer "volume of documentation" may not be used to determine the specific level of billing. Def. Ex. A at 7.

3. Dr. Zorn's Coding Practices

a. Medicare Billing

Dr. Zorn used the 1995 Guidelines for billing purposes and testified that he personally reviewed them. Tr. 49:9–49:14, 284:13–284:15. Pulmonary medicine, which Dr. Zorn practiced for years prior to transitioning into sleep medicine, uses the same coding Guidelines. Tr. 48:9–48:14. He testified at trial that he attended annual courses to maintain his proficiency in sleep medicine and coding. Tr. 48:20–48:22. Dr. Zorn agreed that a code 99205 requires a comprehensive review of medical history, a comprehensive exam, and medical decisionmaking of high complexity. Tr. 49:15–49:19.

Plaintiff's Exhibit 14, which outlines the frequency of specific codes that Dr. Zorn billed to Medicare, reflects his position that his sleep patients are complex and necessitate high levels of billing. For example, in 2012, Dr. Zorn saw 764 new patients. He billed 743 (97.2%) of those initial visits at code 99205. Pl. Ex. 14 at 1. The next year he billed 659 out of his 660 new patients at code 99205 for a rate of 99.8%. *Id.* at 2. In 2014, 98.9% of initial visits were billed at code 99205. *Id.* at 3. 97.1% of initial visits were coded 99205 in 2015. *Id.* at 4. The following year, Dr. Zorn

billed 1,076 (98%) initial visits for new patients at code 99205 out of a total 1097 new patients seen in 2016. *Id.* at 5. During the year 2017, 1094 new patients were seen by Dr. Zorn, and 976 (89.2%) of them were billed at code 99205. *Id.* at 6.

Dr. Zorn's coding changed markedly beginning in 2018. By 2018, he was billing code 99204 much more often than code 99205: 989 initial visits were billed at code 99204 where only 42 initial visits were coded as 99205. *Id.* at 7. This timeline coincides with this lawsuit and the Civil Investigative Demands ("CID") for documents served by the Government. [12] Tr. 444:17–444:25.

At trial, Dr. Zorn described the steps he took to educate and improve his coding. Iowa Sleep retained an external coding consultant to help with coding issues. Tr. 807:16–807:21. He said he read four books on coding and researched the internet to ensure he was coding correctly. Tr. 828:4–828:14. Dr. Zorn said his research did not provide reasons to believe he was out of line or did not understand any coding practice. Tr. 828:15–829:1.

b. AdvanceMed Education Letters

CMS contracts with third-party administrators like AdvanceMed to administer, process, and pay valid claims to qualified providers. They also review,

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[12] This suit is a *qui tam* suit brought on behalf of the United States of America and the State of Iowa. For simplicity, they will be referred to collectively as the "Government" unless a distinction is relevant.

investigate, and audit payments made on behalf of the federal government. *See generally* 42 U.S.C. §§ 1395kk1(a), 1395ddd(a)–(b). One of those authorized reviewers, AdvanceMed, sent a letter to Dr. Zorn on September 6, 2016. The letter noted that he billed 100 percent of his initial patient visits at code 99205 between June 24, 2012, and June 24, 2016, but "more variety would be expected" of the billing codes. Pl. Ex. 20 at 2. The letter described that the majority of his established patient office visits were billed at codes 99214 and 99215. Pl. Ex. 20 at 2. Code 99214 accounted for 76% of Dr. Zorn's established patient visits for that time period. Pl. Ex. 20 at 2. Additionally, AdvanceMed found that Dr. Zorn was "ranked number one for paid amount" among all Medicare providers in Iowa for claims involving billing codes 95810 and 95811, used for sleep studies, and that some patients received three or more sleep studies during the four-year period of review. Pl. Ex. 20 at 4–5. The September 2016 AdvanceMed letter concluded by informing Dr. Zorn that the documentation submitted with the claims was insufficient to support his billing practices for that time period and provided education on the criteria for billing at the relevant rates. *See id.*

In his testimony, Dr. Zorn said this review was probably "cherry-picked." Tr. 71:13. Dr. Alexander described the letter from AdvanceMed as an education letter, generated by a statistical analysis of claims for payment. Tr. 588:7–588:17. The September 2016 AdvanceMed letter did not lead Dr. Zorn to change his billing practices but caused him to increase his

documentation. Tr. 72:11–72:15, 73:3–73:22. Dr. Zorn testified he did not receive any other education or information on his coding practices prior to the September 2016 AdvanceMed letter. Tr. 53:5–53:8.

AdvanceMed sent a second letter to Dr. Zorn on January 22, 2018. Pl. Ex. 25. The purpose of the second letter was to present its findings from a follow-up integrity review and provide additional education to Iowa Sleep. Pl. Ex. 25. It identified overpayments made to Dr. Zorn after finding AdvanceMed's records "indicated a high incidence of billing for the highest level E/M codes." *Id.* Like the September 2016 AdvanceMed letter, the January 2018 AdvanceMed letter noted that Dr. Zorn exclusively billed code 99205 for new patients and selected code 99214 76% of the time for established patients. *Id.* The medical review concluded that documentation did not support the level of service for which Dr. Zorn billed and provided several examples. *Id.* The January 2018 AdvanceMed letter described some of the supporting documentation as copied and pasted, which was shown by duplication of grammatical errors and occasional transferal of incorrect information. *Id.* Despite this observation of copied or templated grammatical errors, Dr. Zorn denied that data from prior visits would auto-populate for established patient encounters. Tr. 860:23–861:18. AdvanceMed's review found that some office visits were separated by less than one month, with no health status change noted. *Id.* Without a change in health status, AdvanceMed noted that a comprehensive history and physical examination would be unnecessary. *Id.*

c. Wellmark Billing Issues

Dr. Zorn was separately notified about coding issues by Wellmark. On January 20, 2017, Wellmark sent a letter to Dr. Zorn that demanded he provide them a refund of $12,790.58 for overpayment. Pl. Ex. 23 at 1. Wellmark objected to Dr. Zorn's coding for both initial and return visits, based upon its review of the medical records he submitted. *Id.* at 6–17.

This letter was sent after Wellmark had previously educated Dr. Zorn on inappropriate use of code 99214 on two separate occasions in 2010. Tr. 150:6–150:10, 150:22–150:25, 153:12–153:16. Dr. Zorn's billing codes submitted to Wellmark changed in the immediate years after the 2010 education. However, Debra Robles, a fraud investigator for Wellmark, testified the insurer observed what it considered up-coding beginning again in 2016. Tr. 152:17–153:8. The alleged up-coding consisted of increased use of codes 99205, 99215, and 99214. Tr. 153:9–153:11.

Dr. Zorn insisted at trial that the medical director for Wellmark never reviewed the medical records and that Wellmark was "relying on MCMC," which he says owns AdvanceMed. Tr. 75:2–75:3, 75:9–75:13. Dr. Zorn testified that, after receiving the Wellmark letter, he was confused about their coding system and requested a meeting. Tr. 805:19–806:6. He eventually met with Dr. Gutshall, the chief medical director for Wellmark. Tr. 806:3–806:6. Dr. Zorn said he did not get answers to his questions about the coding issues at the meeting. Tr. 806:16–806:25.

Dr. Zorn received a second letter from Wellmark on August 1, 2017. Pl. Ex. 24. This second letter concluded that the additional documentation provided by Dr. Zorn in response to their initial audit did not impact Wellmark's original findings. Pl. Ex. 24 at 1. Robles testified that Dr. Zorn did not change his coding practices, so he was placed on prepayment review by Wellmark beginning on May 14, 2018, which required him to submit medical records prior to payment on a claim. Tr. 148:18–148:25, 163:8–163:10. Dr. Zorn denied ever being placed on prepayment review and asserted the first time he heard about it was at trial. Tr. 807:4–807:15.

Wellmark also issued an overpayment letter to Dr. Grant in 2017, demanding $9,493.12. Def. Ex. C. Dr. Grant testified he was initially unaware Wellmark had contacted him to inform him that his coding was not supported by the documentation because he never opened his professional mail personally. Tr. 382:2–382:7. Dr. Grant appealed the overpayment determination which was later denied. Def. Ex. D. After both Dr. Zorn's and Dr. Grant's appeals of the overpayment letters were denied, Wellmark held a conference call with the doctors. Tr. 163:3–163:5. Dr. Grant was not placed on prepayment billing review because he had altered his coding practices. Tr. 163:7–163:8, 163:10–163:12. Dr. Grant testified that he had tapered down his billing from code 99205 to code 99204 after witnessing regular "claw-back" letters from Wellmark. Tr. 390:5–390:18.

Dr. Grant repeatedly testified that Dr. Zorn told him to bill new patients at code 99205 and established

patients at code 99215. Tr. 429:1–429:14, 522:16–522:19, 548:22–549:6. Dr. Zorn denied instructing Dr. Grant how to code his visits, testifying that he presumed that Dr. Grant had training based on the quality of the medical education programs he attended. Tr. 699:18–700:4. Dr. Grant testified he did not have coding training during his residency and he relied on Dr. Zorn for mentorship. Tr. 382:13–382:16.

d. Dr. Zorn's Billing Template

At trial, the Court heard extensive testimony pertaining to a billing template created by Dr. Zorn around 2009 or 2010 to document the medical services he provided. Tr. 50:23–51:3, 52:15–52:16. He explained there were no good templates for sleep medicine in Intergy, the EMR provider for Iowa Sleep, so he began to modify the default option. Tr. 51:6–51:9, 51:15–51:22. Dr. Zorn confirmed that his personal template has been modified more than fifty times. Pl. Ex. 16A; Tr. 51:23–51:52.

Examples of Dr. Zorn's template were introduced into evidence as Exhibit 16B, which shows that only the highest billing codes had shortcut tabs in template. *See* Pl. Ex. 16B. Dr. Grant adduced that Dr. Zorn was "fluffing up the note," meaning adding irrelevant or unnecessary services or documentation, to support a higher level of billing than necessary. Tr. 441:4–441:8. Dr. Suleman echoed this conclusion, opining that of the systems included in the template, gastrointestinal, musculoskeletal, ophthalmologic, dermatologic review of systems, are not medically necessary for evaluation of an established patient

with diagnosed sleep apnea. Tr. 282:4–282:5, 283:17–283:19, 288:6–288:8.

Dr. Zorn denied that the purpose of his template was to enable him to bill at the highest level. Tr. 858:1–858:4. However, Butters testified that the template would be edited or changed to add more boxes for documentation purposes when audit results and feedback indicated insufficient documentation to support Dr. Zorn's coding. Tr. 111:15–111:19, 112:10–112:13, 142:8–142:10. Multiple witnesses testified that Dr. Zorn exhorted other providers to use his template, with his common refrain being "we have to get credit for what we do." Tr. 385:6–385:8, 385:13–385:16. Finally, Dr. Zorn's billing template was often a topic of discussion at management meetings. Tr. 110:8–110:12.

When questioned why he declined to use Dr. Zorn's template, Dr. Grant said he found the template overly complicated and did not accomplish much. Tr. 385:9–385:13. According to Dr. Grant, Iowa Sleep's computer server crashed because the strain the template placed on it. Tr. 386:22–387:2. The template outlined examinations which, in Dr. Grant's opinion, were not medically necessary and could not be physically performed in the examination rooms at Iowa Sleep. Tr. 385:17–385:21, 444:3–444:8.

Dr. Grant said that Dr. Zorn implied that Iowa Sleep was returning money to Wellmark because Dr. Grant was not completing the appropriate documentation which entailed, in part, on using Dr. Zorn's template. Tr. 388:3–388:19. He said Dr. Zorn was consistent in

his position that Iowa Sleep was under-coding and other providers needed to code at his level. Tr. 389:6–389:22. Butters testified similarly, stating that other providers were asked to use Dr. Zorn's template to support their coding but they found the template was "very complex and too convoluted to use." Tr. 111:3–111:12. Dr. Zorn denied asking Dr. Grant to use his billing template. Tr. 93:13–93:20.

In contrast to Dr. Zorn, Dr. Grant testified that he used the Intergy template every day because it closely focused on the pertinent, appropriate questions and data relevant to the history, exam, and decisionmaking required for a sleep patient. Tr. 383:12–383:20. He explained that he used the neurology template in Intergy because the contours were appropriate and he believed other templates included unnecessary information. Tr. 383:23–384:4. Dr. Grant opined that it was difficult to template every patient so he typed the majority of his medical notes, which allowed him to narrate the patient's issues and provided him more flexibility. Tr. 384:16–384:24.

e. Dr. Alexander's Testimony on Coding

Dr. Alexander was retained by Defendants to provide his expert opinion on Dr. Zorn's coding practices. He acknowledged that he does not have any sleep medicine training and has never provided expert testimony in a sleep medicine case, but maintained he has extensive experience with E/M codes, which are used in all types of medical specialties. Tr. 635:11–636:11, 638:7–638:12.

Dr. Alexander opined that sleep medicine is an appropriate specialty to use time-based billing, so long as CC/C accounts for at least half of the time billed. Tr. 592:21–593:5. He testified that, for time-based billing, it is not necessary for a provider to write every detail from a patient visit. There must only be sufficient documentation for a skilled auditor, typically a medical professional, to be able to ascertain that the billed time is accurate. Tr. 598:2–598:7. Dr. Alexander agreed time-based billing must only include tasks that are medically necessary and that medical necessity must be clearly documented. Tr. 627:23–628:6. He said that Medicare permits auditors to exercise clinical judgment based on the medical records, to determine if it would be reasonable that a provider spent half their time on CC/C, even if not expressly documented. Tr. 632:5–632:20. Dr. Alexander agreed that volume of documentation cannot create or substitute for medical necessity. Tr. 650:1–650:5. He testified that Dr. Zorn did not meet the documentation standards for the levels he billed, but he could have satisfied the code 99205 requirements because of the complexity of his patients if he had documented properly. Tr. 600:23–601:9.

Dr. Alexander conducted an audit of 31 randomly selected patient charts coded at 99205 that were submitted to Medicare. Tr. 582:6–582:22. These charts were all initial visits within the timeframe of 2011 to 2017. Tr. 265:19–265:21. Dr. Alexander testified that 31 was an appropriate sample size because it is consistent with the standard used by Medicare for probe audits and reviews of billing

irregularities by Medicare contractors.[13] Tr. 584:6–584:11.

Dr. Alexander's audit found 1 out of 31 (3%) initial patient visits were correctly coded at 99205 under component-based billing. Def. Ex. S.; Tr. 626:12–627:3. He determined that six more visits were permissibly coded at 99205 when using time-based billing, provided there was sufficient time spent on CC/C. Def. Ex. S; Tr. 604:22–605:7. In total, Dr. Alexander opined that 7 out of 31 charts (22.6%) were correctly coded if using component-based or time-based billing.

Dr. Alexander later conducted a supplemental audit based on an assumption that Dr. Zorn spent an hour with each patient—even if not sufficiently documented—yielding an additional four 99205 codes,

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[13] A probe audit is a standardized audit used by Medicare program integrity contractors when investigating billing and coding problems. Tr. 584:21–585:3. Probe audits are initiated when there is a statistically significant departure of coding in a practice. Tr. 585:6–585:12. The cycle of a probe audit goes: first, an education letter is transmitted to a provider explaining the statistical issue with their claims and encouraging education; next, specific claims are selected by the auditor who requests documentation to support the billing and coding; and then the documentation is analyzed to determine if there is a problem and, if there is, provide education to help the provider improve and correct their coding practices. Tr. 585:19–586:12. Three cycles of probe audits are allowed to permit a provider to get into compliance with regulations. Tr. 586:23–587:4. If three probe audits does not bring a provider into compliance, they are place on pre-payment review. Tr. 587:19–587:24.

which increased the accuracy rate to 35.4%. Def. Ex. S; Tr. 605:14–606:21. He determined that the remaining 20 charts under this supplemental audit were still not sufficiently documented to support time-based billing or he did not find it credible that Dr. Zorn spent half his time on CC/C. Tr. 606:22–607:7. In support of this conclusion, Dr. Alexander observed that Dr. Zorn did not typically have a specific statement of time spent in the visit that would document the CC/C in a sufficient manner. Tr. 663:22–664:1.

Dr. Alexander expressly concluded Dr. Zorn was a poor documenter in terms of providing Medicare with enough information to justify his billing codes. Tr. 611:20–611:21, 668:12–668:18. He opined that the primary infirmity in Dr. Zorn's billing was that level of risk and medical decisionmaking was not at a sufficient level to justify code 99205 but rather code 99204. Tr. 662:14–663:6. This is because the patients in the audit sample were medically stable with one exception. Tr. 658:19–658:25. He did opine that sleep patients in general are often "very complex" and most are not simple. Tr. 666:20–666:23. Dr. Alexander testified that the files he reviewed in the sample did not have a templated appearance but were well-organized, logically arranged, and thoughtful. Tr. 666:5–666:19.

f. Dr. Suleman's Testimony on Coding

Dr. Suleman also reviewed the sample of 31 patient charts from Dr. Alexander's audit, maintaining that Dr. Alexander overestimated the frequency Dr. Zorn

appropriately coded his patient visits. Where Dr. Alexander asserted that 6 or 7 charts were coded correctly, Dr. Suleman did not find any charts which met the criteria for code 99205. Pl. Ex. 29; Tr. 265:24–266:7, 266:14–266:18. Dr. Suleman opined the audited charts were frequently over-coded by more than one-level and most should have been billed at code 99202.[14] Pl. Ex. 29; Tr. 266:17–266:18, 319:20–319:22. Dr. Suleman said none of the charts qualified as a high level of risk under the Guidelines. Tr. 271:18–271:21, 308:18–308:22.

Dr. Suleman further explained that a 99205 code for an initial visit is very infrequent in sleep medicine and it would be a major outlier in any practice for the highest level code to be billed exclusively for an initial office visit. Tr. 291:19–291:23. This contention is well supported, as sleep physicians bill code 99205 approximately 13% of visits according to data available on Medicare's website.[15] Tr. 292:2–292:6.

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[14] Dr. Suleman admitted he used an online calculator to determine the E/M coding but said he conducted an independent review of the records beforehand and the calculator was used to confirm his impression. Tr. 368:7–368:11. The calculator includes a proviso that it "does not guarantee a specific audit result" and "requires interpretation of provider documentation." Pl. Ex. 30; Tr. 365:19–365:23. Dr. Suleman agreed with Defendants that there is some subjectivity in billing but not all the same direction and not for 30 of 31 charts. Tr. 367:19–367:24.

[15] On cross-examination, defense counsel pointed out the "sleep medicine" is no longer a specific specialty that can be sorted on the website. Dr. Suleman acknowledged this was

Return visits are billed at code 99215 approximately 7.5% of the time nationally. Tr. 321:2–321:5. Dr. Suleman stated he did not bill code 99205 at all in his own sleep medicine practice and only eight visits were billed at code 99215 in 2019. Tr. 324:19–324:24. He said he coded all 23 of the new patients he saw in his personal practice at code 99204. Tr. 356:10–356:12. Dr. Suleman testified that he sees a combination of pulmonary and sleep patients including patients with shortness of breath and multiple problems beyond sleep disorders, disputing defense counsel's assertion that because his coding was typically one level below Dr. Zorn's, it was not an apples to apples comparison. Tr. 357:10–357:14.

For management options, Dr. Suleman observed some of the charts had over-the-counter allergy medications but generally fell into the low to moderate categories. Tr. 309:22–310:5. Within the audit sample, Dr. Suleman observed that the patients presented with one or two problems—typically snoring, difficulty staying awake, or falling asleep. Tr. 272:10–272:16. None of the patients complained of shortness of breath, used supplemental oxygen, or had any acute neurologic symptoms. Tr. 272:19–272:21. He said this

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accurate and was unable to explain why it was no longer available. The percentage of 99205 codes for pulmonary medicine, which both Dr. Suleman and defense counsel agreed was the closest comparator, was 25 percent. Defense counsel noted this was twice the rate as the 13% quoted by Dr. Suleman for sleep medicine. Tr. 354:1–355:15. To that end 85% of initial visits for pulmonary patients are coded 99204 or 99205. Tr. 355:16–355:21.

was consistent with most patients presenting to a sleep clinic who are generally, if not always, very stable. Tr. 272:17–272:18. He concluded none of the patients had a high, and few had a moderate, level of risk necessitating a code 99205. Tr. 273:4–273:7.

