UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA

UNITED STATES *ex rel.* [UNDER SEAL], Plaintiffs, v. [UNDER SEAL], Defendant.	Case No: 8:18-CV-267-T-24AEP **COMPLAINT FOR VIOLATION OF FEDERAL FALSE CLAIMS ACT, 31 U.S.C. § 3729 *et seq.*** **JURY TRIAL DEMANDED** **FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2) – <u>DO NOT PUT ON PACER</u>**

DOCUMENT TO BE KEPT UNDER SEAL

UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF FLORIDA

UNITED STATES OF AMERICA *ex rel.* DONALD HAIGHT, Plaintiffs, v. PHYSICIAN PARTNERS OF AMERICA, LLC., FLORIDA PAIN RELIEF GROUP PLLC., TEXAS PAIN RELIEF GROUP PLLC., and RODOLFO GARI, Defendants.	Case No: **COMPLAINT FOR VIOLATION OF FEDERAL FALSE CLAIMS ACT; 31 U.S.C. § 3729 *et seq.*** **JURY TRIAL DEMANDED** **FILED UNDER SEAL PURSUANT TO 31 U.S.C. § 3730(b)(2)** **DO NOT PUT ON PACER**

COMPLAINT

Qui tam Plaintiff-Relator Donald Haight ("Relator"), through his attorneys Phillips & Cohen LLP, on behalf of the United States of America, brings this Complaint on behalf of the United States against Physician Partners of America LLC, Florida Pain Relief Group PLLC, Texas Pain Relief Group PLLC (collectively, "PPOA"), and Dr. Rodolfo Gari (collectively, "Defendants"), and alleges as follows:

I. INTRODUCTION

1. This is an action to recover damages and civil penalties on behalf of the United States Government (the "United States" or the "Government") arising from false and/or fraudulent statements, records, and claims made and/or caused to be made by the Defendants and/or their agents and employees in violation of the federal False Claims Act, 31 U.S.C. § 3729, *et seq.*, the federal Stark Law, 42 U.S.C. § 1395nn, and the federal Anti-Kickback Statute ("AKS"), 42 U.S.C. § 1320a-7b(b).

2. Relator brings this *qui tam* case to redress the knowing submission of false or fraudulent claims by PPOA and Dr. Rodolpho Gari. PPOA, including its practice groups Florida Pain Relief Group and Texas Pain Relief Group, is a Florida-based healthcare entity that employs physicians and offers pain management services including urine drug tests ("UDTs").

3. PPOA owns two toxicology laboratories, one on Florida and one in Texas, where it analyzes urine drug test samples referred by its physicians.

11. Since 2013, PPOA has paid physicians employed by or affiliated with its pain clinics based on the volume and value of the UDTs ordered by the physician. PPOA pays physicians a percentage of the net revenue PPOA earns from that physician's UDT orders.

12. By incentivizing physicians to order frequent UDTs, which are then referred to PPOA's laboratories for analysis, PPOA has boosted the revenues and profits earned from its toxicology laboratories.

13. PPOA submits claims for these UDT services directly to Medicare and receives reimbursement from Medicare.

14. Such financial bonuses designed to reward the volume and value of referrals for testing, including medically unnecessary testing, violate the Stark Law and Anti-Kickback Statute's prohibitions on paying employees remuneration based directly or indirectly on the volume or value of referrals. 42 C.F.R. § 411.354(c)(2); 42 U.S.C. § 1320a-7b(b).

15. PPOA also performs medically unnecessary UDTs.

16. Urine drug screens may be performed at different levels of complexity. The first step is a simple dip stick urine screen performed in a medical office. The second level, a qualitative analysis, is performed in a toxicology laboratory to assess the presence of specified drugs. The third level is a high complexity analysis which involves a quantitative

analysis measuring the specific amounts of drugs present in the urine sample. Quantitative tests receive the highest level of reimbursement from Medicare, and qualitative tests receive less reimbursement.

17. PPOA encouraged quantitative and qualitative UDTs be routinely performed on patients at frequent intervals and without regard to whether the tests were medically necessary for that specific patient.

18. Medicare reimburses providers only for the cost of services that are "reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." 42 U.S.C. § 1395y.

19. Despite this, PPOA's policies and practices require physicians to regularly perform qualitative and quantitative UDTs as a routine, repeated practice.

20. Through these practices, which are ongoing, PPOA submitted and continues to submit false or fraudulent claims for reimbursement in violation of the federal False Claims Act.

21. PPOA has also failed to reimburse federal and state health programs under its obligation to repay overpayments. *See* 42 U.S.C. § 1320a-7k(d), 31 U.S.C. § 3729(a)(1)(G).

22. *Qui tam* Plaintiff-Relator Donald Haight seeks through this action to recover all available damages, civil penalties, and other relief for the FCA violations alleged in this Complaint.

II. PARTIES

A. Defendant Physician Partners of America

23. Defendant Physician Partners of America is a Delaware corporation headquartered in Tampa, Florida. Dr. Gari founded PPOA in Texas in 2013 and expanded the company to Florida in 2015. PPOA has eleven locations in Dallas, Texas and eleven locations throughout Florida. PPOA's headquarters are located at 4730 N. Habana Avenue, Suite 204, in Tampa, Florida.

24. PPOA offers a variety of pain management services to patients. As part of its pain management practice, PPOA physicians order UDTs for its pain management patients. Many of PPOA's patients—thirty-one percent in 2017—are covered by Medicare.

25. PPOA owns two clinical laboratories that perform quantitative UDT analysis on patient samples.

26. PPOA submits claims for reimbursement to Medicare for these tests and receives remuneration from Medicare in return. Over half of PPOA's income comes from reimbursement for UDTs.

B. Florida Pain Relief Group PLLC

27. Florida Pain Relief Group is the PPOA-owned physician practice group operating in Florida. It is the entity named as the employer on physician contracts for Florida-based physicians. PPOA manages the administration and business aspect of the relationship, while Florida Pain Relief Group runs the actual patient care aspects of the business in Florida. Dr. Gari is the Manager of the Group.

C. Texas Pain Relief Group PLLC

28. Texas Pain Relief Group is the PPOA-owned physician practice group operating in Texas. It is the entity named as the employer on physician contracts for Texas-based physicians. PPOA manages the administration and business aspect of the relationship, while Texas Pain Relief Group runs the actual patient care aspects of the business in Texas. Dr. Gari is the Manager of the Group.

D. Defendant Dr. Rodolfo Gari

29. Defendant Dr. Rodolfo Gari founded PPOA in 2013. Dr. Gari is a Tampa-based anesthesiologist and has started several healthcare companies. He runs the daily operations of PPOA, including making decisions about physician compensation. Dr. Gari

was personally involved in and aware of PPOA's reimbursement to physicians based on the volume and/or value of UDT ordered by physicians.

E. Plaintiff-Relator

30. Plaintiff-Relator Donald Haight ("Plaintiff" or "Relator") is an individual residing and domiciled in the State of Florida. Relator has extensive experience in the healthcare industry and works as a consultant to healthcare companies. In March 2017, Relator began consulting for PPOA in Florida, where he worked until the conclusion of his contract in October 2017. As part of his arrangement, Relator handled physician recruiting and contracting for PPOA.

31. In his capacity as a consultant to PPOA, Relator had direct knowledge of PPOA's physician reimbursement agreements and drug testing policies.

III. JURISDICTION AND VENUE

32. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331, 28 U.S.C. § 1367, and 31 U.S.C. § 3732, the latter of which specifically confers jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730.

33. This Court has personal jurisdiction over Defendants pursuant to 31 U.S.C. § 3732, which authorizes nationwide service of process. Moreover, Defendants can be found, resides in, or has transacted the business that is the subject matter of this lawsuit in this District.

34. Venue is proper in this District pursuant to 31 U.S.C. § 3732(a) because Defendants can be found, resides in, or has transacted the business that is the subject matter of this lawsuit in this District.

35. The Plaintiff-Relator's complaint is not based upon allegations or transactions of fraud that have been publicly disclosed within the meaning of the False

Claims Act. Even if the allegations or transactions of fraud had been publicly disclosed, the Plaintiff-Relator is an original source of the information within the meaning of the FCA. His information is based upon personal observations, independent of any relevant public disclosure and materially adds to any information that could have been publicly disclosed.

