IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
GREENVILLE DIVISION

THE UNITED STATES OF AMERICA,
***ex rel,* CANDI SIBLEY, RN, BSN** **PLAINTIFF**

V. **CAUSE NO. 4:17-cv-053 (DMB)(JMV)**

DELTA REGIONAL MEDICAL CENTER **DEFENDANT**

JURY TRIAL DEMANDED

RELATOR'S SECOND AMENDED COMPLAINT FOR DAMAGES
UNDER THE FALSE CLAIMS ACT- 31 U.S.C. §§ 3729, *et. seq.*

COMES NOW Plaintiff/Relator Candi Sibley, RN, BSN ("Relator or Sibley") and files this Second Amended Complaint as Relator acting on behalf of the United States of America, as follows:

SUMMARY OF THE CASE

1. This is an action to recover damages and civil penalties on behalf of the United States of America arising out of false claims presented for payment and payments/fines falsely avoided by Delta Regional Medical Center ("DRMC").

2. DRMC has knowingly or with reckless intent made and presented to the United States of America (the "Government") false claims in violation of the Federal Civil False Claims Act, 31 U.S.C. §§ 3729, *et. seq*. ("FCA"). The violations of the FCA involve DRMC's claims for reimbursement from Medicare and Medicaid presented to the Government from 2012 (and possibly earlier) through the present, and DRMC's avoidance of penalties and fines for additional violations of federal and state laws.

3. DRMC opted into *The Emergency Medical Treatment and Active Labor Act* ("EMTALA"), 42 U.S.C. § 1395dd, as a condition of receiving payments from Medicare and Medicaid. As explained in detail below, DRMC engaged in a systematic and fraudulent practice of claiming compliance with EMTALA while submitting claims to the Medicare and Medicaid reimbursement programs during the relevant time frames. Each claim (totaling millions of dollars per year) has been false and fraudulent in that each carried with it a false certification that DRMC satisfied the regulatory conditions for payment, i.e., that DRMC's emergency department was fully compliant with the requirements of EMTALA. Each claim falsely presented is a separate "false claim" subjecting DRMC to criminal sanctions, 42 U.S.C. § 1320a-7b, and civil fines, 42 U.S.C. § 1320a-7a.

4. In order to receive payments under the Medicare and Medicaid programs, a hospital must meet the requirements established under Title XVIII of *The Social Security Act*, 14 U.S.C. § 1395, *et seq.*, commonly known as *The Medicare Act*, as well as the regulations established by the Secretary of Health and Human Services. During the time frame at issue, DRMC falsely certified compliance with EMTALA, such violations being commonly known as "patient dumping." Compliance with the requirements of EMTALA is a condition for payment under the Medicare and Medicaid reimbursement programs. 42 U.S.C. § 1395cc (a)(1)(I)(i).

5. Congress enacted EMTALA out of concern that, due to economic constraints, hospitals were abandoning the traditional practice of providing emergency care to all comers. Instead, hospitals were refusing to treat certain indigent patients, and/or transferring such patients to other institutions.

6. During the time frame at issue, DRMC engaged in repeated and systematic acts of "patient dumping" in violation of EMTALA. DRMC intentionally and purposefully hid its EMTALA violations from various investigating administrative agencies.

7. DRMC's purpose was to hide its non-compliance in order to allow DRMC to continue submitting claims for payment under the Medicare and Medicaid reimbursement programs. DRMC's additional purpose was to falsely and fraudulently avoid payment of required EMTALA violation fines. 42 U.S.C. § 1395dd(d)(1)(A). During the time frame at issue, each claim submitted to the Medicare and Medicaid reimbursement programs and each fine falsely avoided is a separate "false claim" subjecting DRMC to criminal sanctions, 42 U.S.C. § 1320a-7b, and civil fines, 42 U.S.C. § 1320a, 7a.

8. The Mississippi Legislature created Mississippi's Trauma Care System to reduce the death and disability resulting from traumatic injury. Mississippi Law requires every Mississippi licensed acute care facility to participate in the statewide trauma care system at a level commensurate with the abilities of its staff and available resources. Hospitals can elect "Non-Participation" and are then required to pay a non-participation fee which is based upon their capability. Level II facilities pay a non-participation fee based upon their capability as a Level II center, Level III facilities pay a non-participation fee based upon their capability as a Level III center, and so on.

9. During the time frame at issue, DRMC held itself out and continues to hold itself out as a Level III trauma center. As a Level III trauma hospital, DRMC was obligated by State law to have immediate 24 hour coverage for the following medical disciplines: emergency medicine, trauma surgery, general surgery, orthopedic surgery, anesthesia, post-anesthesia care, and intensive care. Mississippi Trauma Care System Regulations Rule 1.3.12.

10. DRMC has failed and continues to fail to participate in the Mississippi Trauma Care System at a Level commensurate with its capabilities, including, but not limited to, the following: 1) through the repeated and systematic failure to have available surgeons willing to provide required treatment for trauma patients presenting to DRMC's Emergency Department; and, 2) repeated and systematic acts of patient dumping.

11. DRMC's purpose was and is to falsely and fraudulently avoid payment of the required fines and falsely and fraudulently obtain Medicare and Medicaid Program Benefits.

12. Each false claim submitted is recoverable under the False Claims Act. Each fine and/or payment falsely and fraudulently avoided is recoverable under the False Claims Act.

JURISDICTION AND VENUE

13. This Court has jurisdiction over the subject matter of this action pursuant to 28 U.S.C. § 1331 (federal question jurisdiction). This Court also has exclusive jurisdiction pursuant to 31 U.S.C. §§ 3730(b), 3730(h), 3732(a), and 3732(b) which confer jurisdiction on this Court for actions brought pursuant to 31 U.S.C. §§ 3729 and 3730. Title 31 U.S.C. § 3732 provides: "Any action under Section 3730 may be brought in any judicial district in which the defendant or, in the case of multiple defendants, any one defendant can be found, resides, transacts business, or in which any act prescribed by Section 3729 occurred. A summons as required by the Federal Rules Civil Procedure shall be issued by the appropriate district court and served at any place within or outside the United States."

14. As established by the pleadings, DRMC transacted business in this judicial district and this action may only be brought in the United States District Court for the Northern District of Mississippi.

PARTIES

15. The Government *ex rel* Relator Candi Sibley - The United States Government appears in this action through Relator Candi Sibley. Relator Sibley is a citizen of the United States and is an adult resident citizen of the State of Arkansas. Relator Sibley seeks recovery under the False Claims Act on behalf of the United States Government. 31 U.S.C. § 3730(b). Pursuant to Fed.R.Civ.P. 4(i)(1), a copy of this Court's summons and the initial Complaint were served via certified mail on: Jeff Sessions – Attorney General of the United States, U.S. Department of Justice, 950 Pennsylvania Avenue, NW, Washington, DC 20530-0001; and, via hand delivery on: Robert H. Norman - Acting United States Attorney for the Northern District of Mississippi, Office of the U.S. Attorney-Civil Division, Ethridge Building, 900 Jefferson Avenue, Oxford, MS 38655.

16. Delta Regional Medical Center - DRMC, during the times complained of herein, had its principal place of business located at: 1400 E. Union St., Greenville MS 38703. Upon order of the Court, a copy of this Court's summons and this Second Amended Complaint shall be served on DRMC's Chief Executive Officer: Scott Christensen.