Dr. Suleman explained why Dr. Zorn was incorrect that his patients were all high risk was because Iowa Sleep is a specialty clinic. The specialization limits the presenting problem and limits the medical necessity for history, physical examination, and diagnostic and treatment options, which in turn reduces billing. Tr. 274:18–274:24. Essentially, medical necessity for a high-level visit is rare because there are limited problems and limited diagnostic and treatment options. Tr. 320:14–320:22. Under this logic, a specialist does not *ipso facto* have complex patients justifying a top-level billing. Tr. 275:13–275:18. Such a billing philosophy violates the principle of medical necessity because even if a physician is a consulting physician, the patient has been referred for a specific problem. Tr. 275:18–275:25.

Dr. Suleman acknowledged that occasionally a patient may have complex sleep-related concerns which requires multiple differentials for evaluation and treatment but did not observe any patients within the audit sample with such complexity. Tr. 274:25–275:3. They were, in his words, "fairly straightforward, noncomplex patients." Tr. 275:6–275:7.

Dr. Suleman rejected the suggestion by Dr. Zorn's counsel that a sleep patient could be high risk for

MDM purposes because a sleep study is analogous to cardiovascular imaging—a specific example of a high risk procedure in the Guidelines. *See* Def. Ex. A at 22. He explained that cardiovascular imaging entails injection of contrast and catheterization of coronary arteries, which could lead to death or arterial perforation. Tr. 346:15–346:20. Dr. Suleman said that a low risk treatment option like a physiologic test not under stress, such as pulmonary function testing, is a more accurate comparator to a sleep study. Tr. 347:14–347:17.

Dr. Suleman testified that established patients rarely require comprehensive history evaluations unless their health circumstances have changed. Tr. 294:20–294:25. One example of a patient's notes discussed at trial states the patient had not reported any changes in status, as shown by the multiple notations of "no change . . . since last clinic visit." Pl. Ex. 17 at 4–5. The CMS Guidelines spell out how rarely an established patient requires complex decisionmaking: "[i]n general, decision making for a diagnosed problem is easier than decision making for an identified but undiagnosed problem . . . [p]roblems that are improving or resolving are less complex than those problems that are worsening or failing to change as expected." Def. Ex. A at 18. The Guidelines further state that "[a]nother indicator of complexity of diagnosis or management problems is a need to seek advice from other health care professionals." Def. Ex. A at 18. Dr. Suleman testified he found no evidence that Dr. Zorn sought the advice or referral to another health care professional. Tr. 303:7–303:11.

As far as any time-based billing, Dr. Suleman opined that none of the 31 charts he reviewed met the 60-minute requirement for code 99205. Tr. 315:8–315:9. One example of patient counseling was shown in Plaintiff's Exhibit 17; Dr. Suleman described it as basic and said it could be completed in five to ten minutes—far below the 30 minutes required for code 99205. Tr. 318:12–318:22.

During his testimony, Dr. Suleman compared patient notes of Dr. Grant and Dr. Zorn during a return visits. He opined that Dr. Grant's notes were focused on the patient's presenting condition—in that case sleep apnea—and did not repeat unnecessary parts of the examination because it was an established patient. Tr. 280:16–280:20; *see also* Pl. Ex. 17. Contrasted with Dr. Grant, he found Dr. Zorn's patient notes for an appointment for an established patient as reflecting unnecessary examinations for an established patient being seen for consultation regarding the result of an at-home sleep study. Tr. 283:2–283:4, 286:3–286:4. Dr. Suleman opined that Dr. Zorn performed numerous unneeded, unnecessary examinations not relevant to the patient's presenting problem. Tr. 286:12–286:13. For example, Dr. Zorn examined the patient's hearing, checked pupil reactivity, and performed abdominal palpations. Pl. Ex. 17; Tr. 282:17–283:5. Dr. Suleman speculated that a patient may wonder why these examinations are being performed at such an appointment at all. Tr. 283:4–283:5. In his testimony, Dr. Zorn confirmed that he conducts a physical examination during

return visits to make sure he is "not missing something." Tr. 743:24–743:25.

g. Dr. Zorn's Coding Changes

Beginning in 2018, Dr. Zorn's coding practices began to change. For the year 2017, Dr. Zorn had billed code 99205 for 976 new patient visits compared with only 104 initial visits at code 99204. Pl. Ex. 14 at 6. This ratio was almost entirely flipped for 2018. In 2018, code 99204 was billed 989 times whereas code 99205 was billed 105 times. Pl. Ex. 14 at 7. Dr. Zorn did not bill code 99205 at all for 2019 or 2020. Pl. Ex. 14 at 8–9.

Dr. Zorn testified that he changed his coding because it was causing a "crisis" in the office stemming from insurance companies requesting patient charts, costing the company money, and harming staff morale. Tr. 741:1–741:8. He insisted that he coded appropriately for all the preceding years and his coding changes saddened him because he "caved" to insurance companies. Tr. 741:9–741:10. This coding change coincided with his placement on prepayment review by Wellmark. Tr. 148:18–148:25.

4. Dr. Grant's Termination

Dr. Zorn fired Dr. Grant on September 28, 2018. Pl. Ex. 53; Tr. 82:4–82:8. According to Dr. Zorn, his decision to terminate Dr. Grant was a financially-driven decision as a way to improve Iowa Sleep's finances. Tr. 846:1–846:4. The company's finances began to deteriorate after the sleep medicine practice underwent significant economic challenges following the increased preference for at-home sleep studies by

insurance companies. The evidence at trial illustrated that Dr. Grant and Dr. Zorn began to clash over Iowa Sleep's finances beginning in 2016.

In October 2016, Dr. Zorn held a performance review with Dr. Grant in which he chastised Dr. Grant for failing to refer more patients to Iowa CPAP.[16] *See* Pl. Ex. 22. The written portion of the review, admitted as Plaintiff's Exhibit 22, noted "Iowa CPAP, no year have our billings matched." Pl. Ex. 22. The first page of the review illustrated the disparity between the two doctors as far as referrals from Iowa Sleep to Iowa CPAP. Tr. 415:13–415:25. Dr. Zorn conceded at trial this remark pertained to referrals from Iowa Sleep to Iowa CPAP. Tr. 26:5–26:10. He described this comment as stemming from his concern that Dr. Grant may not have been providing the benefits of CPAP therapy to patients who had OSA. Tr. 26:20–26:23. Dr. Zorn reiterated at trial his position that CPAP is a first-line therapy according to the AASM, regardless of whether it is mild, moderate, or severe. Tr. 820:18–820:21. He said recommendation of a CPAP is not optional for the provider and is only subject to refusal by the patient. Tr. 820:23–821:1.

The written review also included a side-by-side chart comparing the revenue generated by the two doctors for Iowa Sleep. Pl. Ex. 22 at 4. This also

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[16] Dr. Grant testified that around that time, he had asked Dr. Zorn why Iowa CPAP was loaning money to Iowa Sleep and he believed the meeting in October 2016 was for the purpose of discussing these financial details. Tr. 414:2–414:5, 413:2–413:4.

included the same notation that "[n]o year have our billings matched." Pl. Ex. 22 at 4. The disparity ranges from Dr. Grant billing 70.4% of Dr. Zorn's billings in 2015 to 90.7% in 2013. Pl. Ex. 22 at 4. The chart displayed the partial year billing for 2016 where Dr. Grant had billed only 64.6% of Dr. Zorn's total billing until that date. Pl. Ex. 22 at 4. Dr. Zorn explained at trial that his concern over billing discrepancies was not financial but "patient care" and appropriate treatment of CPAP patients. Tr. 83:3–83:5, 93:11–93:12. He also expressed concern that Dr. Grant was not seeing as many patients as Dr. Zorn. Tr. 820:7–820:14. Dr. Zorn saw 27% more patients than Dr. Grant between 2011 and 2017. Tr. 700:24–701:3.

In the ensuing years, Dr. Grant testified that he learned more about Dr. Zorn's coding practices and believed Dr. Zorn was intentionally, fraudulently billing private insurance companies and Medicare. Tr. 437:14–437:17, 440:2. He said he was stunned when he learned of the referral disparity between the doctors because patients at Iowa Sleep were randomly assigned between them. Tr. 63:7–63:11, 429:23–430:5.

Dr. Grant echoed the testimony of Dr. Suleman regarding coding in sleep medicine, positing that occasionally a patient with undiagnosed OSA could be considered high risk but they typically need to have an occupation where falling asleep is especially dangerous, such as a pilot or driver, or need to have profound comorbidities. Tr. 555:7–555:17. Dr. Grant also testified that he learned, prior to this litigation, that the national average for initial visits billed at code 99205 was at or below 13%. Tr. 407:2–407:19. Dr.

Grant said that his memory was that return visits were billed nationally at code 99215 less than 6% of the time. Tr. 412:11–412:14. Dr. Grant testified that he personally confirmed Dr. Suleman's previous observation of the statistics using a website which archives certain internet pages to verify changes. Tr. 515:23–516:4.

Dr. Grant said Dr. Zorn did not share the September 2016 AdvanceMed letter with him; he only came to learn of its existence after Butters provided it to him in a clandestine manner. Tr. 397:20–398:1. The September 2016 AdvanceMed letter prompted serious concern on the part of Dr. Grant because it noted that disqualification from the Medicare program was a possible consequence, which would have grave implications for Iowa Sleep as a business. Tr. 398:6–399:4.

According to Dr. Grant, his mounting concerns over the propriety and legality of Dr. Zorn's—and Iowa Sleep's—billing practices is why he filed this lawsuit. He said he did so, in part, because if Dr. Zorn's fraud were uncovered, the record would reflect that he had the integrity to report it to the appropriate officials. Tr. 446:23–447:3. One specific personal concern Dr. Grant had was he said he had a possible upcoming polygraph for an upgraded security clearance with the Air Force. He said one focus of such a polygraph is a query about knowledge of fraud committed against the government, which he stated he could not truthfully deny in light of his knowledge of Dr. Zorn's coding practices. Tr. 437:21–438:1.

This case was initially filed under seal in March 2018. [ECF No. 1]. In September 2018, the Government served CIDs on Dr. Zorn and Iowa Sleep.[17] Shortly thereafter, on September 17, 2018, Dr. Grant met with Dr. Zorn to discuss the state of Iowa Sleep's finances. Pl. Ex. 51; Tr. 448:9–448:15. Also in attendance at the meeting was Rod Olson, the certified public accountant ("CPA") for Iowa Sleep, Iowa CPAP, and Dr. Zorn. Tr. 448:18, 913:2–913:25. During the meeting, Dr. Zorn told Dr. Grant that Iowa Sleep was in dire financial stress and all shareholders needed to take a 75% salary reduction. Tr. 449:18–449:21. Dr. Zorn's recounting of the meeting was that the financial difficulties of Iowa Sleep were first discussed by Olson. Tr. 844:1–844:4. Dr. Zorn reports that he then interjected that the only option available was a 75% pay cut reduction for both doctors. Tr. 844:4–844:7. Dr. Grant said he viewed the proposal for a 75% pay cut as "punitive." Tr. 459:17. Dr. Zorn insisted the pay cut proposal was from Olson. Tr. 842:18–842:22. Olson testified that in response to the pay cut proposal, Dr. Grant told Dr. Zorn that his situation was "different" from his own and left the room. Tr. 927:6–927:13. Olson confirmed previous testimony by Dr. Zorn that financial documents—projected cash flow and financial statements—from

[17] Dr. Zorn stated in his deposition that he believed the first round of information had been provided to the government by that date, at trial Dr. Zorn said he could not remember if that was the case, but acknowledged his statements in the deposition. Tr. 87:19–88:14.

2016, 2017, and through June 2018 were offered to Dr. Grant at the meeting. Tr. 844:8–844:12, 923:21–924:2.

After not receiving a response from Dr. Grant regarding the proposal at the meeting, Dr. Zorn sent a letter to Dr. Grant requesting a decision. Pl. Ex. 51; Tr. 845:2–845:8. Dr. Grant responded in writing, declining the proposed pay cut, and requesting access to Iowa Sleep's financial records so he could assess for himself the financial circumstances of the company. Pl. Ex. 52. Dr. Grant said he was hoping to ascertain whether a more modest pay reduction could be appropriate from the documents. Tr. 461:9–461:11. Dr. Zorn responded to the request for financial records four days later on September 28, 2018, by terminating Dr. Grant's employment effective immediately. Pl. Ex. 53; Tr. 84:8–84:18, 461:19–462:3. Dr. Zorn confirmed that terminating Dr. Grant was solely his decision. Tr. 85:1–85:3. Dr. Grant stated he was never provided the requested financial records nor given an opportunity for a counter-proposal prior to his termination. Tr. 462:20–462:25.

Dr. Zorn explained that he thought further negotiations on a smaller salary reduction would not be fruitful because Dr. Grant had rejected a proposal which was insufficient to fix the financial shortfall. Tr. 845:10–845:15. Dr. Zorn testified that the proposed pay cut between both physicians would have covered $360,000 of a $420,000 cashflow shortfall for Iowa Sleep. Tr. 843:12–843:17. Dr. Zorn said after he fired Dr. Grant, he took a 50% salary reduction himself. Tr. 846:5–846:9.

Dr. Zorn acknowledged that he discussed with his wife the identity of any possible whistleblower who had triggered the CIDs on Iowa Sleep, but he dismissed the idea that it was Dr. Grant because "I gave him 10 percent of the company, and I didn't think that he would try and destroy the company." Tr. 89:12–89:16. Dr. Grant expressly testified that he believed the financial difficulties of Iowa Sleep were a false pretext to terminate him in retaliation for his *qui tam* lawsuit. Tr. 469:3–469:7. This is because he had never been previously informed of any dire financial situation for Iowa Sleep prior to the commencement of the lawsuit. Tr. 451:4–451:9.

Dr. Grant testified at length about his personal circumstances following his termination from Iowa Sleep. He stated that he is obligated to report to the Air Force any change in his employment and his termination made him concerned about this issue. Tr. 474:12–474:17. Termination from previous employers must also be reported to medical credentialing and insurance organizations. Tr. 473:18–473:24.

Dr. Grant then began working overnight shifts in the emergency room at the Veterans' Affairs hospital ("VA"). Tr. 476:23–476:24. He had previously picked up shifts at the VA emergency room prior to his termination from Iowa Sleep. Tr. 541:12–541:14. He needed to pay $11,000 for "tail" coverage insurance because his employment contract with Iowa Sleep did not provide for it.[18] Tr. 477:18–477:25, 545:4–545:13.

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[18] "Tail coverage provides coverage for claims that are first made after the policy period expired, but that are based on

Dr. Grant said he was able to take "as needed" shifts in the VA emergency room but it took approximately two weeks after his termination before he could pick up shifts for other doctors, paid on an hourly basis. Tr. 478:10–478:25, 480:18–480:20. The hours available to Dr. Grant at the VA were variable so he said he felt like he needed to work as many hours as possible because he did not know how many would be available during the following two-week period. Tr. 479:14–479:24. He picked up many of the undesirable shifts—overnights, holidays, weekends—through mid-February before availability tapered off abruptly. Tr. 480:3–480:15. Dr. Grant testified that his take-home pay from his work at the VA was the same as Iowa Sleep. Tr. 542:5–542:7.

As far as working conditions, his work at the VA was predominantly overnight shifts, from 6 pm to 6 am. Tr. 482:12–482:13. Dr. Grant estimated that he worked 30 to 40 percent more hours at the VA than Iowa Sleep due to the unpredictable nature of the available hours. Tr. 482:18–482:22. He estimated that he could match his salary from Iowa Sleep working a standard 80-hour pay period at the VA. Tr. 483:9–483:14. Dr. Grant said he began to exceed his earnings from Iowa Sleep beginning around Thanksgiving 2018. Tr. 483:15–483:18. He rejected the suggestion that Iowa Sleep was merely an 8 to 4:30 job, because

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conduct that occurred prior to the policy's expiration date." *Capson Physicians Ins. Co.* v. *MMIC Ins. Inc.,* 829 F.3d 951, 953 n.3 (8th Cir. 2016).

he was always on call for his patients, and available by phone for the sleep technologists. Tr. 482:2–482:7.

A supervisor at the sleep lab for MercyOne contacted Dr. Grant around March 2019 to assess his interest in working there. Tr. 484:11–484:18. Dr. Grant deferred his start date with MercyOne until June 1, 2019 because he had previously volunteered to deploy to Sicily for the Navy. Tr. 484:21–485:5, 542:13–542:15. Dr. Grant said he earns more money at MercyOne than Iowa Sleep. Tr. 542:16–542:18.

Dr. Grant testified that his termination caused personal pain. He said his marriage suffered due to his odd working hours, high stress, and little sleep. Tr. 486:16–486:20. Dr. Grant spoke about the difficulties with his family including his oldest son. Tr. 486:11–486:14. The security manager at the base was suspicious of Dr. Grant's explanation because his long-term employment ended with an out of the blue termination.[19] Tr. 486:24–487:3. He explained his professional reputation was harmed. Tr. 487:7–487:17. Dr. Grant tried to refute questions he received from some people about his purported unhappiness at Iowa Sleep, which apparently was given as an explanation for his departure. Pl. Ex. 54; Tr. 488:1–488:4.

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[19] Although not addressed by him, the Court notes that Dr. Grant's ability to explain the surrounding circumstances were limited because the *qui tam* complaint was not unsealed by the Court until October 4, 2019. [ECF No. 17].

II. PROCEDURAL HISTORY

Dr. Grant commenced this suit in March 2018 by filing a *qui tam* complaint under seal, as required by the federal False Claims Act (the "Act" or "FCA").[20] [ECF No. 1]; *see* 31 U.S.C § 3730(b)(2) (providing that a complaint by a private party for false claims "shall remain under seal for at least 60 days"). He then filed an amended complaint. [ECF No. 8]. After three extensions, the United States and the State of Iowa both declined to intervene. [ECF No. 15]. The amended complaint was then unsealed by order of the Court. [ECF No. 17]. Dr. Grant amended the complaint two more times and both parties moved for summary judgment. [ECF Nos. 48; 51; 52; 59].

Defendants moved for summary judgment on all counts. [ECF No. 51]. They argued that Plaintiff claims failed because they were based on information publicly disclosed during Medicare audits in 2016 and 2018, so they were forbidden under the "public disclosure bar." *See* 31 U.S.C § 3730(e)(4) (providing a court shall dismiss an action "if substantially the same allegations or transactions as alleged . . . were publicly disclosed" in a variety of public contexts). Defendants sought dismissal of Count III, brought

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[20] The language of both the federal and Iowa False Claims Act are "nearly identical" so the Court will refer to the federal iteration unless a distinction is necessary. *United States ex rel. Thayer v. Planned Parenthood of the Heartland,* 765 F.3d 914, 916 n.l (8th Cir. 2014) (observing "case law interpreting the [federal False Claims Act] also applies to the [Iowa False Claims Act]").

under the Stark Law and the Anti-Kickback Statute ("AKS"), arguing a claim pursuant to the Stark Law could not lie because Iowa CPAP never accepted Medicare or Medicaid patients, the only persons to whom that law applies. They contended that, Plaintiff could not maintain a claim under the AKS because there was no evidence that any payments were made or received for patient referrals.

Plaintiff moved for partial summary judgment. [ECF No. 52]. He argued that he was entitled to judgment as a matter of law under Count I and Count II because there was no disputed material fact. Plaintiff urged that he had established all the elements under the FCA supported by evidence in the record.