IV. APPLICABLE LAW

A. The False Claims Act

36. The federal False Claims Act (the "FCA") was originally enacted during the Civil War. After finding that fraud in federal programs was pervasive and that the FCA, which Congress characterized as the primary tool for combating government fraud, was in need of modernization, Congress substantially amended the FCA in 1986 to enhance the ability of the United States Government to recover losses sustained as a result of fraud against it. Congress intended that the 1986 amendments would create incentives for individuals with knowledge of fraud against the Government to disclose the information without fear of reprisals or Government inaction, and to encourage the private bar to commit legal resources to prosecuting fraud on the Government's behalf. Congress further substantially amended the FCA in 2009 and 2010 to, among other things, strengthen whistleblowers' ability to bring and maintain actions on the Government's behalf.

37. The FCA prohibits, *inter alia*: (a) knowingly presenting (or causing to be presented) to the federal government a false or fraudulent claim for payment or approval; (b) knowingly making or using, or causing to be made or used, a false or fraudulent record or statement material to a false or fraudulent claim, and (c) knowingly concealing or improperly avoiding or decreasing an obligation to pay or transmit money or property to the Government. 31 U.S.C. § 3729(a)(1)(A), (B), (G). Any person who violates the FCA is liable for the maximum civil penalty under the statute, plus three times the amount of the damages sustained by the United States. 31 U.S.C. § 3729(a)(1).

38. For purposes of the FCA, a person "knows" a claim is false if that person: "(i) has actual knowledge of [the falsity of] the information; (ii) acts in deliberate ignorance of the truth or falsity of the information; or (iii) acts in reckless disregard of the truth or falsity of the information." 31 U.S.C. § 3729(b)(1). The FCA does not require proof that the Defendant specifically intended to commit fraud. *Id.* Unless otherwise indicated, whenever the word "know" and similar words indicating knowledge are used in this Complaint, they mean knowledge as defined in the FCA.

39. The FCA allows any person having information about an FCA violation to bring an action on behalf of the United States, and to share in any recovery. Such a person is known as a *qui tam* "relator." The FCA requires that the *qui tam* relator's complaint be filed under seal for a minimum of 60 days (without service on the defendant during that time) to allow the government time to conduct its own investigation and to determine whether to join the suit.

B. <u>The Stark Law</u>

40. The federal Stark Law, 42 U.S.C. § 1395nn, prohibits physician self-referrals to entities furnishing designated health services ("DHS") if that physician has a financial arrangement with the entity. Congress passed the law due to concern for the conflict of interest posed by physicians referring patients to entities where the physician would financially benefit as a result of the referral. Congress feared that allowing physicians to refer patients based on financial gain could lead to overutilization of DHS based on physician self-interest rather than medical need.

41. DHS includes clinical laboratory services, such as analysis of test samples. 42 C.F.R. § 411.351(1)(ii).

42. Under the Stark Law, 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 DHS for which payment otherwise may be made under Medicare." 42 C.F.R. § 411.353(a); 42 U.S.C. § 1395nn(a)(1)(A).

43. The Stark Law regulations define a "financial relationship" as "a direct or indirect compensation arrangement . . . with an entity that furnishes DHS." 42 C.F.R. § 411.354(a)(1)(ii). A compensation arrangement is "any arrangement involving remuneration, direct or indirect, between a physician (or a member of a physician's immediate family) and an entity." 42 C.F.R. § 11.354(c).

44. A physician who is part of a medical group but does not hold an ownership or investment interest in the group may have a direct financial relationship if she or he is considered part of a "group practice" as defined by the Stark Law. Under the Stark regulations, a group practice must be a "single legal entity operating primarily for the purpose of being a physician group practice . . . For purposes of this subpart, a single legal entity does not include . . . separate group practices under common ownership or control through a physician practice management company, hospital, health system, or other entity or organization." 42 C.F.R. § 411.352(a).

45. If the employing entity does not meet this standard, the physicians it employs are deemed to have indirect compensation arrangements with their employers. Indirect compensation arrangements exist where, among other requirements:

(i) The referring physician and the entity furnishing the DHS have an "unbroken chain of any number (but not fewer than one) of persons or entities that have financial relationships . . . between them"; and

(ii) The "referring physician (or immediate family member) receives aggregate compensation from the person or entity in the chain with which the physician (or immediate family member) has a direct financial relationship that varies with, or

takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS"; and

(iii) "The entity furnishing DHS has actual knowledge of, or acts in reckless disregard or deliberate ignorance of, the fact that the referring physician (or immediate family member) receives aggregate compensation that varies with, or takes into account, the volume or value of referrals or other business generated by the referring physician for the entity furnishing the DHS."

42 C.F.R. § 411.354(c)(2).

46. While the Stark Law regulations do contain an exception for "bona fide employment relationships" between a physician and the employing entity, compensation under this arrangement must be "consistent with fair market value for services performed" and "not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician." 42 C.F.R. § 411.357(c)(2)(i)-(ii).

47. If an entity furnishes DHS due to a prohibited referral, that entity may not present, or cause to be presented, that claim for DHS to Medicare or to any individual, third party payer, or any other entity. 442 U.S.C. § 1395nn (a)(1)(B); 42 C.F.R. § 411.353(b). No Medicare payment may be made for a DHS furnished pursuant to a prohibited referral. 42 C.F.R. § 411.353(c)(1). Furthermore, an entity that received payment for prohibited DHS must refund all collected amounts from prohibited referrals on a timely basis. 42 U.S.C. §1395nn(g)(2); 42 C.F.R. § 411.353(d). The OIG may impose a penalty against any person who fails to refund these amounts on a timely basis. 42 C.F.R. § 1003.102(b)(9).

48. The Stark Law also sets out monetary penalties. "Any person that presents or causes to be presented a bill or a claim for a service that such person knows or should know is for a service for which payment may not be made under [the Stark Law] . . . shall be

subject to a civil money penalty of not more than $15,000 for each such service." 42 U.S.C. § 1395nn(g)(3); 42 C.F.R. § 1003.102(a)(5).

49. Violations of the Stark Law can form the basis for violations of the False Claims Act. *See e.g., U.S. ex rel. Baklid-Kunz v. Halifax Hosp. Med. Ctr.,* No. 6:09-cv-1002-Orl-31DAB, 2012 U.S. Dist. LEXIS 36304, at *8 (M.D. Fla. Mar. 19, 2012), citing *U.S. ex rel. Schmidt v. Zimmer, Inc.*, 386 F.3d 235, 243 (3d Cir. 2004) ("Falsely certifying compliance with the Stark or Anti-Kickback Acts in connection with a claim submitted to a federally funded insurance program is actionable under the FCA.").

C. The Anti-Kickback Statute

50. The federal Anti-Kickback Statute, 42 U.S.C. § 1320a-7b ("AKS"), arose out of congressional concern that financial inducements can influence health care decisions and result in goods and services being more expensive, medically unnecessary, and harmful to patients.

51. To protect the integrity of federal health care programs, Congress prohibited the payment of kickbacks in any form, regardless of whether the kickback actually gives rise to overutilization or unnecessary care. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 242(b) and (c); 42 U.S.C. § 1320a-7b, Medicare and Medicaid Antifraud and Abuse Amendments, Pub. L. No. 95-142; Medicare and Medicaid Patient and Program Protection Act of 1987, Pub. L. No. 100-93.

52. The AKS prohibits any person or entity from making or accepting payments to induce or reward any person for referring, recommending or arranging for the purchase of any item for which payment may be made under a federally-funded health care program. 42 U.S.C. § 1320a-7b(b).

53. The statute prohibits offering or paying any remuneration, including anything of value, in cash or kind, directly or indirectly, to induce or influence physicians or others to

order or recommend laboratory services that may be paid for by federal health care programs. The AKS has been interpreted to cover any arrangement where one purpose of the remuneration was to obtain money for the referral of services or to induce further referrals.

54. The AKS prohibits employers from paying their employees bonuses or remuneration based directly or indirectly on the volume or value of referrals. 42 U.S.C. § 1320a-7b(b).

55. Compliance with the AKS is a precondition to both participation as a health care provider in and payment under Medicaid, Medicare and other federal health care programs. 42 U.S.C. § 1320a-7(b)(7).

56. For example, to establish eligibility and seek reimbursement from the Medicare Program, hospitals and other providers enter into Provider Agreements with CMS. As part of that agreement, the provider must sign the following certificate:

> I agree to abide by the Medicare laws, regulations and program instructions that apply to [me]. The Medicare laws, regulations and program instructions are available through the [Medicare] contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, the Federal Anti-Kickback Statute 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)

CMS, Medicare Enrollment Application, Form CMS-855O (01/17), *available at* https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms855o.pdf.

57. In sum, physicians, hospitals, and other providers who participate in federal health care programs must certify (often explicitly, in a provider agreement or on claim forms) that they have complied with the applicable federal rules and regulations, including the AKS.