SOURCE AND DISCLOSURE OF MATERIAL INFORMATION

17. Relator Sibley is the original source of the information underlying the allegations herein. Sibley brings this action pursuant to the authority of 31 U.S.C. § 3730(b).

18. A copy Relator Sibley's initial Complaint and the evidentiary disclosures required by the False Claims Act have been served on the U.S. Attorney for the Northern District of Mississippi - Civil Division, 31 U.S.C. § 3730(b)(2).

FEDERAL AND STATE PROGRAMS HARMED

19. The Department of Health and Human Services ("HHS"), through the Center for Medicare and Medicaid Services ("CMS") funds and administers the Medicare program, which is a system of healthcare insurance for the aged and disabled created under Title XVIII of *The Social Security Act*, 42 U.S.C. § 1395, *et. seq*..

20. In 1965, pursuant to Title XIX of *The Social Security Act*, 42 U.S.C. § 1396 et seq., Medicaid was established as a joint federal and state program to provide financial assistance for medical care to individuals with low incomes. Through CMS, HHS provides funds for the State of Mississippi's Medicaid program which is funded in part from federal funds and in part from the state where the facility is located. 42 U.S.C. §§ 1396, *et. seq.*

21. Under Medicaid, each state establishes its own eligibility standards, benefit packages, payment rates and program administration in accordance with certain federal statutory and regulatory requirements. The state pays the health care providers for services rendered to Medicaid recipients, with the state obtaining the federal share of the Medicaid payment from accounts that draw on the United States Treasury. 42 C.F.R. §§ 430.0, et seq.. Therefore, the FCA reaches all false claims submitted to State administered Medicaid programs.

22. EMTALA was enacted by Congress in 1986 as part of *The Consolidated Omnibus Budget Reconciliation Act* ("COBRA"). 42 U.S.C. §1395dd. Referred to as the "Anti-Dumping Law," EMTALA was designed to prevent hospitals from transferring uninsured or Medicaid patients to public hospitals without, at a minimum, providing a medical screening examination to insure that the patients were stable for transfer.

23. After its enactment, EMTALA became the *de facto* National Health Care Policy for

the uninsured, seeking emergency medical treatment or trauma care. EMTALA requires Medicare-participating hospital emergency departments to provide a medical screening to anyone who enters an emergency room and requests an examination for a medical condition. 42 U.S.C. § 1395cc(a)(1)(I)(i).

24. If an emergency medical condition is diagnosed, the participating hospital must provide medical services to stabilize the condition, consistent with such hospital's capabilities. 42 U.S.C. § 1395dd(b)(1)(a)-(b). Participating hospitals are required to treat the emergency medical conditions of patients in a non-discriminatory manner, regardless of their ability to pay, insurance status, national origin, race, creed or color. 42 U.S.C. § 1395dd(h).

25. During the relevant time frame, DRMC, as a participating hospital, agreed to meet the requirements of EMTALA.

26. In order to receive payments under the Medicare and Medicaid reimbursement programs, participating hospitals, as providers of services, are obligated to file certain agreements and certifications with the Secretary of HHS. 42 U.S.C. §1395cc.

27. In the case of a hospital or critical access hospital, such hospital, as a condition for payment, must adopt and enforce a policy to ensure compliance with the requirements of EMTALA, and meet the requirements of EMTALA. 42 U.S.C. §1395cc(a)(1)(I)(i).

28. DRMC, as a participating hospital, agreed to adopt and enforce a policy to ensure compliance with the requirements of EMTALA, and meet the requirements of EMTALA, as a condition for payment under the Medicare and Medicaid reimbursement programs.

29. Annual agreements and/or certifications were made by DRMC during the relevant time frame. In such annual agreements/certifications, DRMC knowingly, intentionally, and falsely

concealed DRMC's non-compliance with EMTALA and certain other state regulations, as described more fully herein.

30. DRMC must, with respect to each patient who is a beneficiary of a Medicare or Medicaid program, submit a claim reimbursement form, Form UB-04 a/k/a Form CMS-1450. On each form (totaling many thousands per year during the relevant time frames), DRMC expressly certified: "...payment and satisfaction of this claim will be made from Federal and State funds, any false claims, statements, documents, or concealment of any material fact, may be prosecuted under applicable Federal or State laws." Form UB-04 (Form CMS-1450).

31. Certifications were made by transferring physicians and/or other qualified medical personnel at DRMC during the relevant time frames with respect to each transferred patient for whom DRMC submitted a Medicare or Medicaid program claim reimbursement form, including, but not limited to, patients whose treatment violated the requirements of EMTALA.

32. The United States Government, acting through its relevant agencies (HHS, CMS) had a right to rely, and did rely, upon the representations and statements made by DRMC in connection with claims submitted for reimbursement during the relevant time frames, including the certification that DRMC had and was providing healthcare services under circumstances satisfying all of Medicare and Medicaid's conditions of payment, including EMTALA.

33. Certification of compliance with EMTALA and compliance with EMTALA is a material and essential condition for payment under the Medicare and Medicaid programs. A false certification of compliance with EMTALA and/or a failure to comply with EMTALA, coupled with the knowing submission of a claim for reimbursement for services that were rendered when DRMC was not in compliance with EMTALA, constitutes a false and fraudulent claim under 31 U.S.C.

§§ 3729, *et. seq.*.

34. Specifically, DRMC made false and fraudulent claims seeking reimbursement from Medicare and Medicaid for services rendered when the following circumstances were present:

a. DRMC failed to comply with the applicable federal laws relating to the health and safety of patients, 42 C.F.R. § 482.11(a), including failure to comply with EMTALA, 42 U.S.C. § 1395dd, i.e. patient dumping.

b. DRMC failed to provide "On-Call" physicians who were available to treat trauma patients who presented to the DRMC emergency department during the relevant time frame;

c. DRMC failed to provide stabilizing treatment to trauma patients who presented to the DRMC emergency department during the relevant time frame;

d. DRMC failed to provide an adequate medical screening to treat trauma patients who presented to the DRMC emergency department during the relevant time frame;

e. DRMC failed to provide appropriate transfers to trauma patients who presented to the DRMC emergency department during the relevant time frame.

f. Additional violations of federal law and regulations will be proven at trial.

35. A facility that discovers or is made aware of material errors or omissions in claims submitted for reimbursement to Medicare and Medicaid is required to disclose those matters to the government. Facilities are not free to keep money that results from such errors, or to conceal such errors, or to retaliate against those who endeavor to correct them. Title 42 U.S.C. § 1320(a)-7(b)(a)(3) creates a duty to disclose such errors by making a failure to disclose a felony, as follows:

> Whoever . . . having knowledge of the occurrence of any event effecting (A) his initial or continued right to any such benefit or payment . . . conceals or failed to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity that is due or when no such benefit or payment is authorized . . . shall (i) in the case of such statement, representation, concealment, failure . . . be guilty of a felony.

Accordingly, DRMC had and continues to have an affirmative duty to disclose material information which indicates their reimbursement claims are inaccurate.