The Court issued an order granting Defendants' motion in part, including dismissing Count III of the Third Amended Complaint for violation of the AKS. [ECF No. 90 at 17]. However, the Court allowed Count I, Count II, and Count IV to proceed, holding that summary judgment was not appropriate because there was a dispute of material fact on the scienter element. *Id.* at 14. Plaintiff withdrew his jury demand in March 2021 and the case proceeded to a bench trial. The trial began on January 10, 2022, and concluded on January 14, 2022. [ECF Nos. 94; 126–130].

III. LEGAL ANALYSIS

A. False Claims Acts

The FCA imposes liability on any person who "knowingly presents, or causes to be presented, a false or fraudulent claim [to the government] for payment

or approval." 31 U.S.C. § 3729(a)(1)(A); *Univ. Health Servs., Inc.* v. *United States ex rel. Escobar,* 579 U.S. 176, 190 (2016). The law also applies to anyone who "knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim." 31 U.S.C. § 3729(a)(1)(B). The scope of liability under the Act is broad because it is "intended to reach all types of fraud, without qualification, that might result in financial loss to the Government." *United States v. Neifert-White Co.,* 390 U.S. 228, 232 (1968). This serves the purpose of "protecting the federal fisc by imposing severe penalties on those whose false or fraudulent claims cause the government to pay money." *United States ex rel. Vigil* v. *Nelnet, Inc.,* 639 F.3d 791, 796 (8th Cir. 2011). "The FCA attaches liability, not to the underlying fraudulent activity, but to the claim for payment." *Olson v. Fairview Health Servs. of Minn.,* 831 F.3d 1063, 1070 (8th Cir. 2016) (quoting *Costner v. URS Consultants, Inc.,* 153 F.3d 667, 677 (8th Cir. 1998)).

The FCA provides two avenues for enforcement. "First, the Government itself may bring a civil action against the alleged false claimant." *Vt. Agency of Nat. Res. v. United States ex rel. Stevens,* 529 U.S. 765, 769 (2000). "Second ... a private person (the relator) may bring a *qui tam* civil action 'for the person and for the United States Government' against the alleged false claimant, 'in the name of the Government.'" *Id.* (quoting 31 U.S.C. § 3730(b)(1)). An FCA lawsuit initiated by a private person must be filed *ex parte* and remains sealed for a period of at least sixty days, to

permit the Government to investigate the allegations. 31 U.S.C. § 3730(b)(2). After it completes its investigation, the Government may choose to intervene in the case, and takeover its prosecution, or decline to intervene and the relator may continue the prosecution of the matter. See 31 U.S.C. § 3730 (b),(c). The Government declined to intervene in this case.

To succeed on a claim under the FCA, a relator must show "(1) the defendant made a claim [to the Government]; (2) the claim was false or fraudulent; and (3) the defendant knew the claim was false or fraudulent." *In re Baycol Prods. Litig.,* 732 F.3d 869, 875 (8th Cir. 2013) (citation omitted). The relator bears the burden of proof pertaining to "all essential elements of the cause of action, including damages, by a preponderance of the evidence." 31 U.S.C. § 3731(d).

1. Preliminary Issues

Count III of the Third Amended Complaint alleged violations of the Stark Law and the AKS. The Court dismissed the AKS theory on summary judgment. Despite not seeking relief from this judgment—and the fact Defendants did not litigate the issue further—Plaintiff now asks for a verdict on that claim. The Court will first address the Stark Law claim.

a. Stark Law

Plaintiff argues that Defendants violated the Stark Law by referring patients insured by Medicare from Iowa Sleep to Iowa CPAP. There is little doubt that Iowa Sleep patients in general were heavily steered toward Iowa CPAP. *See, e.g.,,* Pl. Exs. 42 (notifying a patient that their information will be provided to the

CPAP coordinator); 43 (email from Butters describing the referral process for the CPAP coordinator); Tr. 122:17–122:22, 126:5–126:8 (Butters testifying that the "stated goal" of Iowa Sleep was to create referrals for Iowa CPAP). However, even though Iowa CPAP does not accept Medicare insurance, patients covered by Medicare were still initially sent to the CPAP coordinator for a consultation. Tr. 27:17–27:20, 27:25–28:2. The Court heard testimony that Medicare patients were provided the opportunity to pay cash for CPAP equipment. Tr. 28:7–28:11, 256:2–256:9. Dr. Zorn testified that few patients ever paid in cash because it did not make financial sense to have them do so. Tr. 28:13–28:15. He said he reviewed records from 2011 to 2021 and found that 17 patients in total paid cash for a CPAP machine, which was not limited only to Medicare patients. Tr. 28:18–28:21. Plaintiff argues that the Stark Law prohibits a referral arrangement itself, so Iowa Sleep violated the law by sending its Medicare patients to the CPAP coordinator. The question is whether the act of referral to the CPAP coordinator, without purchase of CPAP equipment, violated the Stark Law.[21]

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[21] It was initially unclear whether the Stark Law applied to Tricare claims as well. During her deposition, Barb Zorn acknowledged that Iowa CPAP serviced approximately 18 Tricare patients between 2012 and 2017. BZ Tr. 58:13–60:22. At the conclusion of trial, Defendants' counsel stated their position that Tricare claims could serve as a potential basis for a Stark Law violation. In post-trial briefing, defense counsel acknowledges this statement was wrong and the

The Stark Law prohibits physicians from referring patients to hospitals or other entities in which they have a financial relationship. *United States ex rel. Benaissa v. Trinity Health,* 963 F.3d 733, 737 n.2 (8th Cir. 2020); *see also* 42 U.S.C. § 1395nn(a)(l) (providing that a physician may not refer Medicare patients to an entity for "designated health services" if the referring physician has a nonexempt "financial relationship" with such entity). The goal of the Stark Law is "to address overutilization of services by physicians who stood to profit from referring patients to facilities or entities in which they had a financial interest." *United States ex rel. Drakeford v. Tuomey Healthcare Sys., Inc.,* 675 F.3d 394, 397 (4th Cir. 2012).

Plaintiff urges the Court to find that it "may determine that the fact each and every patient

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Stark Law only applies to Medicare and Medicaid claims. [ECF No. 135 at 7].

The Court agrees that this amended stance is correct. *See* 42 C.F.R. § 411.353(a) ("[A] physician who has a direct or indirect financial relationship with an entity . .. may not make a referral to that entity for the furnishing of [medical services] for which payment otherwise may be made under Medicare."); *Fresenius Med. Care Holdings, Inc. v. Tucker,* 704 F.3d 935, 937 (11th Cir. 2013) (observing that the Stark Law "prohibits physicians from referring their Medicare and Medicaid patients to business entities in which the physicians or their immediate family members have a financial interest."). The 18 Tricare patients which Defendants concede were serviced by Iowa CPAP does not violate the Stark Law.

(including Medicare and Medicaid patients) was automatically referred to Iowa CPAP militates additional damages." [ECF No. 138 at 10–11]. The basis for this assertion is the fact that the Stark Law prohibits referral arrangements by itself. *Id.* Plaintiff does not provide much support for this capacious interpretation of the Stark Law.

The problem with Plaintiff's theory is that the Stark Law does not contain a private right of action. *Benaissa,* 963 F.3d at 737; *Ameritox, Ltd.* v. *Millennium Labs., Inc.,* 803 F.3d 518, 522 (11th Cir. 2015). Rather, a violation of the Stark Law can be pursued by a relator via the FCA. Thus, for a private actor to bring a Stark Law claim, it is insufficient that a potential violation be predicated on the mere referral of a potentially false claim. *Corsello* v. *Lincare, Inc.,* 428 F.3d 1008, 1012 (11th Cir. 2005) (observing "[t]he act of submitting a fraudulent claim to the government is the '*sine qua non* of a False Claims Act violation.'") (quoting *United States ex rel. Clausen v. Lab. Corp. of Am., Inc.,* 290 F.3d 1301, 1311 (11th Cir. 2002)); *see also United States ex rel. Longhi* v. *Lithium Power Techs., Inc.,* 575 F.3d 458, 467 (5th Cir. 2009) ("the [FCA] attaches liability ... to the claim for payment"); *cf. United States ex rel. Parikh v. Citizens Med. Ctr.,* 977 F. Supp. 2d 654, 663 (S.D. Tex. 2013) (noting that compliance with the Stark Law "is a condition of payment for Medicare and Medicaid."). Because Plaintiff has presented no evidence that these claims were presented for reimbursement by Medicare, he cannot prevail on a Stark Law theory.

b. Anti-Kickback Statute (AKS)

In its order on summary judgment, the Court determined that Plaintiff did not advance evidence of an illegal kickback made in connection with a false claim. [ECF No. 90 at 17]. It reasoned that Plaintiff "describes nothing of value received by Dr. Zorn and Iowa Sleep or paid from Iowa CPAP in exchange for specific referrals to the medical equipment entity." *Id.* Although the loans provided from Iowa CPAP to Iowa Sleep assisted Iowa Sleep in covering operating expenses, there was no evidence in the summary judgment record establishing that the loans were provided in return "'for furnishing or arranging' of service referrals." *Id.* (quoting *United States v. Iqbal,* 869 F.3d 627, 630 (8th Cir. 2017)). The Court determined the summary judgment record only described a scheme that advanced Dr. Zorn's own financial interests by generating more revenue for both businesses. *Id.*

Despite the Court's dismissal of his AKS theory, Plaintiff requests a verdict on it anyway. The argument advanced by Plaintiff is that an AKS violation occurred because Iowa Sleep and Iowa CPAP share an employee that is fully paid for by Iowa CPAP—the CPAP coordinator. The CPAP coordinator position is the "kickback," according to Plaintiff, because Iowa Sleep received free "coordinator" services from Iowa CPAP, a service which Plaintiff claims the company would otherwise have to pay for, and Iowa CPAP receives referrals from Iowa Sleep in exchange. Plaintiff interprets the Court's order on summary judgment to preclude an AKS violation

predicated on an FCA violation but not as foreclosing recovery on the AKS as a stand-alone violation. [ECF No. 138 at 12]. He insists that "it would be improper to withhold *damages*" because his evidence at trial established all the elements of an AKS violation. *Id.* at 13 (emphasis in original). He asserts liability can be found pursuant to subsection (b) of the statute which provides, "[w]hoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind." 42 U.S.C. § 1320a-7b(b).

The AKS can only be enforced by private individuals via a *qui tam* lawsuit pursuant to the FCA because the law does not provide its own private right of action. *See, e.g., United States ex rel. King v. Solvay Pharms., Inc.,* 871 F.3d 318, 324 n.1 (5th Cir 2017) ("The AKS provides no private right of action; therefore, a private plaintiff may not sue a health care provider under the AKS alone."); *United States ex rel. Hart* v. *McKesson Corp.,* 15-CV-0903 (RA), 2022 WL 1423476, at *5 (S.D.N.Y. May 5, 2022) (noting "[t]he AKS and FCA work in conjunction to create a private right of action for violation of the federal criminal anti-kickback statute."); *United States* v. *Halifax Hosp. Med. Ctr.,* No. 6:09-cv-1002-Orl-31TBS, 2013 WL 6196562, at *3 n.3 (M.D. Fla. Nov. 26, 2013); *United States ex rel. Dennis* v. *Health Mgmt. Assocs., Inc.,* No. 3:09-cv-00484, 2013 WL 146048, at *10 (M.D. Tenn. Jan. 14, 2013) (noting that AKS does not provide a private right of action). The Court granted summary judgment for Defendants on the AKS issue

and Plaintiff cannot seek damages as a stand-alone violation. Accordingly, the Court declines to rule in Plaintiff's favor on this issue.

c. Public Disclosure Bar

Defendants renew their request to dismiss the claims pursuant to the FCA's public disclosure bar. *See* 31 U.S.C. § 3730(e)(4) (providing for dismissal of an FCA action if the same allegations were publicly disclosed previously under specified circumstances). Defendants renew this request based on their assertion that Dr. Grant testified at trial that he interpreted the two AdvanceMed letters as evidence of fraud by Dr. Zorn. Plaintiff resists, contending that the letters did not assert that Dr. Zorn "knowingly" billed false codes which means the public disclosure bar does not apply.

Among the "restrictions on suits by relators" under the FCA is the public disclosure bar. *State Farm Fire and Cas. Co. v. United States ex rel. Rigsby,* 137 S. Ct. 436, 440 (2016). This prevents "'opportunistic' plaintiffs who 'merely feed off a previous disclosure of fraud.'" *United States* v. *CSL Behring, L.L.C.,* 855 F.3d 935, 941 (8th Cir. 2017) (quoting *United States v. Walgreen Co.,* 846 F.3d 879, 880 (6th Cir. 2017)). The public disclosure bar prevents individual plaintiffs from bringing a *qui tam* complaint based on "information already in the public domain." *Id.* "Dismissal under the public disclosure bar is thus required if (1) the defendant has shown public disclosure under § 3730(e)(4)(A), and (2) the relator does not fit § 3730(e)(4)(B)'s definition of 'original

source.'" *United States ex rel. Paulos* v. *Stryker Corp.,* 762 F.3d 688, 692 (8th Cir. 2014).

In the order on summary judgment, the Court determined that the AdvanceMed letters "did not reveal any indication of *intentional* fraudulent misrepresentations sufficient to disclose his scienter." [ECF No. 90 at 10] (emphasis in original). Without pointing to any specific testimony by Dr. Grant, Defendants posit he testified that he interpreted the letters to be evidence of fraud.

Even with testimony by Dr. Grant to that effect, the AdvanceMed letters would not constitute "the essential elements exposing the transaction[s] as fraudulent." *United States ex rel. Rabushka v. Crane Co.,* 40 F.3d 1509, 1512 (8th Cir. 1994). Rather, on their face, the letters are remedial and merely offer Dr. Zorn and the Iowa Sleep staff additional education. *See* Pl. Ex. 20 (offering "additional education regarding Evaluation and Management (E/M) services"); Pl. Ex. 25 (same). If the letters were intended to accuse Dr. Zorn of intentional fraud, offering additional education would be ineffectual and would not have been done. Any testimony from Dr. Grant regarding whether the AdvanceMed letters indicated fraud on the part of Dr. Zorn certainly blended with his prior knowledge of Dr. Zorn's coding practices. It cannot be said the letters alerted him to the fraud.[22]

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[22] Plaintiff points out in his resistance, at a minimum, Dr. Grant is an original source "'who has knowledge that is independent of and materially adds' to the prior public

2. Definition of Claim under FCA

A "claim" under the FCA includes "any request or demand, whether under a contract or otherwise, for money or property and whether or not the United States has title to the money or property." 31 U.S.C. § 3729(b)(2)(A). Other courts have found that a claim for Medicare payment is a "claim" under the FCA. *See United States v. Mackby,* 261 F.3d 821, 826 (9th Cir. 2001) (noting the parties did not dispute "a claim for Medicare payment is a 'claim' under the FCA"); *United States v. AseraCare, Inc.,* 938 F.3d 1278, 1284 (11th Cir. 2019) (noting that the FCA "serves as a mechanism by which the Government may police noncompliance with Medicare reimbursement standards after payment has been made."). Iowa Sleep and Dr. Zorn submitted thousands of claims to Medicare for payment. *See* Pl. Ex. 14. Neither party disputes that Iowa Sleep and Dr. Zorn submitted claims to Medicare for payment.

3. Falsity of Claims

Plaintiff contends that Dr. Zorn submitted false and/or fraudulent claims for payment when he billed his office visits at a higher code than warranted to increase his own compensation. The E/M codes alleged to be improperly billed are codes 99205, 99204, 99215, and 99214. According to Plaintiff, these codes were false because they did not meet the criteria for the specific codes— under either component- or time-

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disclosure." *Walgreen Co.,* 846 F.3d at 880 (observing that the public-disclosure bar does not apply to an "original source" of the fraud disclosure).

based billing—and many of the services provided by Dr. Zorn were not medically necessary.

Defendants respond that Dr. Zorn could properly bill code 99205 because he satisfied the Guidelines under either the component- or time-based billing method. They assert that the third component, MDM, is the one on which Defendants disagree with Plaintiff or Dr. Suleman. Thus, Defendants argue the basis for whether Dr. Zorn's billing of code 99205 was false, turns on the complexity of his patients. They maintain that the testimony presented at trial belies Plaintiff's argument that the services performed by Dr. Zorn were medically unnecessary. The Court disagrees.

a. False or Fraudulent

The FCA does not define what makes a claim "false" or "fraudulent," *Escobar,* 579 U.S. at 187, but federal courts have recognized different varieties of false claims. *See United States ex rel. Wilkins* v. *United Health Grp., Inc.,* 659 F.3d 295, 305 (3d Cir. 2011) (describing "two categories of false claims under the FCA: a factually false claim and a legally false claim."); *United States ex rel. Lemmon* v. *Envirocare of Utah, Inc.,* 614 F.3d 1163, 1167-69 (10th Cir. 2010). A factually false claim is one in which the claimant misrepresents the goods or services provided. *United States ex rel. Greenfield v. Medco Health Sols., Inc.,* 880 F.3d 89, 94 (3d Cir. 2018); *United States ex rel. Thomas v. Black & Veatch Special Projects Corp.,* 820 F.3d 1162, 1168 (10th Cir. 2016); *Mikes v. Straus,* 274 F.3d 687, 697 (2d Cir. 2001) (noting that a factually false claim is one where a payee submits "an incorrect

description of goods or services provided or a request for reimbursement for goods or services never provided."). Essentially, the facts appearing on the face of a claim must be untrue. *United States ex rel. Druding v. Care Alts.,* 952 F.3d 89, 96 (3d Cir. 2020).

A legally false claim can arise when a person presents a "knowingly false certification of compliance with a regulation or contractual provision as a condition of payment." *United States ex rel. Polukoff v. St. Mark's Hosp.,* 895 F.3d 730, 741 (10th Cir. 2018) (citation omitted). Under a false certification theory, "[a] claim is also false when a person or entity fails to comply with statutory, regulatory, or contractual requirements but certifies that it has complied with them." *Yates v. Pinellas Hematology & Oncology, P.A.,* 21 F.4th 1288, 1299 (11th Cir. 2021); *United States v. Sci. Applications Int'l Corp.,* 626 F.3d 1257, 1266 (D.C. Cir. 2010); *Rodriguez* v. *Our Lady of Lourdes Med. Ctr.,* 552 F.3d 297, 303 (3d Cir. 2008).

False certification on a claim can be express or implied. *Wilkins,* 659 F.3d at 305. Express false certification is contrasted with an implied false certification, where the issue is not whether a payee "made an 'affirmative or express false statement,' but whether, through the act of submitting a claim, a payee knowingly and falsely implied that it was entitled to payment." *Thomas,* 820 F.3d at 1169 (quoting *Lemmon,* 614 F.3d at 1169) (footnote omitted).

b. "Reasonable and Necessary"

The Medicare Act provides "no payment may be made . . . for any expenses incurred for items or services" which "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y(a)(1)(A); *see also id.* § 1320c-5(a)(1) (obligating health care practitioners to provide medical services "economically and only when, and to the extent, medically necessary" when such services are paid for by Medicare). Medical providers seeking payment under the Act must "certify the necessity of the services and, in some instances, recertify the continued need for those services." 42 C.F.R. § 424.10(a) (2013). CMS has defined a "reasonable and necessary" service as one that "meets, but does not exceed, the patient's medical need," and the service must be furnished "in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition . . . in a setting appropriate to the patient's medical needs and condition[.]" CMS, Medicare Program Integrity Manual § 13.5.4 (2019).