58. Any party convicted under the AKS must be excluded from federal health care programs (*i.e.*, not allowed to bill for services rendered) for a term of at least five years. 42 U.S.C. § 1320a-7(a)(1).

59. Even without a conviction, if the Secretary of the Department of Health and Human Services ("HHS") finds administratively that a provider has violated the statute, the Secretary may exclude that provider from the federal health care programs for a discretionary period (in which event the Secretary must direct the relevant State agency to exclude that provider from the State health program), and may consider imposing administrative sanctions of $50,000 per kickback violation. 42 U.S.C. § 1320a-7(b).

60. Pursuant to the Affordable Care Act passed in 2010, any claim submitted to a federal health care program that includes items or services resulting from violations of the AKS constitutes a false or fraudulent claim for purposes of the False Claims Act. 42 U.S.C. § 1320a-7b(g).

D. The Medicare Program

61. Congress established the Medicare program, Title XVIII of the Social Security Act, in 1965 with the goal of providing nationalized health coverage for Americans aged 65 or older. In addition to the elderly, a large portion of Medicare's patient population is disabled. In 2015, Medicare covered roughly 55 million Americans, either through the traditionally federally administered Medicare program or through a private health plan, also known as a Medicare Advantage plan. Medicare is funded through the Medicare Trust Fund, which relies on workers' payroll deductions and government funds.

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

63. Medicare has four parts: Part A, providing hospital insurance; Part B, providing medical insurance, Part C, which includes managed care plans; and Part D, which provides prescription drug benefits. Medicare Part B includes reimbursement for covered laboratory tests when the tests are medically necessary and reasonable. 42 U.S.C. § 1395k(a)(2)(B).

64. Medicare program regulations require that laboratory tests must be ordered for the treatment of a specific illness or injury. Laboratory test orders that are not individualized to patient need are not reasonable and necessary covered services, and claims for such services will be denied by Medicare. 42 C.F.R. § 410.32(d)(3).

65. Section 1862 of the Social Security Act, codified at 41 U.S.C. § 1395y(a)(1)(A), explains that under Medicare Part B, "no payment may be made under part A or part B for any expenses incurred for items or services . . . [that] are not reasonable and necessary for the prevention of illness." A claim is properly denied where the service provided is not reasonable and necessary and the necessity is not documented in the medical record, or if the Medicare Administrative Contractor has made a local coverage determination that the service is not covered. 42 C.F.R. § 410.32(d)(2)(i)-(iii); (d)(3)(ii)-(iii).

66. As a condition of Medicare payment, a provider must certify that the testing performed is medically necessary and reasonable for the diagnosis and treatment of the patient. 42 U.S.C. § 1395n(a)(2)(B); 42 C.F.R. § 424.10(a).

67. Medicare regulations require providers and suppliers to certify that they meet, and will continue to meet, the requirements of the Medicare statute and regulations. 42 C.F.R. § 424.516(a)(1).

V. ALLEGATIONS

A. PPOA Paid Physicians Based on the Volume and Value of Urine Drug Tests Performed

68. PPOA, through its two physician groups—Florida Pain Relief Group and Texas Pain Relief Group—entered into contracts with individual physicians. These employment contracts governed physicians' compensation arrangements. At the time of Relator's contract with PPOA, PPOA employed approximately 25 physicians.

69. A large part of PPOA's revenue came from conducting and receiving reimbursement from drug tests performed at one of two PPOA-owned laboratories. PPOA conducted two kinds of drug tests: qualitative and quantitative tests.

70. Typically, when medical providers order UDTs, they first order a qualitative UDT to detect the presence or absence of drugs in the sample. A qualitative UDT is a screening panel that includes testing for the presence of several of drugs at once. A qualitative UDT does not measure the concentration of any drugs in the sample—only the presence or absence of a drug.

71. Depending on the initial results from the qualitative UDT, a physician may subsequently perform a quantitative UDT to test the concentration of specific drugs in a patient's system. The purpose of quantitative testing is to confirm any positive results from the qualitative test and to determine the concentration of the drug present. Unlike the qualitative test, which can simultaneously test for numerous drugs from the same sample, quantitative testing requires that a separate test be run for each different drug. Because of this, each quantitative test requires more sophisticated testing equipment, making the test more expensive to perform.

72. Physicians conduct UDTs by collecting a urine sample from the patient in-office. PPOA providers then send the samples to PPOA's laboratories for analysis.

73. PPOA billed patients' insurers, including Medicare, for the cost of conducting UDTs. PPOA's Director of Revenue Cycle Management oversaw the process for billing insurers and receiving payments. In 2016, PPOA providers ordered approximately 39,000

UDTs. On average, in 2016 PPOA received $413.55 per UDT performed. From an August 9, 2017 Financial Review slide deck presented by CFO Dawn Bennett-Johnson, Director of Finance Melissa James, and Controller Melissa Delker to Relator and others at PPOA, Relator learned that PPOA received reimbursement from Medicare for UDT tests.

74. Relator commenced work at PPOA in March 2017 and was assigned the task of reviewing PPOA's new employment contracts with individual physicians. Based on this review, Relator determined that PPOA based part of physicians' compensation directly upon the value of UDTs and other ancillary services ordered by that physician.

75. PPOA designed its physician payment structure to reward physicians for maximizing UDT orders, thereby boosting revenues from the reimbursement for the tests. Incentivizing physicians to conduct as many tests as possible by rewarding them financially per test assisted PPOA in achieving its revenue goals.

76. Relator reviewed PPOA employment agreements guaranteeing its physicians forty percent of the net profits that PPOA made from reimbursement from ancillary services, including qualitative UDTs.

77. PPOA's standard employment agreement with physicians provided payment of a percentage of the net profits received by PPOA from performing specified ancillary services including UDTs:

> Employee will also be paid as compensation forty percent (40%) of the net profit to Employer derived from the sale of durable medical equipment, kits, office based qualitative urine drug screens, neuromonitoring services, or other office ancillary products purchased and sold by Employer or other office ancillary services provided by Employer as each are solely allocable and attributable to Employee and patients under his supervision. Such net profit calculation shall be determined by Employer in its sole and absolute discretion based on actual billings and collections by Employer, and shall be reduced by all applicable payroll taxes.

Ex. 1, Ahmed Employment Agreement Attachment A – Compensation.

78. PPOA used a standard template for their employment agreements with physicians. Although minor changes were made in some cases, PPOA used the same contract template, including the clause *supra*, for all the PPOA physician agreements Relator reviewed.

79. Dr. Gari edited the templates personally, or directed the Vice President of Human Resources, Terri Casey, to make the changes he desired. Dr. Gari personally decided that PPOA physicians would be compensated based on the volume and value of UDT testing.

80. Recognizing that compensation based on the volume or value of referrals could violate the Stark and/or Anti-Kickback Statutes, Relator met with Dr. Gari in early April 2017 and informed him of his concerns with physicians' compensation for UDTs and other ancillary services. However, Dr. Gari brushed off Relator's concerns and assured him that the arrangement was legitimate.

81. Relator then asked PPOA's CFO, Dawn Bennett-Johnson, how PPOA distributed ancillary income to physicians. She confirmed that PPOA distributed it to physicians as a percentage of the net profits earned by PPOA determined by the volume and value of ancillary services, including UDTs, ordered by the physician. Subsequently, Relator confirmed the same with Michelle Delker, PPOA's Controller, and Director of Finance Melissa James. Delker and James both confirmed to Relator that income from UDTs (and other ancillary services) were paid to physicians as outlined in the contracts.

82. Relator requested another meeting with Dr. Gari, COO Tracie Lawson, and Chief Medical Director Dr. Abraham Rivera. That meeting occurred on June 20, 2017. Relator brought a copy of the relevant portions of the Stark Law to the meeting and reiterated his concerns.

83. After the June 20 meeting and further discussion with senior management, Dr. Gari directed Dr. Abraham and Lawson to cease paying physicians a percentage of the

income from the tests generated for future contracts. The distribution method would instead be changed to distribute ancillary income based on doctors' wRVUs (work relative value units—a measure of work expended by a physician in treating patients). The contracts that Relator prepared for new physicians whose practices were acquired by PPOA were changed to include a sentence stating that income from UDTs and other office services would be paid in accordance with the Stark Law. However, PPOA did not amend any preexisting physician contracts to do away with the clause calculating compensation based on the value of UDT referrals.

84. Moreover, although PPOA's new contracts stated that compensation will be compliant with the Stark law, Dr. Gari directed PPOA's Director of Finance, Melissa James, to still pay physicians their second quarter ancillary income based on the net profits attributable to their qualitative UDT order value. Consequently, in the second quarter of 2017 PPOA continued to pay physicians based on the profits generated from UDT income.