36. In order for DRMC be eligible for payments under the Medicare and Medicaid programs, DRMC had to file with HHS an agreement "to adopt and enforce a policy to ensure compliance with the requirements" of EMTALA. 42 U.S.C. § 1395cc(a)(1)(I)(i). DRMC knew that actual compliance with EMTALA, certification of compliance with EMTALA, and reporting suspected EMTALA violations were material to the Government's payment position, so much so that CMS had the authority to terminate DRMC's provider agreement. 42 C.F.R. § 489.24(g).; 42 C.F.R. § 489.20(m), (q), and (r); 42 C.F.R. § 489.53(b)(1)(A), and, (b)(2).

37. As a participating hospital, DRMC was and continues to be subject to fines and civil penalties for each negligent violation of EMTALA. 42 U.S.C. § 1395dd(d)(1)(A).

38. The Mississippi Legislature created the State Trauma Care System to "reduce the death and disability from traumatic injury." Mississippi law requires every Mississippi licensed acute care facility to participate in the statewide Trauma Care System. Facilities are designated as Levels I-IV trauma centers based on specific criteria, including the services each facility offers. Any hospital that chooses not to participate in the Trauma Care System or that participates at level lower than the level at which it is capable of participating, as determined by the Mississippi Department of Health, must pay a non-participation fee. Joint Legislative Committee on Evaluation and Expenditure Review (PEER), *Report the Mississippi Legislature* (January 3, 2013); and, Mississippi Trauma Care System Rule 1.3.13.

39. The Mississippi Legislature established the Mississippi Trauma Care Systems Fund ("MS Trauma Fund") for use by the State Department of Health in the administration and

implementation of the comprehensive State Trauma Care Plan. The MS Trauma Fund receives revenues, in part, from penalties assessed against hospitals that choose not to participate in the state's trauma care system, or that participate at a level lower than the level at which it is capable of participating. *Id.*

40. The Mississippi Department of Health uses the MS Trauma Fund to cover administrative expenses of the State Trauma Care System. Beginning in fiscal year 2010, the MS Department of Health continued to use the MS Trauma Fund to cover administrative expenses of the System, but also distributed the remaining balance in a formulated manner based on each hospitals specific designation as a trauma center. *Id.*

41. During the relevant time frame, DRMC obligated itself to participate in the Mississippi Trauma Care System as a Level III Trauma Center, and held itself out to the public as a Level III trauma center with the requisite capacity and capabilities. However, DRMC continuously and repeatedly failed to provide the services required of a Level III Trauma Center. Mississippi Trauma Care System Rule 1.3.12.

42. As a Level III trauma hospital, DRMC was obligated by State law to have immediate 24 hour coverage for the following medical disciplines: emergency medicine, trauma surgery, general surgery, orthopaedic surgery, anesthesia, post anesthesia care unit, and intensive care unit. However, DRMC continuously and repeatedly failed to provide the services required of a Level III Trauma Center. Mississippi Trauma Care System Rule 1.3.12.

43. Distributions from the MS Trauma Fund are made according to the Mississippi Trauma Care Distribution Formula and Distribution Calculation. Mississippi Trauma Care System Rules 1.3.4; and, 1.3.5..

44. A participating Level IV Trauma Center is entitled to only receive a $10,000 annual stipend, with the possibility of receiving an additional $10,000 in the form of an educational grant. Mississippi Trauma Care System Rule 1.3.5.

45. After deduction of administrative expenses, and stipends disbursed to Level IV facilities, the remaining MS fund balance is distributed to EMS providers, Level I - III facilities, and the JMS Burn Center, as follows: 15% to EMS providers, and 85% to Level I - III trauma centers and the Burn Center. The 85% is further allocated as follows: 1) 30% of the net balance to the trauma centers according to a fixed distribution method based upon their trauma designation, i.e., Level I, Level III, or Level III; 2) 50% of the net balance to the trauma centers according to a variable distribution method using patient data to compute an injury severity score, i.e., each trauma center's distribution is based on the number, type, and severity of trauma cases handled by the center; and, 3) the 5% remaining balance to the JMS Burn Center. Mississippi Trauma Care System Rule 1.3.5.

46. Through repeated reports to DRMC administrative staff, Relator Sibley provided substantial proof that DRMC was not in compliance with the Mississippi Trauma Care System as a Level III Trauma Center. Further, Sibley uncovered extensive fraudulent reporting to state agencies covering up DRMC's non-compliance. These reports intentionally omitted critical information to state regulators. Supervisory personnel had actual knowledge of this fraudulent reporting and encouraged the same.

47. By falsely and fraudulently hiding its non-compliance, and misrepresenting its level of participation, DRMC was able to receive substantial distributions from the MS Trauma Fund (suspected to be in the millions of dollars) instead of being paid a Level IV stipend, in the thousands of dollars. By falsely and fraudulently hiding its non-compliance, and misrepresenting its level of

participation, DRMC avoided being assessed a non-participation fee/penalty for violating the Mississippi Trauma Care System Regulations.

48. As required by EMTALA, if a transfer occurs, a physician or qualified medical person must certify that the transfer conditions of EMTALA have been met, and "the certification must contain a summary of the risks and benefits of the transfer." 42 C.F.R. § 489.24(e)(1)(ii)(B), and (C). As required by EMTALA regulations, the Physician Certification would be executed by the DRMC Transferring Physician and/or other DRMC "Qualified Medical Personnel." In this Second Amended Complaint, Relator Sibley identifies 52 representative false certifications by DRMC staff.

ADDITIONAL FACTS SUPPORTING RELATOR'S CLAIMS

49. Relator Sibley re-alleges those facts previously pled and incorporates them herein.

50. Relator Sibley uncovered numerous ongoing and systematic compliance violations confirming that DRMC had engaged in a pattern of healthcare practice, mismanagement and fraud that systematically violated the conditions of participation and eligibility standards set forth above.

51. As part of its systematic and ongoing activities, DRMC engaged in regular communications with federal and state government agents, intermediaries, and accrediting authorities on which the government relies in making Medicare and Medicaid eligibility determinations. DRMC's purpose was to create, portray, and foster a false pretense of entitlement to participate in the Medicare and Medicaid programs.

Dr. Robert Corkern

52. At all times relevant hereto, Dr. Robert Corkern (Corkern) was/is the Emergency Department Medical Director at DRMC and was/is acting in the course and scope of his employment and/or agency with DRMC.

53. In or about 2012, Corkern was convicted of bribing a former Panola County administrator to use public funds as a part of a medical kickback scheme involving public funds, resulting in the revocation of his medical license on or about January 24, 2013. As a product thereof, Corkern was placed on the list of physicians prohibited from billing for services provided to patients qualified for Medicaid. The Office of the Inspector General (OIG) was timely notified by the Mississippi Department of Medicaid of this prohibition.

54. The Medicaid program is a cooperative venture funded by both Federal and State governments that pays for medical costs for certain individual and families with low incomes and/or limited resources. Certain Medicaid recipients are also "dual eligible beneficiaries" who are enrolled in both Medicare and Medicaid, and this classification includes individuals who are enrolled in Medicare Part A and/or Part B and receive full Medicaid benefits or assistance with Medicare premiums or cost sharing through the Medicare Savings Program categories such as Qualified Medicare Beneficiary Program (QMB), Specified Low-Income Medicare Beneficiary Program (SLMB), Qualifying Individual (QI) Program , and Qualified Disabled Working Individual (QDWI) Program.