Courts have held certification by a medical provider about whether a service or procedure is "reasonable and necessary" can constitute a false claim for FCA purposes, if the provider's determination does not comport with Medicare's definition of what is reasonable and necessary. *Polukoff,* 895 F.3d at 743 (holding "a doctor's certification to the government that a procedure is 'reasonable and necessary' is 'false' under the FCA if the procedure was not reasonable

and necessary under the government's definition of the phrase."); *Druding,* 952 F.3d at 97-98; *United States ex rel. Riley v. St. Luke's Episcopal Hosp.,* 355 F.3d 370, 376 (5th Cir. 2004) (recognizing that "claims for medically unnecessary treatment are actionable under the FCA."). A claim for a medically unnecessary procedure is false "if the opinion is not honestly held, or if it implies the existence of facts—namely, that [the service] is needed to diagnose or treat a medical condition, in accordance with accepted standards of medical practice—that do not exist." *Winter ex rel. United States* v. *Gardens Reg'l Hosp. & Med. Ctr., Inc.,* 953 F.3d 1108, 1119 (9th Cir. 2020), *cert. denied sub nom. RollinsNelson LTC Corp. v. United States ex rel. Winters,* 141 S. Ct. 1380 (2021).

In *Polukoff,* the United States Court of Appeals for the Tenth Circuit held a relator stated a claim under the FCA when he alleged another physician performed unnecessary procedures that were submitted to Medicare for payment. 895 F.3d at 743. The pertinent allegations were: (1) the defendant had performed an unusually large number of surgical procedures; (2) the procedures violated industry guidelines; (3) other physicians had objected to the defendant's practice; (4) an audit uncovered numerous cases where guidelines were violated; and (5) the defendant knew that Medicare would not pay for the procedure for a specific purpose so he represented to the agency that the procedure had been performed for a different medical need. *Id.* These allegations were sufficient to state an express false certification claim. *Id.*

Dr. Suleman and Dr. Grant both testified Dr. Zorn's physical examinations were littered with unnecessary and unperformable services. One example was stomach palpations. Dr. Zorn disagreed with the testimony of Dr. Suleman that stomach palpations are not medically necessary to diagnose sleep issues. Tr. 54:6–54:9. Regardless of the merits, it does not appear that they can even be effectively performed at Iowa Sleep. Testimony established that the exam rooms at Iowa Sleep are approximately eight feet by ten feet. Tr. 58:24–59:2, 442:10–442:12. There is no examination table in the rooms at Iowa Sleep, only a four-foot love seat for the patient. Tr. 59:3–59:11, Tr. 441:11–441:13. The Court credits the testimony of Dr. Suleman regarding stomach palpations which is supported by evidence that they cannot be performed properly within the examination rooms.

Further, iterations of his template reflect Dr. Zorn engaged in review of a plethora of body parts and systems including the skin, joint mobility, heart, speech, gastrointestinal tract, ear, among others. Tr. 57:14–57:15, 58:3–58:18, 59:20–59:23. Even to the untrained observer, Dr. Zorn's recounting of his examinations shows he addressed patently medically unnecessary topics for a visit to a sleep specialist: lactose intolerance, psoriasis, humor-induced loss of consciousness, hallucinations, bleeding issues, side effects from cancer medications, and handwriting difficulties. [23] Tr. 719:25–723:25. For example, a

[23] Dr. Zorn said his handwriting observations come from the administration of the Epworth Sleepiness Scale, which is a

broken leg may make it difficult to sleep, but it is not an appropriate medical issue for a sleep specialist to address.

This conclusion is supported by the fact that the vast majority of the patients at Iowa Sleep were referred by another physician, typically a general practitioner, who is more appropriately suited to address such issues. Dr. Grant and Dr. Zorn testified to this point. Dr. Zorn and Dr. Grant testified that patients are typically referred to sleep specialist because the referring doctor is not entirely comfortable treating the sleep issue. It quite clear that fatigue from pharmaceuticals is not one of those areas. Dr. Zorn said that this extensive of an examination is necessary because "if you don't ask, you don't know. And if you don't know, then you're not a very good physician." Tr. 724:18–724:21.

Dr. Zorn described an exhaustive head to toe examination of a patient which included many services which Dr. Suleman testified as medically unnecessary: pupil examination, possible Parkinson's Disease, abdominal mass, and leg edema. Tr. 726:16–730:9. Dr. Zorn testified that a failure to conduct this type of examination limits a differential diagnosis. Tr. 731:1–731:3. Many of these services were performed on returning patients, leading Dr. Suleman to observe

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series of questions asking a patient to scale their sleepiness in a variety of situations. Tr. 733:8–733:13. Dr. Zorn testified he supplements the Epworth Sleepiness Scale with a series of his own questions verbally. Tr. 734:2–734:10.

that such patients would likely wonder why they were being performed at all. Tr. 283:4–283:5.

However, Medicare regulations clearly require that services performed by providers must be within the scope of their practice. Dr. Zorn expanded examinations far beyond the scope of what is typical of a sleep physician, which included repeating services over and over again. Despite claiming to have performed extensive examinations, Dr. Zorn failed to document much of the services he allegedly performed. On the witness stand, he explained that despite his extensive physical examination of patients, he does not write down every negative result in his letter to a referring physician, so the referred doctor does not get "bored with the letter." Tr. 731:10–731:14, 737:1–737:2. Dr. Zorn opined that the referring physician would get bored because it would include a lot of details which would not be important to them. Tr. 737:3–737:4. He said he does not conduct his examination in a seriatim manner but it is a mixed process as he discusses issues with the patient during the examination. Tr. 732:3–732:7. Simply put, the Court did not find Dr. Zorn credible.

The Court holds Dr. Zorn submitted false claims to Medicare for reimbursement by billing for medical services that were medically unnecessary, beyond the scope of his practice, and unrelated to the treatment of his patient's condition. Unlike Dr. Zorn's testimony, the Court finds on the testimony of Dr. Suleman regarding the lack of necessity for numerous services performed to be credible and persuasive. Secondarily, the Court finds that Dr. Zorn's patients did not

require the level of MDM to bill at the highest levels, a point to which Dr. Suleman also credibly testified. Dr. Alexander largely echoed this opinion that Dr. Zorn's patients were stable. Thus, Dr. Zorn cannot rely on time-based billing because Dr. Alexander testified the necessary CC/C was not documented and his failure to comply with the "reasonable and necessary" requirement inflated the overall time spent with patients.

4. Scienter

Having determined that Dr. Zorn submitted "false" codes under the FCA, the Court must still determine whether he had the requisite scienter to be held liable under the statute. Dr. Zorn argues that, to the extent the billing codes he submitted to Medicare were false, they were the result of complicated and confusing coding Guidelines. In the face of these regulations, Dr. Zorn maintains that he had a reasonable, good-faith interpretation of the Guidelines, which precludes liability.

The Supreme Court has held that the FCA is not "a vehicle for punishing garden-variety breaches of contract or regulatory violations." *Escobar,* 579 U.S. at 194. The Act's scienter requirement is "rigorous" in its application to alleviate "concerns about fair notice and open-ended liability." *Id.* at 192; *see United States ex rel. Schutte v. Supervalu Inc.,* 9 F.4th 455, 463 (7th Cir. 2021) ("The FCA levies significant consequences against parties found liable under the Act and balances the severity of its penalties by carefully circumscribing liability, in part through its scienter

requirement."). Strict enforcement of the scienter element can ensure that innocent interpretive mistakes made in the absence of definitive guidance "are not converted into FCA liability, thereby avoiding the potential due process problems posed by 'penalizing a private party for violating a rule without first providing adequate notice of the substance of the rule.'" *United States ex rel. Purcell v. MWI Corp.,* 807 F.3d 281, 287 (D.C. Cir. 2015) (citation omitted). To this end courts have held, "the FCA does not reach an innocent, good-faith mistake about the meaning of an applicable rule or regulation." *Id.*

Unlike the false or fraudulent element, scienter is defined by the FCA. Knowledge of a false or fraudulent claim can be established by showing actual knowledge, deliberate ignorance of its truth or falsity, or reckless disregard of its truth or falsity. 31 U.S.C. § 3729(b)(1)(A). The Act does not require "proof of specific intent to defraud," but the intent must be "knowing" and it is not sufficient for a person to be merely negligent when presenting a false claim. 31 U.S.C. § 3729(b)(1)(B). The reckless disregard standard "is the lowest scienter threshold under the FCA" which is "tantamount to gross negligence." *Yates,* 21 F.4th at 1303.

A claimant does not "knowingly" submit a false claim is when it reasonably interprets an ambiguous law or regulation. In *United States ex rel. Ketroser v. Mayo Found.,* 729 F.3d 825, 832 (8th Cir. 2013), the Eighth Circuit held that a defendant does not act with the scienter required by the FCA "when 'the defendant's interpretation of the applicable law is a

reasonable interpretation." *Id.* at 832 (quoting *United States ex rel. Hixson* v. *Health Mgmt. Sys., Inc.,* 613 F.3d 1186, 1190 (8th Cir. 2010)). A reasonable interpretation of an ambiguous regulation "belies the scienter necessary to establish a claim of fraud under the FCA." *Id.* The Eighth Circuit later expanded on its holding in *Ketroser,* clarifying that a reasonable interpretation of an ambiguous regulation is not a sweeping rule precluding liability under the FCA. Rather, scienter may still be established if a relator "produces sufficient evidence of government guidance that 'warn[ed] a regulated defendant away from an otherwise reasonable interpretation' of an ambiguous regulation." *United States ex rel. Donegan v. Anesthesia Assocs. of Kansas City, PC,* 833 F.3d 874, 880 (8th Cir. 2016) (quoting *Purcell,* 807 F.3d at 290). In short, "a defendant does not knowingly present a false claim when: (1) the requirement at issue is 'ambiguous'; (2) the defendant acted pursuant to an 'objectively reasonable' interpretation of the requirement; and (3) no formal government guidance warned the defendant away from its interpretation of the requirement." *United States ex rel. Johnson* v. *Golden Gate Nat'l Senior Care L.L.C.,* 223 F. Supp. 3d 882, 891 (D. Minn. 2016) (quoting *Donegan,* 833 F.3d at 878-79).

Defendants' position on scienter is that any up-coding by Dr. Zorn was based on a reasonable interpretation of the Guidelines and a good-faith belief that they were proper requests for payment under the relevant laws and regulations. Dr. Zorn states that he has always believed his patients are

highly complex, thus permitting him to bill at the highest codes. Based on this argument, the determination of whether a patient is "highly complex" or "moderately complex" is inherently ambiguous and entitles them to judgment because Dr. Zorn lacked the necessary scienter.

Dr. Zorn's position at trial regarding AdvanceMed's view on the propriety of his billing was inconsistent. He insists that nearly all of his patients are appropriately billed at the highest level. Yet he claimed that the information in the 2016 AdvanceMed letter—which demonstrated that he was billing at almost exclusively the highest level—was "cherry-picked."

Dr. Zorn's template is very persuasive evidence of his scienter. There is no satisfactory explanation for why his template underwent so many changes, which appears to be a results-oriented purpose for his template. It is especially curious why a template would change so frequently, but still result in the same code for nearly every patient. Dr. Suleman testified that despite the frequent alterations Dr. Zorn made to his template, it does not alter the MDM required for a patient because the MDM is based on the patient's presenting problem and personal characteristics. Tr. 311:8–312:4. In other words, MDM depends on the patient, not the boxes Dr. Zorn checked. Dr. Suleman surmised that Dr. Zorn's physical examinations became more comprehensive after he developed his template because it was much easier and efficient to document an examination by clicking boxes on a template. Tr. 276:24–277:5.

The lack of clarity regarding whether Dr. Zorn's billing was time-based or component-based—Dr. Zorn testified that he used both—only buttresses the conclusion that his billing was ends-oriented. Tr. 883:21–883:22. He was determined to bill at the highest rate, which he almost exclusively did for new patients until 2018, it was only a matter of getting there. *See* Pl. Ex. 14.

Other factors indicating knowing fraud abound. The overutilization of the highest level of reimbursement; the degree to which Dr. Zorn was a billing outlier; duration and pattern of his billing; and falsification of medical records. Tr. 655:7–657:13. Dr. Alexander credibly testified to many of these factors as indicative of fraud. Tr. 648:19–649:3, 652:20–652:24.

For their part, Defendants point out that Dr. Grant had received a letter from Wellmark in January 2018 demanding a refund for up-coding some patient visits. Def. Ex. C. Defendants assert this is evidence that the coding Guidelines are complicated, and Dr. Grant shared in the confusion. Dr. Grant testified that he did not receive coding training during his medical residency, so Dr. Zorn was his subject matter expert on billing. Tr. 381:22–381:24. He said Dr. Zorn observed him interact with patients initially, and instructed him on billing and coding. Tr. 380:24–381:1. Dr. Grant stated that Dr. Zorn's directed him to bill at the highest level supported by documentation based on time. Tr. 381:7–381:14. Dr. Zorn denied that he helped Dr. Grant code at first, assuming he had training on the subject because Dr. Grant had attended high-quality medical education programs.

Tr. 699:18–700:4. The Court finds Dr. Grant credible that any up-coding he billed was a result of inexperience and honest mistake. Crucially, only one such letter addressed to Dr. Grant was submitted in evidence. It is apparent Dr. Grant took the education from Wellmark and adjusted his billing accordingly. Furthermore, unlike for Dr. Zorn, there is not a plethora of other evidence in the record that Dr. Grant was actively working to ascertain how to bill at top levels.

The Court also finds Dr. Zorn had a multitude of "fair warning" he was coding improperly and excessively. He received education letters from a private insurance company, Wellmark. *See* Pl. Exs. 23, 28. Dr. Zorn received similar letters from AdvanceMed. *See* Pl. Exs. 20, 25; *see Schutte,* 9 F.4th at 471 (holding that "authoritative guidance" on interpretive guidelines must "at minimum . . . come from a governmental source."). He explained he hired outside consultants and read books on proper coding but he said none of the outside help illuminated what was causing his coding issues. Tr. 828:4–828:14, 828:15–829:1.

Dr. Zorn's interpretation of the coding Guidelines was not reasonable, demonstrated by the wide disparity between what he coded and what should have been the proper code. The testimony of both expert doctors illustrate this. Defendants' own expert, Dr. Alexander, did not expressly testify that Dr. Zorn was intentionally up-coding but opined he was a poor documenter, in need of education on the subject. Tr. 611:20–611:21, 668:12–668:18. Dr. Alexander also

found that only 1 out of 31 initial patients visits were properly coded at 99205. Def. Ex. S; Tr. 626:12–627:3. Under a time-based billing scenario—presuming Dr. Zorn spent sufficient time on CC/C—Dr. Alexander identified only 6 more patients who met the billing code. Def. Ex. S; Tr. 604:22–605:7.

Dr. Alexander only provided modest support to Dr. Zorn's claim that his patients were highly complex. He presumed that all patients referred to a sleep specialist are of sufficient complexity to warrant a top-level billing. This testimony is undermined in light of the testimony the Court heard from Dr. Suleman, the national statistics, and Dr. Alexander's lack of experience in sleep medicine.

Dr. Suleman did not find any charts which met the billing criteria for code 99205, opining that the charts were up-coded by more than one level. Pl. Ex. 29. To the extent that Dr. Suleman's testimony regarding the sample of charts conflicts with Dr. Alexander, the Court credits the testimony of Dr. Suleman. Dr. Alexander is not a sleep physician whereas Dr. Suleman is a long-term practicing physician in the specialty.

The Court also heard probative circumstantial evidence of scienter, which is often needed to prove intent or knowledge. *See United States v. Smith,* 508 F.3d 861, 867 (8th Cir. 2007) (noting a fact-finder "rarely has direct evidence of a defendant's knowledge, and it is generally established through circumstantial evidence") (citation omitted). One example was apparent "pre-billing" where the front

desk would charge cash-paying patients *before* their office visit. Dr. Grant testified that the amounts reflected in Plaintiff's Exhibit 13, an email sent by Iowa Sleep biller Sharon Jones to the receptionists, conveyed the prices for particular medical codes and testing diagnostics. *See* Pl. Ex. 13; Tr. 393:4–393:16. These prices needed to be shared with those employees because patients without insurance but were expected to pay cash prior to their visit with the provider. Tr. 394:3–394:10.

Another example, and one of the most persuasive pieces of circumstantial evidence of Dr. Zorn's scienter, is the directionality of his purported billing errors. His position throughout this case has been that he billed correctly and, to the extent that he billed erroneously, it was a product of confusion stemming from complicated Guidelines. This is simply unpersuasive.

If Dr. Zorn merely made good-faith interpretive errors, one would expect a scattershot billing history where *some* incorrect billing codes would go against his economic interest, *i.e.,* down-coding rather than up-coding. But his confusion did not manifest in codes that were both over- and under-coded. His coding was remarkably consistent as he coded nearly all of his visits at the highest levels. There was no evidence presented during the trial of that any patient chart was incorrectly coded lower than it should have been. All the coding errors were to Dr. Zorn's and Iowa Sleep's financial benefit. In light of the financial problems experienced by Iowa Sleep, this is particularly illuminating. This implies he was

working backwards, which is to say—his confusion did not arise from what the appropriate code should be, but that his confusion was how could he justify coding at the highest level. His steadfastness that code 99205 is the appropriate billing level for his patients, even in the face of significant evidence to the contrary, is further indication that his goal with the coding consultant was not to find the path to code each patient visit appropriately, but to justify what he thought the appropriate code was for every patient he saw. Tr. 817:1–817:9.

It is difficult to find that his interpretation of the regulations was reasonable when Dr. Zorn continually altered his template and regularly sought coding training. Any coding training would have shown Dr. Zorn evidence similar to what the Court heard—that the highest level coding for sleep patients is quite uncommon. Rather than genuine confusion as to the correct billing codes under the Medicare regulations, the Court finds this was an attempt by Dr. Zorn to retrofit his predetermined billing code into the highest available reimbursement category.

In conclusion, the Court finds Dr. Zorn knowingly submitted false codes to Medicare for reimbursement. It rejects Defendants' claim that Dr. Zorn reasonably interpreted the coding Guidelines and did not have the scienter necessary to violate the FCA. The evidentiary record is rife with examples, such as the countless iterations of his template, of Dr. Zorn attempting to work backwards into being able to code at the highest levels. This is not a situation where an FCA defendant "take[s] advantage of a disputed legal

question." *Hagood v. Sonoma Cnty. Water Agency,* 81 F.3d 1465, 1478 (9th Cir. 1996), or that "the relevant legal question was unresolved," *Hixson,* 613 F.3d at 1190. Culpable scienter is supported by the expert testimony of Dr. Suleman and Dr. Alexander—whose audits demonstrate the vast disparity between appropriate coding and Dr. Zorn's coding—and broad circumstantial evidence of Dr. Zorn's intent. The Court finds Defendants liable under the FCA (both state and federal) for submitting false claims to Medicare. *See United States v. Advance Tool Co.,* 902 F. Supp. 1011, 1016 n.4 (W.D. Mo. 1995) ("Corporate officers are liable, in their individual capacity, under the FCA if they knowingly make false claims for payment to the United States on behalf of the corporation."); *United States ex rel. Drummond* v. *BestCare Lab'y Servs., L.L.C.,* 950 F.3d 277, 284 (5th Cir. 2020) (finding it is not necessary to "pierce the corporate veil" because the FCA allows an individual to be held personally liable.).

5. Materiality

"The False Claims Act is not 'an all-purpose antifraud statute." *Escobar,* 579 U.S. at 194 (quoting *Allison Engine Co. v. United States ex rel. Sanders,* 553 U.S. 662, 672 (2008)). Materiality "cannot be found where noncompliance is minor or insubstantial." *Id.* A relator must show "the defendant knowingly violated a requirement that the defendant knows is material to the Government's payment decision." *Escobar,* 579 U.S. at 181. The FCA defines materiality as "having a natural tendency to influence, or be capable of influencing, the payment or

receipt of money or property." 31 U.S.C. § 3729(b)(4). "[P]roof of materiality can include, but is not necessarily limited to, evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement." *Escobar,* 579 U.S. at 194–95; *Yates,* 21 F.4th at 1300 (describing other relevant factors for materiality such as whether the matter is an express condition to payment; it has an effect on the governmental entity if it were aware of the misrepresentation; and "whether the misrepresentations went to the essence of the bargain.").