85. Compensation agreements between a medical practice management entity such as PPOA and its physicians that pay compensation based in part or in whole on the volume or value of Medicare-reimbursed services violate the Stark Law. By linking physicians' pay directly with the profits PPOA gained from the tests performed, some of which were reimbursable by Medicare, PPOA entered into compensation arrangements that failed to fall into any of the exceptions to the Stark Law, and were thus prohibited by the law.

86. Likewise, paying physicians forty percent of the net profit per test ordered violates the AKS's prohibition against paying physicians to order or recommend laboratory services that may be paid for by federal health care programs.

87. Claims presented for payment to Medicare by PPOA in violation of the Stark and Anti-Kickback statutes are false claims, and such violations are material to Medicare's payment decision. *See* 42 U.S.C. § 1320a-7b(g) ("a claim that includes items or services

resulting from a violation of [the AKS] constitutes a false or fraudulent claim for purposes of [the False Claims Act]."); *see also U.S. ex rel. Emanuele v. Medicor Assocs.*, 242 F. Supp. 3d 409 (W.D. Pa. 2017), *reconsideration denied*, No. CV 10-245, 2017 WL 3675921 (W.D. Pa. Aug. 25, 2017) (holding violations of the Stark and Anti-Kickback Statutes are material to false claims); *United States v. Rogan*, 517 F.3d 449 (7th Cir. 2008) (omissions disclosing referrals in violation of the Stark Law in Medicare claims are material to false claims).

88. PPOA presented false claims to Medicare in violation of the Stark and Anti-Kickback statutes and received reimbursement for those claims.

E. PPOA's Urine Drug Screen Policies Result in Unnecessary Tests and the Submission of False or Fraudulent Claims to Medicare for Reimbursement

89. Drug testing can be an appropriate clinical tool in the medical management of pain patients. By performing drug tests, medical practitioners can verify whether pain patients have taken prescribed drugs, and if the patient is taking other drugs, including illicit ones, which could interfere with treatment or pose addiction dangers.

90. For this reason, many pain patients receive drug tests at appropriate intervals, when the physician deems the tests medically necessary for management of the patient and an appropriate part of that patient's care. Under those circumstances, drug tests may properly be reimbursed by insurers including Medicare.

91. However, tests performed routinely without any basis in the patient's individualized need are not medically necessary or reasonable. Medicare reimbursement is limited to UDTs performed when the test is reasonable and medically necessary for the patient's individual medical management and care as evaluated by medical practitioners.

92. A policy that requires all patients to be tested at certain intervals cannot by nature be based on any individualized need.

93. Routine and indiscriminate quantitative testing of all pain patients is not medically necessary because the same test is not reasonable and necessary for every patient in a physician's practice.

94. Although an initial "baseline" UDT can be acceptable in certain circumstances, frequency of testing beyond an initial baseline qualitative UDT must be based on individual patient needs. Ongoing testing in patients can be acceptable only under specific conditions particular to the individual patient, such as a prior history of drug abuse or previous positive drug tests. For patients lacking those risk factors, repeated urine drug screens would not be medically necessary. OIG Compliance Guidance states that "laboratories should encourage physicians or other authorized individuals to submit diagnosis information for all tests ordered, as documentation of the medical necessity of the service" and that "Medicare generally does not cover routine screening tests." 63 Fed. Reg. 45076, 45079 (Aug. 24, 1998).

95. The Medicare National Coverage Determinations Coding Policy Manual and Change Report states that "[s]ervices that are excluded from coverage include . . . services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury. CMS interprets these provisions to prohibit coverage of 'screening' services, including laboratory test services furnished in the absence of signs, symptoms, or personal history of disease or injury, except as explicitly authorized by statute." CMS, The Medicare National Coverage Determinations Coding Policy Manual and Change Report, 2 (Oct. 2015) (emphasis added) *available at* https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/Downloads/manual201510_ICD10.pdf.

96. Likewise, Medicare rules limit quantitative screening to clinical situations where qualitative screening has been performed and the results of the test indicate that quantitative tests for particular drugs are needed.

97. Despite Medicare's rules, PPOA's policy requires physicians to order unnecessary, repetitive, and indiscriminate UDTs for its patients, and to submit claims for reimbursement for those tests to Medicare and private insurers.

98. PPOA incentivizes its physicians to order qualitative UDTs for every patient by paying physicians a percentage of the net profit that PPOA acquired from that physician's testing. Giving the physician a direct financial stake in the number of tests ordered makes it personally profitable for physicians to order as much qualitative testing as possible, encouraging physicians to order medically unnecessary tests.

99. From conversations with Dr. Gari, Relator learned that PPOA's policy encourages physicians to order a qualitative UDT for every new patient that enters the practice, and each time the patient returns to refill their medication. Patients typically return once a month to refill medications, as pain medications are only dispensed in thirty-day quantities. PPOA's policy is that physicians should not refill a prescription unless the patient has received a qualitative UDT.

100. Relator also understood from conversations with Dr. Gari that PPOA's policy directs physicians to order a quantitative UDT for each patient once every three months. This policy fails to take into account the patient's individualized medical history but rather uses a "one size fits all" approach for all patients.

101. This policy also directly harms some patients by burdening them with large and unexpected medical expenses for the quantitative tests. PPOA's laboratory where quantitative tests are sent for analysis does not contract with any insurers except Medicare. Therefore, when PPOA sends samples to its laboratories for quantitative testing, some

patients are charged out-of-network costs for the tests. A quantitative test costs approximately $9,000. Some patients' insurers paid a small out-of-network portion of this cost, while the patient carried most of the cost. Some patients were unable to get any portion of this out-of-network test paid for by their insurance.

102. About sixty percent of PPOA physicians adhere to PPOA's policies and practices for once monthly qualitative UDTs and once every three months quantitative UDTs for patients.

103. PPOA did not base its testing policy on medical necessity but rather on its corporate goal of achieving revenue targets from laboratory income.

104. Relator understood that Dr. Gari and Dr. Rivera directed and implemented these policies. It is well known and commonly understood at PPOA that doctors were expected to follow this testing schedule.

105. By routinely submitting claims to Medicare for patients who received UDTs without regard to medically necessity, PPOA submits false and fraudulent claims to Medicare. PPOA knew that many of the claims submitted for its UDTs were materially false and, in conducting indiscriminate, unnecessary, and repetitive UDTs, and submitting claims for reimbursement for these tests to Medicare, acted recklessly and in deliberate indifference to material conditions of reimbursement.

106. PPOA received payment from Medicare for these false and fraudulent claims and, to Relator's knowledge, has not repaid Medicare for these overpayments.

VI. CAUSES OF ACTION

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

107. Relator realleges and incorporates by reference the allegations contained in paragraphs 1-106 above as though fully set forth herein.

108. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. § 3729, *et seq.* as amended.

109. By and through the acts described above, Defendants have knowingly presented or caused to be presented false or fraudulent claims for payment or approval, in violation of 31 U.S.C.§ 3729(a)(1)(A).

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

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

112. The Government, unaware of the falsity of all such claims made or caused to be made by Defendants, has paid and continues to pay such false or fraudulent claims that would not be paid but for Defendants' illegal conduct.

113. By reason of Defendants' acts, the United States has been damaged, and continues to be damaged, in a substantial amount to be determined at trial.

114. Additionally, the United States is entitled to the maximum penalty for each and every violation alleged herein.

VII. PRAYER

WHEREFORE, Plaintiff prays for judgment against Defendants as follows:

1. That Defendants cease and desist from violating 31 U.S.C. § 3729, *et seq.*;

2. That this Court enter judgment against Defendants in an amount equal to three times the amount of damages the United States has sustained because of Defendants' actions, plus the maximum civil penalty for each violation of 31 U.S.C. § 3729.

3. That Relator be awarded the maximum amount allowed pursuant to § 3730(d) of the Federal False Claims Act.

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

5. That the United States and Plaintiff-Relator recover such other and further relief as the Court deems just and proper.

REQUEST FOR TRIAL BY JURY

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

Dated: February 1, 2018

Respectfully submitted,

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Attorneys for *Qui Tam* Plaintiff Donald Haight

CERTIFICATE OF SERVICE

I, Jillian L. Estes, hereby certify that the foregoing Complaint for Violations of the False Claims Act was filed with the Court on February 1, 2018, but was not served on the Defendants pursuant to 31 U.S.C. 3730(b)(2) which provides that, "The complaint shall be filed in camera…and shall not be served on the defendant until the court so orders." Relator will serve the Complaint on Defendants when so ordered by the Court.