55. Corkern has routinely seen/treated Medicaid patients and billed those patients "through" other providers, including but not limited to Physician Assistant (PA) Kyle Campbell, using their User IDs in the electronic health record. Certain nurse practitioners have been instructed that if they consult Corkern on a patient, they are required to falsify medical records by affirmatively "documenting" that they consulted the Physician Assistant instead. Such procedure creates billing records for Medicaid patients which are fraudulent and which represent charges illegally created by Corkern. Additionally, nurse practitioners have been instructed by DRMC's supervisory personnel

that certain Medicaid admissions must be "turned over" to a PA (a lateral move), where Corkern then writes admission orders under the PA's name.

56. Corkern, in a deliberate, knowing and fraudulent scheme to defraud the Medicaid program has returned to DRMC following his conviction and revocation of his medical license.

Failure to Meet Emergency Needs of Patients as Required of a Level III Trauma Center and Repeated Systematic Violations of EMTALA

57. As a member of the DRMC staff, Relator Sibley became aware of multiple instances of patients presenting to the DRMC Emergency Department and being denied the care required by a Level III Trauma Center and/or being transferred/dumped to a Level I facility in violation of EMTALA. Many if not all of these patients were covered by Medicaid or uninsured. By way of specific illustration and without limitation, Relators offer the following:

CASE 1
Patient No. MXXX041

58. On February 28, 2015, at 5:13 a.m., A.J., a 20 year old uninsured African American female, presented to the DRMC emergency department ("DRMC ED") with a partial amputation of her arm above the elbow. A.J. was hypotensive and tachycardia in route. A.J. arrived in traumatic hemorrhagic shock. Code Bravo was called upon arrival although A.J. met the criteria for Code Alpha. A.J. was upgraded to Code Alpha 32 minutes following arrival in shock. No blood was given.

59. The on-call trauma surgeon was called at 5:40 a.m. but never responded. No other doctors were called to respond. DRMC had the available on-call staff and capabilities to evaluate and treat A.J.

60. The unstable patient was inappropriately transferred to UMMC.

CASE 2
Patient No. MXXX281

61. On January 8, 2014, at 9:20 p.m., a 31 year old African American male presented to the DRMC ER with multiple gunshot wounds.

62. A CT revealed that the patient had a bullet in his stomach, an indication for emergency operating room admission/laparotomy.

63. The patient was not taken to the operating room. Orthopedic services were not paged or consulted. Anesthesiology was not paged or consulted.

64. Instead, the patient was transferred unstable to UMMC, despite the emergency operation indicated by his injuries and the availability and presence of the on-call trauma surgeon.

65. DRMC staff were capable of performing the emergency operation.

66. The unstable patient was inappropriately transferred to UMMC.

CASE 3
Patient No. MXXX820

67. On January 13, 2014, at 8:12 a.m., a 48 year old African American male presented to the DRMC ER in diabetic ketoacidosis with multiple ligament tears and fractures. Code Bravo was called upon arrival.

68. The on call orthopedic surgeon was paged and responded by phone with "Recommends transfer, possible allograft." The surgeon did not present.

69. The trauma surgeon was not called.

70. DRMC and its staff were capable of performing the orthopedic services for reduction of hip and evaluation of limb viability.

71. The unstable patient was inappropriately transferred to UMMC.

CASE 4
Patient No. MXXX388

72. On January 3, 2016, at 3:24 a.m., an 18 year old African American male presented to the DRMC ER with a gunshot wound to the posterior neck and an occipital bone fracture. Code Alpha was called at 3:30 a.m., but this was inappropriately downgraded to Code Bravo at 3:49 a.m. The on call trauma surgeon was paged and responded but did not present. A transfer order was entered with the stated reason of "trauma services."

73. The unstable patient was inappropriately transferred to UMMC.

CASE 5
Patient No. MXXX998

74. On January 1, 2016, at 6:45 p.m., a 42 year old African American male presented to the DRMC ER with a gunshot wound to the chest and multiple fractures. Code Alpha was called upon arrival.

75. The on call trauma surgeon was paged and responded by phone but did not present.

76. DRMC and its staff were capable of performing trauma services.

77. The unstable patient was inappropriately transferred to UMMC.

CASE 6
Patient No. MXXX891

78. On February 8, 2016 at 6:48 p.m., a 34 year old African American male presented to the DRMC ER with a stab wound to his back. Code Alpha was activated.

79. The patient was a ward of the federal government.

80. The on call trauma surgeon was paged and responded by phone but did not present

to evaluate the patient. The patient was admitted to the floor without evaluation.

81. The operation was delayed until the afternoon following admission.

CASE 7
Patient No. MXXX056

82. On February 21, 2016 at 7:47 a.m., a 26 year old African American male presented to the DRMC ER with a stab wound to the chest and blunt trauma to his periorbital region. Code Alpha was called upon arrival.

83. The on call trauma surgeon was paged and responded by phone but did not present to evaluate the patient. Instead, the patient's condition was downgraded to Code Bravo at 8:10 a.m., the time at which the on call trauma surgeon responded.

84. DRMC and its staff were capable of performing trauma services.

85. The unstable patient was inappropriately transferred to UMMC.

CASE 8
Patient No. MXXX794

86. On February 21, 2016 at 2:25 p.m., an 18 year old African American male presented to the DRMC ER with a multiple fractures and a mediastinal hematoma from single motor vehicle accident in which the driver/patient hit a tree without wearing a seatbelt. The patient's condition called for a Code Alpha activation but was inappropriately downgraded to a Code Bravo.

87. The on call trauma surgeon was paged and responded by phone but did not present, instead ordering transfer to UMMC for the stated reason of "orthopedics."

88. DRMC and its staff were capable of performing orthopedic and trauma services.

89. The unstable patient was inappropriately transferred to UMMC.

CASE 9
Patient No. MXXX907

90. On February 28, 2016 at 8:50 p.m., an 18 year old African American male presented to the DRMC ER with stab wound to the right thigh and a right pulmonary hematoma, an alpha activation.

91. The on call trauma surgeon responded at 8:58 p.m. but refused to present to the emergency room. The patient died at 9:49 p.m. (almost one hour after arrival) due to blood loss.

CASE 10
Patient No. MXXX418

92. On March 11, 2016 at 8:50 p.m., a 35 year old Caucasian male presented to the DRMC ER with major lacerations and fractures and altered levels of consciousness due to being ejected from a motor vehicle. Code Alpha was called upon arrival.

93. The on call trauma surgeon was paged and responded by phone but did not present. Instead, the patient was admitted to the floor.

94. The patient's condition was never downgraded, but he did not receive an operation until the following morning at 10:12 a.m.

CASE 11
Patient No. MXXX920

95. On March 11, 2016 at 9:12 p.m., a 48 year old Caucasian male presented to the DRMC ER with multiple fractures, a dislocation, and an abdominal wall contusion, a Code Alpha activation.

96. The on call trauma surgeon was paged and responded by phone but did not present.

97. DRMC and its staff were capable of performing trauma services.

98. The unstable patient was inappropriately transferred to UMMC.

CASE 12
Patient No. MXXX783

99. On March 16, 2015 at 9:25 p.m., a patient presented to the DRMC ER with a gunshot wound to left thigh and a mid-shaft femoral fracture. Code Alpha was called upon arrival.