Defendants do not dispute any assertion that the coding of patient visits is material to the Government's payment decision. The specific level of code certainly goes to "the essence of the bargain" because the Government determines the level of reimbursement for the medical provider depending on the services provided to the Medicare-insured patient. The AdvanceMed letters are clear evidence that the Government considers a proper coding level to be an express condition to reimbursement of a certain amount. *See* Pl. Exs. 20; 25.

6. Damages

The FCA calculates damages in the following manner: (1) actual loss to the Government trebled; (2) a civil penalty per false claim; and (3) reasonable attorneys' fees and costs. 31 U.S.C. §§ 3729; 3730. Damages do not need to be proven to establish a

violation of the FCA. *See United States* v. *Rivera,* 55 F.3d 703, 709 (1st Cir. 1995) (explaining that the statute's "focus on the claim for payment appears to reflect a congressional judgment that fraud by government contractors is best prevented by attacking the activity that presents the risk of wrongful payment, and not by waiting until the public fisc is actually damaged."); *Hagood,* 929 F.2d at 1421; *United States* v. *Killough,* 848 F.2d 1523, 1533–34 (11th Cir. 1988); *United States ex rel. Watson v. Connecticut Gen. Life Ins. Co.,* 87 Fed. App'x 257, 260 (3d Cir. 2004).

In addition to treble damages, FCA violators are liable for a mandatory civil penalty for each false claim. *See* 31 U.S.C. § 3729(a)(1). The Act specifies the civil penalty range from not less than $5,000.00 to not more than $10,000.00. *Id.* For violations occurring after November 2, 2015, all civil penalties under the FCA are subject to an annual adjustment for inflation pursuant to Section 701 of the Bipartisan Budget Act of 2015. Pub. L. No. 114-74, § 701, 129 Stat. 584, 599-600 (2015). The adjusted range for penalties assessed after May 9, 2022 is $12,537.00 to $25,076.00 per false claim. 28 C.F.R. § 85.5.

In his post-trial brief, Dr. Grant asserts that Dr. Zorn submitted at least 4,311 false claims to state and federal payors. [ECF No. 136 at 13]. He arrives at this amount through two assertions. First, he contends that the Court can properly extrapolate this amount from the sample of 31 patients encounters coded 99205 in Defendants' Exhibit R. *Id.* at 13–16. Second, he argues that Dr. Zorn also falsely billed codes 99215,

99214, and 99204, in addition to the charts coded 99205, as reflected in the sample. *Id.* at 18–20.

Additionally, Dr. Grant argues that every false claim submitted resulted in a 100% loss to the Government. This results in the entire reimbursement rate for each false claim being counted as the actual loss to the Government. Dr. Grant calculates the total actual loss to the Government as $664,476.38. *Id.* at 21–23. Trebled, this amount totals $1,993,429.14. *Id.* at 23. Dr. Grant's proposed civil penalty range is $54,047,007.00-$ 108,102,636.00.

Defendants resist Dr. Grant's damages proposal on several fronts. First, they claim that the sample of 31 patient visits coded 99205 cannot be properly extrapolated. Second, Defendants insist that they cannot be held liable for patient visits coded 99204, 99214, and 99215 because there was no expert testimony on the propriety of any of those charts. Third, they argue that Dr. Grant did not offer any evidence on reimbursement rates for Tricare or Iowa Medicaid reimbursement rates for the years 2011-2012 and 2016-2020 and therefore did not provide an adequate factual basis for this extrapolation. And finally, Defendants challenge Dr. Grant's assertion that actual loss to the Government was 100 percent for each false claim. The Court will address each argument in turn.

a. Extrapolation

During the discovery phase of this case, Defendants expressed an objection about producing all the medical files requested by Dr. Grant's counsel.

Asserting that such a request was overly burdensome, the parties apparently worked out an agreement to a representative sample of 31 patient charts, all coded 99205, which were to be randomly and systematically selected.

i. D. Richard Ten Braak's Testimony

D. Richard Ten Braak, a certified public accountant, was retained by Defendants to systematically sample 31 patient charts. Tr. 746:13–746:14, 746:21–746:23. He explained that the population of patient files was provided by defense counsel in list form. *See* Pl. Ex. 31. Ten Braak then highlighted a patient chart at an interval of every 38th item from a starting point chosen by a random number generator. Tr. 747:21–747:25, 748:4–748:7. He testified that he did not conduct any calculations or analysis regarding the statistical significance or relevance of 31 charts to the sample size. Tr. 748:16–748:19. Ten Braak disclaimed any opinion on whether the sample size was adequate. He testified that he was not provided the information required to determine an adequate sample size, specifically expected error rate and desired confidence level. Tr. 763:1–763:6. In response to further questioning by Dr. Grant's counsel, Ten Braak steadfastly maintained he did not have enough information about the population to know whether 31 charts was sufficient to extrapolate to the entire population. Tr. 765:5–765:12. He stated that he was simply asked to obtain an unbiased, random sample but was not provided the parameters for a statistically valid random sample. Tr. 768:4–768:10.

ii. Ted Lodden's Testimony

Dr. Grant called Ted Lodden, also a certified public accountant, to testify about whether extrapolation from the sample of the 31 patient charts was statistically appropriate. Tr. 935:11. He defined statistical sampling as testing for characteristics in a population. Tr. 936:14–936:15. Lodden said he reviewed the sample chosen by Ten Braak, reviewed the reports by Dr. Alexander and Dr. Suleman, and reviewed the AdvanceMed letters. Tr. 937:6–937:12. He testified that the entire population on which Ten Braak drew the sample were all 99205 codes by Dr. Zorn billed to governmental payors. Tr. 938:10–938:20.

According to Lodden, the results from the 31 patient charts could be projected across the sample. Tr. 939:8–939:11. He added that 30 is a common sample size for a population of 1000. Tr. 939:15–939:17. Lodden based his opinion on Dr. Alexander and Dr. Suleman's review and on AdvanceMed's letters finding that much more variety would be expected. Tr. 939:20–939:25. He determined that conclusions can appropriately be drawn from the population sample in light of these facts. Tr. 940:1–940:3. Lodden testified that a statistically valid random sample is necessary for extrapolation if the extrapolation was intended to do a projection of some kind, but he added that conclusions can also be drawn from random systematic sampling. Tr. 944:19–944:23. He acknowledged that he did not have access to more than 31 charts so he was unable to draw a statistically valid random sample from the total charts. Tr.

946:17–946:19. Lodden said he does not know the proper margin of error or appropriate confidence level for this population of patient charts, but he did not believe it is necessary in this case. Tr. 946:24–947:1, 947:16–947:23. He said that controlling for such variables is less important in a situation like this because the set of data is homogenous. Tr. 949:25–950:2. Lodden concluded that he feels confident to a reasonable degree of certainty that conclusions can be drawn from the sample relative to the population. Tr. 950:7–950:22.

"Courts have routinely endorsed sampling and extrapolation as a viable method of proving damages in cases involving Medicare and Medicaid overpayments where a claim-by-claim review is not practical." *United States* v. *Fadul,* No. DKC 11-0385, 2013 WL 781614, at *14 (D. Md. Feb. 28, 2013) (collecting cases). The United States Court of Appeals for the District of Columbia Circuit has found it is permissible for Medicare itself to determine overpayments based on extrapolation from a sample audit. *Chaves Cnty. Home Health Serv.* v. *Sullivan,* 931 F.2d 914, 916-17 (D.C. Cir. 1991).

Defendants object to the Court using extrapolation of the sample, arguing that Lodden failed to perform any calculations regarding statistical validity, rendering his opinion speculative. To support this contention, they rely on *United States ex rel. Loughren v. UnumProvident Corp.,* 604 F. Supp. 2d 259 (D. Mass. 2009) and *United States ex rel. Jackson v. DePaul Health Sys.,* 454 F. Supp. 3d 481 (E.D. Pa. 2020). Both cases are distinguishable. Particularly,

they are distinguishable on the procedural posture where the expert evidence was sought to be excluded prior to a jury trial and their analysis entailed more complex methodology. *Jackson,* 454 F. Supp. 3d at 490; *Loughren,* 604 F. Supp. 2d at 260. The Court is the fact-finder in this case and holds that Lodden's testimony was valid and reliable. *See In re Zurn Pex Plumbing Prods. Liab. Litig.,* 644 F.3d 604, 613 (8th Cir. 2011) (finding "[t]here is less need for the gatekeeper to keep the gate when the gatekeeper is keeping the gate only for himself.") (citation omitted).

b. Damages analysis

Although the 31 chart sample evaluated by Dr. Suleman and Dr. Alexander consisted only of patient visits coded 99205, Dr. Grant asserts that the Court should find that *all* patient visits coded 99215, 99214, and 99204 were also false claims. His argument unfolds by asserting that Dr. Zorn could not meet either time or medical complexity requirements to bill at such levels for any of the codes. However, Dr. Grant is standing in the shoes of the Government as a relator in this *qui tam* action. Thus, he is "required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence." 31 U.S.C. § 3731(c). The Court finds that he has failed to do so as it relates to codes 99215, 99214, and 99204. Not a single patient chart coded with those three codes was introduced into evidence. Although the Court has found that extrapolation from the 31 chart sample is appropriate for charts coded 99205, extrapolation is not warranted for entirely different

codes, where no patient charts were ever examined by any expert witness.

Dr. Grant's counsel argued at trial that the limited universe of patient charts was a compromise proposed by defense counsel to avoid a burdensome production. But the narrowness of the sample limits the Court's fact-finding ability. In his post-trial briefing, Dr. Grant correctly points out that supplementing incomplete production is mandatory under the Federal Rules of Civil Procedure. An adverse inference or sanctions can result from a failure to do so. *See Smith v. United States,* 128 F. Supp. 2d 1227, 1232 (E.D. Ark. 2000) (adverse inference); *Books Are Fun, Ltd.* v. *Rosebrough,* 239 F.R.D. 532, 551 (S.D. Iowa 2007) (sanctions). However, the adverse inference or sanctions sought by Dr. Grant here is staggering. He seeks a damages verdict in the amount of $50 to $100 million predicated on patient visits on which no evidence was introduced at trial.

Defendants describe Dr. Grant's position on this issue as a procedurally improper means to request discovery sanctions under Federal Rule of Civil Procedure 37. [ECF No. 135 at 5]. This argument has some validity to it. *See Long* v. *Howard Univ.,* 561 F. Supp. 2d 85, 91 (D.D.C. 2008) (discussing that Rule 37(c)(1) for discovery sanctions "does not establish any express time limits within which a motion for sanctions must be filed, [but] unreasonable delay may render such a motion untimely."). Plaintiff had an option of moving for the Court's intervention regarding Dr. Zorn's discovery failures. He opted not to do so.

Furthermore, the Court is not persuaded on this record that falsity or scienter would be proven with respect to the other codes. Dr. Suleman testified that he also bills most of his patients at code 99204. Tr. 356:10–356:12. Although the Court finds that Dr. Zorn acted with reckless disregard in coding nearly all his new patients at 99205, the necessary scienter is much less clear on lower coded visits. The Court does not have the benefit of any expert testimony on these codes either.

To compensate for the lack of direct evidence of falsity on codes 92215, 99214, and 99204, Dr. Grant relies on evidence of the issue of up-scoring sleep studies. At trial, the Court heard extensive evidence regarding allegations that Dr. Zorn would alter the score on patient's sleep studies. Specifically, the allegation is that he would re-score sleep studies which fell just below an AHI of 5 to make the patient eligible for CPAP therapy. Among the testimony the Court heard regarding "up-scoring" of sleep studies included the destruction of previous sleep study records. Numerous former Iowa Sleep employees testified that Dr. Zorn frequently altered or destroyed medical records. Tr. 174:15–174:19 (Stacie Baker), 184:20–185:5 (Victoria Richmond), 222:2–223:16 (Audrean Barton), 244:21–245:13 (Sonia Naber).

In their first motion in limine, Defendants sought to exclude evidence of up-scoring on the basis that it was irrelevant. [ECF No. 80-1 at 3–4]. Dr. Grant resisted the motion to exclude the evidence, asserting it was relevant and accurately pled. [ECF No. 82 at 5–7]. The Court admitted the evidence at least for purposes of

Rule 404(b) and requested post-trial briefing from the parties regarding whether the evidence could be considered as direct evidence of up-coding.

The Court finds that the evidence of up-scoring, and the attendant allegations of destroying and/or altering medical records, is credible as Rule 404(b) evidence. *See* Fed. R. Evid. 404(b)(2) (permitting evidence of other crimes, wrongs, or acts to prove "motive, opportunity, intent, preparation, plan, knowledge, identity, absence of mistake, or lack of accident."). Several former Iowa Sleep employees testified that Dr. Zorn would alter sleep study records in order to qualify a patient for a CPAP machine. This is consistent with other evidence tending to show that Dr. Zorn would up-code his patient visits, all with the goal of increasing his overall financial compensation. However, even if considered as direct evidence, this is insufficient to meet Dr. Grant's burden on codes 92215, 99214, and 99204.

c. Damages calculation

FCA damages are "liberally calculated to ensure that they 'afford the government complete indemnity for the injuries done it.'" *United States ex rel. Compton v. Midwest Specialties, Inc.,* 142 F.3d 296, 304 (6th Cir. 1998) (quoting *United States ex rel. Marcus v. Hess,* 317 U.S. 537, 549 (1943)). This calculation need not be with mathematical precision but there must be "some reasonable basis on which to estimate damages." *United States ex rel. Landis v. Tailwind Sports Corp.,* Case No. 10-cv-00976 (CRC) 2017 WL 5905509, at *5 (D.D.C. Nov. 28, 2017) (quoting *Hill v.*

Republic of Iraq, 328 F.3d 680, 684 (D.C. Cir. 2003)). This is because the speculative character to imprecise damages accounts "for the fact that the defendants' own misconduct has foreclosed any exact calculation of" damages. *United States ex rel. Miller* v. *Bill Harbert Int'l Const., Inc.,* 608 F.3d 871, 905 (D.C. Cir. 2010).

"[T]here is no set formula for determining the government's actual damages because 'fraudulent interference with the government's activities damages the government in numerous ways that vary from case to case.'" in an FCA case. *Yates,* 21 F.4th at 1304 (quoting *Killough,* 848 F.2d at 1532) (internal alterations omitted). Damages are measured "by the amount of money the government paid by reason of the false statement above what it would have paid absent the false statement." *United States ex rel. Harrison v. Westinghouse Savannah River Co.,* 352 F.3d 908, 922 (4th Cir. 2003); *United States* v. *Peters,* 927 F. Supp. 363, 368 (D. Neb. 1996) ("The measure of actual damages is determined by the amount paid due to the false claim minus the amount paid had the claim been truthful.").

i. Number of false claims

Based on the foregoing discussion, the Court finds that only code 99205 claims are false. The number of false claims will have to be calculated on an estimated basis. Defendants urge the Court to disregard Dr. Suleman's opinions on the accuracy of Dr. Zorn's coding. They argue that Dr. Suleman "arrived at his opinions by simply inputting information from each of

the 31 charts into the first free internet calculator he found." [ECF No. 137 at 13]. Defendants also complain that Dr. Suleman did not credit Dr. Zorn for any time-based billing prior to May 2016.

Dr. Zorn's own expert, Dr. Alexander found that only 1 out of the 31 (3%) initial visits for new patients were correctly coded if using component-based billing. Def. Ex. S.; Tr. 626:12–627:3. That number rose to 7 out of 31 charts (22.6%) if Dr. Zorn used component- or time-based billing. But Dr. Alexander did not testify that it was documented, or apparent from the records that sufficient time was spent on CC/C. Tr. 604:22–605:7. Dr. Suleman did not find any charts which met the billing criteria for code 99205. Pl. Ex. 29; Tr. 265:24–266:7, 266:14–266:18. Medicare publishes statistics that reflect that sleep physicians bill code 99205 approximately 13% of the time nationwide. Tr. 292:2–292:6.

Relying on this, the Court finds that a fair and reasonable estimate of the proportion of false 99205 codes billed to Medicare is 90%.[24] The Court rejects Defendants' request to disregard Dr. Suleman's opinion. His testimony at trial was persuasive and convincing. Dr. Suleman is himself a sleep physician and the assertion that he merely entered information into a calculator to ascertain the correct code is a mischaracterization of his testimony. Although Dr.

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[24] The Court finds that a falsity rate slightly above the national average is appropriate in light of the testimony and evidence that none of Dr. Zorn's patient charts satisfied the requirements of code 99205.

Suleman found no patient charts satisfied the requirements for code 99205, the Court finds it would be inaccurate to find that none of Dr. Zorn's patients could be properly coded at 99205 in light of Medicare's statistics that over 10% of sleep physicians bill at that code.

Furthermore, Dr. Zorn's contention that he should be credited for time-based billing is unpersuasive. Dr. Alexander, Dr. Zorn's own expert, testified that Dr. Zorn's documentation was inadequate to support time-based billing. And the Court discussed earlier the dubious medical necessity of many of the services provided during Dr. Zorn's patient visits. The Court's decision is further bolstered by Dr. Zorn's altering of medical records and persistent up-coding of other services. His pervasive misconduct does not earn any inferences in his favor.

In his post-trial briefing, Dr. Grant estimated that approximately 19.7% of Dr. Zorn's billings were to public payors. [ECF No. 136 at 16–17]. Defendants do not dispute this estimate. The Court believes it to be accurate and fair after reviewing the underlying materials. This percentage is based on a total of 1,167 code 99205 billed to Medicare, Medicaid, and Tricare out of 5,915 total bills. *Id.* Defendants never contest this number beyond a general objection to the appropriateness of extrapolation. Therefore, the Court finds that Dr. Zorn submitted 1,050 (1,167 codes x 90% falsity) false billings coded 99205. This amount breaks out to 230 false claims to Medicaid; 764 false claims to Medicare; and 56 false claims to Tricare under the uncontested evidence.

ii. Damage per false claim

The Court must next determine the amount of damages to the Government per false claim. Dr. Grant's request for damages of 100 percent for each false claim is incorrect as a matter of law because Dr. Zorn provided some covered medical services. *Yates,* 21 F.4th at 1304 ("[I]n the context of Medicare claims . . . courts have measured damages as the difference between what the government paid and what it would have paid had the defendant's claim been truthful and accurate."); *cf. Drakeford,* 792 F.3d at 386 (finding a defendant was not entitled to a calculation of damages based on the difference in value of services because "[t]he Stark Law prohibits the government from paying *any* amount of money for claims submitted in violation of the law.").

Rather, the damage per false claim will be calculated based on what the Government would have paid if Dr. Zorn had billed correctly, relying on Dr. Suleman's review as a basis. The Court has reproduced a table of the 31 chart sample demonstrating that Medicare overpaid Dr. Zorn approximately $113 per false claim.[25] *See* Appendix A. The Court will apply this average overpayment to the total false Medicare claims for a total of $86,332.00 ($113 x 764 false claims). This amount is trebled for a total $258,996.00.

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[25] This amount is derived from the difference between Dr. Zorn's billed code and the code assessed by Dr. Suleman in his review.

However, Dr. Grant does not offer evidence on reimbursement rates for Tricare or Medicaid for the years 2011-2012 or 2016-2020. Defendants' Exhibit P reflects a payment amount to Medicaid for code 99205 of $143.89 in 2014 and 2015. Def. Ex. P. There does not appear to be a basis to determine the Medicaid reimbursement rates for other E/M codes to calculate the difference. The Court does not find, and the parties do not highlight, evidence on reimbursement rates for Tricare at all. The Court will not assess any damages amount for the false Medicaid or Tricare claims in the absence of this evidence. Those claims, however, are still subject to the mandatory civil penalty provision of the Act.

iii. Civil Penalties

For the statutory civil penalty, the fine range differs depending on when the false claim was submitted. For violations occurring after November 2, 2015 but assessed after May 9, 2022 is $12,537 to $25,076 per false claim. 28 C.F.R. § 85.5. Dr. Grant does not distinguish between when the claims were submitted in his briefing, simply applying the higher civil penalty to all false claims, even those submitted from 2011-2015.[26] [ECF No. 136 at 22]. Iowa law provides that the civil penalty for false claims under Medicaid track the federal FCA. *See* Iowa Code section 685.2.