Dated: February 1, 2018

Jillian L. Estes
Counsel for Plaintiff-Relator Donald Haight

EXHIBIT 1

EMPLOYMENT AGREEMENT

THIS EMPLOYMENT AGREEMENT (this ***"Agreement"***) made and entered into June 20, 2017 and effective 9/25/17 (the ***"Effective Date"***), by and between FLORIDA PAIN RELIEF GROUP, PLLC, a Florida professional limited liability company (the ***"Employer"***), and Taufiq Uddin Ahmed , M.D., an individual resident in the State of Florida (the ***"Employee"***) (each a ***"party"*** and collectively the ***"parties"***).

AGREEMENT

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the parties agree as follows:

1. Employment. The Employer hereby employs the Employee, and the Employee hereby accepts full time employment.

2. Term. Subject to the provisions of termination as hereinafter provided, the term of this Agreement shall begin on the Effective Date and terminate on 9/24/18 (***"Initial Term"***); provided, however, that this Agreement shall automatically be renewed for successive one (1) year terms unless employment is terminated as otherwise provided in this Agreement (each, a ***"Renewal Term"***). The Initial Term and any Renewal Term(s) of this Agreement may be referred to herein collectively as the ***"Term."***

3. Compensation. In exchange for the services rendered hereunder, the Employee shall be entitled to the compensation as more particularly described on **Attachment A** ("**Compensation**"). Any Compensation due hereunder shall be payable by the Employer in accordance with its normal payroll practices. The Employer shall withhold amounts from the Employee's Compensation in accordance with the requirements of applicable law for federal and state income tax, FICA, FUTA, and other employment or payroll taxes. The Employee has the sole responsibility to report and pay all federal, state, and local taxes arising from the Employee's actual receipt of Compensation hereunder.

4. Duties. The Employee is engaged to practice medicine, specializing in Pain Management ***("Specialty")***, on behalf of the Employer in accordance with the laws of the State of Florida ***("State")*** and principles of medical ethics of the Florida Board of Medicine, and in addition, the Employee shall have such other duties as may from time to time be reasonably assigned to the Employee by the Employer. The Employee shall also perform all services and duties hereunder in accordance with **Attachment B** and **Attachment C** (collectively, the ***"Duties"***).

5. Devotion to Practice of Medicine. Except to the extent necessary to fulfill the Duties required of the Employee under this Agreement, during the Term, the Employee shall not engage in, conduct, be engaged as, or be employed by, directly or indirectly, any other person, entity, or business regarding any aspect of the practice of medicine or the Employee's Specialty, without the prior written consent of the Employer; except that the Employee may seek and accept any elective or appointive office or position within any recognized medical association or hospital, attend medical meetings and conventions, and perform such other professional activities as may be mutually agreed upon in writing by the Employee and the Employer. Nothing herein contained shall prohibit the Employee from investing or trading in

stocks, bonds, commodities or other securities or forms of investments, including real property; provided, however, that such activities do not interfere with the Employee's performance of the Duties required hereunder or are not otherwise prohibited by **Sections 14 or 15** of this Agreement.

6. Medical Practice of Employer.

A. Professional Policies and Procedures. The Employer shall have the authority to establish the professional policies and procedures to be followed by the Employee in handling each individual patient of the Employer. The parties acknowledge that the foregoing provisions of this Section are not intended to interfere in any way with the traditional physician-patient relationship between the Employee and patients served by the Employee or the Employee's independent medical judgment.

B. Patients and Patient Records. The Employer shall have the authority to determine who will be accepted as patients of the Employer, and the Employee recognizes that such patients accepted are patients of the Employer and not the Employee. The Employer shall have the authority to designate, or to establish a procedure for designating, which professional employee of the Employer will handle each such patient. All patient records, case histories, x-ray films, and files of any type concerning patients of the Employer, or patients consulted, interviewed, or treated and cared for by the Employee, shall belong to and remain the property of the Employer, notwithstanding the subsequent termination of this Agreement.

C. Fees. The Employer shall have exclusive authority to determine the fees, or a procedure for establishing the fees, to be charged to patients of the Employer. All sums paid by any patient of the Employer in the way of fees for medical services rendered by the Employee and all sums received by the Employee for medical related activities, including teaching, compensation, and expert witness fees, shall be and remain property of the Employer and shall be included in the Employer's income and deposited in the Employer's name in such checking account or accounts as the Employer may from time to time designate. The Employee will be entitled to receive honorariums, as long as the honorariums are obtained on the Employee's own time.

D. Third Party Payor Programs. The Employee shall cooperate in obtaining reimbursement for the services hereunder, including without limitation, executing and ratifying managed care and any other discounted or other third party payor arrangements, whenever requested by the Employer, to facilitate the entry into or maintenance of any third party payor arrangement. In furtherance thereof, the Employee shall participate in Medicare, Medicaid and all third-party payor arrangements made available by or through the Employer and agrees to promptly review, complete, and submit any and all documents reasonably requested by the Employer to assist the Employer and its affiliates in connection with participation in Medicare and such third-party payor arrangements and the validation and credentialing of the Employee in connection with such arrangements. The Employee hereby agrees to assign to the Employer or the relevant applicable affiliate or subsidiary or other entity designated by the Employer: (i) the Employee's right to bill for all services which the Employee renders to patients of the Employer or its affiliates, and (ii) the Employee's right to collect and retain the proceeds of such billings. The Employee further agrees to execute any and all other reasonably required documentation to effectuate such assignment or reassignment,

including but not limited to a Form CMS-855R. The Employee shall not bill, charge, collect, or seek compensation in any form from any patients or third-party payment source for the services provided pursuant to this Agreement. The Employee agrees to appoint the Employer and hereby does appoint the Employer as the Employee's attorney-in-fact to execute, deliver or endorse checks, applications for payment, insurance claim forms or other instruments required or convenient, as determined by the Employer in its sole discretion, to collect fully, secure or realize all sums due to the Employer for medical and professional services rendered by the Employee to patients of the Employer and its affiliates during the Term. The power of attorney granted to the Employer by the Employee in the preceding sentence shall survive expiration or termination of this Agreement for a period of twelve (12) months but relate only to services provided to patients of the Employer and its affiliates during the Term.

E. Medical Records. The Employee shall maintain, in accordance with the Employer's policies, a standard medical record for each patient treated by the Employee pursuant to this Agreement, containing such information and preserved for such time period as may be required by the Employer and by law. The Employee acknowledges and agrees that in performing Duties hereunder, the Employee will have access to and be provided with protected health information (as that term is defined in 45 C.F.R. § 160.103) and will be creating, using and disclosing such protected health information solely for purposes of treatment of the Employer's patients. Any and all protected health information to which the Employee has access or creates in the Employee's performance hereunder shall be and remain the property of the Employer. Specifically, but not by way of limitation, the Employee represents and warrants that the Duties owed by the Employee hereunder shall comply with all applicable statutes, rules, regulations, accreditation standards and other applicable standards of: Medicare; Medicaid; the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act, and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Parts 160 and 164; and any other federal or state health programs.

F. Fraud and Abuse. The parties acknowledge and agree that it is not a direct or indirect purpose of this Agreement that either party is inducing, or attempting to induce, the other to refer any individual to the other or to any other person or facility 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 Medicare, Medicaid, or any other governmental or private payment program, and that there is no obligation on the part of the Employee to refer patients to the Employer. The parties specifically intend to comply with the federal Anti-Fraud and Abuse provisions (42 U.S.C. § 1320a-7b(b)) and the Ethics in Patient Referrals Act (42 U.S.C. § 1395nn) or regulations promulgated thereunder (commonly known as the Stark Law), or any analogous state law.

G. Ancillary Businesses. The Employee agrees to refer patients to those ancillary businesses, including facilities, designated in writing or verbally by the Employer to the Employee from time to time subject to applicable laws.

H. Use of Preferred Vendors. Employer and Employee acknowledge and agree that Employer has a negotiated list of preferred vendors for Employer equipment and supply items. In an effort to improve quality of care and to manage costs, Employer expects Employee to use the equipment and supply items offered by these preferred

vendors for his/her patients. Employee agrees to disclose to Employer any arrangement with any vendor of equipment or supply items for which Employee receives compensation.

7. Work Schedule. The Employee shall be assigned to work full-time days, scheduled Monday through Friday and share equal call responsibilities with other providers of the Employer in the same specialty as Employee, including with respect to the Employee's own patients.

8. Facilities. The Employer shall furnish the professional office space, medical, personnel, medical equipment, secretarial help, supplies, and such other facilities and services determined by the Employer to be needed by the Employee in rendering professional services on behalf of the Employer.