100. The on call trauma surgeon was paged and responded by phone but did not present. After, the patient's condition was downgraded (without evaluation by the trauma surgeon) to Code Bravo.

101. DRMC and its staff were capable of performing trauma and orthopedic services.

102. The unstable patient was inappropriately transferred to UMMC.

CASE 13
Patient No. MXXX402

103. On December 10, 2015 at 1:58 p.m., a 49 year old African American male presented to the DRMC ER with multiple stab wounds. Code Alpha was called upon arrival.

104. The on call trauma surgeon was paged and responded by phone but did not present.

105. The patient was discharged without the evaluation of a trauma surgeon.

106. The patient's condition was never downgraded to Code Bravo.

CASE 14
Patient No. MXXX309

107. A patient presented to the DRMC ER with blunt trauma injuries including a splenic laceration and broken lumbar vertebrae. Code Alpha was called by the EMS.

108. The on call trauma surgeon was paged and responded by phone but refused to present.

109. The unstable patient was inappropriately transferred to UMMC.

CASE 15
Patient No. MXXX021

110. On December 12, 2015 at 12:06 a.m., a 35 year old African American male presented to the DRMC ER with a gunshot wound to the neck resulting in an epidural hematoma, cervical fracture, and paralysis. Code Alpha was activated.

111. The on call trauma surgeon was paged and responded by phone but did not present.

112. The unstable patient was inappropriately transferred to UMMC.

CASE 16
Patient No. MXXX475

113. On November 27, 2015 at 10:44 p.m., a Medicaid patient presented to the DRMC ER with a gunshot wound to the abdomen resulting in a lumbar fracture with a bullet in the vertebrae and active colon, retro peritoneal, and bowel hemorrhages. Code Alpha was called by the EMS.

114. The on call trauma surgeon was paged and responded by phone but did not present.

115. The unstable patient was inappropriately transferred to UMMC.

CASE 17
Patient No. MXXX453

116. On November 4, 2015 at 10:33 p.m., a patient thrown from a motor vehicle presented to the DRMC ER with an intra-cerebral hemorrhage, multiple fractures, contusions to both lungs, a ruptured spleen, etc. Code Alpha was called by the EMS.

117. The on call trauma surgeon was paged and responded by phone but did not present.

118. The patient was not given a chest tube.

119. The unstable patient was inappropriately transferred to UMMC.

CASE 18
Patient No. MXXX551

120. On November 3, 2015 at 12:22 a.m., a patient presented to the DRMC ER with multiple gunshot wounds, severe bleeding, a brachial artery injury, and other injuries. Code Alpha was called by the EMS.

121. The on call trauma surgeon was paged and responded by phone but did not present. The transfer order was entered for "vascular surgery." However, the control of hemorrhage is a basic tenet of a trauma surgeon, as a vascular surgeon is not needed for a brachial artery injury.

122. In other words, the patient was bleeding to death.

123. The unstable patient was inappropriately transferred to UMMC.

CASE 19
Patient No. MXXX148

124. On November 2, 2015 at 10:25 a.m., a patient presented to the DRMC ER with open fractures to the right tibia and fibula and injuries that included an open ankle fracture, a dislocated foot, and a vascular injury to the right peroneal artery. These injuries call for a Code Alpha activation, but this case was inappropriately activated as a Code Bravo. These injuries were confirmed by CT and CTA.

125. The on call trauma surgeon was paged and responded by phone but refused to present. Instead, a transfer order was entered with the listed reason of "orthopedics."

126. Further, the use of CT and CTA was not needed for these injuries.

127. DRMC and its staff were capable of performing orthopedic services, and the control of a hemorrhage is a basic tenet of a trauma surgeon. However, the transfer took place when the patient had **an active arterial hemorrhage.**

128. The unstable patient was inappropriately transferred to UMMC.

CASE 20
Patient No. MXXX759

129. On October 29, 2015 at 5:52 p.m., a 1 year old (infant) male presented to the DRMC ER with a head injury and scalp laceration due to a motor vehicle crash, a Code Alpha activation. Code Alpha was activated by EMS.

130. The on call trauma surgeon was paged and responded by phone but did not present. The patient's condition was then downgraded to Code Bravo.

131. The unstable patient was inappropriately transferred to UMMC.

CASE 21
Patient No. MXXX796

132. On March 11, 2016 at 9:12 p.m., a 48 year old Caucasian male presented to the DRMC ER with multiple fractures, a dislocation, and an abdominal wall contusion, a Code Alpha activation.

133. The on call trauma surgeon was paged and responded by phone but did not present.

134. DRMC and its staff were capable of performing trauma services.

135. The unstable patient was inappropriately transferred to UMMC.

CASE 22
Patient No. MXXX324

136. On October 29, 2015 at 5:49 p.m., a 34 year old Caucasian male presented to the DRMC ER with a brain contusion (with loss of consciousness) and facial lacerations from being hit by a car. Code Alpha was activated upon arrival. At 6:38 p.m., the patient's condition was inappropriately downgraded to a Code Bravo.

137. The on call trauma surgeon was paged and responded by phone but did not present.

138. The unstable patient was inappropriately transferred to UMMC.

CASE 23
Patient No. MXXX965

139. On September 30, 2015 at 12:28 a.m., a 41 year old African American male presented to the DRMC ER after being ejected from a vehicle during a motor vehicle crash. His injuries included facial abrasions, a pulmonary contusion, and two broken ribs. A Code Alpha was activated.

140. The on call trauma surgeon was paged and responded by phone but did not present.

141. DRMC and its staff were capable of performing trauma services and the patient's injuries did not constitute a need for a transfer.

142. The unstable patient was inappropriately transferred to UMMC.

CASE 24
Patient No. MXXX012

143. On September 28, 2015 at 3:50 p.m., an 18 year old African American male presented to the DRMC ER with multiple contusions and abrasions after being involved in a motor vehicle accident (in which another passenger died), a Code Alpha activation.

144. The on call trauma surgeon was paged and responded by phone but did not present. Thereafter, the patient's condition was downgraded to Code Bravo.

145. The patient was then inappropriately admitted to a floor without an evaluation by a trauma surgeon.

CASE 25
Patient No. MXXX851

146. On September 3, 2015 at 11:01 p.m., an 33 year old African American male presented to the DRMC ER after being hit by a car. His injuries included facial and scalp lacerations, multiple

closed rib fractures, a Grade 2 liver laceration, a right scapular fracture, and a right pulmonary contusion. A Code Alpha was activated.

147. The on call trauma surgeon was paged and responded by phone but did not present. Instead, he ordered that the patient be admitted to the floor.

148. The patient was then inappropriately admitted to a floor and hospitalized for three days without an evaluation by a trauma surgeon.

CASE 26
Patient No. MXXX623

149. On August 22, 2015 at 11:41 p.m., a 34 year old African American male presented to the DRMC ER after being hit by a car. His injuries included "abdominal injury," "injury to chest wall," and a closed fracture of the radius/ulna. A Code Alpha was activated by EMS at 11:10 p.m., prior to the patient's arrival.

150. The on call trauma surgeon was paged and responded by phone at 11:15 p.m but did not present.

151. The patient died at 11:43 p.m.

CASE 27
Patient No. MXXX314

152. On August 27, 2015 at 6:22 p.m., a 48 year old African American male presented to the DRMC ER with an open fracture to his ankle, a Code Alpha activation.