Dr. Grant estimates that Dr. Zorn billed code 99205 to Medicare, Medicaid, and Tricare 806 times between

[26] Because the inflation adjustment goes into effect on November 1, 2015, the Court will consider all claims in 2015 under the reduced civil penalty.

2011-2015. Applying the Court's 90% falsity rate, this totals 725 false claims. For the years 2016-2018, the code 99205 was bill to government payors 361 times. The estimated number of false claims is 325. There is little statutory direction on where within the range the civil penalty should be assessed. The Court will apply the lowest end of the range. The civil penalty calculation for false claims is as follows:

2011-2015: $5,000 x (725 false claims) = $3,625,000.00

2015-2018: $12,537 x (325 false claims) = $4,074,525.00

Based on the record before the Court, the aforementioned reasoning yields the following breakdown for damages:

Trebled Damages: $258,996.00

Total Civil Penalty: $7,699,525.00

Total FCA Damages: $7,958,521.00

d. Excessive Fines Clause

Defendants argue that the treble damages and statutory penalties sought by Dr. Grant are excessive under the Eighth Amendment's Excessive Fines Clause. [ECF No. 137 at 14]. Dr. Grant responds that Dr. Zorn engaged in a broad scheme to defraud the government, thus a higher penalty is warranted. [ECF No. 138 at 9].

The Eighth Amendment provides that: "[e]xcessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted." U.S. Const., amend. VIII. The Excessive Fines Clause

"limits the government's power to extract payments, whether in cash or in kind, 'as punishment for some offense.'" *United States* v. *Bajakajian,* 524 U.S. 321, 328 (1998) (citation omitted). The clause applies only to "'fines," which means "payment[s] to a sovereign as punishment for some offense." *Id.* at 327.

The Supreme Court has held the FCA's civil penalties are "essentially punitive in nature." *Stevens,* 529 U.S. at 784. But the Court has not directly addressed whether the Excessive Fines Clause applies to a non-intervened FCA *qui tam* action. *See Browning-Ferris Indus. of Vt., Inc. v. Kelco Disposal, Inc.,* 492 U.S. 257, 259 n.1 (1989) (leaving open the question whether a *qui tam* action implicates the Excessive Fines Clause); *Austin v. United States,* 509 U.S. 602, 607 n.3 (1993) (finding the question left open in *Browning-Ferris* to be inapplicable because the United States intervened in that case). The Eighth Circuit has noted, in dicta, "that FCA penalties are punitive in nature and therefore fall within the reach of the Excessive Fines Clause," when the government does not intervene. *Hays v. Hoffman,* 325 F.3d 982, 992 (8th Cir. 2003). The United States Court of Appeals for the Eleventh Circuit has found that damages in a non-intervened *qui tam* FCA action are a "fine" under the Eighth Amendment and a fine imposed by the government. *Yates,* 21 F.4th at 1307.

The *Yates* court described several persuasive reasons why the monetary damages under the FCA are a fine under the Eighth Amendment. First, a relator is vindicating the injuries of the United States (and potentially of the relevant state, in this case,

Iowa). The protection of the public fisc is the duty of the government and "[t]he FCA's *qui tam* provisions merely grant the United States the flexibility to do so effectively through an avatar in litigation." *Id.* at 1310. Second, the Government retains significant control even in actions where it declines to intervene. This includes a right to intervene during the action itself, or to settle the action with court approval. *Id.* at 1310-11; 31 U.S.C. § 3730(c)(3), (c)(2)(B). A relator cannot dismiss a *qui tam* action unless the Government consents in writing. *Yates,* 21 F.4th at 1311; § 3730(b)(1). Third, the Government receives "the lion's share of the monetary award." *Yates,* 21 F.4th at 1311 (citing 31 U.S.C. § 3730(d)(2)).

The court in *Yates* noted that this level of control retained by the Government is why several circuits have found that federal FCA *qui tam* actions do not violate the Take Care Clause of Article II, the principle of separation of powers, or the Eleventh Amendment. *Id.* at 1312 (collecting cases). This analysis, in conjunction with Eighth Circuit case law finding that FCA penalties fall within the Excessive Fines Clause when the Government does intervene in the action, persuades the Court that an Excessive Fines Clause analysis should apply here.

i. Excessive Fines Clause analysis

"The touchstone of the constitutional inquiry under the Excessive Fines Clause is the principle of proportionality: The amount of the forfeiture must bear some relationship to the gravity of the offense that it is designed to punish." *Bajakajian,* 524 U.S. at

334. The Eighth Circuit has applied the Due Process Clause's test for punitive damages when determining if FCA penalties are grossly excessive. Under this rule, "[p[unitive damages are grossly excessive if they 'shock the conscience' of the court or 'demonstrate passion or prejudice on the part of the trier of fact.'" *May* v. *Nationwide Mortg.,* LLC, 852 F.3d 806, 815 (8th Cir. 2017) (quoting *Ondrisek* v. *Hoffman,* 698 F.3d 1020, 1028 (8th Cir. 2012)).

In *United States v. Aleff*, 772 F.3d 508 (8th Cir. 2014), the Eighth Circuit found a treble damages award for an FCA claim was not grossly disproportionate. *Id.* at 512. The *Aleff* court considered a variety of factors such as the reprehensibility of the defendant's conduct; the relationship between the penalty and the harm to the victim; and the sanctions in other cases for comparable misconduct, legislative intent, and defendant's ability to pay. *Aleff 772* F.3d at 512 (internal citations omitted). The defendants were assessed a $1.3 million penalty for a "scheme to defraud the government [which] spanned two states and more than six years." *Id.* at 512-13. Because the United States had to bear costs related to investigating the fraud and suffered damage to the integrity of a loan deficiency program, the *Aleff* court found that a judgment of 4.3 times the actual damages, in that case $303,890, was not an unconstitutionally excessive fine. *Id.* at 513.

Dr. Grant argues courts have rejected requests to reduce a statutory civil penalty by pointing to out-of-circuit authority to support the proposition. [ECF No.

138 at 8 n.4]. These cases appear to be distinguishable. *See United States ex rel. Drakeford* v. *Tuomey,* 976 F. Supp. 2d 776, 793 (D. S.C. 2013) (questioning whether the treble damages provision was punitive or "a substitute for consequential damages"); *Advance Tool Co.,* 902 F. Supp at 1018 (declining to impose a $3.43 million civil penalty as unconstitutionally excessive but entering a civil penalty of $365,000).

In *Drakeford,* the court declined to reduce a civil penalty of $119 million after a jury found the defendant liable for $39 million in compensatory damages. 976 F. Supp. 2d at 792-93. On appeal, the United States Court of Appeals for the Fourth Circuit found that the $119 million civil penalty was indeed punitive and the treble damages were a "hybrid of compensatory and punitive damages." *Drakeford,* 792 F.3d at 389. The ratio of punitive to compensatory damages was "approximately 3.6-to-1" in that case, "fall[ing] just under the ratio" the Supreme Court "deems constitutionally suspect." *Id.* (footnote omitted).

The court in *Advance Tool* found that $3.43 million in civil penalties would be excessive under the Eighth Amendment. 902 F. Supp. 1011. The court there based its determination on the "Plaintiff's inability to prove actual damages at trial, the government's poor investigative procedures, and its confusing regulatory and contractual purchasing arrangements." *Id.* at 1018. It did find that a civil penalty of $5,000 per claim for a total amount of $365,000 in civil penalties

did not violate the Excessive Fines Clause. *Id.* at 1018-19.

A fact-finder has "considerable flexibility in determining the level of punitive damages." *Ondrisek,* 698 F.3d at 1028 (citation omitted). In finding substantial punitive penalties proper for Medicare and Medicaid fraud, courts have noted that "[f]raudulent claims make the administration of Medicare more difficult, and widespread fraud would undermine public confidence in the system." *Mackby,* 339 F.3d at 1019. A large monetary award also serves as a deterrent for other would-be fraudsters. *United States ex. rel. Bunk v. Gosselin World Wide Moving, N.V.,* 741 F.3d 390, 409 (4th Cir. 2013) (considering an "award's deterrent effect on the defendant and on others" when conducting a disproportionality analysis).

However, the Supreme Court has invalidated punitive damages awards which far outpace actual damages. *See State Farm Mut. Auto. Ins. Co. v. Campbell,* 538 U.S. 408, 429 (2003) (holding a punitive damages award of 145 times the compensatory damages was "neither reasonable nor proportionate to the wrong committed."); *BMW of N. Am., Inc. v. Gore,* 517 U.S. 559, 582 (1996) (reversing a punitive damages award of 500 times actual damages). The Eighth Circuit has held some punitive damages awards with double digit ratios are permissible. *See Adeli v. Silverstar Auto., Inc.,* 960 F.3d 452, 462-63 (8th Cir. 2020) (24.75 to 1 ratio); *Grabinski v. Blue Springs Ford Sales, Inc.,* 203 F.3d 1024, 1026 (8th Cir. 2000) (27:1); *but see Quigley* v.

Winter, 598 F.3d 938, 955 (8th Cir. 2010) (affirming a district court's determination that a punitive damage award of 18 times compensatory damages was excessive).

The calculated damages above, a civil penalty of $7,699,525.00 based on $258,996.00 in actual damages renders a multiplier of 29.7. This is above previously permitted multipliers under relevant precedent and the Court will reduce the overall award to align with case law. However, the Court finds that a large multiplier—25 times the actual damages—is appropriate. This calculates to a total civil penalty of $6,474,900.00. This is a significant penalty which the Court believes reflects the appropriate proportionality in light of Dr. Zorn's conduct discussed herein. *Campbell,* 538 U.S. at 419 (when examining reprehensibility of conduct, the court must consider whether the harm "was the result of intentional malice, trickery, or deceit, or mere accident.").

The Court also finds that the deterrent effect of such a penalty is especially important given the asymmetrical nature of information between the medical provider and the government payor. The Government does not have the access to information or the resources to ensure that medical providers are billing it properly. It is required to rely on audits and the integrity of medical providers. A significant penalty serves to deter for those contemplating similar conduct.

B. Wrongful Discharge

In addition to his *qui tam* complaint, Dr. Grant brings a claim for wrongful discharge against Iowa Sleep. He contends that Iowa Sleep retaliated against him for reporting potential FCA violations to the Government. [ECF No. 136 at 27]. Defendants dispute this interpretation, arguing that Iowa Sleep dismissed Dr. Grant as a cost-saving measure after Dr. Grant declined to take a pay cut to alleviate the financial distress the company was experiencing.

1. FCA Retaliation Generally

The Act prohibits retaliation against employees who are "discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment because of lawful acts done by the employee . . . in furtherance of" a civil action under the FCA "or other efforts to stop" violations of the FCA. 31 U.S.C. § 3730(h)(1); *see also United States ex rel. Strubbe v. Crawford Cnty. Mem'l Hosp.,* 915 F.3d 1158, 1167 (8th Cir. 2019). To prevail on his FCA retaliation claim, Dr. Grant must establish (1) he was engaged in conduct protected by the FCA; (2) Iowa Sleep knew that he was engaged in protected activity; (3) Iowa Sleep retaliated against him; and (4) the retaliation was motivated solely by the protected activity. *Schuhardt* v. *Washington Univ.,* 390 F.3d 563, 566 (8th Cir. 2004) (citation omitted).

Only Iowa Sleep, and not Dr. Zorn personally, may be held liable for retaliation. *Strubbe,* 915 F.3d at 1167 ("[T]he FCA does not impose individual liability

for retaliation claims."); *United States ex rel. Golden v. Ark. Game & Fish Comm'n,* 333 F.3d 867, 870 (8th Cir. 2003) (noting an FCA claim "can only be against an 'employer.'"). However, Dr. Zorn's personal knowledge and motivation are at issue because he acted in his capacity as owner of the company.

2. FCA Retaliation Analysis

a. Protected activity and adverse employment action

Two elements of Dr. Grant's retaliation claim—engaging in a protected activity and an adverse employment action—are met. There is no dispute Dr. Grant engaged in protected activity under the Act by filing a *qui tam* complaint in March 2018. The same goes for the adverse action element. Dr. Zorn discharged him, which is expressly identified in the statute as one of the prohibited actions. *See* 31 U.S.C. § 3730(h)(1). The final two elements of the claim—knowledge of protected activity and motivation—are the disputed elements of the claim.

b. Iowa Sleep's knowledge of protected activity

Dr. Zorn's knowledge of Dr. Grant's protected activity is essential to establish retaliation or else Iowa Sleep could not have been motivated to retaliate based on activity of which he was unaware. *See Schuhardt,* 390 F.3d at 568; *United States ex rel. Hopper v. Anton,* 91 F.3d 1261, 1269 (9th Cir. 1996) ("Unless the employer is aware that the employee is investigating fraud, the employer could not possess the retaliatory intent necessary to establish a violation of § 3730(h)."). To establish the requisite notice for a retaliation claim, Dr. Grant must present

evidence sufficient to allow the Court to reasonably find that Dr. Zorn was on notice that Dr. Grant "was either taking action in furtherance of a private *qui tam* action or assisting in an FCA action brought by the government." *Schuhardt,* 390 F.3d at 568 (citation omitted). Constructive knowledge of protected activity is enough to maintain a retaliation claim. *Id.* In essence, "the knowledge prong of § 3730 liability requires the employee to put his employer on notice of the 'distinct possibility' of False Claims Act litigation." *Hutchins v. Wilentz, Goldman & Spitzer,* 253 F.3d 176, 188 (3d Cir. 2001) (citations omitted).

Sitting as the fact-finder, the Court determines that Dr. Zorn, and by extension Iowa Sleep, had notice of Dr. Grant's protected activity. The temporal evidence indicates that he believed Dr. Grant was implicated in the Government's investigation of his billing practices. Very shortly after receiving CIDs, Dr. Zorn undertook several actions to retaliate against Dr. Grant.

The temporal link between requests for information from the Government and Dr. Zorn's sudden request for a very large pay cut provides strong evidence that Dr. Zorn and Iowa Sleep were "on notice" regarding the possibility of litigation. *Hutchins,* 253 F.3d at 188; *Strubbe,* 915 F.3d at 1169 (finding a close connection in time "between protected conduct and adverse action" is probative of retaliation). In short, the evidence is sufficient for the Court to conclude by a preponderance of the evidence that Dr. Zorn was on notice.

c. Retaliatory Motive

Motivation to retaliate may be shown by direct and circumstantial evidence. *Townsend v. Bayer Corp.,* 774 F.3d 446, 457 (8th Cir. 2014). "[E]vidence showing an employer's stated reason for taking an adverse action against him is pretextual, such evidence also serves to prove retaliation." *Townsend*, 774 F.3d at 457. The causal link required for a successful FCA retaliation claim is "tighter than that required in other types of retaliation and discrimination claims." *Sherman* v. *Berkadia Com. Mortg. LLC,* 956 F.3d 526, 532 (8th Cir. 2020). Despite this tight causal link, the Court finds by a preponderance of the evidence that it is met.

The evidence supporting a retaliatory discharge here is more than a "mere coincidence in timing," which federal courts have found to be insufficient by itself to support a claim. *See Kipp* v. *Mo. Highway and Transp. Comm'n,* 280 F.3d 893, 897 (8th Cir. 2002); *Kiel v. Select Artificials, Inc.,* 169 F.3d 1131, 1136 (8th Cir. 1999) (en banc) (holding "more than a temporal connection between the protected conduct and the adverse employment action is required to present a genuine factual issue on retaliation.").

Dr. Zorn repeatedly testified about the financial struggles of Iowa Sleep. No persuasive evidence was presented regarding any drastic financial change in 2018, after Dr. Grant had filed this action and Dr. Zorn had begun receiving CIDs. Nevertheless, in mid-September, Dr. Zorn convened an urgent meeting with Dr. Grant and Olson to discuss the need for both

of the doctors to take a 75% salary reduction.[27] Tr. 449:18–449:21.

Considerable evidence also demonstrates the financial hardships did not cause changes prior to the firing of Dr. Grant. Olson's testimony at trial supports the conclusion that there was no major change from previous years although Iowa Sleep continued to struggle financially. Olson testified that in June 2019 revenue for Iowa Sleep was down 20% from the prior year. Tr. 914:12–914:15. The company had sustained a loss of about $120,000 by that point in the calendar year. Tr. 914:16–914:18. He opined that its financial condition was not "horrible," but he alerted both Zorns to the issue. Tr. 914:19–914:22. Evidence in the record derived from the Intergy patient management software reflects that revenues from Iowa Sleep in 2018 were within one percent of the previous year. *See* Pl. Ex. 62. In his testimony, Butters agreed with the statement that there was no drastic decrease in revenue over the course of his time at Iowa Sleep. Tr. 109:2–109:5. Barb Zorn's testimony supports Dr. Grant's assertion that no catastrophic financial circumstances warranted a large pay reduction for the physicians. BZ Tr. 63:12–63:24.

Additional circumstantial evidence supports the determination on Dr. Zorn's motivation. Dr. Zorn stated in Dr. Grant's 2016 review that "patient care" was a major concern because, in Dr. Zorn's opinion, Dr. Grant was not prescribing CPAP therapy in

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[27] It is notable that, after terminating Dr. Grant, Dr. Zorn himself only took a 50% salary reduction. Tr. 846:5–846:9.

instances when it was necessary. See Pl. Ex. 22 at 5–7. But after Dr. Grant declined Dr. Zorn's request to take a pay cut—and review the financial records of the company—Dr. Zorn fired him with no notice and no ability to wind down patient care.

Defendants urge that Dr. Grant was not fired as retaliation for filing this lawsuit but as a last ditch emergency effort to keep the company afloat. This is not credible and the explanation is unpersuasive. First, the financial headwinds faced by private sleep medicine practices date back several years. According to Dr. Zorn, the shift from in-lab sleep studies to at-home sleep studies began in the central Iowa area around 2011 and has since increased.[28] Tr. 94:6–94:18, 94:21–95:2, 536:12–536:14. However, within the span of a few months after the filing of this lawsuit and the serving of CIDs on Iowa Sleep by the Government, Dr. Zorn decided that both physicians each needed to take a 75% pay cut. There was no negotiation or further discussion of an alternate pay cut or alternative financial changes. Within the span of 11 days—from September 17, 2018 to September 28, 2018—Dr. Zorn demanded Dr. Grant take a draconian pay cut, and then terminated him after Dr.

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[28] Dr. Zorn testified he began working Saturdays in 2013; Iowa CPAP's first loan to Iowa Sleep was made in 2013 for $55,000; and he took a salary reduction beginning in 2012 until April 2019. Tr. 95:4–95:24. He said that if Dr. Grant had accepted his proposal to a pay cut, they both would have made the same amount—$60,000 per year. Tr. 97:3–97:4. No other Iowa Sleep employees were asked to take a pay cut. Tr. 96:19–96:25.

Grant sought further information regarding the necessity of such a drastic action. No evidence was offered at trial that other, similarly severe cost-cutting measures were taken.

The only employee that was requested to take a pay cut was the only employee who had filed a *qui tam* lawsuit against Dr. Zorn and Iowa Sleep. It is not at all clear how the finances of Iowa Sleep would be alleviated by terminating one of the two top-level medical providers. Dr. Grant was the second highest revenue generator at Iowa Sleep, per Dr. Zorn's review from 2016. *See* Pl. Ex. 22. To accept that his termination was a cost-cutting move, rather than retaliation for whistleblowing, would mean Dr. Grant was a *net negative* employee for the clinic. No evidence was offered to support this inference that termination of Dr. Grant would improve the bottom line of Iowa Sleep.