9. Employee Benefits. The Employer shall provide the Employee with employee benefits in accordance with the Employer's policies as in effect from time to time.

10. Malpractice Insurance. The Employer shall maintain during the Term and pay for on behalf of the Employee malpractice and professional liability insurance in accordance with the Employer's policies as in effect from time to time. If Employee voluntarily resigns or is terminated for cause, Employee will pay for malpractice tail coverage; if Employer terminates employment without cause Employer will pay tail coverage. Employer will cover the full cost of malpractice tail coverage related to Employee's current employment. If Employee's employment with Employer, pursuant to this agreement, is terminated within three years of the effective date of this Agreement, Employee agrees to reimburse Employer for the cost of said tail coverage through payroll deductions. Additionally, if Employee's employment is terminated, at any time, Employee agrees to pay the cost of tail insurance to cover claims that may originate from the Employee's service to the Employer. Employee agrees that the cost of such coverage will be paid through payroll deductions. Any amounts due and not paid through payroll deductions shall be paid by Employee within thirty days of termination of employment.

A. Illness or Incapacity. The Employer intends to comply with its obligations under the Americans with Disabilities Act, as amended, and the Family Medical Leave Act, if applicable.

11. Death During Employment. f the Employee dies during the term of the Employee's employment, the Employer shall pay to the estate of the Employee to the extent permitted by applicable laws the Compensation then owing at the time of death and termination of this Agreement as described on **Attachment A**. After receiving the payment provided in this Agreement, the Employee and the Employee's estate shall have no further rights under this Agreement, except for those which may be available under the Employee Retirement Income Security Act of 1974.

12. Disclosure. The Employee agrees that during the Term, the Employee will disclose and disclose only to the Employer all ideas, methods, plans, development or improvements known to or discovered by the Employee which relate directly or indirectly to the practice of the Employer, to the extent acquired by the Employee during the Employee's employment by the Employer; provided that nothing in this Section shall be construed as requiring any such communication where the idea, plan, method or development is lawfully protected from disclosure as a trade secret of a third party or by any lawful prohibition against such communication.

13. Confidentiality; Non-Disparagement; Trade Secrets.

A. The Employer may provide the Employee access to its Confidential Information (as defined below), to enable the Employee to perform the Duties.

B. The Employee agrees to keep in strict secrecy and confidence any and all information the Employee assimilates or to which the Employee has access during the Employee's employment by the Employer and which has not been publicly disclosed and is not a matter of common knowledge in the areas of practice in which the Employer is engaged. The Employee agrees that both during and after the terms of the Employee's employment by the Employer, the Employee will not without prior written consent by the Employer, disclose any such confidential information to any third person, partnership, joint venture, company, corporation or other organization except the Employee may disclose confidential information to his attorney and accountant solely to the extent necessary for such individuals to assist the Employee and provided that the Employee informs such attorney and accountant of the confidentiality restrictions set forth herein and the Employee is responsible for any further disclosure by such attorney or accountant in violation and in breach of this Agreement. The term "***Confidential Information***" shall include, without limitation, patient lists and related patient information, patient files, billing information, names and addresses of managed care organizations and contract relationships, physician and other referral sources, processes, procedures, marketing, proprietary information, trade secrets, business plans financial data and other information, whether in paper form, any computer file, or in any other form developed by or on behalf of the Employer or information that is otherwise treated as confidential by the Employer. The term "Confidential Information" does not include any information that: (i) is or becomes generally available to the public other than as a result of disclosure by the Employee, (ii) becomes available to the Employee on a non-confidential basis from a source other than the Employer, which source is not prohibited from disclosing such information to the Employee by a legal, contractual or fiduciary obligation to the Employer, or (iii) was in the Employee's possession at the time of disclosure by the Employer to the Employee, provided that it was not received from a source known to the Employee to be in a confidential relationship with the Employer.

C. The Employee shall not make or cause to be made any written (including, but not limited to, any e-mails or internet postings, remarks or statements) or verbal assertions, statements or other communication s regarding the Employer, its business, customers, patients, equity holders, officers, managers, directors or other agents or affiliates which may be in any manner whatsoever defamatory, detrimental or unfavorable to the Employer.

D. All right, title and interest in all copyrightable material that the Employee shall conceive or originate, either individually or jointly with others, and which arise out of the performance of this Agreement, will be the property of the Employer and are by this Agreement assigned to the Employer along with ownership of any and all copyrights in the copyrightable material. Upon request and without further compensation therefor, but at no expense to the Employee, the Employee shall execute all papers and perform all other acts necessary to assist the Employer to obtain and register copyrights on such materials. Where applicable, works of authorship created by the Employee for the Employer in performing his responsibilities under this Agreement shall be considered "works made for hire," as defined in the U.S. Copyright Act. All know-how and trade secret information conceived or originated by the Employee that arises out of the performance of his obligations or responsibilities under this Agreement or any

related material or information shall be the property of the Employer, and all rights therein are by this Agreement assigned to the Employer.

14. Non-Competition and Non-Solicitation.

A. The Employee acknowledges and agrees that the Employer is engaged in a highly competitive profession and business and must protect its Confidential Information against unauthorized use or disclosure, which would irreparably harm the Employer's interests. The Employee recognizes that the disclosure by the Employer of certain of the Employer's Confidential Information will be necessary and useful to the Employee's performance of his Duties for the Employer. As a result, the Employer shall provide the Employee access to Confidential Information that could be used by the Employer's competitors and clients in a manner that would irreparably harm the Employer's competitive position in the marketplace.

B. In consideration for Employer's employment of Employee, and other good and valuable consideration as stated herein, the Employee agrees to the following:

i. Employee warrants that Employee's performance under this Agreement will not conflict with any prior agreements to which Employee may be bound.

ii. During the term of Employee's employment, whether pursuant to this Agreement, any automatic or other renewal hereof or otherwise and for a period of twelve (12) months after the termination of the Employee's employment regardless of the reason the Employee's employment is terminated with or without cause, the Employee shall not directly or indirectly: (1) enter into or engage in the practice of the Specialty, either as an individual on the Employee's own account, or as a partner or as an employee, for any person or entity, or as an officer, director or stockholder of a corporation, or otherwise, within a ten (10) mile radius of any office location of the Employer at which Employer engages or plans to engage in any element of the Specialty and, at which, the Employee performed services during the term of this Agreement (the "***Restricted Territory***"); or (2) have any financial relationship in or with any person or entity engaging in the practice of or management of Specialty within the Restricted Territory. For purposes of this Section, Employer will be deemed to have "plans to engage" in any element of the Specialty if Employer (x) is actively considering engaging in such element of the Specialty as of date of termination of Employee's employment and (y) engages in such element of the Specialty within one hundred twenty (120) days after the date of termination of employment.

iii. During the Employee's employment with the Employer, and for a period of twenty four (24) months after the termination of the Employee, the Employee will not, directly or indirectly,

as an independent contractor, an employee, consultant, agent, partner, joint venturer, or otherwise, solicit: (1) any of the employees of the Employer, who were employees in the twenty (24) months prior to termination of the Employee's employment, to terminate or curtail their employment with the Employer; or (2) any referral source, patient, payor, hospital, surgery center, or person or organization for which the Employer or the Employee engaged in any business relationships during the twenty four (24) months prior to termination of the Employee's employment, to terminate, curtail or otherwise divert such relationship with the Employer.

iv. The period of time during which the Employee is prohibited from engaging in such business practices shall be extended by any length of time during which the Employee is in breach of such covenants. Any length of time is defined as the period of time in which the Employee is in violation of this agreement.

C. The Employer has the right to disclose the terms of this **Section 15** to any future employer or business association, which engages the Employee without incurring further liability.

15. Enforcement of Covenants.

A. It is understood by and between the parties that the covenants set forth in **Section 15** are essential elements of this Agreement intended to protect the legitimate business interests of the Employer, and that, but for the agreement of the Employee to comply with such covenants, the Employer would not have agreed to enter into this Agreement. Such covenants by the Employee shall be construed as agreements independent of any other provision in this Agreement. The existence of any claim or cause of action of the Employee against the Employer, whether predicated on this Agreement or otherwise, shall not constitute a defense to the enforcement by the Employer of such covenants.