153. The on call trauma surgeon was paged and responded by phone but did not present. No orthopedics surgeon was consulted.

154. DRMC and its staff were capable of performing orthopedic services.

155. The unstable patient was inappropriately transferred to UMMC.

CASE 28
Patient No. MXXX349

156. On August 14, 2015 at 9:30 a.m., a 24 year old African American male presented to the DRMC ER with a crush injury with partial amputation, a Code Alpha activation.

157. The on call trauma surgeon was paged and responded by phone but did not present. No consult with orthopedic services was conducted.

158. DRMC and its staff were capable of performing orthopedic services.

159. The unstable patient was inappropriately transferred to UMMC.

CASE 29
Patient No. MXX161

160. On August 2, 2015 at 4:58 p.m., a 47 year old female presented to the DRMC ER with an acetubular fracture from being an unrestrained passenger in a motor vehicle crash, a Code Alpha activation.

161. The on call trauma surgeon was paged and responded by phone but did not present.

162. The unstable patient was inappropriately transferred to UMMC.

CASE 30
Patient No. MXXX906

163. On August 2, 2015 at 12:18 p.m., a 2 year old African American male presented to the DRMC ER after suffering a fall that resulted in a skull fracture, subdural hemorrhage, and an altered level of consciousness. multiple fractures, a Code Alpha activation.

164. The on call trauma surgeon was paged and responded by phone but refused to present.

165. The child, in critical condition, was inappropriately transferred to UMMC.

CASE 31
Patient No. MXXX845

166. On May 5, 2016 at 9:11 p.m., a 72 year old male presented to the DRMC ER after hitting a tree in a motor vehicle accident. His injuries included respiratory failure following the trauma, bilateral pulmonary contusions, bilateral rib fractures, and multiple fractures to the face and eye sockets. Prior to arrival, a Code Bravo was activated, but this was upgraded to a Code Alpha activation at 9:14, three minutes after the patient presented.

167. The on call trauma surgeon was paged and responded by phone but did not present.

168. The patient, in critical condition, was inappropriately transferred to UMMC.

CASE 32
Patient No. MXXX380

169. On May 3, 2016 at 3:21 p.m., a 6 year female presented to the DRMC ER after being hit by a car. Her injuries included a pulmonary contusion, a fracture to her right leg, and a large hepatic laceration – a condition indicating emergency operation. A Code Alpha was activated just prior to the child's arrival at the DRMC ER.

170. The on call trauma surgeon was paged and responded by phone but did not present.

171. Despite the indication for emergency surgery, a transfer order was entered for the child.

172. The unstable patient was inappropriately transferred to UMMC.

CASE 33
Patient No. MXXX722

173. On May 2, 2015 at 10:01 p.m., a 37 year old female presented to the DRMC ER after being a rear seat passenger in a motor vehicle that hit a tree. Her injuries included lacerations to and

a hematoma on her right kidney, a pulmonary contusion, a liver contusion, a collapsed lung, a fractured vertebrae, multiple broken ribs, and unstable blood pressure. The patient suffered respiratory failure following the trauma and was later intubated. Although these injuries met the criteria for a Code Alpha activation, only a Code Bravo was activated.

174. The on call trauma surgeon was paged and responded by phone but did not present.

175. The unstable patient was inappropriately transferred to UMMC.

CASE 34
Patient No. MXXX823

176. On May 1, 2015 at 11:47 p.m., a 21 year old male presented to the DRMC ER after a rollover motor vehicle crash in a topless Jeep. The patient suffered from loss of consciousness and multiple open jaw fractures. Initially he was activated as a Code Bravo, but eight minutes after his arrival, the patient's condition was upgraded to a Code Alpha.

177. The on call trauma surgeon was paged and responded by phone but did not present.

178. The unstable patient was inappropriately transferred to UMMC.

CASE 35
Patient No. MXXX504

179. On April 11, 2015 at 9:24 p.m., a 40 year old male presented to the DRMC ER with a multiple gunshot wounds and suffering from hemorrhagic shock. A Code Alpha was activated by EMS.

180. The on call trauma surgeon was paged at 9:45 p.m. and responded by phone at 9:47 p.m. but did not present.

181. The patient bled to death and died at 9:51 p.m.

CASE 36
Patient No. MXXX093

182. On June 22, 2014 at 5:01 p.m., a 71 year old male presented to the DRMC ER with a laceration to his forearm after being thrown from a car during an accident (criteria for a Code Alpha activation). A Code Bravo was activated upon arrival.

183. The on call trauma surgeon was paged and responded by phone but did not present, stating (without examining the patient) that the laceration was "too big" and recommending transfer.

184. The on call orthopedic surgeon was called but also refused to see the patient, recommending transfer without an examination.

185. The unstable patient was inappropriately transferred to UMMC.

CASE 37
Patient No. MXXX037

186. On June 4, 2014 at 11:03 p.m., a 22 year old male presented to the DRMC ER with a gunshot wound to his left arm. His left arm was pulseless and broken, and the brachial artery was occluded. A Code Alpha was activated upon arrival.

187. The on call trauma surgeon was paged and responded by phone but did not present.

188. DRMC and its staff were capable of performing the necessary trauma and orthopedic services.

189. The unstable patient was inappropriately transferred to UMMC.

CASE 38
Patient No. MXXX759

190. On May 24, 2014 at 3:27 a.m., a 29 year old female presented to the DRMC ER as a result of being an unrestrained passenger in a motor vehicle crash. Her injuries included a

lacerated liver, a pelvic fracture, injury to the abdominal aorta, and an initial heart rate of 150 beats per minute. These injuries met the criteria for a Code Alpha, but the patient was only classified as a Code Bravo.

191. Due to this failure, no trauma surgeon was called or otherwise notified.

192. The unstable patient was inappropriately transferred to UMMC.

CASE 39
Patient No. MXXX351

193. On July 5, 2014 at 2:25 a.m., a 20 year old male presented to the DRMC ER with a gunshot wound to the head. A Code Alpha was activated.

194. The on call trauma surgeon was paged and responded by phone but did not present.

195. At 4:26 a.m., two hours after arrival, the patient was transferred.

196. The unstable patient was inappropriately transferred to UMMC.

CASE 40
Patient No. MXXX757

197. On May 24, 2014 at 3:10 a.m., a 26 year old female presented to the DRMC ER after suffering blunt trauma from a motor vehicle crash. Her injuries included closed fractures to her leg and ribs, with an initial heart rate of 129 beats per minute and a respiratory rate of 40 breaths per minute. A Code Bravo was activated upon arrival.

198. No trauma surgeon was called or otherwise consulted.

199. DRMC and its staff were fully capable of treating all of the patient's injuries, yet the patient was transferred to UMMC almost four hours later, at 6:55 p.m.

200. The unstable patient was inappropriately transferred to UMMC.

CASE 41
Patient No. MXXX707

201. On April 19, 2016 at 10:33 p.m., a 63 year old male presented to the DRMC ER after suffering an assault to his chest and abdomen with an altered level of consciousness (criteria calling for a Code Alpha activation). The patient's injuries included a subarachnoid hemorrhage and alcohol poising.