It is hard to conjure up any other reasonable explanation for Dr. Zorn's conduct. Dr. Zorn requested his top-level employee take a three-quarters pay cut in a tense, after-hours meeting that only lasted a few minutes. Days later, he sent a terse letter demanding a response to this request. *See* Pl. Ex. 51. After Dr. Grant declined the request and exercised his right to review financial documents as a shareholder of the company, Dr. Zorn terminated his employment without further discussion or providing the documents. Pl. Exs. 52, 53. Dr. Grant was fired by Dr. Zorn in retaliation for this lawsuit, plain and simple. It is of no occasion that the lawsuit was still under seal. Iowa Sleep had received CIDs regarding his

coding practices and Dr. Zorn admitted to speculating with his wife about who may have blown the whistle. Tr. 884:13–884:23. Dr. Zorn stated that there was one other person who he and his wife discussed but he did not want to name the individual. After a direct question about the person's name from the Court at trial, Dr. Zorn testified he could no longer remember their name. Tr. 885:16–885:23. Clearly, and accurately, Dr. Zorn concluded Dr. Grant notified the Government about his coding practices and terminated his employment in retaliation.

3. FCA Retaliation Damages

Statutory remedies available for retaliation include (1) job reinstatement; (2) double back pay; (3) interest on back pay; and (4) special damages "as a result of the discrimination, including litigation costs and reasonable attorneys' fees." 31 U.S.C. § 3730(h)(2).

a. Back Pay

The FCA anti-retaliation provision mandates an award of "2 times the amount of back pay" for a successful claimant. Dr. Grant submits this amount is $80,000 for approximately two months' of back pay from September 28, 2018.[29] [ECF No. 136 at 29]. Defendants' position is that Dr. Grant's back pay should be limited to two weeks' pay at his annual salary which totals $18,500 after doubling. [ECF No. 135 at 6].

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[29] At trial, evidence was introduced that Dr. Grant's annual salary was $240,000. He declines the option of reinstating his employment at Iowa Sleep.

The Eighth Circuit has observed that "neither the FCA nor its legislative history specifically addresses the question of how to calculate '2 times the amount of back pay.'" *Hammond v. Northland Counseling Ctr., Inc.,* 218 F.3d 886, 891–92 (8th Cir. 2000). Dr. Grant's proposal, that he be awarded his full salary up until the time he matched his Iowa Sleep income around Thanksgiving 2018, would amount to a windfall. "When an employer makes a discriminatory employment decision against an individual, that individual has a duty to look for another position to mitigate his damages." *Chalfant v. Titan Distrib., Inc.,* 475 F.3d 982, 992 (8th Cir. 2007) (citation omitted). In rejecting the plaintiff's argument that she was entitled to doubling her back pay before any consideration of mitigation, the court in *Hammond* held that "the overarching purpose of the statute is clear: to provide an aggrieved plaintiff with complete compensation for any injuries incurred as a result of the employer's retaliatory conduct." *Hammond,* 218 F.3d at 891–92. Subsequent Eighth Circuit case law has found that back-pay damages should be doubled only after subtracting mitigation wages. *Wilkins* v. *St. Louis Hous. Auth.,* 314 F.3d 927, 934 (8th Cir. 2002).

The Court's determination regarding the amount of back pay to which Dr. Grant is entitled is complicated by the limited evidence of mitigation of damages presented at trial. There is no documentary evidence in the record about Dr. Grant's income after he started at the VA. Dr. Grant's testimony on the subject was also limited. He conceded that he could exceed his salary at Iowa Sleep during a standard 80-hour pay

period working at the VA. Tr. 484:9–484:14. Upon further questioning from his counsel, he opined that by Thanksgiving he was making as much or more than he was making at Iowa Sleep. Tr. 484:6–484:8, 484:15–484:18. This gap arises from the inconsistent hours Dr. Grant received working in the ER on an as-needed basis. However, without documentation as to how many hours Dr. Grant actually worked during the time period, the Court can only speculate as to the amount of mitigation.

Accordingly, Dr. Grant will be awarded $25,000 in back pay based on approximately two weeks of salary for retaliation damages.[30] Because the Court is satisfied that Dr. Grant's earnings were less than his Iowa Sleep salary to *some* degree prior to Thanksgiving of 2018, it will round the proposed number up to $25,000 which will be doubled to $50,000.[31]

b. Special damages

Dr. Grant also seeks special damages, which are authorized by the FCA anti-retaliation provision. He cites his testimony regarding the emotional impact he suffered as a result of the termination from Iowa

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[30] This calculation is based on Dr. Grant's $240,000 annual salary ($240,000/26 weeks= $9,230.76 x 2 = $18461.53). Dr. Grant testified that he needed to wait until the next pay period before he could begin working at the VA. Tr. 479:10–479:18.

[31] He will also be entitled to interest on his backpay. *See* 31 U.S.C. § 3730(h)(2). The Court will accept post-judgment briefing by the parties on the proper amount of interest.

Sleep. Included in this impact is sleeplessness; professional stress; harm to his military career; social and reputational harm; mental anguish; and strained relationship with his friends and family. [ECF No. 136 at 29]. The amount he requests for special damages is "at least $480,000." *Id.*

"Damages for emotional distress caused by an employer's retaliatory conduct plainly fall within this category of special damages." *Hammond,* 218 F.3d at 893; *Brandon v. Anesthesia & Pain Mgmt. Assocs., Ltd.,* 277 F.3d 936, 944 (7th Cir. 2002) (finding "special damages" can include "recovery for emotional distress."). Special damages can also include attorney fees and costs. *See Neal,* 191 F.3d at 831–34. To receive emotional distress damages pursuant to the FCA, Dr. Grant must offer specific facts regarding the nature of his emotional distress and the causal connection to the retaliation. *Hammond,* 218 F.3d at 893. Proving emotional distress does not require expert evidence and "[a] plaintiff's own testimony, along with the circumstances of a particular case, can suffice to sustain the plaintiff's burden." *Id.* (quoting *Kim* v. *Nash Finch Co.,* 123 F.3d 1046, 1065 (8th Cir. 1997)).

Defendants respond to Dr. Grant's request for special damages by noting that Dr. Grant had been seeking substitute employment even prior to his termination from Iowa Sleep. Also, he obtained employment at Mercy within months and "is presumably happy, since he still practices there." [ECF No. 137 at 15]. They also dispute he is entitled to such a large award of special damages, pointing to

Townsend where the Eighth Circuit found that emotional distress damages of $568,000 was excessive as a matter of law. [ECF No. 138 at 10]. In *Townsend,* the plaintiff had testified that his termination from his job had had an adverse effect on his family's financial condition, as well as causing shame and embarrassment. *Townsend,* 774 F.3d at 466. Townsend lost his home in foreclosure and his family struggled providing basic needs for his children. *Id.* The plaintiff also suffered through "a two-and-a-half-year period of untreated depression and sleeplessness." *Id.* at 467. The panel found that the emotional distress award was excessive, and the evidence of emotional distress was "garden-variety" and justified no greater than a $300,000 award for emotional distress. *Id.*

Dr. Grant responds to the *Townsend* case by noting that some of the issues cited by the plaintiff in that case, such as the foreclosure proceeding and other financial struggles, predated the retaliatory termination. [ECF No. 138 at 10] (citing *Townsend,* 774 F.3d at 467). He points out that Dr. Zorn had pressured Dr. Grant to engage in fraud for as far back as 2016. *See* Pl. Ex. 22.

The Court finds a special damages amount is appropriate here. Dr. Grant testified credibly and convincingly about the emotional distress he experienced after his termination from Iowa Sleep. He explained that many people in his life were puzzled at his sudden exit from a medical practice at which he had worked for several years. The impact of his termination on his professional career was evident,

including the requirement to report his job change to the security manager at his Air Force base, who was suspicious about the termination. The Court credits Dr. Grant's assertion that his professional reputation was harmed as a result of the termination.

Dr. Grant's family and personal life also experienced difficulties through lost sleep in part due to odd and unpredictable hours working at the VA. The sudden financial stress caused harmed to Dr. Grant and his family. In sum, a substantial award of special damages is appropriate given these adverse consequences on Dr. Grant as a result of Iowa Sleep's illegal and retaliatory termination. The Court will award an amount of $300,000, in line with Eighth Circuit precedent in *Townsend.*

Compared with the plaintiff in *Townsend,* Dr. Grant did not testify to over two years of "untreated depression and sleeplessness." *Townsend,* 774 F.3d at 467. Most of the testimony from Dr. Grant at trial pertained to adverse effects he suffered in the period after his termination, a period lasting until approximately March 2019 when he obtained employment at MercyOne. Still, the panel found that a jury award of $568,000 was excessive as a matter of law. *Id.* The Court finds that Dr. Grant has special circumstances warranting an amount equal to that in *Townsend* even absent evidence of prolonged emotional distress. These stem from the adverse professional consequences he experienced, particularly as related to his military service and the requirement that he report the termination for his medical licensing purposes, matters complicated by

the sealed *qui tam* suit Dr. Grant could not legally discuss.

c. Punitive Damages

Dr. Grant offers that punitive damages in the amount of $800,000 are also appropriate. He acknowledges that punitive damages are not expressly authorized by the FCA but asserts that the Court may rely on state common law punitive damages to support them. The FCA provides that an employee who suffer retaliation is "entitled to all relief necessary to make that employee. . .whole." 31 U.S.C. § 3730(h)(1). Dr. Grant urges that the enumerated list of damages is illustrative and punitive damages can also serve the purpose of making an employee "whole" after an unlawful retaliatory action. The Court will decline this invitation.

One reason why punitive damages should not be read into the anti-retaliation provision of the FCA is that the law expressly provides for double back pay. Awarding double back pay goes beyond a compensatory purpose and signals an intent by Congress to impose punitive relief. Other courts have observed a similar operation of the law. *See Hammond* v. *Northland Counseling Ctr., Inc.,* No. CIV.5-96-353MJD/RLE, 1998 WL 315333, at *5–6 (D. Minn. Feb. 27, 1998) (finding an award of punitive damages would violate interpretive canons by making a double back pay award superfluous); *cf. United States ex rel. Mooney* v. *Americare, Inc.,* 172 F. Supp. 3d 644, 645–46 (S.D. N.Y. 2016) (noting the "inherent tension" in "stating that the victim of unlawful retaliation is

entitled to be made 'whole,' [while] Congress commanded that the relief to such plaintiffs should go beyond pure restitution by awarding double back pay."). Other federal courts considering the question of punitive damages have found that Congress declined to include a provision for punitive damages in the final version of § 3730(h). *Hammond,* 1998 WL 315333, at *6; *Neal v. Honeywell, Inc.,* 995 F. Supp. 889, 896 (N.D. Ill. 1998); *Leggins v. Orlando Hous. Auth.,* No. 6:13-cv-232-Orl-37DAB, 2013 WL 937739, at *2–3 (M.D. Fla. Mar. 11, 2013) (holding that Congress did not intend for punitive damages to be available under the § 3730(h)).

Alternatively, Dr. Grant asks the Court to award punitive damages under the state law version of the FCA. He does not offer any distinct legal analysis for why Iowa state courts would interpret the identical provision of the state FCA differently than the federal courts interpret the federal FCA. The Court holds that the same analysis applies to the state FCA which provides for "two times the amount of back pay." *See* Iowa Code § 685.3(6).

IV. CONCLUSION

It is not the duty of the judiciary to second-guess the conduct of physicians. However, it is the role of the Court in this case to sit as a factfinder to determine whether Dr. Zorn and Iowa Sleep submitted billing claims that violated the False Claims Act. The Court has relied on the expert testimony of Dr. Suleman and Dr. Alexander to guide its finding as to what services are medically necessary for a sleep physician. It is

further informed by the evidence presented by Wellmark and CMS as to medically necessary services. Dr. Grant, while an adversary and not a disinterested party, testified under oath regarding his practice as a sleep physician. Dr. Zorn himself gave extended testimony on separate days to explain his processes with his patients.

The Supreme Court has observed, "[p]rotection of the public fisc requires that those who seek public funds act with scrupulous regard for the requirements of law," therefore, "[a]s a participant in the Medicare program, [Iowa Sleep] had a duty to familiarize itself with the legal requirements for cost reimbursement." *Heckler* v. *Cmty. Health Servs. of Crawford Cnty., Inc.,* 467 U.S. 51, 63–64 (1984). For the reasons set forth above, the Court finds in favor of Plaintiff/Relator Dr. Stephen Grant on Count I (violation of the federal False Claims Act), Count II (violation of the Iowa False Claims Act), and Count IV (Wrongful Termination). The Court finds in favor of Defendants Dr. Steven K. Zorn, Iowa Sleep, and Iowa CPAP on Count III (Violation of the Stark Law). For summary purposes, the following amounts are awarded as damages:

Actual Loss (trebled): $258,996.00

Adjusted Civil Penalty: $6,474,900.00

Back pay: $50,000

Special Damages: $300,000

Total: $7,083,896.00.

No judgment shall enter at this time. The Court will accept further briefing from the parties on the following issues: (1) attorneys' fees and costs; (2) relator's share of damages award; (3) interest calculation on damages for wrongful discharge; and (4) proper division of award between the United States of America and the State of Iowa. Plaintiff/Relator shall submit his brief within 30 days of the date of this Order. Defendants shall have 14 days to respond to Plaintiff/Relator's post-verdict brief.

IT IS SO ORDERED.

Dated this 23rd day of September, 2022.

STEPHANIE M. ROSE, CHIEF JUDGE UNITED STATES DISTRICT COURT

APPENDIX A

Chart/ PDF number	Date	Dr. Zorn E/M Code	Dr. Suleman E/M code	Reimbursement rate (actual)	Reimbursement rate (proper)	Difference	Payor
29714	5/16/2011	99205	99202	$185.15	$66.86	$118.29	Medicare
33696	10/7/2011	99205	99202	$185.15	$66.86	$118.29	Medicare
34207	10/24/2011	99205	99202				Medicaid
38100	2/29/2012	99205	99202	$185.15	$66.86	$118.29	Medicare
41815	7/12/2012	99205	99202	$185.15	$66.86	$118.29	Medicare
43472	9/5/2012	99205	99202				Medicaid
44895	10/24/2012	99205	99202				Tricare
55248	11/8/2012	99205	99202				Medicaid

45782	11/28/2012	99205	99202	$185.15	$66.86	$118.29	Medicare
50098	4/30/2013	99205	99202	$189.00	$68.64	$120.36	Medicare
53073	8/21/2013	99205	99201	$189.00	$40.19	$148.81	Medicare
56247	12/16/2013	99205	99202	$189.00	$68.64	$120.36	Medicare
59157	4/3/2014	99205	99202	$193.07	$69.02	$124.05	Medicare
62130	7/14/2014	99205	99202	$193.07	$69.02	$124.05	Medicare
63470	8/21/2014	99205	99202				Medicaid
64936	10/7/2014	99205	99203	$193.07	$100.05	$93.02	Medicare
70560	4/8/2015	99205	99203	$194.38	$100.83	$93.55	Medicare
70672	4/11/2015	99205	99202				Medicaid
74582	8/6/2015	99205	99203	$194.38	$100.83	$93.55	Medicare
77811	11/7/2015	99205	99203	$194.38	$100.83	$93.55	Medicare
78792	12/3/2015	99205	99204				Medicaid
81793	2/24/2016	99205	99202	$194.33	$69.68	$124.65	Medicare
85034	5/28/2016	99205	99203	$194.33	$100.65	$93.68	Medicare
87524	8/2/2016	99205	99202	$194.33	$69.68	$124.65	Medicare
90858	10/31/2016	99205	99202	$194.33	$69.68	$124.65	Medicare
94323	1/31/2017	99205	99202	$195.26	$70.30	$124.96	Medicare
98050	5/4/2017	99205	99202	$195.26	$70.30	$124.96	Medicare
99053	5/21/2017	99205	99204				Tricare
102811	8/30/2017	99205	99204	$195.26	$154.92	$40.34	Medicare
103838	9/25/2017	99205	99204				Medicaid
107823	12/27/2017	99205	99202	$195.26	$70.30	$124.96	Medicare
						$2485.60	$112.98

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No. 22-3481

STEPHEN B. GRANT, ON BEHALF OF THE UNITED STATES OF AMERICA AND ON BEHALF OF THE STATE OF IOWA,

Appellee

UNITED STATES,

Intervenor

v.

STEVEN ZORN, ET AL.,

Appellants.

No. 22-3591

STEPHEN B. GRANT, ON BEHALF OF THE UNITED STATES OF AMERICA AND ON BEHALF OF THE STATE OF IOWA,

Appellant

UNITED STATES,

Intervenor

v.

STEVEN ZORN, ET AL.,

Appellees.

Appeal from U.S. District Court for the Southern District of Iowa – Central

(4:18-cv-00095-SMR)

(4:18-cv-00095-SMR)

Submitted: December 13, 2023

Filed: July 5, 2024

ORDER

The petitions for rehearing en banc are denied. The petitions for panel rehearing are also denied.

Judge Erickson, Judge Stras, and Judge Kobes would grant the petitions for rehearing en banc.

October 9, 2024

Order Entered at the Direction of the Court:
Acting Clerk, U.S. Court of Appeals, Eighth Circuit

/s/ Maureen W. Gornik

APPENDIX D

PLAINTIFF'S ATTACHMENT 6 TO
THIRD AMENDED COMPLAINT

Civil No. 4:18-cv-00095-SMR-SBJ
R. 59-6

NCI AdvanceMed
An NCI Company

CMS Centers for Medicare and Medicaid Services

September 6, 2016
Iowa Sleep Disorders Center, P.C.
Attn: Dr. Steven Zorn
4060 Westown Pkwy
West Des Moines, Iowa 50266
RE: Provider Education
Medicare Provider Transaction Access Number (PTAN): I11762
National Provider Identifier (NPI): 1407819816
Dear Dr. Zorn:

AdvanceMed understands that most providers strive to work ethically, render high-quality care and submit proper claims for Medicare payment, and the Federal Government places enormous trust in providers to do so. We received information that suggests you and your staff may require additional education regarding Evaluation and Management (E/M) services, and Polysomnography services.

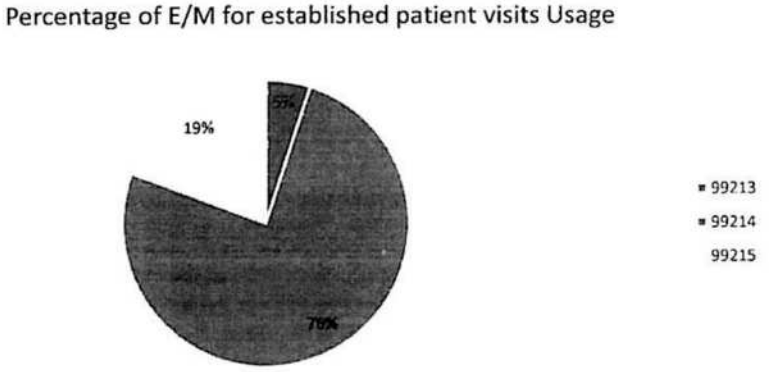
Statutory Basis for AdvanceMed's Actions

In accordance with section 1893 of the Social Security Act [Section 42 of the United States Code (U.S.C.) 1395ddd] and Title II §202 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Centers for Medicare & Medicaid Services (CMS) is authorized to contract with entities to fulfill program integrity functions for the Medicare program. These entities are called Zone Program Integrity Contractors (ZPICs). As a ZPIC, AdvanceMed performs program integrity activities designed to reduce fraud, waste, and abuse in the Medicare program.