B. If any portion of the covenants set forth are held to be unreasonable, arbitrary or against public policy, then such covenants shall be considered divisible as to scope, time and geographical area. The Employer and the Employee agree that, if any court of competent jurisdiction, tribunal, arbitrator or other decision makers, agreed upon by the Employee and Employer, determines any portion of Section 15, including, without limitation, the specified time period or the specified geographical area applicable to Section 15 to be unreasonable, arbitrary or against public policy, then a lesser time period or geographical area or fewer restrictions which are determined to be reasonable, non-arbitrary and not against public policy may be enforced against the Employee. Likewise, if any court of competent jurisdiction determines that either all or any portion cannot be revised to be enforceable, then and in that event, the portion which is not enforceable shall, as to such jurisdiction, be ineffective to the extent of such unenforceability without invalidating the remaining provisions hereof or affecting the validity, enforceability or legality of such provisions in any other jurisdiction. In any such case, such determination shall not affect any other provisions of this Agreement, and the remaining provisions of this Agreement shall remain in full force and effect. The Employer

and the Employee agree that the foregoing covenants are appropriate and reasonable when considered in light of the nature and extent of the practice conducted by the Employer, and do not prevent the Employee from otherwise earning a living as a physician in the Specialty in compliance with Section 15.

16. Specific Performance. The Employee agrees that damages at law will be an insufficient remedy to the Employer in the event that the Employee violates the terms of this Agreement, and that the Employer shall be entitled upon application to a court of competent jurisdiction, to obtain injunctive relief to enforce the provisions of such Sections, which injunctive relief shall be in addition to any other rights or remedies available to the Employer.

17. Compliance with other Agreements. The Employee represents and warrants that the execution of this Agreement by the Employee and the Employee's performance of the obligation s hereunder will not conflict with, result in the breach of any provisions of or the termination of or constitute a default under any agreement to which the Employee is a party or by which the Employee is or may be bound, including, without limitation, any non-compete covenants or other restrictive covenants, if any, by which the Employee may be bound. The Employee further represents and warrants that this Agreement is a legally valid and enforceable agreement against the Employee and that the Employee has been advised to consult with and has had an opportunity to consult with legal counsel prior to entering into this Agreement.

18. Termination of Agreement.

A. The Employee or the Employer may voluntarily elect to terminate this Agreement without cause by delivering to the other party written notice of such intention to terminate at least ninety (90) days prior to the date upon which termination is desired.

B. The Employer may terminate the employment of the Employee hereunder immediately upon notice upon the Employee's losing the Employee's license to practice medicine under the laws of the State of Florida, upon the suspension or revocation of the Employee's medical staff privileges at any facility at which the Employer provides services, or upon notice that the Employee has been excluded from participation in any federally or state-funded health care program, including, without limitation, Medicare or Medicaid.

C. The Employer may terminate the employment of the Employee for good cause. The term "good cause" as used in this Agreement shall include, but shall not be limited to, (i) insubordination, (ii) a pattern of conduct which tends to hold the Employer up to ridicule in the community, (iii) conduct disloyal to the Employer, (iv) conviction, plea of no contest, deferred adjudication, or guilty plea regarding any felony or serious misdemeanor, (v) substance dependence, as determined by the Employer, (vi) the use of any addictive substances, including but not limited to amphetamines, barbiturates, methadone, cannabis, cocaine, PCP, THC, LSD or narcotic drugs, (viii) the Employee's failure to comply with the Employer's policies and procedures or any federal, state, and local laws, including, without limitation, any and all Employer policies and procedures (including Employer's employee handbook) or federal, state and laws relating to workplace hostility, harassment, discrimination, compliance plan, the giving or taking of kickbacks, bribes, or rebates, patient brokering, fee-splitting, health care self-referral laws, or the use and disclosure of patient information; (ix) the Employee's failure to immediately cease materially disruptive behavior after receiving written notification from the Employer stating with specificity such behavior; (x) the Employer's receipt of notice from any third

party payor that the Employee's employment jeopardizes Employer's participation in such third party payor program; (xi) the Employer's receipt of notice from any hospital that Employee's medical staff privileges at such hospital have been terminated; (xii) the Employee committing an act of fraud, misappropriation or embezzlement in connection with the Employer's business; (xiii) the Employee's failure to promptly and adequately perform the Duties assigned to the Employee by the Employer, such performance to be judged in the sole discretion of the Employer, or the Employee's breach of any provisions of this Agreement or (ix) the Employer's or the Employee's bankruptcy or insolvency.

D. The Employee further agrees that following any termination of employment, the Employee shall reasonably cooperate with the Employer in all matters relating to the Employee's continuing obligations under this Agreement, including but not limited to the winding up of pending work on behalf of the Employer and the orderly transfer of work to other employees.

19. Notices. Any notices required or permitted to be given under this Agreement shall be sufficient if in writing and if sent by certified or registered mail, return receipt requested, to the parties at the following addresses or such other addresses as may be provided in writing to the other party from time to time.

If to Employer: Florida Pain Relief Group, PLLC
4730 North Habana Ave., Suite 204
Tampa, FL 33614
Attn:_____

If to Employee: _____
_____
_____

20. Indemnification. Employer shall indemnify Employee from and against claims, brought by Advantacare, Inc., related to violations of contractual noncompete restrictive covenants which arise out of or result from Employee's acceptance of employment with Employer.

21. Waiver of Breach. The waiver by the Employer of a breach of any condition of this Agreement by the Employee shall not be construed as a waiver of any subsequent breach by the Employee.

22. Assignment. This Agreement will not be assignable, in whole or in part, by either party without the written consent of the other party, except that the Employer may, without the consent of Employee, assign the Employer's rights and delegate its obligations under this Agreement to any corporation or other entity (i) with which the Employer merges or consolidates, (ii) to which the Employer sells or transfers all or substantially all of its assets or the Employer's owner transfers all of the equity interests of the Employer, (iii) of which 50% or more of the equity interests or the voting control is owned, directly or indirectly, by the Employer or any of its subsidiaries or affiliates, or (iv) by way of collateral assignment, to any bank, financial institution, or other lender providing financing to the Employer (including any

agent, successor, or assign of any such bank, financial institution, or other lender). Upon any assignment by the Employer pursuant to clause (i) or (ii) above, the Employer will be discharged from all further liability hereunder and such assignee will thereafter be deemed to be the "Employer for all purposes under this Agreement, including this **Section 22**. Employee specifically agrees that in the event of any such permitted assignment by Employer, the assignee shall be entitled to enforce the Non-Competition and Non-Solicitation and other restrictive covenant provisions in this Agreement.

23. Attorney's Fees. In the event legal action is brought in to enforce the terms of this agreement, the prevailing party shall recover from the non-prevailing party all of the prevailing party's costs and attorney's fees, including fees incurred in appeals.

24. Governing Law. This Agreement shall be governed by the laws of the State of Florida.

25. Complete Agreement. This Agreement is the sole instrument of the parties related to the subject matter of the Agreement. This Agreement supersedes any prior agreements, understandings, or negotiations, whether written or oral and may only be amended through a writing formally executed by both parties.

[Signatures on Following Page]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first written above to be effective as of the Effective Date.

Employer:	**Employee:**
FLORIDA PAIN RELIEF GROUP, PLLC	TAUFIQ AHMED
By: _____	_____
Rodolfo Gari, Jr., Manager	
Date: _____	**Date:** 6/22/17

Attachment A - Compensation

Compensation. Employer shall pay Employee Compensation based on the employee normal bi-weekly payment schedule. The amount of the Compensation shall be calculated based on the following agreed upon formula:

Forty percent (40%) times "net cash collections," defined as the sums actually collected by the Employer during the calendar quarter for services rendered to patients by the Employee, reduced by any patient or third party insurer refunds during such quarter relating to services rendered to patients by Employee. To the extent the Employee has direct supervision of a Midlevel (*i.e.*, a Nurse Practitioner or Physician Assistant), Employee will also be paid as Compensation forty percent (40%) of the profits allocable to the Midlevel (*i.e.*, net cash collections during the calendar quarter from the services provided by the Midlevel and billed under the Employee, less the total compensation paid to the Midlevel by Employer, including but not limited to salary, bonus, benefits and any other form of compensation). For example, during a quarter, if Employee's net cash collections is $83,333 for a month (with no refunds), and a Midlevel's monthly net cash collections for services billed under Employee is $50,000, and the Midlevel's total monthly compensation and benefits is $12,500, the Compensation payment for a quarter to Employee would be $145,000 = $100,000 (40% X $250,000), plus $45,000 (40% X profit {$150,000 less $37,500}).