202. A Code Bravo was inappropriately activated and no trauma surgeon was called or otherwise notified.

203. The unstable patient was inappropriately transferred to UMMC.

CASE 42
Patient No. MXXX014

204. On April 17, 2014 at 12:04 a.m., a 36 year old male presented to the DRMC ER after suffering a stab wound to his right thigh. The patient's injuries included a laceration to the right superficial femoral artery with an active arterial hemorrhage. A Code Alpha was activated upon arrival.

205. The on call trauma surgeon was paged and responded by phone but did not present.

206. A transfer order was entered, although DRMC and its staff were fully capable of treating the patient's injuries.

207. The unstable patient was inappropriately transferred to UMMC.

CASE 43
Patient No. MXXX997

208. On March 6, 2014 at 1:01 a.m., a 44 year old female presented to the DRMC ER after suffering a single vehicle accident with a tree and a car fire. The patient's injuries included fractures

to the femur, foot, and toes, and a 4 percent body surface area third degree burn to the leg. A Code Alpha was activated by EMS in the field.

209. The on call trauma surgeon was paged and responded by phone but did not present, ordering transfer (without examination of the patient) based on an alleged inability to treat the patient's burns. Notably, the JMS Burn Center at Central Mississippi Medical Center stated that the patient's burns did not warrant transfer. Further, DRMC is the former Mississippi Burn Center.

210. A transfer order was entered, although DRMC and its staff were fully capable of treating the patient's injuries, or, at a minimum, stabilizing the patient prior to transfer.

211. The unstable patient was inappropriately transferred to UMMC.

CASE 44
Patient No. MXXX657

212. On March 3, 2014 at 11:15 a.m., a 50 year old male presented to the DRMC ER after suffering a single vehicle rollover accident involving a tree. The patient, whose injuries included fractures to the cervical vertebrae and knee, along with a full thickness laceration of the eyelid, featured an altered level of consciousness (so therefore the criteria for Code Alpha were met). However, only a Code Bravo was activated.

213. The on call trauma surgeon was paged and responded by phone but did not present.

214. The unstable patient was inappropriately transferred to UMMC.

CASE 45
Patient No. MXXX977

215. On March 27, 2014 at 11:41 a.m., a 42 year old male presented to the DRMC ER after being hit by a car. A Code Alpha was activated at 11:43 a.m. The patient's injuries included fractures to his forehead, sacrum, and coccyx, dislocation of the sacroiliac joint, a pelvic hemorrhage,

and seizures.

216. The on call trauma surgeon was paged at 11:45 a.m. and responded at 11:48 a.m. However, the trauma surgeon did not arrive until 1:00 p.m. – a delayed arrival/response time of one hour and twelve minutes. The patient was transferred two minutes after the surgeon's arrival, at 1:02 p.m.

217. The delays in the presentation by the trauma surgeon and the patient treatment were unnecessary and inappropriate.

218. The unstable patient was inappropriately transferred to UMMC.

CASE 46
Patient No. MXXX048

219. On March 14, 2014 at 8:52 p.m., a 20 year old male presented to the DRMC ER with a gunshot wound to the head. A Code Alpha was activated by EMS prior to arrival.

220. The on call trauma surgeon was paged and responded by phone but did not present.

221. The unstable patient was inappropriately transferred to UMMC.

CASE 47
Patient No. MXXX306

222. On January 16, 2015 at 7:13 p.m., a 16 year old male presented to the DRMC ER with a gunshot wound to the right thigh. A Code Alpha was appropriate for this type of injury and activated.

223. The on call trauma surgeon was paged and responded by phone but did not present. At 8:10, the patient was downgraded to Code Bravo.

224. The unstable patient was inappropriately transferred to UMMC.

CASE 48
Patient No. MXXX463

225. A 29 year old female presented to the DRMC ER with a tibial plateau fracture. A Code Bravo was activated.

226. Neither the orthopedic nor trauma surgeons were consulted.

227. DRMC and its staff were capable of treating the patient's injuries.

228. The patient was inappropriately transferred to Memphis.

CASE 49
Patient No. MXXX328

229. On February 8, 2015 at 3:55 p.m., a 19 year old male presented to the DRMC ER after being thrown from a motorcycle during a collision (meeting the criteria for Code Alpha).

230. The patient's injuries included an open ankle fracture. A Code Alpha was activated upon arrival.

231. The on call trauma surgeon was paged and responded by phone but did not present. The patient's condition was downgraded to Code Bravo. A transfer order was entered with the stated reason of "orthopedics." The on call orthopedic surgeon was not consulted.

232. DRMC and its staff were capable of treating the patient's injuries.

233. The unstable patient was inappropriately transferred to UMMC.

CASE 50
Patient No. MXXX247

234. On January 6, 2015 at 6:20 p.m., a 64 year old male presented to the DRMC ER after being hit by a car. The patient's injuries included two open compound fractures to the right leg, and a tourniquet was applied to the right foot. A Code Alpha was activated at 6:22 p.m.

235. The on call trauma surgeon was paged and responded by phone at 6:34 p.m. but did not present until 7:30 p.m. (56 minutes later).

236. The unstable patient was inappropriately transferred to Memphis.

CASE 51
Patient No. MXXX864

237. On July 28, 2014 at 11:28 p.m., a 20 year old male presented to the DRMC ER with a gunshot wound to left shoulder and a hemothorax. A bullet was lodged in the patient's spinal canal and he had bilateral paraplegia in his lower extremities. EMS had inserted a chest tube in the field. A Code Alpha was activated.

238. The on call trauma surgeon was paged and responded by phone but did not present.

239. The unstable patient was inappropriately transferred to UMMC.

CASE 52
Patient No. MXXX919

240. On February 8, 2014 at 6:10 a.m., a 35 year old male presented to the DRMC ER with a gunshot wound to right hip/thigh. A Code Alpha was activated by EMS prior to arrival.

241. The on call trauma and orthopedic surgeons were paged and responded by phone but did not present. However, the patient was not transferred to another provider until 10:25 a.m. (over four hours from the time of the patient's arrival).

242. DRMC and its staff were capable of treating the patient's injuries.

243. The unstable patient was inappropriately transferred to UMMC.

CAUSES OF ACTION

COUNT ONE
Express False Certification
31 U.S.C. § 3729(a)(1)(A), (B)

244. Relator Sibley incorporates by reference all allegations in this Second Amended Complaint.

245. Through the acts described above, DRMC, through its agents, employees, and staff knowingly presented and/or caused to be presented to the United States Government false and fraudulent claims to obtain reimbursement for health care services provided under the subject health care reimbursement programs.

246. DRMC, through its agents, employees, and staff knew or should have known that actual compliance with EMTALA, certification of compliance with EMTALA, and reporting suspected EMTALA violations were material to the Government's payment position and would influence the Government's decision to allow reimbursement for health care services provided under the subject health care programs.

247. Through the acts described above, DRMC through its agents, employees, and staff knowingly made, used, and/or caused to be made or used, false records or statements material to a false or fraudulent claim and/or material to the payment of money or property from the United States Government to DRMC. These records include, but are not limited to, false statements by DRMC transferring physicians or qualified medical persons "CERTIFYING" that the treatment of emergency department patients transferred to a Level I facility was not within the capacity and capabilities of DRMC staff and/or was otherwise in compliance with EMTALA.