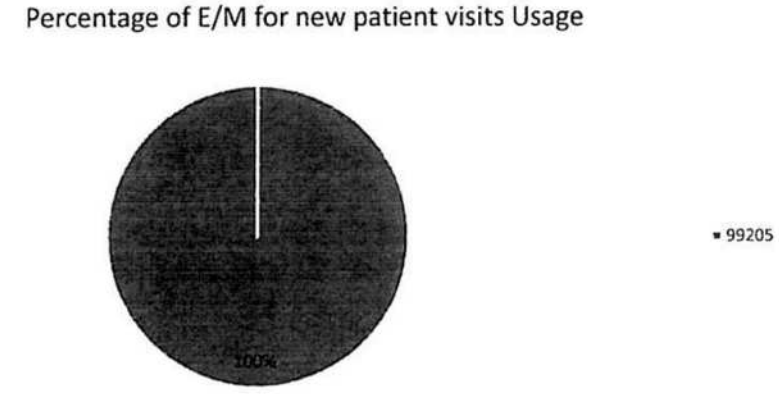
Outcomes of Data Analysis and Action Needed for E/M Services:

AdvanceMed performed data analysis of Dr. Zom's submitted claims to Medicare. Data analysis findings demonstrated Current Procedural Terminology (CPT) code 99214 make up a significant portion of your submitted claims from June 24, 2012 through June 24, 2016. In 2013, CPT code 99214 compromised approximately 36% of your total submitted claims and 16% of your total paid amount. In 2014, CPT code 99214 compromised approximately 24% of your total submitted claims and 8% of your total paid amount. In 2015, CPT code 99214 compromised 27% of your total submitted claims and 9% of your total paid amount. The majority of the Established patient office visits Dr. Zorn billed at the highest levels with CPT codes 99214 and 99215. Comparison among E/M CPT Codes (99213, 99214, and 99215) for established

patient visits shows CPT code 99214 was used 76% of the time.



Data Analysis indicated Dr. Zorn billed CPT Code 99205 (highest level of initial office visits) 100% of the time. More variety would be expected.



Based on the aforementioned findings, AdvanceMed would like to educate your office regarding Evaluation and Management visit coding, proper medical records documentation and use of CPT codes 99205 and 99214.

CPT Code Requirements

The Centers for Medicaid and Medicare Services' (CMS) website provides the following description for the CPT codes 99205, 99213,99214, and 99215.

- CPT code 99205: Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
- CPT code 99213: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15

minutes are spent face-to-face with the patient and/or family.

- CPT code 99214: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.
- CPT code 99215: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

Documentation Requirements

Social Security Act Section 1128(a)(1)(A), (B) Under Section 1128 of the Social Security Act, the Act states false or fraudulent claims for items or services including incorrect coding (up-coding) or providing medically unnecessary services could be subject to civil monetary penalties. *Section 1128* of the Act states: Sec. 1128A. [42 U.S.C. 1320a-7a] (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) is for a medical or other item or service that the person knows or should know was not provided as claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided, (B) is for a medical or other item or service and the person knows or should know the claim is false or fraudulent.

In general, the Medicare program is designed only to provide payment for services that are considered to be medically reasonable and necessary to the overall diagnosis and treatment of a patient's condition. This

means for every service submitted the medical record should be complete and legible and should include the reason for the encounter and relevant history, assessment, clinical impression or diagnosis and the medical plan of care as well as the date and identify of the observer. The diagnosis and treatment codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.

Also, please see the following section from the Medicare Claims Processing Manual, Publication 100-04, Chapter 12, Section 30.6.1 (D),

D. Use of Highest Levels of Evaluation and Management Codes

Contractors must advise physicians that to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient's medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.

The comprehensive examination may be a complete single system exam such as cardiac, respiratory, psychiatric, or a complete multi-system examination.

Outcomes of Data Analysis and Action Needed for Polysomnography Services

Based on data analysis, it was noted Dr. Zorn had a potential for overutilization of CPT code 95810 — Ploysomnography four or more and CPT code 95811 — Polysomnography with Continuous Positive Airway Pressure (CPAP). Dr. Zorn ranked number one for paid amount for CPT codes 95810 and 95811 among all Iowa Part B providers. It was noted some beneficiaries received three or more sleep studies for dates of service June 24, 2012 through June 24, 2016.

Based on the aforementioned findings, AdvanceMed would like to educate your office regarding Polysomnography Services, and use of CPT codes 95810 and 95811.

CPT Code Requirements

CMS website provides the following description for the CPT codes 95810 and 95811.

- CPT code 95810: Polysomnography; age six years or older, sleep staging with four or more additional parameters of sleep, attended by a technologist. Sleep monitoring of patient (six years or older) in sleep lab.
- CPT code 95811: Polysomnography; age six years or older, sleep staging with four or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a

> technologist. Sleep monitoring of patient (six years or older) in sleep lab with continued pressured respiratory assistance by make or breathing tube.

According to Wisconsin Physicians Service (WPS) Local Coverage Determinations (LCD) 31082 — Polysomnography and Other Sleep Studies. Sleep Studies and Polysomnography (PSG) refers to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep furnished in a sleep laboratory facility that includes physician review, interpretation and report. A technologist is physically present to supervise the recording during sleep time and has the ability to intervene, if needed. The studies are performed to diagnose a variety of sleep disorders and to evaluate a patient's response to therapies such as CPAP. PSG is distinguished from sleep studies by the inclusion of sleep staging.

In addition, please see the following section from the Medicare Benefit Policy Manual, Chapter 15, Section 70,

Sleep disorder clinics are facilities in which certain conditions are diagnosed through the sleep study of sleep. Such clinics are for diagnosis, therapy, and research. Sleep disorder clinics may provide some diagnostic or therapeutic services which are covered under Medicare. These clinics may be affiliated either with a hospital or a freestanding facility. Whether a clinic is hospital-affiliated or freestanding, coverage for diagnostic services under some circumstances is

covered under provisions of the law different from those coverage of therapeutic services.

A. Criteria for Coverage of Diagnostic Tests

All reasonable and necessary diagnostic tests given for the medical conditions listed in subsection B are covered when the following criteria are met:

- The clinic is either affiliated with a hospital or is under the direction and control of physicians. Diagnostic testing routinely performed in sleep disorder clinics may be covered even in the absence of direct supervision by physician;
- Patients are referred to the sleep disorder clinic by their attending physicians, and the clinic maintains a record of the attending physician's orders, and
- The need for diagnostic testing is confirmed by medical evidence, e.g; physician examinations and laboratory tests.

Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered because it is not reasonable and necessary under §1862(a)(1)(A) of the Act.

References

- American Medical Association (AMA) CPT/Healthcare Common Procedural Coding System (HCPCS) Codebook, Effective July 1, 2016
- Medicare Benefit Policy Manual (Publication 100-02), Chapter 15 — Covered Medical and Other Health Services,

https:/www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf

- Medicare Claims Processing Manual (Publication 100-04), Chapter 12 — Physicians/Nonphysician Practitioners, Sections 30.6.1 D and 30.6.6 B, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/c1m104c12.pdf
- Medicare Coverage Database "CPT/HCPCS Codes included in Range 99211-99215" Web page, https://www.cms.govimedicare-coveraqe-database/staticpages/cpt-hcpcs-code-range.asbx?DocType=LCD&DocID=32007&Group=1&RangeStart=99211&RangeEnd=99215
- Centers for Medicare and Medicaid Services, Evaluation and Management Services Guide, (Nov 2014), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval mgmt sery guide-ICN006764.pdf
- Social Security Act, Title 11, Section 1128 "Exclusion of Certain Individuals and Entities from Participation in Medicare and State Health Care Programs" https://www.socialsecurity.gov/OP Home/ssact/titlell/1128.htm
- Social Security Act, Title VIII — Health Insurance for the Aged and Disabled, Section 1862 — Exclusions from coverage and Medicare

as secondary payer, https://vvww.ssa.gov/OP Home/ssact/titlel8/1862.htm

To keep the provider community up to date with any changes in policy, WPS Government Health Administrators maintains the most current publications and makes available education resources on their web site located at http://www.wpsmedicare.com/i5macpartb/.

Please review the information provided in this letter to ensure you and your staff understand Medicare coverage and payment requirements. Use this information to determine whether corrections to your billing and claim submission procedures are required to prevent future errors.

In addition, we remind you that our regulation at 42 CFR § 424.535 authorizes us to revoke Medicare billing privileges under certain conditions. In particular, we note that per 42 CFR § 424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider's or supplier's Medicare billing privileges if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

Authority to Conduct Reviews

Under *Section 1893* of the Act, AdvanceMed is required to conduct reviews of providers to ensure that Medicare claims have been appropriately billed. It is Congress' intent, as stated in *Section*

APPENDIX E

PLAINTIFF'S ATTACHMENT 7 TO
THIRD AMENDED COMPLAINT

Civil No. 4:18-cv-00095-SMR-SBJ
R. 59-7

January 22, 2018
Attn; Dr. Steven Zorn
Iowa Sleep Disorders Ctr., PC
4060 Westown Pkwy.
West Des Moines, Iowa 50266-1010

RE: Results of Post-Payment Review
Medicare Provider Transaction Access Number (PTAN): I11760
National Provider Identifier (NPI): 1992725782

Dear Dr. Zorn:

As you know, most Medicare providers strive to work ethically, render high-quality medical care to their patients, and submit proper claims for payment. The Federal Government places enormous trust in providers, relying on their medical judgment to treat patients with appropriate services, and to submit accurate and truthful claims information when seeking reimbursement. ***As a Medicare provider, you play a vital role in protecting the Medicare Program.***

You are receiving this letter as a result of a Medicare program integrity review conducted by AdvanceMed. This letter serves as additional education regarding these findings, as explained in more detail below.

Statutory Basis for AdvanceMed's Actions

In accordance with section 1893 of the Social Security Act [42 U.S.C. 1395ddd] and Title II §202 of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, the Centers for Medicare and Medicaid Services (CMS) is authorized to contract with entities to fulfill requirements of the Medicare Integrity Program. Section 6034 of the Deficit Reduction Act (DRA) of 2005 established the Medicaid Integrity Program. CMS utilizes Unified Program Integrity Contractors (UPIC) to perform these functions. AdvanceMed is the UPIC for the Midwestern Jurisdiction[1]. As the UPIC, AdvanceMed performs program integrity activities aimed to reduce fraud, waste, and abuse in the Medicare and Medicaid programs.

Scope of Review

AdvanceMed conducts reviews based on information from various sources, including but not limited to: 1) requests from CMS or the Office of the Inspector General (OIG); 2) data analysis; 3) complaints; and 4) inquiries from various entities. Our review was prompted by receipt of information that suggests you

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[1] UPIC Midwestern consists of the following states: Illinois, Indiana, Iowa, Kansas, Kentucky, Michigan, Minnesota, Missouri, Nebraska, Ohio and Wisconsin.

are improperly billing Evaluation and Management services.

Based on this information, on October 2, 2017, AdvanceMed requested medical records from your practice or facility for dates of service January 25, 2017 through September 2, 2017. A second request for records was sent October 24, 2017. AdvanceMed reviewed 33 claims. **Based on the claims and supporting documentation we reviewed, we identified overpayments made to you.** This letter constitutes formal notice to you of the outcomes of our review, as well as any actions you should take.

Outcome of the Review and Education

Previous data analysis was conducted. Our records indicated a high incidence of billing for the highest level E/M codes. CPT code 99214 was billed 76% of the time for established patients and 99205 was billed 100% of the time for new patients. You were educated by AdvanceMed on September 6, 2016 regarding when to bill high level evaluation and management services and the supporting documentation needed.

The current medical review resulted in the following general findings:

- Documentation did not support level of service.

The following are specific examples of our findings, designed to help you better understand coverage criteria. The rationale listed below are not exhaustive. You must refer to the documents contained on the included secured CD for detailed information about the coverage decision on each reviewed claim.

CCN 740917034054340

The documentation did not support the level of evaluation and management (E/M) service billed, CPT code 99215, "office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a comprehensive history; a comprehensive examination; medical decision making of high complexity". The beneficiary was seen for review of her polysomnography results. Obstructive sleep apnea (OSA) was diagnosed by the Apnea-Hypopnea Index (AHI) of 5.6 events per hour in conjunction with complaints of fatigue. PSG with CPAP (continuous positive airway pressure) titration was planned.

The E/M service was scored using the Centers for Medicare and Medicaid Services (CMS) 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. The records reflected a problem focused history, a problem focused examination and moderate complexity medical decision making, which supported the reduced level of E/M service CPT code 99212.

CCN 740917067068920

The documentation did not support the level of evaluation and management (E/M) service billed, CPT code 99214, "office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a detailed history; a detailed examination; medical decision making of moderate complexity". The beneficiary was seen for a re-check

for obstructive sleep apnea (OSA). She previously reported improvement of insomnia and daytime sleepiness with BiPAP (bi-level positive airway pressure), but on this date stated the machine was causing mouth dryness. The provider suggested changing from a full face mask to nasal pillows if the beneficiary desired; an order was submitted. The Epworth Sleepiness Scale score was 10; before BiPAP treatment, her score was 14.

The E/M service was scored using the Centers for Medicare and Medicaid Services (CMS) 1995 and 1997 Documentation Guidelines for Evaluation and Management Services. The documentation reflected a problem focused history, an expanded problem focused examination and moderate complexity medical decision making, which supported the reduced E/M service CPT code 99213.

AdvanceMed also noted the following trends persistent throughout the medical review:

Most of the E/M services reviewed were billed at higher levels than necessary, according to the scored documentation. The medical records did not contain the high level history and physical examination components or the high complexity medical decision making required to support the medical necessity for CPT codes 99205 and 99215. It was also noted that some of the office visits were separated by less than one month, with no health status changes, which would not dictate the need for a comprehensive history and physical exam. Many of the claims for CPT code 99214 were not supported due to lack of detailed history and physical exam documentation.

Billing these codes resulted in inappropriate payments to the provider.

Some of the documentation was found to be copied or templated. This resulted in duplication of grammatical errors, and in some cases, the transferral of incorrect information from one record to another. Some elements of the documentation were excluded from scoring for this reason.

Based on our findings as explained in this letter, AdvanceMed has determined that you have been overpaid by Medicare in the amount of $866.66. Please keep this letter and all attached documentation for your records. **This is not a demand letter; you will be notified at a later date by your Medicare Administrative Contractor (MAC) regarding the amount due, potential repayment options, and any formal appeal processes you may pursue.** The CMS publication "Medicare Overpayments" explains more about overpayments: https://www.cms.gov/Outreach-and-Education/Medicare-Leaming-Network-MLN/MLNProducts/Downloads/OverpaymentBrochure508-09.pdf.

Accompanying this letter is an encrypted CD containing an electronic copy of this letter, a Claim Line Spreadsheet, and various references cited in this letter. Specific information regarding these findings, per claim, is explained in the attached Claim Decision Spreadsheet. All documents are contained within a password protected ZIP file.

Again, please review the attachments, along with this letter, to ensure you understand Medicare coverage

and payment requirements. Consider and implement corrections to billing procedures that could prevent such errors in the future. Further, we recommend you maintain documentation of any changes you implement to your current processes or procedures as a result of the information provided herein.

Publications at the following links give you additional information you need to protect the Medicare Program, your patients, your organization and yourself.

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Avoiding_Medicare_FandA_Physicians_FactSheet_905645.pdf
- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf

If you misrepresent, falsify, or conceal essential information required for payment of federal funds, then you may be subject to civil or criminal liability, which can result in fine, imprisonment, civil penalty, and potential collateral consequences.

Additionally, CMS published a final rule regarding overpayments in the Federal Register on February 12, 2016 [CMS-6037-F] to provide clarity and consistency in the reporting and returning of self-identified overpayments: https://www.gpo.gov/fdsys/pkg/FR-2016-02-12/pdf/2016-02789.pdf.

Authority to Conduct Reviews

Under *Section 1893* of the Act, AdvanceMed is required to conduct reviews of providers to ensure that Medicare claims have been appropriately billed. It is Congress' intent, as stated *in Section 1156* of the Act, that services and items will be: provided economically; of a quality which meets professionally recognized standards of health care; and supported by evidence of medical necessity. Services or items not proven to be reasonable or medically necessary are denied under *Section 1862(a)(1)* of the Act.

Requirement to Provide Documentation Upon Request

Section 1815(a) of the Act and *Title 42 CFR Part 424.5(a)(6)* place the burden upon the provider to furnish such information as may be necessary if payment is (or was) due and the amount of the payment.

Statutory Requirement: Medical Necessity

Social Security Act:

§1862(a)(1) of the Act states, "Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Laws governing Medicare are generally found in the Act as amended. Most provisions are in Title XVIII of the Act and may also be included in Title XI. Medicare

regulations are found in Title 42 of the Code of Federal Regulations (CFR). Instructions are issued by CMS via *MLN Matters* articles, the Medicare Internet-Only Manuals (e.g., Pub. 100-02 and 100-04) and other means (e.g., by Medicare Administrative Contractors via bulletins, letters, notices, web articles).

Statutory Requirement: Liability for Overpayments

Our determinations were made in accordance with sections 1879 and 1870 of the Social Security Act (the Act) as well as the specific statutory and regulatory references provided in this letter.

- **Section 1879 of the Social Security Act** - The determinations which follow a §1862(a)(1) denial may require a decision if the beneficiary or provider knew or could have known that a service would not be covered by Medicare because it would be considered medically unnecessary. The provider is liable if it is determined the provider knew, or could reasonably have been expected to know, that the items or services provided were not covered under Medicare. The beneficiary is liable if it is determined the beneficiary knew, or could reasonably have been expected to know that the items or services provided were not covered under Medicare. However, the Medicare program accepts liability if neither the beneficiary nor the provider knew, or could reasonably be expected to have known, that the services were not covered. Waiver of liability exists when both the beneficiary and the

provider did not and could not reasonably have been expected to know that payment would not be made for services.

- **Section 1870 of the Social Security Act-** Section 1870 permits Medicare to not recover inappropriate payments with respect to an individual deemed without fault in having caused the overpayment. For the "without fault" provision to apply, the individual must have complied with all pertinent regulations and instruction materials. A provider is responsible for an overpayment if he/she knew or had reason to know that service(s) were not reasonable and necessary, and/or he/she did not follow correct procedures or use care in billing or receiving payment.

Other Laws

Other laws pertaining to penalties associated with Medicare fraud and abuse include:

- Social Security Act (SSA), Sections 1128A(a)(l) and 1128B(a)(l)
- Civil False Claims Act, 31 U.S.C. § 3729
- 18 U.S.C. § 1001, 1035, and 1347
- 18 U.S.C. § 1516, Obstruction of Federal Audit

Our goal is to ensure that you are fully aware of the laws, regulations, and Medicare instructions which apply to you and other providers who furnish services or items to Medicare beneficiaries. We hope this information is helpful to you.

AdvanceMed will continue to monitor future Medicare claim submissions in order to verify adherence to this education.

In addition, we remind you that the regulation at 42 CFR §424.535 authorizes us to revoke Medicare billing privileges under certain conditions. In particular, we note that per 42 CFR §424.535(a)(8)(ii), CMS has the authority to revoke a currently enrolled provider's or supplier's Medicare billing privileges if CMS determines that the provider or supplier has a pattern or practice of submitting claims that fail to meet Medicare requirements.

This is not a demand letter. You will be notified at a later date by Wisconsin Physicians Service Insurance Corporation regarding the overpayment due and the repayment and appeal options available to you.

For the password to the enclosed encrypted CD or if you have any questions, please contact me at (248) 839-5005.

Sincerely,

Eboni Rousell
/s/Ebony Rousell
Program Integrity Analyst

AT #: 2017_256_334194064

UCM: CSE-170822-00008

Enclosed CD

1. Attachment 1: Medical Records Request Letter

2. Attachment 2: Second Medical Records Request Letter

3. Signed Acknowledgment Form

4. Medical Review.

a. Claim Line Decision Spreadsheet

b. Medical Review Export

c. Citations applicable to the medical review

5. Provider Education Letter 2016

6. Signed Digital Copy of Overpayment Determination / Education letter