These wages will be paid as an estimated flat amount, based on the Transitional Compensation rate defined below, each pay period with reconciliation for the prior quarter's actual cash collections. The estimated flat rate paid to Employee each pay period will not be modified from quarter to quarter unless the forty percent (40%) of the applicable net cash collections in an applicable quarter is less than the flat rate paid to Employee (a "Collection Deficiency"). In the event of a Collection Deficiency, the flat rate paid to Employee in the following quarter shall be decreased based on the previous quarter's net cash collections. This pay adjustment from the reconciliation will be made on a quarterly basis after the first pay period of the month following each quarter. Payment of net cash collections in accordance with the foregoing formula shall not include any collections collected after the expiration or termination of this Agreement for any reason. For the purposes of the Agreement the term "personally performed" whenever used in herein shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services guidance and applicable laws and regulations and in accordance with the group practice definition and in-office ancillary exception to the Stark Law. Employee Compensation shall be reduced by all applicable payroll taxes.

Termination. Upon termination or expiration of this Agreement, Employee shall be paid the above referenced forty percent (40%) of any net cash collections as actually received prior to the date of termination, but not any net cash collections received thereafter.

Benefits. Employee will be eligible for the Physician Partners of America Employee

Employee's Initials: TA

benefits package.

Transitional Compensation. Employee will be paid on a prorated basis for the first six (6) months of employment at an annualized rate of $300,000 (three hundred thousand) or forty percent (40%) of "net cash collections" as defined above in the Compensation section of this Attachment A, whichever is greater. Following six (6) months of employment, Employee will be paid the above referenced forty percent (40%) of net cash collections defined in the above Compensation section of this Attachment A. It is provided, however, that after the first six (6) months of employment, if Employee's Compensation is less than such above referenced annualized rate, Employer may, but is under no obligation to do so, continue paying Employee compensation based on an annualized rate of $300,000 (*i.e.*, $25,000 per month) with the difference to be reconciled and deducted from Employee's Compensation as soon as reasonably practicable.

Class B Distributions. Upon obtaining employment with Employer, Employee is eligible to be issued Employer's nonvoting, Class B Profits Units ("Class B Units") representing certain rights in the operating cash flow (exclusive of capital transactions) derived from distributions received from Employer's subsidiaries engaged in an ambulatory surgery center business or other ancillary medical business. Issuance of the Class B Units will be on terms and conditions set by Employer, including, but not limited to, the execution and delivery by Employee of an operating agreement of Employer evidencing the Class B Units and containing restrictions on transfer of the Class B Units, buy-sell provisions, management and cash flow and allocation provisions, restrictive and confidentiality covenants, and other terms customary in an operating agreement, all on terms determined by Employer in its sole and absolute discretion.

Office Ancillaries. Employee will also be paid as compensation forty percent (40%) of the net profit to Employer derived from the sale of durable medical equipment, kits, office based qualitative urine drug screens, neuromonitoring services, or other office ancillary products purchased and sold by Employer or office ancillary services provided by Employer as each are solely allocable and attributable to Employee and patients under his supervision. Such net profit calculation shall be determined by Employer in its sole and absolute discretion based on actual billings and collections by Employer, and shall be reduced by all applicable payroll taxes.

Allowances. Employee will be reimbursed a $2,500.00 total annual allowance towards professional organization memberships and programs providing CME credit for which valid receipts are submitted. Employee may take up to five work days, annually, to attend CME training.

PTO. Employee will be entitled to four weeks (twenty days) of paid time off annually in addition to five days to attend CME training.

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Attachment B

Provider Performance Standards

1. All new providers at Employer are expected to obtain and maintain board certification with their respective medical or surgical specialties and/or subspecialty.

2. All providers at Employer are expected to maintain and keep current their annual/biannual continuing education requirements as required by their respective Board.

3. Employer supports a patient-centric medical practice. Patient Satisfaction surveys are an integral part of how we measure our service quality. Employer providers are expected to work with their management staff to:

   a. Review survey results with their staff members to identify areas needing improvement;

   b. Work with their staffs in the design and implementation of process improvement measures.

4. Patient complaints, patient terminations (physician or patient initiated), and patient requests to transfer to another provider will be monitored and trended.

5. Employer has invested significant financial and management resources in a state of the art electronic medical record (EMR) to facilitate and improve patient care. Each provider and their office staffs are expected to update the patient's medications, allergies, and problem list during each patient visit.

6. Employer expects timely review and completion of patient related communication/information to the office including:

   a. Timely return of all patient phone calls and completion of prescription requests within 24 hours (sooner depending on the urgency of the request);

   b. Review of all patient laboratory results within 24 hours;

   c. Completion of all medical documentation within 24 hours after the patient visit;

   d. Review forwarded provider notes (including consultants notes) within 24 hours of receipt of such information;

   e. Signing off on all completed medical documentation within 24 hours of completion.

7. Employer expects each provider to begin office hours on time (unless an emergency situation prevents this) and to try to stay on schedule throughout the day.

8. Employer strongly discourages the rescheduling of patient appointments with minimal prior notification to the office staff (i.e., less than 1 week notice) except for emergency situation.

9. Employer expects all providers to treat patients, staff and their peers with respect and professionalism. Please see Employer's Policy Code of Conduct/Disruptive Provider Policy.

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Attachment C - Florida Pain Relief Group ("Employer") Clinical Protocols Overview

Daily operations

1. Employer uses Greenway electronic medical records. All providers are expected to complete and sign records within 2 days of encounter.
2. Scheduling is performed centrally, allowing offices to focus on seeing patients
3. Offices are open 8 AM until 5 PM. Providers are expected to be on time for their appointments. Providers are expected to work all hours that the office is open with exceptions made on a rate exception basis.
4. Staffing, purchasing and logistics are coordinated by the Chief Operating Officer/ local designee.
5. Durable medical equipment, supplies and medications are all centrally purchased.

Patient flow

1. After arrival, patients are taken to exam rooms and processed by the medical assistant (MA). Once MA completes intake patient is then ready for the provider to see.
2. Procedures ordered are sent to authorization department and booked once approved.

Scheduling/Operational Protocols

1. Same Day/Walk-In Appointments
    a. Employer prides itself in providing same day/walk in appointments to patients in pain. Not only is this practice a humanitarian one, it also makes business sense as a significant competitive advantage. Patients are to be seen same day regardless of lack of records at time of visit. If a patient does not have medical records that substantiate the pain problem, provider will take this into consideration in his or her treatment plan and prescribe medications, if any, accordingly.
2. Prescription Drug Monitoring
    a. Employer follows an evidence based Psychologic and opioid abuse risk protocol to determine frequency of UDS testing. Given the high frequency of false negatives and positives from qualitative screen, and testing of additional illicit substances via quantitative testing, all UDS are sent for confirmation via definitive assay (GC, MS).
    b. Psychologic testing and opioid abuse risk stratification (ORT or equivalent) is done on every visit, consistent with evidence based Employer UDS testing protocol.
    c. Providers are expected to act accordingly with aberrant drug behavior and refer to an addiction medicine specialist or drug rehabilitation center any patient found to be suffering from the disease of drug addiction.

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3. Pharmacogenomics
    a. There is much clinical value in establishing genetics based pharmacogenomics profile. Thus, all new patients are tested for pharmacogenomics so that providers can obtain actionable clinical relevance from pharmacogenomics testing.

Pharmacy

1. E Prescribing
    a. Employer utilizes electronic prescribing. As a matter of monitoring, all prescribers are expected to eprescribe, except in cases where it is neither feasible nor practical.
2. Choice of pharmacy
    a. Preferred pharmacy should be based on the best interest of the patient; it is good medical practice to utilize one pharmacy for all controlled substances while a different pharmacy can be utilized for non controlled medications.
1. CDC Opiate Prescribing Guidelines
    a. Employer prescribes in compliance with CDC Opiate prescribing guidelines.
    b. Employer protocol aims to maximize non opiate meds in treating pain by utilizing topicals, nsaids, local anesthetics, etc.
2. Employer Affiliated Pharmacy (Patient Rx Solutions, Stonebriar)
    a. For patient convenience, our affiliate Pharmacies readily stock commonly prescribed pain treatment medications, including topicals and compounded meds that are not typically available at local pharmacies.
    b. Our affiliate Pharmacy will deliver medications same or next day to patient's home or other location.
    c. To avoid withdrawals, opiates are typically prescribed to local pharmacy while non opiate meds s are typically prescribed to our affiliate pharmacy

Surgery Center/Procedure room

1. For patient safety Employer utilizes the service of Anesthesia for all patients undergoing interventional procedures at either the ASC or Procedure room. This allows both safely monitoring and sedating patients as needed.
2. For ease of scheduling, each provider will have assigned ASC/Procedure days.

Credentialing/Regulatory Compliance

1. Providers are expected to maintain their licenses, board certifications and required CME.
2. Providers are expected to refer to risk management department any encounter, patient or event that may result in a risk of liability to the company or provider.

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