248. As a direct result of DRMC's express false certifications, the United States

Government was unaware of the falsity of the records, statements and claims made or submitted by DRMC, and therefore, such claims were paid and continue to be paid.

249. As a direct and proximate result of Defendants DRMC's false claims and omissions, the United States Government has been damaged in an amount to be proven at trial, equal to annual funds which would not have been paid from the subject health care reimbursement programs.

250. As a direct and proximate result of the acts and/or omissions of DRMC, DRMC is liable for treble damages, forfeitures, and other damages under the False Claims Act and other laws to be proven at trial.

COUNT TWO
Reverse False Claim
31 U.S.C. § 3729(a)(1)(G)

251. Relator Sibley incorporates by reference all allegations in this Second Amended Complaint.

252. Through the acts described above, Defendant DRMC and its agents and employees have knowingly concealed and/or failed to disclose to the United States Government material facts that would have resulted in substantial repayment of fines and penalties, including, but not limited to the following

a) Fines and civil penalties for each bill and/or request for payment fraudulently submitted under the False Claims Act. 28 C.F.R. § 85.3(a)(9).

b) Fines and civil penalties for each violation of EMTALA. 42 U.S.C. § 1395dd(d)(1)(A).

c) Additional fines, penalties, program fees, etc., owed will be proven at trial.

253. As a direct and proximate result of the acts and omissions by DRMC, DRMC has avoided payment of civil fines and penalties, and have been paid program fees for which DRMC

were not entitled. Therefore, the United States Government has not recovered funds that otherwise would have been recovered, and/or paid program fees that would not otherwise have been paid.

254. As a direct and proximate result of DRMC's false claims and omissions, the United States Government and/or the State of Mississippi have been damaged in an amount to be proven at trial, equal to fines and penalties owed and program fees wrongfully paid from the subject health care reimbursement programs.

255. As a direct and proximate result of the acts and/or omissions of DRMC, DRMC is liable for treble damages, forfeitures, and other damages under the False Claims Act and other laws to be proven at trial.

COUNT THREE
31 U.S.C. § 3729(a)(1)(A), and (B)
Implied False Certification

256. Relator Sibley incorporates by reference all allegations of this Second Amended Complaint.

257. Each time that DRMC transferred a patient in violation of EMTALA, one of its "qualified medical person[s]" certified that the transfer conditions of EMTALA had been met. 42 C.F.R. § 489.24(e)(1)(ii)(B), and (C). Specifically, for each submission, DRMC staff impliedly and falsely certified compliance with EMTALA, 42 U.S.C. § 1395cc(a)(1)(I)(i), requiring hospitals with emergency departments such as DRMC to provide a medical screening to anyone who enters an emergency room and requests an examination for a medical condition, without regard to the patient's ability to pay. 42 U.S.C. 1395dd(a), and (h); and, 42 C.F.R. § 489.24(d)(4)(i). Such certifications were not only false, but also amounted to specific representations that the medical services provided to each patient wrongfully transferred were in compliance with the capacity and staff capabilities of

DRMC, including the patient stabilization and transfer provisions of EMTALA. 42 U.S.C. 1395dd(b)(1), and (c).

258. In order for DRMC to be eligible for payments under the Medicare and Medicaid programs, DRMC had to file with HHS an agreement "to adopt and enforce a policy to ensure compliance with the requirements" of EMTALA. 42 U.S.C. § 1395cc(a)(1)(I)(i). DRMC knew that actual compliance with EMTALA, certification of compliance with EMTALA, and reporting suspected EMTALA violations were material to the Government's payment position, so much so that CMS had the authority to terminate Jackson HMA's provider agreement. 42 C.F.R. § 489.24(g); 42 C.F.R. § 489.53(b)(1) (A); and, 42 C.F.R. § 489.53(b)(2). DRMC, through its agents, employees, and staff at DRMC, knew or had reason to know that the above implied certifications of compliance with EMTALA would influence the Government's decision to allow reimbursement for health care services provided under the subject health care programs.

259. In addition to the above, DRMC falsely certified compliance with the requirements of the State of Mississippi Trauma Systems Fund, specifically DRMC's adherence to the requirements of a trauma center commensurate with DRMC's capabilities.

260. Through the acts described above, DRMC, through its agents, employees, and staff at DRMC, knowingly made, used, and/or caused to be made or used, false records or statements material to a false or fraudulent claim and/or material to the payment of money or property from the United States Government to DRMC.

261. Due to DRMC's implied false certifications of compliance with EMTALA, the United States Government was unaware of the falsity of the records, statements and claims made or submitted by DRMC, therefore, such claims were paid.

262. As a direct and proximate result of DRMC's false claims and omissions, the United States Government has been damaged in an amount to be proven at trial, equal to ALL funds/program payments which would not have been paid from the subject health care programs.

263. As a direct and proximate result of DRMC's false claims and omissions, the United States Government is entitled to recover ALL fines and penalties permitted by law in an amount to be proven at trial.

264. As a direct and proximate result of the false certifications of DRMC, DRMC is liable for treble damages, forfeitures, and other damages under the False Claims Act and other laws to be proven at trial.

COUNT FOUR
Worthless Services

265. Relator Sibley incorporates by reference all allegations of this Second Amended Complaint.

266. DRMC intentionally and knowingly provided sub-standard and deficient services to the United States Government, upon information and belief, by providing and charging for inadequate medical screening through its emergency department for tests and procedures that had to be repeated after patients were inappropriately transferred to UMMC.

267. As a direct and proximate result of the worthless services provided by DRMC, Defendant is liable for treble damages, forfeitures, and other damages under the False Claims Act and other laws to be proven at trial.

COUNT FIVE
Fraudulent Billing by DRMC and Dr. Robert Cockern, a Prohibited Provider

268. Relator Sibley incorporates by reference all allegations of her Second Amended Complaint.

269. Cockern, in the scope and course of his employment agency with DRMC, has knowingly submitted, or caused to be submitted, fraudulent charges to the Medicaid program.

270. As a direct and proximate result of DRMC's false claims and omissions, the United States Government has been damaged in an amount to be proven at trial.

271. As a direct and proximate result of the acts and/or omissions of DRMC, DRMC is liable for treble damages, forfeitures, and other damages under the False Claims Act and other laws, to be proven at trial.

WHEREFORE, PREMISES CONSIDERED, Relator Candi Sibley respectfully requests that this Court enter final judgment against Delta Regional Medical Center, as follows:

A. Entry of a judgment in favor of the United States of America against Defendant DRMC for three times the amount of damages the United States has sustained as a result of the actions of Defendants, as well as a civil penalty for each violation of 31 U.S.C. § 3729;

B. Entry of a judgment awarding Relator Sibley the maximum amount allowed pursuant to 31 U.S.C. § 3730(d) of the False Claims Act;

C. Entry of a judgment in favor of Relator Sibley for all costs, expenses, pre-judgment interest, post-judgment interest, attorneys' fees, and all such additional damages to which Relator would be entitled by law; and

D. Entry of a judgment in favor of the United States of America for all such damages and other/further relief as the Court deems appropriate.

DATED this the 22nd day May, 2018.

Respectfully submitted,

CANDI SIBLEY RN, BSN, by:

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/s/ LANCE L. STEVENS
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